

Chapter 11

ERISA

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11.1 SUPREME COURT

11.1.1 *Great-West Life & Annuity Ins. Co. v. Knudson*

On January 8, 2002 the Supreme Court issued a 5-4 decision that ERISA § 502(a)(3) does not provide a cause of action for a medical plan to enforce the plan's reimbursement requirement when a participant who had received benefits also recovered from a third party in settlement of a lawsuit. *Great-West Life & Annuity Ins. Co. v. Knudson*, 122 S. Ct. 708 (2002). The Court held that the remedy sought by the plan was legal in nature, and thus not available under ERISA § 502(a)(3), which authorizes only appropriate "equitable relief".

The respondent, Janette Knudson, was seriously injured in a car accident. At the time of the accident, Knudson was covered under her then-husband's health plan. The plan paid \$411,157.11 of her medical expenses, all but \$75,000 of which was paid by Great-West pursuant to a stop-loss insurance agreement with the plan. The plan included a reimbursement provision that provided the plan with "the right to recover from the [beneficiary] any payment for benefits' paid by the plan that the beneficiary [recovered] from a third party." If the beneficiary recovered from a third party and failed to reimburse the plan, he would be personally liable to the plan. The plan assigned to Great West its rights to make, litigate, negotiate, settle, compromise, release or waive its claims under this reimbursement provision.

In 1993, Knudson filed a tort action against the manufacturer of the car she was riding in at the time of the accident. Pursuant to a settlement agreement, the car manufacturer paid the Knudsons \$650,000, which was allocated by the settlement agreement as follows: \$256,745.30 to a "Special Needs Trust" to provide for Knudson's medical care; \$373,426 to the Knudsons' attorneys for fees and costs; \$5,000 to reimburse the California Medicaid program; and \$13,828.70 to reimburse Great-West. Not surprisingly, Great-West rejected this amount and filed an action in federal court.

Great-West filed an action for injunctive and declaratory relief under ERISA § 502(a)(3) to enforce the reimbursement provision of the plan. Specifically, Great-West sought to require the Knudsons to pay the plan the entire \$411,157.11 that Great-West previously paid in benefits. The district court granted summary judgment to Knudson, holding that the language of the plan limited its right of reimbursement to the amount allocated by the parties for past medical treatment, equal to \$13,828.70. The Ninth Circuit affirmed, but for a different reason, holding that reimbursement is not an equitable remedy, and is therefore not authorized by ERISA § 502(a)(3).

ERISA § 502(a)(3) authorizes a civil action "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of the plan." The Court began its opinion by noting that under its holding in *Mertens v. Hewitt Associates*, 113 S. Ct. 2063 (1993), the "equitable relief" available under ERISA § 502(a)(3) refers to those categories of relief that were typically available in equity. In this case, the Court held that Great-West was seeking, in essence, to impose a contractual liability for failure to comply with the plan's reimbursement obligation, and that such remedy is a classic form of *legal* relief not typically available in equity.

Great-West argued that it was seeking to enjoin an act or practice, *i.e.*, the Knudson's failure to reimburse the plan, which is a remedy available under Section 502(a)(3). The Court, however, rejected this argument, holding that Great-West in effect sought specific performance of a contract to pay money. According to the Court, an injunction to compel the payment of money past due under a contract, or specific performance of a past due monetary obligation, was not typically available in equity. The Court also rejected Great-West's argument that it was merely seeking restitution, which Great-West characterized as a form of equitable relief. The Court held that where the nature of the case is essentially legal rather than equitable, restitution is also a legal remedy.

The Court also rejected an argument, raised by the U.S. as *amicus*, that the common law of trusts provides equitable remedies for Great-West. Referring to its *Mertens* decision again, the Court stated that ERISA § 502(a)(3) does not incorporate all the special equity court powers applicable to trusts, but only those categories of relief that were typically available in equity. In addition, according to the Court, the common law right of a trustee to charge a beneficiary's interest in the trust with a debt owed to the trust did not give the trustee a separate equitable cause of action for payment from the beneficiary's other assets.

Finally, although the Court acknowledged that its decision in *Varity Corp. v. Howe*, 166 S. Ct. 1065 (1996) described ERISA § 502(a)(3) as a "catchall" provision, the Court clarified in a footnote that the remedy sought must still be "appropriate equitable relief":

In *Varity Corp.*, however, it was undisputed that respondents were seeking *equitable* relief, and the question was whether such relief was "appropriate" in light of the apparent lack of alternative remedies. *Varity Corp.* did not hold, as petitioners urge us to conclude today, that § 502(a)(3) is a catchall provision that authorizes *all* relief that is consistent with ERISA's purposes and is not explicitly provided elsewhere. To accept petitioners' argument is to ignore the plain language of the statute, which provides fiduciaries with only equitable relief. (footnote 5) (emphasis in original).

Great-West had argued that if it could not enforce the reimbursement provision under ERISA, it would be left without a remedy to enforce the terms of the plan. The Court stated that its decision with respect to the scope of ERISA § 502(a)(3) does not necessarily leave the plan without a remedy:

We note, though it is not necessary to our decision, that there may have been other means for petitioners to obtain the essentially legal relief that they seek. We express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA. Nor do we decide whether petitioners could have obtained equitable relief against respondents' attorney and the trustee of the Special Needs Trust, since petitioners did not appeal the District Court's denial of their motion to amend their complaint to add these individuals as codefendants.

11.1.2 ***Egelhoff v. Egelhoff***

In *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001), the Supreme Court held that ERISA preempted a Washington state statute that provided that the designation of a spouse as beneficiary of a nonprobate asset is automatically revoked upon divorce. The court concluded that the statute had a “connection with” ERISA and was therefore preempted, noting that differing state requirements affecting a plan’s system for processing of claims and paying benefits imposed precisely the burden that ERISA preemption was intended to avoid, in conflict with ERISA’s requirements that plans be administered and benefits be paid in accordance with plan documents. The dissenting opinion filed by Justice Breyer and joined by Justice Stevens described the potential burden on plan administrators as “a one-time requirement that would fall primarily upon the few who draft model ERISA documents, not upon the many who administer them.”

While David Egelhoff was married he was employed by Boeing Company, which provided him with a life insurance policy and a pension plan. Mr. Egelhoff designated his wife as the beneficiary of both the insurance policy and pension plan, which were governed by ERISA. In 1994, the Egelhoffs divorced and two months later, Mr. Egelhoff died intestate following an automobile accident. The former Ms. Egelhoff was still listed as the beneficiary under the insurance policy and pension plan at the time of his death. Mr. Egelhoff’s children by a previous marriage sued the former Ms. Egelhoff under a state statute that provided that the designation of a spouse as the beneficiary of a nonprobate asset, including a life insurance policy or benefit plan, is revoked automatically upon divorce. The plaintiffs claimed that the proceeds should pass directly to them since there was no qualified named beneficiary.

The district court concluded that ERISA preempted the state statute as it pertained to the insurance policy and pension plan, both of which the court determined to be governed by ERISA. On appeal, both the court of appeals and state supreme court disagreed, finding that the statute did not refer to or have connection with an ERISA plan, but the United Supreme Court upheld the district court’s conclusion, holding that ERISA preempted the state statute.

11.2 Disclosure Obligations

11.2.1 *Lettrich v. J. C. Penney Company, Inc.*

In *Lettrich v. J. C. Penney Co., Inc.*, 213 F.3d 765 (3d Cir. 2000), the Third Circuit held that an employer may have “actively concealed” a summary of material modifications (SMM) relating to the termination of a severance program by placing the notice of termination in its annual proxy statement, even though all participants in the plan were shareholders of the company and therefore received the notice. Under the Third Circuit’s previous cases, a failure to comply with ERISA’s disclosure obligations with respect to a plan modification ordinarily does not give rise to any substantive remedy for plan participants. However, a remedy may be available under “extraordinary circumstances” (including the possibility of voiding a plan amendment). Extraordinary circumstances include situations where the employer has acted in bad faith, or has actively concealed a change in the benefit plan, and the covered employees have been substantively harmed by virtue of the employer’s actions.

In the 1980s, Lettrich’s employer adopted a separation pay program for certain management employees, providing a lump-sum severance payment if an eligible employee was terminated within two years of a change in control of the company. The company chose to

terminate the program five years later. The company notified participants of this change by describing the program's termination in its 1993 annual proxy statement.

Several years after the date of the program's termination, Lettrich resigned from the employer. At the time of his resignation, he requested severance pay pursuant to the separation pay program. The employer denied his request on the ground that it had terminated the program in 1993 (although it is not at all clear whether Lettrich would have qualified for benefits even if the program had not been terminated). Lettrich filed suit under Section 502(a)(1)(B) of ERISA, contending that the employer failed to comply with ERISA's notice and disclosure requirements (in this case, the requirement under ERISA § 102(a) that the employer provide an SMM with respect to the program's termination). In order to attempt to come within the existing Third Circuit precedent, Lettrich also claimed that the employer "actively concealed" the program's termination by placing the notification in the proxy statement and by failing to use effective and customary internal procedures for notification of benefit changes.

The district court granted the employer's motion for summary judgment. The court concluded that Lettrich did not receive the notification required by ERISA and regulations, but "defects in notice do not entitle an employee to receive the benefits unless the employee can show extraordinary circumstances such as bad faith by his employer or active concealment of a change in the benefits plan." Because the judge concluded that Lettrich had failed to provide evidence of extraordinary circumstances, the district court granted J. C. Penney's motion for summary judgment.

The Third Circuit reversed, stating that the district court applied too narrow an interpretation of the circumstances in which an employer may be found to have "actively concealed" a plan amendment. In this case, although each plan participant received a copy of the notice, the Third Circuit held that placement of the notice in the middle of a proxy statement, combined with failure to use other customary employee communication procedures, could support a factfinder's inference that the company intended to conceal the program's termination. The Third Circuit noted that its decision was not creating an inference of bad faith or an active concealment simply from a failure to comply with ERISA's reporting and disclosure requirements. However, the court determined that the case should not have been dismissed on summary judgment.

11.2.2 Daniels v. Thomas & Betts Corp.

In *Daniels v. Thomas & Betts Corp.*, 263 F.3d 66 (3d Cir. 2001), the Third Circuit held that the \$100 per day penalty for failure to provide documents required by ERISA § 104(b)(4) can be awarded to someone who is neither a participant nor beneficiary, provided the person had a "colorable claim" to benefits at the time the request for documents was made. The court also reaffirmed its holdings that a plan administrator can be found liable for misrepresentations to plan participants if detrimental reliance can be established.

Charles Daniels worked for Thomas & Betts Corporation from 1955 until his death in 1993. Prior to 1993, the company provided life insurance for Mr. Daniels equal to one times his annual salary. Mr. Daniels elected supplement insurance by purchasing group life insurance equal to 1.5 times his annual salary. Effective January 1992, the company changed carriers and the structure of the life insurance benefits. It continued to provide life insurance equal to one times an employee's annual salary and to allow the purchase of supplemental life insurance, but under the new program supplement life insurance could only be purchased in whole multiples of salary. In late 1992, the company sent documentation to Mr. Daniels regarding the changes in

life insurance benefits, which included a statement that “[i]f you currently have supplemental coverage, you will be grandfathered up to your current amount.” Although what the company intended to grandfather was only the right to receive coverage without evidence of insurability, Mr. Daniels thought he continued to have supplemental coverage for 1.5 times salary.

Mr. Daniels executed a “Group Insurance Enrollment/Change Form,” which provided an option for supplemental life insurance. On the form, Mr. Daniels checked the box “None” for the amount of supplemental insurance, but later expressed to his wife that he continued his supplemental life insurance. He told her that she would receive 2.5 times his salary in life insurance benefits. Following Mr. Daniels’ death in 1993, his wife received \$53,000, equal to one times Mr. Daniel’s annual salary. The company informed her that Mr. Daniels did not have supplemental insurance.

Ms. Daniels obtained counsel who wrote to the company and requested all benefit plan documents and plan summaries, which the company finally delivered 291 days later. Ms. Daniels sued the corporation for breach of fiduciary duty, delay in providing ERISA plan documents, and attorney’s fees. The district court granted her motion for summary judgment as to liability on the breach of fiduciary duty and her claim for failure to provide plan documents, awarding her a total of \$104,127.28 including attorney’s fees. The court made no finding as to whether Mr. Daniels actually relied on the misrepresentation. With regard to the company’s delay in producing documents, the district court concluded that the company violated Section 104 of ERISA and imposed a penalty of \$100 per day for the 291 days that the company refused to respond.

On appeal, the Third Circuit reversed the district court’s grant of Ms. Daniels’ motion for summary judgment because the district court failed to address the reliance issue, which is an essential element of a misrepresentation claim. Specifically, to prove a claim for breach of fiduciary duty for material misrepresentation, a plaintiff must show the following: (1) the defendant is an ERISA fiduciary; (2) the defendant made a misrepresentation; (3) the misrepresentation was material; and (4) the plaintiff relied on the misrepresentation to his or her detriment. Finding that the statements in the company’s documents were intended to provide an opportunity for an employee to purchase supplemental life insurance in “addition” to existing coverage, the Third Circuit affirmed the district court’s finding of a material misrepresentation. However, the circuit court did not believe that the record mandated a finding of reliance, which remained an issue to be decided by the lower court.

The Third Circuit also agreed with the district court’s conclusion that the company violated its duty under ERISA to provide documents to any “participant or beneficiary” upon written request. Although Ms. Daniels was suing for an alleged breach of fiduciary duty, not for benefits under the plan, the court held that she could recover the penalty as a “beneficiary”. According to the court, beneficiary status should be decided at the time the documents are requested. At the time of her request, Ms. Daniels reasonably believed that she was entitled to a benefit and had a “colorable claim to additional insurance proceeds.” Therefore, the company was required to provide her with documents within 30 days of her request, and its failure to do so for nearly a year warranted the full penalty of \$100 per day, beginning 30 days after her request.

11.2.3 *Flanigan v. General Electric Co.*

In *Flanigan v. General Electric Co.*, 242 F.3d 78 (2d Cir. 2001), the Second Circuit addressed several fiduciary breach claims relating to GE’s sale of its aerospace division to Lockheed. The court found no breach either in connection with communications to affected employees regarding

their future benefits with the purchaser nor in transfer of pension plan assets to the purchaser. The court held that GE's decision to spin off the division and its plan was a settlor decision rather than a fiduciary decision and further held that no inurement in violation of § 403 of ERISA had occurred, noting that although GE might have received some benefit such as a higher sale price due to the transfer, the transferred assets were used only to fund pension benefits and any benefit GE derived from the transaction "was, at most, indirect."

In 1993, Martin Marietta Corporation (now Lockheed Martin) acquired GE's aerospace division, agreeing to hire all 37,000 GE aerospace employees and to give them benefits that were "substantially similar" to their GE benefits. To provide such benefits, a portion of GE's pension assets were to be transferred to Lockheed to fund the pension obligations Lockheed was to assume for those employees. In November 1992, GE and Lockheed distributed a letter to all employees, assuring them that they would receive "comprehensive information on [their] benefits, including the successor employer provisions of GE's plans and the terms for transition to [Lockheed's] generally comparable benefits package." Later that same year, the companies began distributing to employees "Teaming Updates," which included information about the post-closing benefits. On March 23, 1993, employees received another update detailing the post-closing benefits available through Lockheed for employees who transferred to Lockheed.

A group of employees unhappy with the deal filed suit against Lockheed and GE. The plaintiffs claimed that GE should have disclosed information about the Lockheed benefits more quickly. Because GE described the benefits as "substantially similar" to those provided by GE, the plaintiffs argued that they were pressured into retiring prior to the closing of the transaction. Second, a group of plaintiffs claimed that GE breached its fiduciary duty of prudence when it invested \$1 billion of the plan assets earmarked for transfer to the Lockheed plan in 90-day Treasury bills. Third, the plaintiffs claimed that the district court erred when it rejected claims challenging the ancillary benefit that GE derived from the transfer of plan assets to the Lockheed plan. Because of a surplus that went over to the Lockheed plan in the transfer, the plaintiffs asserted that GE received a higher sale price for its aerospace business and gained an advantage in dealing with government contract claims.

With regard to the plaintiffs' claim of inadequate communication, the Second Circuit concluded that GE fulfilled its communication obligations. Fiduciaries have an obligation to communicate information about future plans and will be held liable if a fiduciary knows that statements are false or lack a reasonable basis in fact. Fiduciaries may also be held liable for non-disclosure if omitted information is necessary to an employee's intelligent decision about retirement. However, in this case, the Second Circuit concluded GE's series of communications were sufficient. There was no evidence that GE withheld material information or purposely misled the plaintiffs in any way, which are the two requirements for a fiduciary breach in this situation. The courts stated that ERISA does not require fiduciaries to anticipate all future changes in employee benefits, to disclose internal deliberations, or to voluntarily disclose changes before they are adopted. GE's communications were provided prior to the time that any final employment or retirement decisions had to be made by GE employees and were, therefore, timely.

The Second Circuit also found in favor of GE with regard to the investment claim. Although the Court determined that the plaintiffs lacked standing with regard to this issue, it felt that GE's investment decision was nevertheless prudent. "In making investment decisions, plan trustees must conduct a 'careful and impartial investigation,' with 'an eye . . . to the interests of

the participants and beneficiaries.”” In this case, the facts showed that GE employed appropriate methods to investigate the T-Bill investment.

Finally, in connection with the unlawful inurement claim, the court held that GE was acting as a settlor rather than a fiduciary and that there was no unlawful inurement to GE. First, GE was acting as a settlor when it made the decision to spin off the division and the pension plan. Such a decision is a corporate decision, not a fiduciary one; therefore, ERISA’s fiduciary rules are inapplicable. Additionally, GE did not receive an unlawful benefit. All of the pension surplus that GE transferred to Lockheed was used to fund pension benefits; any benefit that GE received was purely incidental. Therefore, the plaintiffs’ claim for unlawful inurement was unjustified.

11.2.4 *Griggs v. E.I. DuPont de Nemours & Co.*

In *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371 (4th Cir. 2001), the Fourth Circuit found a breach of fiduciary duty where the employer provided misleading information regarding the taxation of lump-sum payments. As a result of Internal Revenue Code benefit limits (Code § 415), a portion of benefits paid were not eligible for rollover treatment, resulting in \$50,000 of income tax on the plaintiff’s distribution. The court held that DuPont had a duty to inform the participant that his lump sum rollover election would not be possible, and noted that if the description of the payment had included a more thorough explanation that only qualified portions of distributions could be rolled over, or that not every employee could roll over distributions, it may have viewed their duty in a different light. The plaintiff sought reinstatement to his pre-election position as the remedy for the breach under § 502(a)(3) of ERISA. The Court of Appeals remanded to the district court the issue of whether reinstatement would be “appropriate equitable relief” under the circumstances, holding that reinstatement is within the range of redress permitted by § 502(a)(3).

Upon his early retirement, Griggs elected to receive the benefits under the temporary system in a lump sum, believing that he could roll the benefits into a SIP without incurring immediate tax liability. On the application form for the benefits under the temporary system, Griggs selected the “rollover settlement” which indicated his desire to roll the lump sum benefit into the SIP. Griggs’ retirement became effective in September 1994, and in October he received a notice indicating that DuPont was processing his pension payments. DuPont, however, did not honor Griggs’ election to roll over his lump sum payment, even though it had said in the description of the temporary program that benefits could be rolled over. In fact, early calculations by DuPont suggested that the benefits could not be rolled over, but the company failed to communicate such information to Griggs. Because Griggs was not able to roll over the payment, he was forced to pay taxes equal to approximately \$50,000. He initially sued DuPont for negligent misrepresentation, but because ERISA preempted this state law claim, Griggs amended his complaint to include a claim for breach of fiduciary duty under Section 502(a)(3).

The Fourth Circuit concluded that DuPont did not have a duty to provide Griggs with an individualized notice of tax laws. However, once DuPont discovered that Griggs’ lump sum could not be rolled over, it had a duty to inform him of the development prior to making a fully taxable lump sum distribution.

11.3 TOP-HAT PLANS

11.3.1 *Garratt v. Knowles*

In *Garratt v. Knowles*, 245 F.3d 941 (7th Cir. 2001), the Seventh Circuit held that a supplemental retirement plan that makes up for the benefit limits imposed by Internal Revenue Code § 415 and also the compensation limit of Code § 401(a)(17) does not qualify as an “excess benefit plan” within the meaning of ERISA, and therefore is subject to ERISA (including ERISA’s preemption of state laws).

In 1998, Garratt’s employer, Knowles Electronics, adopted an unfunded SERP, which, according to its language, was established “solely for the purpose of providing benefits for certain salaried employees and those of its affiliates who participate in the Knowles Electronics Pension Plan *in excess of the limitations imposed by the Internal Revenue Code* on the benefits available under the Knowles Electronics, Inc. Pension Plan.” (emphasis added) The SERP was later amended to exclude a special bonus from the compensation that would be taken into account under the SERP, which negatively affected Garratt’s benefit.

After Garratt received a lump sum payment under the SERP, he sued the members of the Knowles family who received the difference between the benefits he would have received had the amendment not been adopted and the amount he received because of the amendment, the Board of Directors who approved the amendment, and the lawyer and firm that assisted in implementing the amendment. His lawsuit consisted of three state law claims: tortious interference with a prospective economic advantage, civil conspiracy, and unjust enrichment. After the case was removed to federal court, Garratt filed a motion to remand the matter to state court, arguing that the SERP was an unfunded excess benefit plan exempt from ERISA. The district court disagreed, concluding that the SERP was not an unfunded excess benefit plan and was subject to ERISA. According to the district court, Garratt’s complaint failed to properly state a cause upon which relief could be granted because “ERISA permits suits to recover benefits only against a Plan as an entity.” ERISA does not provide relief against Board members and attorneys; therefore, the court dismissed Garratt’s claim without prejudice to his right to bring an action against the proper entity. On appeal, Garratt asserted that the court erroneously determined that the SERP was not an excess benefit plan exempt from ERISA and, therefore, the district court lacked jurisdiction over his complaint. The defendants argued that the SERP was a top-hat plan and that suits to recover benefits owed under such a plan are governed by ERISA.

The Seventh Circuit affirmed the district court’s ruling, holding that the SERP was not an excess benefit plan and that ERISA therefore applied. ERISA defines an “excess benefit plan” as “a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by *section 415 of Title 26* on plans to which that section applies without regard to whether the plan is funded.” ERISA § 3(36) (emphasis added). Whether a plan is an excess benefit plan depends on the general purpose of the plan rather than on the specific way that the plan applies to a party. The sole purpose of an excess benefit plan must be to avoid the limitations of Section 415 of the Internal Revenue Code. A plan with a different purpose is not an excess benefit plan even if the plan has the effect of avoiding Section 415 limitations. The SERP at issue in this lawsuit stated that its purpose was to provide certain salaried employees with benefits “in excess of the limitations imposed by the Internal Revenue Code.” The SERP did not reference Section 415, but rather stated a broader purpose of avoiding any limitations on benefits imposed by the Internal Revenue Code.

Garratt argued that because the plain language of the plan did not specifically mention Section 415, it is possible to consider that the plan had the stated purpose of avoiding Section

415. Because the stated purpose of the plan does not rule out the possibility, he suggested that the court could examine how the plan operates to determine the true purpose. The Seventh Circuit, however, disagreed with Garratt. The plain language of the SERP clearly provided a broad purpose, which was to avoid *any* limitation under the Internal Revenue Code. For example, the language also had the effect of avoiding the annual limit under section 401(a)(17) of the Code. Although Garratt argued that Section 401(a)(17) had an insignificant, indirect effect on the benefits paid out, the Seventh Circuit viewed the 401(a)(17) limitations as significant. Because the purpose of the SERP was, as stated, to avoid *any* limitations, not just Section 415 limitations, the SERP did not qualify as an excess benefit plan. Instead, the SERP was a top-hat plan subject to ERISA, which allowed Garratt to recover benefits only against the plan as an entity. Therefore, the Seventh Circuit upheld the district court's dismissal of Garratt's complaint, leaving him with the option of bringing suit against the SERP.

11.3.2 ***Carrabba v. Randalls Food Markets Inc.***

In *Carrabba v. Randalls Food Mkts., Inc.*, 252 F.3d 721 (5th Cir. 2001) (*Carrabba II*), the Fifth Circuit affirmed a district court decision to invalidate a waiver or release of ERISA benefits under a failed top-hat plan. The district court also concluded in *Carrabba II* that ERISA remedies should be available to all participants in the plan, even those who could have been included in a valid top-hat plan.

In 1974, Cullum Companies, Inc. established a Management Security Plan ("MSP"), which provided death and retirement benefits to some of the employees of Cullum Companies, Inc. and its subsidiaries. The Company stated that it intended for the plan to be administered as an unfunded welfare benefit plan established and maintained for a select group of management or highly compensated employees (*i.e.*, a so-called "top-hat" plan). In *Carrabba v. Randalls Food Mkts.*, 468 F. Supp. 2d 468 (N.D. Tex. 1999) (*Carrabba I*), the district court concluded that the MSP did not cover only a "select group of management or highly compensated employees", and therefore did not qualify as a top-hat plan. (A valid top-hat plan is exempt from the vesting, participation, funding and fiduciary duty requirements of ERISA.)

For over 14 years, all salaried employees of Cullum Companies were eligible to participate in the plan. In 1974, participants had salaries ranging from \$11,180 to \$40,000 annually, with only one above \$30,000 and three above \$20,000. By 1983, all but two of the plan participants earned more than \$20,000 per year, with several salaries in excess of \$40,000. All levels of management were represented by the participants from 1974 through 1983. From 1984 to 1986, eligibility requirements were amended to provide that only an employee with an annual salary of at least \$25,000 could become a new participant. The goal of Cullum was to allow all key employees, including everyone in management, to participate in the plan. Eligibility requirements continued to tighten between 1987 and 1992, but, through the plan's existence, the company considered all enrollees to be members of management or highly compensated individuals.

The plan was eventually terminated in 1992, after Cullum was acquired by Randalls Food Markets. The plaintiffs claimed that Randalls, as successor employer sponsoring the plan, failed to provide benefits due and owing to them when the plan was terminated. They claimed that the plan was subject to the vesting, funding, trusteeship and reporting provisions of ERISA. The defendants argued unsuccessfully that the plan was a top-hat plan, exempt from the vesting, funding, trusteeship, reporting and disclosure requirements of ERISA and that the plaintiffs received all benefits to which they were entitled.

In *Carrabba I*, the district court concluded that the MSP was not a top-hat plan because the MSP participants were not a “select group out of the broader group of highly compensated employees”. In other words, for this court a plan covering all highly compensated employees could not qualify as a top-hat plan. Prior to *Carrabba I*, we are not aware of any other case that has even suggested that the “select group” concept needed to be applied within the group of highly compensated or management employees, as opposed to requiring that the group consist of only management or highly compensated employees that is a “select group” compared to the total employee population. In addition, the court also referred to Department of Labor Advisory Opinion 90-14A, which suggested that participants in a top-hat plan should “have the ability to affect or substantially influence, through negotiations or otherwise, the design and operation of their deferred compensation plan.” Finally, the court also concluded that the burden of proof with respect to the top-hat plan exemption belonged to the employer.

The district court in *Carrabba II* had to decide the nature and level of benefit owed to the plaintiffs. “In return for a severance payment based on years of service and accrued vacation time, some participants, when terminating employment with the defendant after the [plan] was terminated, signed a document releasing and discharging defendant ‘from all claims, liabilities, demands and causes of action, known or unknown, fixed or contingent, which [they might] have or claim to have against [defendant] as a result of [their] employment and this termination.’” The companies argued that the plaintiffs had waived or released their benefits and claims.

The district court acknowledged that waivers of pension benefits under ERISA may be valid, but “they are subject to closer scrutiny than a waiver of general contract claims. Courts scrutinize an ostensible waiver with care in order to ensure that it reflects the purposeful relinquishment of an employee’s rights.” The party attempting to enforce the waiver has the burden to show that the waiver was given knowingly and voluntarily, *i.e.*, the party “intentionally relinquished or abandoned a known right or privilege.” In this case, the district court concluded that the waiver was invalid because the party seeking to enforce the waiver had failed to meet its burden. “In particular, there [was] no evidence that any plaintiffs understood that they were releasing claims relating to the [plan]. . . . The indication from the evidence [was] that neither party to the waiver/release documents gave any thought to the [plan] or any claims arising under the [plan] when the documents were drawn, signed, and delivered. There [was] certainly no basis in the evidence for any finding that any signatory on such a release/waiver document intended by execution and delivery of the document to release defendant of any claim that [was] being asserted in this action.”

11.3.3 Goldstein v. Johnson & Johnson

In *Goldstein v. Johnson & Johnson*, 251 F.3d 433 (3d Cir. 2001), the Third Circuit ruled that the *Firestone Tire & Rubber Co. v. Bruch* standard of review for plan administrative decisions does not apply to matters relating to top-hat plans. However, if the top-hat plan document grants the plan administrator discretion to construe the terms of the plan, the deferential standard of review can still be applied as a matter of contract law.

During Goldstein’s employment with Johnson and Johnson, the company maintained a qualified pension plan, under which benefits were capped by Internal Revenue Code limitations. The company also maintained a top-hat plan, designed to pay benefits due to an employee under the pension formula that, due to the Internal Revenue Code limitations, could not be paid from the qualified pension plan. Both benefit plans were administered by a committee. The top-hat plan provided that the “decisions made by and the actions taken by committee in the

administration of [the top-hat plan] shall be final and conclusive for all persons.” The amended summary plan description no longer contained a sentence excluding forms of compensation not otherwise specified.

When Goldstein retired, a dispute arose regarding the determination of his compensation for purposes of the top-hat plan, and therefore the calculation of his benefit under the plan. After the committee reviewed and rejected Goldstein’s claims, he filed suit against Johnson and Johnson for additional benefits. Johnson and Johnson argued that the plan administrator’s interpretation of the plan should be given deference under the Supreme Court’s holding in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In *Firestone*, the Supreme Court held that a plan fiduciary’s decisions should receive deferential review from courts, but only if the plan’s terms grant discretionary authority to the fiduciary. Decisions by administrators who are not given discretionary authority to construe a plan should receive no deference, and therefore should be reviewed *de novo*.

The Third Circuit agreed that administrators of ordinary ERISA plans that are given broad discretion should be subject to the standards set forth in *Firestone*, but concluded that administrators of top-hat plans, which are not subject to ERISA’s fiduciary duty standards, are not governed by the *Firestone* holding. Because of the exemptions applicable to top-hat plans, which according to the Third Circuit are more akin to unilateral contracts than to the trust-like structure normally found in ERISA plans, the court held that application of the *Firestone* standard is inappropriate.

Although the *Firestone* standard does not apply, ordinary contract principles require that, where the terms of a plan grant discretion to a party, that discretion must be given effect if it is exercised in good faith. Any grant of discretion must be read as part of the unilateral contract; therefore, it must be given the same effect given to other contract terms. In this case, the Third Circuit concluded that the district court’s determination that Johnson and Johnson acted in good faith was reasonable. The terms of the plan granted broad discretion to the administrators. Nothing indicated that Johnson and Johnson acted in bad faith when interpreting the language and reviewing Goldstein’s claim for additional benefits. Therefore, based on ordinary contract principles rather than the holding in *Firestone*, the Third Circuit affirmed the district court’s judgment in favor of Johnson and Johnson.

11.4 Interference With Erisa Rights

11.4.1 *Eichorn v. AT&T Corp.*

In *Eichorn v. AT&T Corp.*, 248 F.3d 131 (3d Cir. 2001), the Third Circuit addressed the issue of whether work force decisions made in connection with a corporate transaction can violate ERISA § 510’s prohibition on interference with rights under ERISA plans. The court remanded the case after concluding that circumstantial evidence created a genuine issue of fact.

In July 1995, AT&T decided to sell one of its affiliates, Paradyne Corp. To ensure that Paradyne remained a viable entity and to make it more attractive to buyers, AT&T prohibited Paradyne employees who voluntarily left Paradyne from being hired by any other division of AT&T. Under AT&T’s pension plan, employees had the right to retain their accrued pension benefits if they left AT&T and returned within six months (“bridging rights”). Employees who

returned after six months, however, could not regain their previous pension benefits until they had been reemployed for five years.

Shortly after adopting this plan, AT&T underwent a reorganization resulting in the formation of three independent companies: AT&T, Lucent Technologies, which gained ownership of Paradyne, and NCR Corp. Paradyne employees who became employees of Lucent were precluded from seeking employment at any other AT&T division or affiliate. On July 31, 1996, Lucent sold Paradyne to Texas Pacific Group. As part of the sale, Lucent agreed that it would not hire, rehire, retain, or solicit the services of any Paradyne employee whose annual income exceeded \$50,000 for at least eight months after the sale. The eight month no-hire agreement that Lucent and Texas Pacific Group agreed to basically cancelled rights of affected employees to retain pension benefits if they returned to work within six months. Before the deal closed, Texas Pacific Group hired an outside consultant to determine the benefit package that it would offer Paradyne employees. Paradyne's Vice President of Human Resources assisted in drafting the benefit plan proposals.

In addition to a claim under the Sherman Act, former Paradyne employees filed a claim alleging that the no-hire agreement violated Section 510 of ERISA. Section 510 provides:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of [an] employee benefit plan . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

According to the Third Circuit's holding in a 2000 case, an employer violates Section 510 if it acts with the specific intent to interfere with an employee's right to benefits. *DiFederico v. Rolm Co.*, 201 F.3d 200, 204-05 (3d Cir. 2000). To establish a prima facie case, a plaintiff must show (1) that an employer took specific actions (2) for the purpose of interfering (3) with an employee's attainment of pension benefit rights. Once a plaintiff establishes a prima facie case, the burden shifts to the employer to present a legitimate non-discriminatory reason for its conduct. The burden then shifts back to the plaintiff to show that the employer's rationale was pre-textual and the cancellation of benefits was the "determinative influence" on the employer's actions.

Although the district court held that the plaintiffs' evidence in this case was insufficient, the Third Circuit concluded that the plaintiffs' circumstantial evidence was sufficient to create a genuine issue of material fact as to the employer's intent to interfere with the plaintiffs' benefit rights. The plaintiffs pointed out that the eight month restriction on re-employment was suspiciously close to the six month vesting period in the pension plan. Additionally, the role of Paradyne's Vice President of Human Resources in proposing Texas Pacific Group's ultimate pension package provided additional support for the plaintiffs' claims. Evidence also included a confidential memorandum between two Lucent Technologies' employees, which acknowledged that the eight month restriction had the practical effect of canceling the Paradyne employees' pension rights. Finally, plaintiffs brought to the court's attention the economic benefits that both Lucent and AT&T received from the no-hire requirement when the defendants were relieved of the responsibility to pay for the pension benefits. Because the court concluded that the plaintiffs had submitted sufficient prima facie evidence, it reversed the district court's grant of the defendant's motion for summary judgment and remanded the case for further proceedings.

11.5 What Is An Erisa Plan?

11.5.1 *Bowles v. Quantum Chemical Co.*

In *Bowles v. Quantum Chemical Co.*, 266 F.3d 622 (7th Cir. 2001), the Seventh Circuit addressed the issue of whether a severance plan was subject to ERISA. As is often the case, the employee argued that the arrangement was not an ERISA plan, since an ERISA plan is not subject to the state law tort claims or punitive damage awards of which plaintiffs are so fond.

Dr. Bowles was employed by Quantum in a senior-level management position. As a senior-level manager, Bowles was eligible for certain bonuses and benefits, including an annual incentive bonus under the senior manager performance plan. Additionally, Bowles was eligible to participate in the company's incentive award deferral plan, which allowed him to invest some or all of his bonuses in the company's general fund. The plan required the company to pay out any and all funds thirty days after a change in control.

While experiencing financial trouble in the early 1990s, Quantum revised its severance plan "to protect certain key managers from the effects of an actual or possible [c]hange in [c]ontrol." Severance benefits were available to employees who suffered a loss of employment within one year following a change in control. An employee would receive benefits if he resigned following a "diminution of [his] authority, duties, responsibilities or status" or if he resigned following an acquiring company's "failure to provide [him] with the opportunity to participate, on terms no less favorable than those existing immediately prior to the [c]hange in [c]ontrol, in any incentive bonus, savings, pension or other employee benefit plan of Quantum in effect immediately prior to the [c]hange in [c]ontrol." Additionally, an employee entitled to receive a severance benefit was entitled to an annual incentive bonus award, intended to ensure that an employee who earned a bonus prior to a change in control still received his bonus after the change. Finally, the severance plan provided that the company would pay all legal fees and expenses incurred by an eligible employee seeking to obtain or enforce any right or benefit under the plan.

On September 30, 1993, Hanson acquired Quantum. This "change in control" triggered Quantum's obligation to pay severance benefits to employees who lost their employment. Dr. Bowles claimed that he "lost employment" under the terms of the severance plan because Hanson's acquisition significantly diminished his authority, duties, responsibilities, and status. Consequently, Bowles informed Quantum that he was terminating his employment and was entitled to severance benefits. Quantum, however, concluded that Bowles' authority, duties, responsibilities, and status had not been diminished and he was not denied the opportunity to participate in the benefit program. Bowles then sued to enforce the terms of the severance plan.

The district court awarded Bowles severance benefits plus attorney fees and prejudgment interest, and concluded that the severance plan was an ERISA "plan." On appeal, the parties disputed whether the severance plan was covered by ERISA. Quantum argued that ERISA applied because the plan required an on-going administrative scheme. Bowles, on the other hand, argued that ERISA did not apply because the plan did not require an exercise of discretion. Instead, he argued that the plan involved only a one-time, lump sum payment upon the occurrence of a specified event. The Seventh Circuit agreed with the district court's conclusion, holding that ERISA applied to the plan. Quantum's severance plan closely resembled a severance plan that the Seventh Circuit considered in *Collins* and held subject to ERISA. *Id.*, at

631 (referring to *Collins v. Ralston Purina Co.*, 147 F.3d 592 (7th Cir. 1998)). In the *Collins*' plan and Quantum's plan, covered employees had a one-year period in which to demand severance benefits. The employers had to budget for the possibility of making multiple payments throughout the course of that year. Additionally, both employers had to consider individual jobs and monitor the conditions of employees' employment throughout the one-year eligibility period. These responsibilities amounted to an administrative scheme that brought the plans within ERISA.

11.5.2 ***O'Connor v. Commonwealth Gas Co.***

In *O'Connor v. Commonwealth Gas Co.*, 251 F.3d 262 (1st Cir. 2001), the First Circuit held that an early retirement incentive program involving severance benefits, enhanced pension credit, COBRA premiums and educational/outplacement assistance was NOT a "plan" subject to ERISA. Surprisingly, the court determined that the plan did not require enough of an administrative scheme to warrant treatment as an ERISA plan.

In January 1997, Commonwealth Gas Company decided to merge with Commonwealth Electric Company. It announced the merger to the public on February 6, 1997, including its intention to eliminate fifteen percent of the workforce through attrition and a personnel reduction program. The reduction program was finalized on May 13 and contained several benefits for employees who opted to retire, including a severance bonus, pension credit, payment of COBRA premiums, and reimbursement for educational assistance and outplacement services. The program was offered to all non-officer employees but was limited to 300 employees based on seniority.

Employees of Commonwealth Gas Company who retired in January and February of 1997 brought an action claiming that Commonwealth Gas Company made material misrepresentations that induced them to retire before the effective date of the personnel reduction program. Finding that the program was not an ERISA plan, the First Circuit concluded that the misrepresentation claims were moot, since such claims grow out of ERISA's fiduciary duty of loyalty.

In determining whether a program is an ERISA plan, a court must look at the nature and extent of an employer's benefit obligations. Programs that involve an administrative scheme subject to mismanagement and require a certain amount of discretion and subjectivity are more likely to be considered an ERISA plan. On the other hand, one-time "take-it-or-leave-it" benefits administered by a mechanical formula that requires little or no discretion may fall outside ERISA's definition of a plan. According to the First Circuit, "what constitutes an ERISA plan thus turns most often on the degree of an employer's discretion in administering the plan."

In its evaluation of the Commonwealth Gas Company's program, the court focused on the severance bonus, which it deemed to be "the meat and potatoes" of the program, and concluded that the program was not an ERISA plan. Although the other benefits under the program might constitute benefits under ERISA, the court disregarded them because it believed they bore little weight compared to the non-ERISA nature of the severance benefit. According to the First Circuit, the severance benefits "fit comfortably within the category of benefit [it had] deemed not subject to ERISA coverage." The benefit was a one-time, lump sum payment and was based on tenure, calculated at the rate of two-and-a-half weeks' pay for each of the first ten years of service plus two weeks for each additional year, up to a maximum of 78 weeks' salary. A series of increasingly more lucrative severance incentives, such as this benefit, requires no complicated administrative scheme.

In *Rodowicz v. Mass. Mut. Life Ins. Co.*, 192 F.3d 162 (1st Cir. 1999), the court determined that a similar voluntary termination program was not an ERISA plan. Like the Commonwealth Gas Company program, the *Rodowicz* severance was calculated by multiplying some number of weeks' salary by years of service and was capped at 78 weeks. The fact that the program was offered during a five-week period as opposed to a fifteen week period was immaterial. The court distinguished the Commonwealth Gas Company program from programs deemed to be covered by ERISA. For example, this program did not contain a for-cause criterion as found in *Simas v. Quaker Fabric Corp.*, 6 F.3d 849 (1st Cir. 1993). In *Simas*, employees were eligible for a severance bonus during a twenty-four month election period unless they were fired for cause. Such for-cause criterion involves the type of discretionary determination that is protected by ERISA's fiduciary rules. The court reasoned that there was no similar discretionary determination with regard to the Commonwealth Gas Company program.

The court's discussion of the other benefits under the program was brief as it decided that they were "little more than afterthoughts to the severance bonus." With regard to the educational and outplacement assistance portion of the program, the court acknowledged that the benefit involved some type of subjective decision-making by Commonwealth Gas Company, but concluded that the degree of discretion was negligible because the benefit was a one-time payment available only within a year of retirement. Similarly, the pension credit was a lump-sum benefit that played no part in calculating when a retiree who opted for the program would begin receiving disbursements. Although the payment of COBRA premiums by itself would be an ERISA plan, the benefit was relatively insignificant compared to the severance plan. Therefore, the court felt justified in concluding that the entire Commonwealth Gas Company program was not an ERISA plan.

11.5.3 Waks v. Empire Blue Cross/Blue Shield

In *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001), the Ninth Circuit held that an individual insurance policy received upon exercise of a conversion right under an ERISA-covered group health plan is not itself an ERISA "plan". Individual converted insurance policies cover individuals rather than employees as required in Section 514 of ERISA. Additionally, claims related to rights under a converted insurance policy do not relate to an ERISA plan.

Barbara Waks had been covered under a health plan sponsored by her husband's employer, SCS Systems. However, she lost coverage when SCS ceased operations and terminated its plan. After losing coverage under the ERISA regulated group insurance plan, Waks purchased an individual policy for comprehensive hospital and medical benefits from Empire Blue Cross Blue Shield pursuant to the conversion rights of the group policy. A converted policy, such as Waks' individual policy, is created when an ERISA plan participant leaves a plan and obtains a new, separate, individual policy based on conversion rights in the ERISA plan.

In 1996, Empire authorized Waks' emergency hospital admission, but later denied her insurance claims for the hospital visit. Waks filed a complaint alleging breach of contract, breach of the covenant of good faith and fair dealing, and breach of statutory duties. Empire defended on the ground that ERISA preempted Waks' state law claims.

The Ninth Circuit disagreed with Empire's preemption claim, holding that Waks' converted policy could not be an ERISA plan because it covered her as an individual, not as an employee. Section 514(a) of ERISA provides that "[i]f a state law 'relate[s] to . . . employee benefit plan[s],' it is pre-empted." *Waks*, 263 F.3d at 875 (quoting *Pilot Life Ins. Co. v.*

Dedeaux, 481 U.S. 41, 45 (1987)). ERISA preempts state laws that “relate to” employee benefit plans, not employee benefits. *Id.* (citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 7 (1987)). Only an employee benefit plan that covers at least one employee constitutes an ERISA benefit plan. *Id.* (referring to *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 407 (9th Cir. 1995)).

The second issue before the court was whether Waks’ state-law claims related to an ERISA plan. According to the court, claims arising under a converted insurance policy are not “related to” an ERISA plan. By definition, a converted policy is created when an ERISA plan participant leaves the plan and obtains a new, separate, individual policy. The contract exists directly between the insurer and insured, independent of the ERISA plan, and places no burden on the plan administrator or the plan. In this case, there is no ERISA plan or administrator since SCS ceased operations and terminated its plan. However, even if the SCS plan still existed, the new policy would not “relate to” the plan because the policy is an individual policy, no longer regulated by ERISA.

Although there is dicta in earlier Ninth Circuit cases that suggest converted policies remain subject to ERISA after conversion, the court distinguished those cases from the one at hand. Two of those cases did not involve a converted policy and one actually involved state-law claims based on the right to convert under an ERISA plan, rather than on rights provided by the policy itself. See *id.*, at 876-77 (citing *Peterson v. Am. Life Health Ins. Co.*, 48 F.3d 404 (9th Cir. 1995), *Qualls v. Blue Cross of Cal., Inc.*, 22 F.3d 838 (9th Cir. 1994), and *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124 (9th Cir. 1992)). Unlike the claims in those cases, “Waks’ claims are neither claims brought under an ERISA plan nor claims for conversion rights under such a plan. Rather, Waks’ claims are brought under her converted individual policy,” which the court has never held to be preempted by ERISA.

11.6 Retiree Medical Benefits

11.6.1 *Empire Blue Cross & Blue Shield Cases*

Over the past decade, courts have universally held that retiree welfare benefits may be modified or terminated as long as the employer has reserved the right to do so. In addition, courts have generally been less willing to find ambiguity in an employer’s reservation of rights simply because of minor differences in wording between the plan and the summary plan description (SPD), and less willing to infer a promise of vested benefits simply because a plan or SPD with a clear reservation of rights also includes statements that could imply a fixed level of benefits if read in isolation from the rest of the plan or SPD.

Despite the universal agreement of courts that retiree welfare benefits generally can be modified or terminated as long as the employer has reserved the right to do so, retirees continue to sue when substantial changes are made to their benefits and continue to search for new theories that may gain a sympathetic ear from a court. Faced with mounting defeats of claims that focus on plan documents, retirees are looking for other avenues to arrive at the desired result. In particular, employees who were induced to retire as part of an early retirement program have raised claims based on theories of equitable estoppel, bilateral contract and breach of fiduciary duty, and in some cases have prevailed. In two related Second Circuit cases

involving a reduction in retiree life insurance benefits by Empire Blue Cross & Blue Shield, the court reversed most of the district court's summary judgments in favor of the employer, finding that material issues of fact remained as to whether certain retirees were entitled to recover under contract, estoppel and breach of fiduciary duty claims. The retirees claims were based on language of the SPDs, and on theories of promissory estoppel and breach of fiduciary duty. *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001); *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90 (2d Cir. 2001).

Plaintiffs were employed by Empire Blue Cross and Blue Shield, which provided life insurance benefits at no cost to its employees and retirees. All of the plaintiffs retired from Empire between 1989 and 1993, some pursuant to an early retirement incentive program known as the Voluntary Separation Opportunity Program ("VSOP") and others pursuant to a similar program known as the Voluntary Incentive Program ("VIP"). Other plaintiffs retired pursuant to Empire's normal retirement program. The pre-1987 SPD did not indicate that Empire would or could reduce or eliminate the benefits. However, a separate SPD contained in an employee handbook distributed in 1987 reserved the company's right to amend or terminate each plan if necessary. This right was also found in the two early retirement incentive programs.

Empire implemented the VSOP in 1992. The program was available to eligible employees who voluntarily resigned from Empire in exchange for certain benefits, including life insurance coverage on substantially the same terms as provided in other plans. Empire reserved the right to amend or terminate the VSOP at any time for any purpose and warned that it may or may not adopt new programs or benefits or take other actions, depending on the circumstances. In 1993, Empire offered the VIP, under which insurance benefits might be extended for life, depending on the recipient's age and years of service. The VIP provided for life insurance benefits identical to those described in the other plans. Empire once again reserved the right to amend or terminate the VIP at any time and to announce new or different plans as necessary.

In 1998, Empire adopted a number of new benefit provisions for current employees and retirees. The provisions affected individuals who retired after January 1, 1989 but before June 23, 1998. The changes reduced life insurance coverage to a flat \$7,500. Two groups of retirees filed suit, claiming several ERISA claims and a claim for promissory estoppel. The plaintiffs claimed that employer communications promised lifetime life insurance benefits equal to their annual salary. Their argument, however, was rejected by the district court, which concluded that relevant documents contained unambiguous reservations of Empire's rights. The plaintiffs' rights to the life insurance benefits were not vested and, therefore, Empire was free to reduce the benefits. The district court also rejected the plaintiffs' claims for breach of fiduciary duty, holding that Empire acted in accordance with plan documents and had properly provided the documents to its employees. Finally, the district court concluded that the plaintiffs had failed to allege extraordinary circumstances necessary for a claim of promissory estoppel.

As the Second Circuit explained, employers are generally free under ERISA to adopt, modify or terminate welfare benefit plans. However, if an employer promises to provide vested benefits under the terms of a plan document, those benefits must be enforced. For purposes of surviving a motion for summary judgment, an employee does not have to point to unambiguous language promising lifetime benefits. According to the Second Circuit, it is sufficient to show language capable of reasonably being interpreted as creating a promise on the part of the employer to vest the recipient's benefits.

Referring to the pre-1987 SPDs, which indicated that life insurance coverage would remain at a level equal to a retiree's annual salary for the retiree's lifetime, the court concluded

that the language did not specifically express an intent to vest the plaintiffs with life insurance benefits before they retired. The benefits vested only if the plaintiffs retired prior to 1987. However, the language also provided that “retired employees, after completion of twenty years of full-time permanent service and at least age 55 will be insured . . . at the [annual salary level] for the remainder of their lives.” The court believed that the statement could be reasonably read as promising insurance so long as employees retire after age 55 and at least twenty years of full-time employment. Therefore, by performing (*i.e.*, working for at least twenty years until attaining age 55), the plaintiffs had accepted the offer which the offeror could not then revoke. On the other hand, with respect to regular retirees who argued for vested benefits solely on the basis of the 1987 SPD (a portion of the *Abbruscato* plaintiffs), the Second Circuit agreed with the district court that Empire had unambiguously reserved its right to alter benefits, and therefore the court affirmed the summary judgment with respect to the contract claim by these regular retirees.

With regard to the promissory estoppel claim, the court held that plaintiffs had to show a promise, reliance on the promise, injury caused by the reliance, and an injustice if the promise is not enforced. Additionally, a plaintiff must satisfy an “extraordinary circumstances” requirement, such as an employer’s use of a promise to induce retirement. In the Second Circuit, the plaintiff may satisfy the extraordinary circumstances requirement by demonstrating that the defendant made a promise that it reasonably should have expected to induce action or forbearance, but “extraordinary circumstances” are not limited to circumstances of inducement. In this case, the plaintiffs claimed that the injustice they suffered due to Empire’s reduction in life insurance benefits satisfied the extraordinary circumstance requirement. However, the court rejected this claim, noting that “injustice” is one of the four basic elements and therefore cannot rise to the level of “extraordinary.”

Plaintiffs also claimed that they were induced by Empire to work for over twenty years in order to receive the lifetime benefits at no cost, which constituted “extraordinary circumstances.” Although the district court rejected this contention, the Second Circuit agreed that a trier of fact could reasonably conclude that Empire intentionally promised lifetime benefits to retain employees and lure them away from other firms paying higher salaries. Because this raised a genuine issue of material fact, the court vacated the district court’s grant of summary judgment with regard to the promissory estoppel claims.

In addition to the aforementioned claims, the plaintiffs claimed that Empire breached its fiduciary duties when it reduced the benefits in violation of the plan documents. The court rejected Empire’s and the district court’s conclusion that Empire was not acting in a fiduciary capacity when it reduced plaintiffs’ life insurance benefits. Empire may have been acting as a fiduciary with respect to the plan when it reduced the benefits and when it communicated with employees and retirees about the contents of the welfare benefit plan. Empire may have also violated its duty to deal honestly when it repeatedly described the life insurance benefits as remaining for life. Empire’s communications should have been evaluated by a trier of fact; therefore, the court remanded the case to district court for a determination of these issues.

11.7 Erisa Vs. The Treating Physician Rule

Based on the Supreme Court's now familiar decision in *Firestone Tire & Rubber Co. v. Bruch*, when an ERISA plan document gives the plan administrator discretion to interpret the terms of the plan, a court should not overturn the decision of the administrator unless the administrator's decision constituted an abuse of discretion. The year 2001 brought two conflicting views of whether the "treating physician rule" applied in Social Security disability determinations should or can be reconciled with the *Firestone* abuse of discretion standard. As applied in Social Security determinations, the treating physician rule requires an administrative law judge to give deference to the opinions of the claimant's treating physician. This deference is based on the treating physician's greater opportunity to observe the patient.

11.7.1 Delta Family-Care Disability & Survivorship Plan v. Marshall

In *Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834 (8th Cir. 2001), the Eighth Circuit held that a plan administrator is not required to give special deference to the medical opinions of a participant's treating physician in connection with a claim for benefits under a long-term disability plan. In doing so, the court distinguished a 1996 case in the same circuit, which seemed to apply the treating physician rule.

Delta Airlines, Inc. sponsored the Delta Family-Care Disability and Survivorship Plan, a non-contributory employee welfare benefit plan that provided short-term and long-term disability benefits. The plan provided that an employee who became disabled as a result of demonstrable injury or disease (including mental or nervous disorders) that prevented him from engaging in any occupation whatsoever was eligible for long-term benefits under the plan.

From 1979 to 1991, Marshall worked for Delta Airlines and participated in the plan. In March 1989, he suffered lower back injury at work, which required him to undergo surgery in November, 1991. Marshall's doctor advised Delta that he would need two to five years to recover from the surgery. In 1994, Marshall underwent a second back surgery. At the end of 1995, his doctor informed the plan that he would not be able to work because of constant back pain. He referred Marshall to a psychiatrist, who also determined that Marshall was unable to work because of chronic pain, traumatic injury, and unremitting depression. After receiving the maximum amount of short-term benefits, Marshall filed a claim for long-term disability under the plan. The plan approved his request and paid benefits between March 18, 1992 and March 31, 1998. In March, 1998, the plan required Marshall to submit a Functional Capacity Evaluation from a physical therapist, who concluded that, from a physical standpoint, Marshall was capable of performing some type of work in the sedentary category with certain lifting restrictions. Consequently, the plan terminated Marshall's long-term benefits effective April 1, 1998. Marshall timely appealed the decision, but after several additional Independent Medical Examinations ("IMEs"), the administrative committee denied Marshall's appeal based on medical evidence that he was physically and psychologically capable of doing some work.

Marshall filed a complaint under Section 502(a) of ERISA, seeking reinstatement of his long-term disability benefits. Concluding that it was unreasonable for the plan to disregard reports from Marshall's personal physicians most knowledgeable about his condition, the district court directed the plan to reinstate Marshall's long-term disability benefits.

Applying the abuse-of-discretion standard, the Eight Circuit vacated the district court's decision, and clarified its 1996 decision on the same subject:

We agree with the Plan that the district court incorrectly reasoned that the Plan should have accorded greater deference to the opinions of Marshall's treating

physicians. As authority for this proposition, the district court relied solely on *Donaho v. FMC Corp.*, 74 F.3d 894 (8th Cir. 1996). The administrative record in this case, however, is much different from the record before the plan administrator in *Donaho*. The only doctor who opined that Donaho was not disabled was a physician who had merely reviewed her medical records and had never examined her. We therefore stated in *Donaho* that “where the *reviewing physician’s* conclusions are contradicted by an *examining physician* and two *treating physicians*, reliance on the reviewing physician’s conclusions seems especially misplaced and constitutes an abuse of discretion.” *Donaho*, 74 F.3d at 901 [emphasis by Eighth Circuit]. As we recently observed, however, a treating physician’s opinion does “not automatically control, since the record must be evaluated as a whole.” *Fletcher-Meritt v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n.3 (citing *Bentley v. Shalala*, 52 F.3d 784, 786 (8th Cir. 1995)).

Where a record reflects conflicting medical opinions, as in this case, a plan administrator does not abuse its discretion solely because it finds the employee not to be disabled. The contradictory medical opinions constituted “substantial evidence” to support the plan’s decision to terminate Marshall’s long-term disability benefits. Because the plan’s decision was reasonable, the court vacated the district court’s judgment and directed that judgment be entered in favor of the plan.

11.7.2 *Regula v. Delta Family-Care Disability Survivorship Plan*

In the *Regula* case, 266 F.3d 1130 (9th Cir. 2001), the Ninth Circuit expressly adopted the treating physician rule in connection with a claim for disability benefits under an ERISA plan (oddly enough, the same plan that was at issue in the Eighth Circuit’s *Marshall* decision). The Ninth Circuit believes that the treating physician rule can be applied without doing irreparable violence to ERISA’s abuse of discretion standard:

Just as in the Social Security context, the disputed issue in ERISA disability determinations concerns whether the facts of the beneficiary’s case entitle him to benefits. Therefore, for reasons having to do with common sense as well as consistency in our review of disability determination where benefits are protected by federal law, we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator’s positions. (footnote omitted)

The dissenting opinion in *Regula* argued that adoption of the treating physician rule to ERISA would impermissibly erode the discretion granted to a plan administrator under the terms of the plan document and the Supreme Court’s *Firestone* decision. In addition, the dissent argued that it was inappropriate to incorporate a rule that has been expressly adopted in the Social Security regulations but not in ERISA.

11.8 Worker Classification

11.8.1 ***Hensley v. NW Permanente P.C. Retirement Plan & Trust***

In *Hensley v. NW Permanente P.C. Retirement Plan & Trust*, 258 F.3d 986 (9th Cir. 2001), the Ninth Circuit held that, where a plan gives an administrator absolute and sole discretion to interpret terms of a plan and to determine eligibility of benefits, it is reasonable for an administrator to use the W-2 definition of “employee”, because the administrator construed the term consistently and there was no evidence of irregular procedures.

Northwest Permanente P.C. (“NWP”), a private corporation formed by a group of physicians to provide medical services to members of the Kaiser Permanente Medical Care Program, was the administrator of two pension plans: the Northwest Permanente P.C. Retirement Plan and Trust (“NWP Plan”), a defined contribution plan administered by a ten-member committee, and the Permanente Physicians Retirement Plan for Northwest Permanente P.C. (the “Physicians Plan”), a defined benefit plan administered by a separate ten-member committee. A program called the Kaiser Program provided prepaid healthcare services to individuals enrolled in the Kaiser Health Plan, a nonprofit qualified HMO. This program maintained an affiliate, Kaiser Foundation Hospitals, to provide hospital facilities and contracted with independent groups of physicians to provide medical services. A group of nurse practitioners and physician assistants worked for and received compensation and benefits from the Kaiser Health Plan; however, they were not allowed to participate in either of NWP’s pension plans.

The nurse practitioners and physician assistants filed a suit for benefits under the NWP pension plans. Both plans rejected the plaintiffs’ claims for benefits after concluding that the plaintiffs were not “employees” of NWP. The NWP Plan defined a “qualified employee” as “any employee of Employer,” defined as NWP. Similarly, the Physicians Plan defined a “qualified employee” as “any employee of the Medical Group,” which was also defined as NWP. Because neither plan specifically defined “employee,” the administrators applied a “W-2” definition when it reviewed the plaintiffs’ claim for benefits, finding that the plaintiffs were not eligible for benefits as they were never treated as employees for Internal Revenue Service purposes.

The district court vacated the administrators’ decisions that the plaintiffs were not “employees” after deciding that it was an abuse of discretion to apply the W-2 definition of employee. The court remanded the case to the plan administrators for a new determination under the common law definition. The Ninth Circuit affirmed in part and reversed in part.

On appeal, the plaintiffs argued that the administrators of the NWP plans had a conflict of interest because, as NWP employees, the administrators’ salaries were directly affected by the financial performance of NWP. Therefore, the committee members had a personal pecuniary interest in the outcome of their decisions, which would affect NWP’s financial performance and, therefore, indirectly affect their salaries. In cases in which a beneficiary alleges that the administrator has a conflict of interest, the court must determine “whether the beneficiary provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary’s self-interest caused a breach of the administrator’s fiduciary obligations to the beneficiary.” *Hensley*, 258 F.3d at 995 (citing *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995)). If the beneficiary has made the required showing, the plan bears the burden of providing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits. *Id.* (referring to *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 798 (9th Cir. 1997)). If the plan fails to satisfy its burden, the court must review the administrator’s decision under the *de novo* standard, giving it

little deference. In this case, however, the Ninth Circuit affirmed the district court's decision to adopt the abuse of discretion standard, because the plaintiffs provided no evidence that the administrators engaged in any irregular procedural conduct in handling the claims and the administrators consistently denied the claims because the plaintiffs were not "employees".

Having determined the appropriate standard of review, the court then turned to the issue of the plan administrators' interpretation of the term "employee" under the plans. Nothing in the language of the plans limited the administrators' discretion to interpret the defined terms. In fact, the plans expressly provided that the administrators had "absolute" or "sole discretion" to interpret the terms and to determine eligibility of benefits. Therefore, the Ninth Circuit ruled that the district court was in error when it concluded that, in the absence of a definition in the plans, the administrators were required to apply the federal common law definition of employee. The administrators' use of the W-2 definition was reasonable in light of their discretion under the plans. Their interpretation was not arbitrary or capricious, considering the plans were designed with only W-2 employees in mind. Furthermore, the administrators relied upon an Internal Revenue Service private letter ruling that stated that W-2 employees of entities within the Kaiser Program were not considered employees for tax purposes. The administrators' consistent pattern of interpreting the term also provided sufficient evidence that they acted reasonably.

11.9 Contribution And Other Remedies

11.9.1 *McDannold v. Star Bank*

In *McDannold v. Star Bank*, 261 F.3d 478 (6th Cir. 2001), the Sixth Circuit rejected a secured creditor's claims to funds from the settlement of malpractice and misrepresentation claims against legal and financial advisors for allegedly failing to properly represent the plan in an ESOP transaction. Such settlement funds do not constitute earnings on stock, collateral, or proceeds of pledged collateral. The court remanded the case to the district court for reassessment of the nondefendants' right to contribution in light of *Harris Trust*, in which the Supreme Court held that a nonfiduciary may be liable for knowingly participating in a fiduciary's breach.

In 1987, John Endres sold his stake in Electro-Jet Tool & Manufacturing to the company's employees. As part of the transaction, the company's profit sharing plan was converted into an ESOP, which contributed \$2.3 million of its own assets toward the \$12.5 million purchase. Additionally, the ESOP obtained a non-recourse loan of \$10.2 million from Start Bank, which secured the loan by a pledge of the 268,000 shares in Electro-Jet purchased with the loan. Star Bank perfected its interest by taking possession of the shares.

After discovering that the shares they bought were worthless, the plaintiffs filed a claim against Endres, the officers of Electro-Jet, and several former Electro-Jet executives for breach of fiduciary duty under ERISA. They sued Star Bank, as former trustee, for failure to investigate or bring any action on their behalf. The plaintiffs also sued the professional advisors, including legal and financial advisors retained by the plan to structure the transaction, for malpractice and misrepresentation, alleging they failed to represent the plan properly. The parties settled the malpractice and misrepresentation claims for \$1.75 million, which was approved by the United States District Court for the Southern District of Ohio. Following the settlement, Star Bank claimed an interest in the resulting fund as proceeds of the pledged stock. The Sixth Circuit did

not consider the merits of the ERISA or malpractice claims because the former was pending in district court and the latter settled. Instead, the court was asked to decide “whether a secured creditor is entitled to the settlement as ‘proceeds’ of a stock pledge and what effect, if any, the settlement should have upon the on-going litigation between plaintiffs and the remaining defendants.”

Generally, no person entitled to payment under an exempt loan has a right to assets of an ESOP. However, regulations provide three exceptions to this general rule. A lender has a right to assets of an ESOP that constitute (1) loan collateral, (2) contributions to the ESOP that meet loan obligations (other than a contribution of employer securities) and (3) earnings attributable to the collateral and investment of such contributions. 29 C.F.R. § 2550.408b-3(e). Star Bank argued that the settlement fund constituted earnings attributable to the Electro-Jet stock. In the alternative, the funds were collateral to the loan.

The Sixth Circuit rejected the bank’s first argument, noting that earnings flow from deliberate and productive uses of resources, not malfeasance of others. Therefore, the settlement did not constitute earnings on the stock.

The court also rejected the bank’s argument that the settlement funds constituted collateral to the loan. Although the stock remained in the bank’s possession, the bank argued that its interest in the collateral extended to traceable proceeds. Under the Uniform Commercial Code adopted by Ohio, the term “proceeds” includes the following:

whatever is received upon *the sale, exchange, collection, or other disposition* of collateral or proceeds. Insurance payable by reason of loss or damage to the collateral is proceeds, except to the extent that it is payable to a person other than a party to the security agreement. Any payments or distributions made with respect to investment property collateral are proceeds.

McDannold, 261 F.3d at 482 (citing Ohio Rev. Code § 1309.25A) (emphasis added). Because the settlement funds could not represent “payments or distributions” on investment property for the same reason it could not be considered earnings, the bank had to show a disposition of the stock from which the plaintiffs received the settlement fund. Although the bank acknowledged that it retained possession of the stock, it maintained that “the satisfaction of plaintiffs’ malpractice claims in settlement represents a ‘disposition’ of stock from which the \$1.75 million fund flows as proceeds.” It supported the argument by pointing out the functional concept of proceeds as any economic substitute for a secured asset.

The Sixth Circuit agreed with the general proposition that a security interest attaches to assets that replace collateral once damaged or destroyed, but nothing in the case at hand had been replaced. “At most, the fund represents a disposition of potential malpractice liability, not of Electro-Jet shares.” The settlement fund compensates the plaintiffs for unsound legal and financial advice, not for loss of collateral. The plan was injured as a purchaser of professional services rather than as a purchaser of stock; therefore, the fund did not constitute proceeds. Because the settlement did not affect the ownership of the pledged stock or result in a disposition, the court affirmed the district court’s decision denying the bank’s claim to the fund as proceeds of the pledged collateral.

In addition to the issue of the bank’s right to the settlement fund, the Sixth Circuit also examined the effect of the settlement upon remaining defendants. The bank, Endres, and the trustee of a grantor trust in which Endres held the Electro-Jet shares objected to the settlement. First, they protested a “bar order” that prevented them from asserting claims against defendants

who settled the malpractice suit. The district court had rejected the non-settling defendants' request for a hearing to assess the fairness of the bar order, concluding that no hearing was necessary because the non-settling defendants had no right to contribution.

Additionally, the non-settling defendants argued that their liability should be reduced proportionately, rather than the dollar-for-dollar basis contained in the agreement. Rejecting the second argument, the district court concluded that a proportionate allocation was contrary to the joint-and-several design of ERISA. According to the district court, the settlement agreement was fair, reasonable, and adequate as to all parties.

In avoiding a decision as to whether the defendants had a right to contribution against the settling defendants, the Sixth Circuit determined that it merely had to decide that such a claim could exist. Relying on the Supreme Court's decision in *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000), the court vacated the district court's decision with respect to the settlement's effect on the remaining defendants and remanded the case for a determination of this issue. In *Harris Trust*, the Supreme Court held that an action lies under Section 502(a)(3) of ERISA against a nonfiduciary for "appropriate equitable relief." Additionally, a nonfiduciary may be liable for "knowingly" participating in a fiduciary's breach. Because the district court did not have an opportunity to apply *Harris Trust* to the facts of this case and did not address whether the parties shared liability and how much common liability might affect a right to contribution, the court remanded the case to the district court for a determination of this issue. "To the extent *Harris Trust* supports common liability and a right to contribution in this case, the District Court should reassess the fairness and sufficiency of the set-off as to the non-settling defendants."

11.10 Mailbox Rule

11.10.1 *Schikore v. BankAmerica Supplemental Retirement Plan*

In *Schikore v. BankAmerica Supplemental Retirement Plan*, 269 F.3d 954 (9th Cir. 2001), the Ninth Circuit held that the federal common law "mailbox rule" applies to decisions related to benefits under an ERISA plan when receipt of a required form is a factual issue in dispute. It is an abuse of discretion for an administrator to not apply the rule when the plan does not provide for a particular form of mailing or for how receipt is to be determined and existing evidence is inconclusive.

Karla Schikore was employed by Bank of America from 1978 until 1998, when she voluntarily terminated her employment. During her employment, she participated in several retirement plans sponsored by the parent corporation of the bank, including an unfunded retirement plan intended to supplement benefits for certain highly compensated employees and other members of management. The unfunded plan gave the plan administrator discretionary authority to determine eligibility for benefits and to construe the terms of the plan.

Schikore completed an election form in December 1996 and mailed it to the bank's service center, retaining a copy for herself. In March 1998, prior to terminating her employment, she applied for a lump-sum distribution of her benefits, but the plan informed her that it did not have an election form on file. Although she faxed her copy of the 1996 form to the service center, the plan nevertheless denied her request for a lump-sum distribution, stating it had not

received an election form prior to her request. Schikore filed an appeal, which the plan also denied.

After her claim and appeal were denied, Schikore filed a claim under Section 502(a)(1)(B) of ERISA. The district court granted summary judgment in favor of Schikore after finding the plan administrator abused its discretion. On appeal, the Ninth Circuit affirmed the district court's decision, concluding that the plan abused its discretion in (1) concluding ERISA preempted the common law mailbox rule, (2) finding the rule was one of construction and therefore inapplicable to the plan's "actual receipt" requirement, and (3) failing to adequately develop the factual record before denying Schikore's claim for eligibility of benefits.

The mailbox rule, developed under federal common law, provides that "the proper and timely mailing of a document raises a rebuttable presumption that the document has been received by the addressee in the usual time." The rule is used to determine whether or not receipt has actually been accomplished and, as a rebuttable presumption, it is not a rule of construction.

The United States Supreme Court and the Ninth Circuit have both held that federal common law, such as the mailbox rule, may be used to evaluate claims under an ERISA plan if it is not inconsistent with the purposes of ERISA. "In enacting ERISA, Congress painted with a broad brush, expecting the federal courts to develop a 'federal common law of rights and obligations' interpreting ERISA's fiduciary standards." Schikore, 269 F.3d at 962 (citing *Bins v. Exxon Co. U.S.A.*, 220 F.3d 1042, 1047 (9th Cir. 2000) (en banc) (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996))). The purpose of ERISA is to protect employees' rights in their benefit plans, which is consistent with the mailbox rule. Therefore, the common law mailbox rule applies to ERISA where receipt is a factual issue in dispute.

In the case at hand, there is an issue over who bears the burden of establishing receipt when receipt is disputed and the evidence is inconclusive. The plan requires actual receipt, but does not specify any particular form of mailing. Actual receipt is difficult to prove without a returned envelope or the use of registered or certified mail. Therefore, the mailbox rule seems most appropriate in a case such as this when the evidence is inconclusive.

Furthermore, absent the rule, plan participants could be disadvantaged and their rights made wholly dependent on the plan administrator's choice between unproved assertions of a participant and similarly unproved assertions of the plan. Permitting such arbitrary decision-making would clearly violate the purpose of ERISA to "protect the interests of participants in employee benefit plans and their beneficiaries." *Id.* at 963 (referring to ERISA §2(b)). Use of the mailbox rule, however, allows a plan to rebut an unfounded claim with adequate evidence, avoids arbitrariness and preserves the policies and purposes of ERISA.

Therefore, the Ninth Circuit concluded that the plan administrator abused its discretion when it failed to apply the mailbox rule. Additionally, the administrator's failure to develop any meaningful factual record upon which to make its decision about Schikore's claim was arbitrary and capricious and demonstrated an abuse of discretion. Concluding the administrator abused its discretion, the Ninth Circuit affirmed the district court's decision as it pertained to the administrator's abuse of discretion and remanded the case to the district court with orders to apply the common law mailbox rule under the facts provided in the administrative record.

11.11 Statute Of Limitations

11.11.1 *Caputo v. Pfizer, Inc.*

In *Caputo v. Pfizer, Inc.*, 267 F.3d 181 (2d Cir. 2001), the Second Circuit concluded that a claim for intentional misrepresentations about future voluntary separation options may be subject to a six-year statute of limitations if a plaintiff's complaint specifically alleges fraud. A complaint for breach of fiduciary duty under Section 413 of ERISA is subject to a three-year statute of limitations, which is triggered when a plaintiff has "actual knowledge" or knowledge of all material facts indicating a breach, but a plaintiff may avail himself of the six-year statute by specifically pleading fraud rather than breach of fiduciary duty. A plaintiff who files a claim under Section 413 should be allowed to amend the complaint to allege common law fraud, subject to the six-year statute of limitations.

Anthony Caputo, a mechanic trade oiler, worked for Pfizer Inc. in the Engineering Department of the Groton, Connecticut plant until his retirement on April 1, 1991. As part of the downsizing initiative, management of the Groton plant proposed a voluntary separation option ("VSO"), which would offer additional pension benefits as an early retirement incentive. Management presented its proposal, including the VSO, to the corporate headquarters for approval in January 1990. Management intended to offer another, even larger VSO in early 1992 as part of a second downsizing, but management feared that affected employees would postpone retiring if they knew about the larger 1992 VSO. Therefore, even though Groton intended to offer the larger VSO in 1992, management proposed to state in its communications that it had no plans to offer a second program in the foreseeable future. Groton managers told benefits personnel and foremen to deny the possibility of future "golden handshakes" by saying that they knew of no such thing.

On numerous occasions from August 1990 through March 1991, Caputo asked supervisors and human resource representatives about possible VSOs. On each occasion, he claimed that he was told that they had no knowledge of such a program. Supervisors and human resource personnel also told other employees, including David Cook, Duncan Robertson and Paul Pebbles, that no early retirement enhances would be offered. These employees also retired in 1991.

However, as early as August, 1990, Groton plan managers were planning the next group of layoffs. Pfizer claimed managers first requested permission for the VSO on September 18, 1991 and received approval on November 6, 1991, but evidence suggested that permission for the second VSO was requested prior to September, 1991. The VSO was formally announced on November 11, 1991. Caputo, Cook, Pebbles and Robertson learned about the VSO shortly thereafter.

Although Caputo, Cook, Pebbles and Robertson knew they would have been eligible for the benefits had they not retired and they suspected that management had been "fudging" when it denied that such a package was going to be offered, they did not know or suspect that anyone had knowingly lied until after they learned about *Mullins v. Pfizer, Inc.*, 147 F. Supp. 2d 95 (D. Conn. 2001) (concluding that Pfizer breached its fiduciary duties when it misled Mullins, a lab technician who had retired in April, 1990, about plans to offer the 1990 VSO). After learning about the *Mullins* suit, Cook, Pebbles and Roberts sued Pfizer in October 1996, complaining it violated ERISA by fraudulently inducing them to retire and thereby depriving them of benefits under the 1991 VSO.

The district court granted Pfizer's motion for summary judgment, concluding that the plaintiffs' claims were barred by the three-year statute of limitations under ERISA § 413(2). The six-year statute of limitations for "fraud or concealment" did not apply because the plaintiffs

failed to plead fraud with the requisite particularity required by Rule 9(b) of the Federal Rules of Civil Procedure. Their claim was barred under the three-year statute of limitations because they had “actual knowledge” of Pfizer’s alleged breach when they learned that the VSO was announced in November 1991. Denying the plaintiffs’ request for leave to amend their complaint because it was futile, the district court granted Pfizer’s motion for summary judgment.

On appeal, the plaintiffs argued that the district court erred because their claims were not subject to the three-year statute of limitations and even if the three-year statute of limitations applied, they did not have “actual knowledge” until September 1995 when they learned about the evidence in the *Mullins* trial. Additionally, they claimed the district court erred by denying their leave to amend their complaint to adequately plead fraud, which would have brought their claims within the six-year statute of limitations.

The Second Circuit agreed with the plaintiffs, vacating the district court’s grant of summary judgment and remanding the case to the district court. First, the district court erred by denying the plaintiffs’ request to amend the complaint in order to earn the six-year statute of limitations. Additionally, even if the six-year statute of limitations was not available, the district court erred when it concluded the three-year statute of limitations had run; the plaintiffs did not have “actual knowledge” of Pfizer’s breach until they learned of the evidence in the *Mullins* trial in 1995.

With regard to the “fraud or concealment” claim, Pfizer argued that the “fraud or concealment” provision of Section 413 of ERISA applies only “to actions in which the plaintiff alleges that the defendant engaged in conduct intended to hide its breach of fiduciary duty, thereby preventing the plaintiff’s recovery of the underlying breach.” Various circuits have held that the “fraud or concealment” provision incorporates the federal concealment rule or doctrine rather than automatically applying to fraud claims. Under the concealment rule, “when a defendant’s wrongdoing ‘has been concealed, or is of such character as to conceal itself, the statute [of limitations] does not begin to run until the [wrongdoing] is discovered’ by the plaintiff.” *Caputo*, 267 F.3d at 188-89 (citing *Bailey v. Glover*, 88 U.S. (21 Wall.) 342, 349-50 (1874)). Therefore, Pfizer argued that plaintiffs are entitled to the six-year statute of limitations only if they allege a breach of fiduciary duty and “a self-concealing act” or “active concealment” or a “self-concealing act,” defined as an act committed during the course of a breach that has the effect of concealing the breach.

The Second Circuit, however, disagreed with Pfizer, finding that the “fraud or concealment” provision of ERISA applies “in cases of fraud or [fraudulent] concealment.” The plain language of the statute states that the six-year limitations period applies to “case[s] of fraud or concealment.” When the statute was enacted, “fraud” was defined as “a false representation of a matter of fact, whether by words or conduct, by false or misleading allegations or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury.” *Id.* at 189 (quoting *Black’s Law Dictionary* 799 (Rev. 4th ed. 1968)). “Concealment” was defined as “[a] withholding of something which one knows and which one, in duty, is bound to reveal.” *Id.* at 189-90. Based on these definitions and the legislative history, the six-year statute of limitations should apply where a fiduciary has “(1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce an employee/beneficiary to act to his detriment; or (2) engaged in acts to hinder the discovery of a breach of fiduciary duty.” *Id.* at 190 (citing *In re Unisys Corp. Retire Med. Benefit “ERISA” Litig.*, 242 F.3d 497, 513-16 (3d Cir. 2001)).

Additionally, the Second Circuit held that the district court abused its discretion when it denied the plaintiffs' motion to amend their complaint to include a claim for fraud. First, representations made to the plaintiffs were arguably material because no reasonable employee would have retired after more than 30 years of employment if he had known that a "golden handshake" would be offered in just a few months. Second, the record contained sufficient evidence to show that Pfizer knew about the misrepresentation. The plaintiffs provided evidence that Pfizer knew its statements to Pebbles that he would "never live long enough to see a golden handshake," and to Robertson stating that "no other package would be offered in the future -- it was a once in a lifetime package" were false. They also offered evidence presented at the *Mullins* trial, including Pfizer's policy of withholding information about benefit enhancements." Third, the plaintiffs provided evidence of an intent to defraud, including evidence that five jobs had already been slotted to be eliminated and plant managers were planning another VSO. Finally, the circuit court concluded that there was a material issue as to whether reasonable employees would have relied on Pfizer's false representations. Finding sufficient evidence to support each element of a fraud claim, the court concluded that the district court should have allowed the plaintiffs to amend their complaint to include a common law claim for fraud, thereby invoking the six-year statute of limitations.

Even though the court concluded that the six-year statute of limitations would apply if the plaintiffs had amended their complaint, the Second Circuit also expressed its opinion that the plaintiffs' claims were not barred even under the three-year statute of limitations. A plaintiff has "actual knowledge" of a breach or violation under ERISA when "he has knowledge of all material facts necessary to understand that an ERISA fiduciary has breached his or her duty or otherwise violated the Act." *Id.* at 193 (referring to *Maier v. Strachan Shipping Co.*, 68 F.3d 951 (5th Cir. 1995) and *Gluck v. Unisys Corp.*, 960 F.2d 1168 (3d Cir. 1992)). "It is not enough that [plaintiffs] had notice that something was awry; [plaintiffs] must have had specific knowledge of the actual breach of duty upon which [they sued]." *Id.* (citing *Brock v. Nellis*, 809 F.2d 753, 755 (11th Cir. 1987)). "Constructive knowledge" does not trigger a breach under Section 413, meaning the three-year statute of limitations is not triggered on the day the plaintiffs *should have known* that a party may have breached its fiduciary duty. In this case, the plaintiffs did not necessarily gain knowledge of a breach when Pfizer announced the VSO because the plaintiffs did not know that Pfizer actually knew about the program when the plaintiffs made their inquiries.

11.12 Partial Terminations

11.12.1 *Matz v. Household Int'l Tax Reduction Inv. Plan*

On remand from the Supreme Court, the Seventh Circuit held that only nonvested participants should be counted when determining whether or not a plan has undergone a partial termination. The Seventh Circuit also confirmed its earlier holding that multiple plan years may be aggregated for purposes of the partial termination determination. *Matz v. Household Int'l Tax Reduction Inv. Plan*, 265 F.3d 572 (7th Cir. 2001). Based on the Supreme Court's guidance in remanding the case, the Seventh Circuit held that the Internal Revenue Service's position that both vested and nonvested participants should be included was not entitled to deference.

From March 28, 1989 until he was terminated on September 1, 1994, Robert Matz worked for Hamilton Investments, Inc., a subsidiary of Household International, Inc. *Matz v. Household Int'l Tax Reduction Inv. Plan*, 227 F.3d 971, 972 (7th Cir. 2000), *vacated by* 121 S. Ct. 2545, *remanded to* 265 F.3d 572. Hamilton sponsored a retirement benefit plan, which provided that a participant became vested at a rate of twenty percent per year. In August 1994, Household sold Hamilton Investments. From August 1994 through May 1996, the company continued to sell or discontinue several subsidiaries, including Mortgage Services, Inc., various branches of Household Bank, F.S.B., and Alexander Hamilton Life Insurance Co.

When Matz was terminated on September 1, 1994, he had a sixty percent vested benefit in employer matching contributions under the retirement plan. Under section 411(d)(3) of the Internal Revenue Code, “the rights of all affected employees to benefits accrued to the date of [a] termination, partial termination or discontinuance, to the extent funded as of such date, or the amounts credited to the employee’s account” will be nonforfeitable. Neither ERISA nor the Code defines “partial termination,” but the Treasury Regulations state that whether or not a partial termination has occurred depends on all of the facts and circumstances. Treas. Reg. § 1.411(d)-2(b)(1). Courts have generally held that partial terminations occur only when there is a significant reduction in plan participants, measured by using the ratio of terminated plan participants over total participants. *Matz*, 227 F.3d at 975 (citing *Kreis v. Charles O. Townley, M.D. & Assoc.*, 833 F.2d 74, 79 (6th Cir. 1987)).

Matz sued to recover the forty percent that was forfeited, claiming the plan was partially terminated beginning in August, 1994 and ending in May, 1996. He argued that corporate transactions during that timeframe were part of a single reorganization that resulted in the plan’s partial termination. Furthermore, in determining whether a partial termination occurred, Matz claimed that all fully vested employee terminations as well as nonvested employee terminations should be counted.

In its first decision in September 2000, the Seventh Circuit concluded that, because nothing in the language of the rule requires a significant corporate event to occur within a single plan year, plan terminations may occur over a series of years. *Id.*, at 977. This is consistent with reality because mergers and corporate reorganizations frequently involve large, complex events that cannot be completed in one year. With regard to the issue of whether to count both vested and nonvested participants, the Seventh Circuit decided that vested and nonvested termines should be counted based on an opinion by the IRS in a 1991 *amicus* brief. Concluding that the IRS’s interpretation is reasonable, the Seventh Circuit agreed.

On petition for writ of certiorari, the Supreme Court, however, vacated the Seventh Circuit’s judgment and remanded the case to the Seventh Circuit for further consideration in light of *United States v. Mead Corp.*, 121 S. Ct. 2164 (2001). In *Mead*, the Supreme Court held judicial deference is mandatory and owed to actions by administrative agencies when Congress has expressly or implicitly indicated that it intended for an agency to speak with the force of law and when the agency’s position is reasonable. *Matz*, 265 F.3d at 574 (citing *Mead Corp.*, 121 S. Ct. at 2176). “An agency’s interpretation may merit some deference whatever its form, given the ‘specialized experience and broader investigations and information available’ to the agency,” turning on the “‘thoroughness of evidence in [the agency’s] consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.’” *Id.* (citing *Skidmore v. Swift & Co.*, 323 U.S. 134, 139 (1944)).

On remand from the Supreme Court, the Seventh Circuit reversed its earlier decision to give deference to IRS's interpretation, concluding that the IRS's position in the *amicus* brief was an informal agency policy not entitled to complete deference. The IRS did not base its opinion on formal policymaking procedures nor was the position supported by some Revenue Ruling or agency manual. Analyzing the issue without deference to the IRS's position, the court concluded that only nonvested participants should be counted when determining whether a partial termination has occurred. In the opinion of the Seventh Circuit, counting vested participants would not further ERISA's purpose of protecting employees' legitimate expectations of pension benefits and preventing employers from abusing pension plans to reap tax benefits since benefits of vested participants are nonforfeitable.

11.13 Independent Contractor As An Erisa Beneficiary

11.13.1 *Hollis v. Provident Life & Accident Ins. Co.*

According to the Fifth Circuit's decision in *Hollis v. Provident Life & Accident Ins. Co.*, 259 F.3d 410 (5th Cir. 2001), an independent contractor may qualify as a beneficiary under ERISA. In this case, the court concluded that ERISA preempted an independent contractor's claims against disability insurers for breach of contract and bad faith because the employer-paid policy was part of an ERISA employee benefit plan and the independent contractor qualified as a beneficiary.

Between 1970 and 1981, Larry Hollis was employed as a salesman by R.M. Hendrick Graduate Supply House Inc. Pursuant to a 1981 agreement between Hollis and the company, Hollis became an independent contractor. The agreement provided that Hollis would pay his own travel expenses, provide his own vehicle, and pay his own employment and income taxes. In return for maintaining Graduate Supply's contracts with various schools, Hollis received a commission on the items he sold. He had the same duties as employee-sales representatives and shared in year-end bonuses similar to those provided to other Graduate Supply employees. Graduate Supply provided life, medical, and disability insurance to its employees, in which Hollis participated. Pursuant to this program, Hollis procured disability insurance from Provident Life & Accident Insurance Company and a second policy from Paul Revere Insurance Company. Employee-sales representatives obtained policies from Lincoln Life. Graduate Supply paid \$600 per year of the premium for each salesman's policy, including Hollis's Provident policy. For premiums exceeding \$600.00 per year, Graduate Supply paid the excess and then deducted it from a salesperson's monthly compensation.

In August 1995, Hollis resigned from Graduate Supply and submitted claims for permanent disability to Provident and Paul Revere because of severe back problems caused by excessive driving, bending, lifting, and stopping. Both policies provided benefits in the case of "total disability," but defined the term differently. The Provident policy defined "total disability" to mean that "due to injury or sickness [the insured is] not able to perform the *substantial and material duties* of [his] occupation." The Paul Revere Policy defined that term to mean "because of injury or sickness [the insured is] unable to perform the *important duties* of [his] occupation." Both policies began paying benefits to Hollis, but terminated his benefits in early 1998 after deciding that he was not totally disabled.

In April of 1998, Hollis sued Provident and Paul Revere for breach of contract and bad faith denial of disability insurance benefits. After the court denied Provident's motion for summary judgment on the ground of ERISA preemption, a jury concluded that Hollis was totally disabled under the Provident policy and that Provident acted in bad faith, but Hollis was not totally disabled under the Paul Revere policy. The jury awarded \$100,000 in damages for mental anguish and emotional distress.

On appeal, Hollis claimed that the district court erred by failing to award attorney's fees and costs and that the jury's determination that he was not totally disabled under ERISA should be set aside. Provident contended that ERISA preempted Hollis's state law claims and, in the alternative, the evidence was insufficient to support an award for emotional distress.

The Fifth Circuit agreed with Provident, concluding that ERISA preempted Hollis's claims because his disability policy was part of an ERISA plan and he was a beneficiary. First, the employer paid policy was part of an employee benefit plan. Salesmen were allowed to choose disability insurance policies pursuant to the terms of Graduate Supply's plan. Additionally, the terms provided that Graduate Supply would pay \$600 per year in premiums. Although Graduate Supply and Hollis had entered into an agreement designating Hollis as an independent contractor, Graduate Supply had treated Hollis the same as it treated any other salesman with respect to disability insurance. Therefore, like the policies of employees, Hollis's disability insurance policy was part of Graduate Supply's ERISA plan.

Additionally, Hollis qualified as a beneficiary even though he was classified as an independent contractor. For preemption to occur, claims must "directly affect the relationship between traditional ERISA entities - the employer, the plan and its fiduciaries, and the participants and beneficiaries." 29 C.F.R. § 2510.3-3(b). Therefore, a plaintiff must be either a beneficiary, as Provident claimed, or a participant. ERISA defines a beneficiary as "a person designed by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." ERISA § 2(8). Hollis was the beneficiary of a disability insurance policy that was part of Graduate Supply's ERISA plan and was entitled to benefits under that policy. In fact, he received benefits from Provident for several months. The fact that Hollis was an independent contractor was irrelevant. Although the Fifth Circuit held in 1994 that independent contractors can be participants, it did not rule out the possibility that they can also be beneficiaries. *Hollis*, 259 F.3d at 415-16 (reviewing the court's decision in *Weaver v. Employers Underwriters, Inc.*, 13 F.3d 172 (5th Cir. 1994) (providing that an independent contractor can be a beneficiary so long as he is a person who is or may become entitled to a benefit under an ERISA plan)).