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ERISA Case Update

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The Second Circuit and the U.S. District Court for the District of Connecticut have issued the following notable ERISA decisions between May 1, 2008 and May 30, 2009:

I. SECOND CIRCUIT DECISIONS

Chapman v. Choicecare Long Island Long Term Disability Income Plan, No. 07-2518-cv, 2009 U.S. App. LEXIS 233 (2d Cir. Jan. 8, 2009)
(Denial of Attorney's Fees to Successful Claimant)

Plaintiff Cheryl Chapman successfully challenged the Plan's denial of her claim for long term disability benefits as untimely. On her third appeal to the Second Circuit, Chapman argued that the district court improperly denied her attorney's fees, and moved for attorney's fees and costs related to her two previous appeals. The Court of Appeals held that the district court had properly applied the factors in Chambless v. Masters, Mates & Pilots Pension Plan, 815 F.2d 869 (2d Cir. 1987), in denying plaintiff's fee application.

Addressing the fourth Chambless factor—the relative merits of the parties' positions—the Second Circuit concluded that the district court did not abuse its discretion because the case was close on the merits. With respect to the fifth factor—whether the action conferred a common benefit on a group of plan participants—the Court of Appeals again concluded that the district court did not abuse its discretion in holding that the decision that plaintiff was entitled to equitable tolling did not confer a common benefit on all plan participants. The Court noted that equitable tolling is limited to "rare and exceptional circumstances," and that, given the highly case-specific nature of equitable tolling, the number of plan participants who would be assisted by the holding in Chapman's case was seemingly small.

Fisher v. JPMorgan Chase & Co., No. 07-0032-cv, 2008 U.S. App. LEXIS 26272 (2d Cir. Dec. 24, 2008)
(Standing to Recover Benefits for Subset of Plan Participants)

Plaintiffs were participants and beneficiaries of defendant JPMorgan Chase's deferred employee compensation plan. Portions of plaintiffs' individual accounts were invested in the JPMorgan Chase Stock Fund, which invested in the company's own common stock. Plaintiffs alleged that the investment was improper because defendant failed to disclose certain banking, accounting and investment misfeasance connected with Enron Corporation. Plaintiffs appealed the district court's conclusion that they lacked standing to bring this action under Section 502(a)(2) because they sought damages for only a subset of plan participants. The Second Circuit reversed, holding

that the Supreme Court's decision in LaRue v. DeWolff, Boberg & Assocs., Inc., 128 S. Ct. 1020 (2008) (decided after plaintiffs had appealed) allowed plaintiffs to seek recovery for "misconduct [that] impaired the value of plan assets in the participant's individual account[s]" and that the requirement of plan-wide recovery under Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985), was "beside the point in the defined contribution context."

Frommert v. Conkright, 535 F.3d 111 (2d Cir. 2008)
(*Remedies for Retroactive Pension Cutback, Release of ERISA Rights*)

Defendants, the Xerox Corporation's pension plan and its administrators, argued that the district court fashioned an improper remedy for an ERISA violation associated with the implementation of a "phantom account" offset mechanism and erroneously concluded that the claims of certain plaintiffs were not barred by their releases. The Court of Appeals rejected defendants' first argument and accepted the second.

In an earlier decision, the Court held that defendants had improperly amended the pension plan through their method of determining retirement benefits for beneficiaries who left Xerox and were later rehired. The plan administrator used a "phantom account" offset mechanism, which calculated the current value of the employee's lump sum distribution at the time of termination by adjusting for "hypothetical investment gains and/or losses" attributable to the payment if it had remained in the employee's account rather than been paid out. The Court of Appeals concluded in its earlier decision that the phantom account offset mechanism constituted a retroactive cut-back, in violation of 29 U.S.C. § 1054(g). Applying the plan's non-duplication of benefits provision (and employing "equitable principles," as directed by the Second Circuit), the district court decided that the appropriate remedy was to order the plan administrator to recalculate the relevant plaintiffs' benefits to deduct only the nominal value of their prior, lump-sum distributions, i.e., without a "phantom account" adjustment reflecting hypothetical investment gains or other adjustments. The Second Circuit affirmed this methodology. It also held that the district court's decision to fashion a remedy itself rather than remanding to the plan administrator was a permissible exercise of discretion.

Several employees had signed general releases at the time of their initial termination in exchange for salary continuation. The Court of Appeals concluded that the releases constituted a knowing and voluntary waiver of ERISA rights with regard to pension payments even though the forgone pension benefits turned out to be worth more in hindsight than the releasing plaintiffs realized at the time.

Hirt v. Equitable Retirement Plan for Employees, Managers and Agents; Bryerton v. Verizon Comm'ns, Inc., 533 F.3d 102 (2d Cir. 2008)
(Validity of Cash Balance Plans)

In separate cases, beneficiaries of The Equitable and Verizon Communications retirement plans alleged that their cash balance defined benefit plans violated the rule against age-based reductions in the rate of benefit accrual set forth in ERISA § 204(b)(1)(H)(i), 29 U.S.C. § 1054(b)(1)(H)(i). Both cases were filed before the effective date of the Pension Protection Act, which amended ERISA to expressly permit cash balance defined benefit plans. The Second Circuit affirmed the holding of the district court that, even prior to the passage of the Act, cash balance plans did not violate ERISA. It found that Congress used the term "rate of benefit accrual" rather than "accrued benefit" in Section 204(b)(1)(H)(i) and thus meant to incorporate the concept of a retirement age annuity into the provision, a conclusion supported by the legislative history. The Second Circuit joined the conclusions of the Third, Sixth and Seventh Circuits, the other circuits to have considered this issue, and put to rest a division among the district courts within the Second Circuit regarding the validity of cash balance plans. Compare Richards v. Fleet Boston Fin. Corp., 427 F. Supp. 2d 150, 167 (D. Conn. 2006) (concluding that cash balance plans violate ERISA § 204(b)(1)(H)) with Amara v. CIGNA Corp., 534 F. Supp. 2d 288, 318-20 (D. Conn. 2008) (concluding that cash balance plans do not inherently violate ERISA).

Kendall v. Employees Retirement Plan of Avon Products, 561 F.3d 112 (2d Cir. 2009)
(Standing to Challenge Pension Calculations)

Plaintiff Irene Kendall filed a class action complaint on behalf of participants in the Avon pension plan alleging numerous breaches of fiduciary duty, including that the Plan's early retirement benefit and social security offset were calculated improperly, that it illegally reduced accrued benefits and that the calculation used to determine Average Final Compensation violated IRS regulations. Kendall requested declaratory and injunctive relief, a reformation of the Avon plan, and recalculation of accrued benefits for pensions of all class members. The district court dismissed the claims for lack of standing.

On appeal, the Second Circuit reaffirmed its holding in Central States Se. & Sw. Areas Health and Welfare Fund v. Merck-Medco Managed Care, 433 F.3d 181, 199 (2d Cir. 2005) ("Central States I"), that an ERISA plan participant must establish both statutory and constitutional standing, meaning a "statutory endorsement of the action" and a "constitutionally sufficient injury arising from a breach of statutorily imposed duty." It rejected Kendall's claim that § 502(a)(3) does not require a showing of direct injury as a "clear misstatement of law." It reiterated the holding of Central States I that, where a plaintiff sought restitution or disgorgement under ERISA, she must demonstrate an injury-in-fact. The Court held that Kendall's claim that Avon deprived her of the right to a

plan that complied with ERISA was insufficient to establish standing. It also rejected her claim that she was receiving less in benefits than she would have if the Plan did not violate ERISA. While the Court stated that a plan participant may allege a constitutional injury-in-fact based on a "theoretical injury," (e.g., where plaintiffs claim they were theoretically injured by a fund's mismanagement of assets, some of which could be theirs), it held that a plaintiff must be able to point to "an identifiable and quantifiable pool of assets to which they had colorable claims." Kendall, by comparison, alleged an injury based on an "as-yet-to-be determined increase in benefits" as a result of elimination of the Social Security Offset or general amendments to the Plan.

Kickham Hanley P.C. v. Kodak Retirement Income Plan, 558 F.3d 204 (2d Cir. 2009).
(Anti-Alienation Provision)

A law firm filed an administrative challenge to the denial of pension payments to a plan participant and arguably obtained a favorable result for him and others. It then obtained a preliminary injunction in the district court, which prevented defendants from making pension benefit payments to those plan participants unless they placed 15% of the payments in escrow pending a determination of the law firm's right to an attorney's fee award from the benefits. The Second Circuit reversed, holding that the law firm's claim for attorney's fees drawn from undistributed vested pension benefits violated the anti-alienation of ERISA, 29 U.S.C. § 1056(d)(1).

The Second Circuit noted that a principal rationale behind the anti-alienation provision was "the prohibition of involuntary levies by third party creditors on vested plan benefits" and that, as the Supreme Court stated in Guidry v. Sheet Metal Workers Nat'l Pension Fund, 493 U.S. 365, 376 (1990), Section 1056(d) reflects a "considered congressional policy choice . . . to safeguard a stream of income for pensioners . . . even if that decision prevents others from securing relief for the wrongs done them." The allegation that the law firm had helped bring about defendants' recognition that plan participants were entitled to their pension benefits did not alter the conclusion that these were pension entitlements and that the "common fund" doctrine did not provide plaintiff with a unique interest in the benefits that made it anything more than a garden-variety creditor. Further, the common fund cases cited by Kickham involved class action suits in which settlement negotiations resulted in the creation of a special fund that was never designated as vested pension benefits. The facts of the case did not support an exception to the anti-alienation provision and did not avoid the statutory protection ERISA extended to pension benefits while they were held by the plan administrator.

McCauley v. First Unum Life Ins. Co., 551 F.3d 126, 128 (2d Cir. 2008)
(Conflict of Interest after MetLife v. Glenn)

McCauley addresses the effect of Metropolitan Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008), on the Second Circuit's approach to alleged conflicts of interest. Prior to Glenn, the Second Circuit dealt with situations in which a plan administrator had the dual authority to determine the validity of a claim and pay benefits under the policy by allowing a court to review de novo the administrator's decision when it was shown that a conflict of interest actually influenced the decision. See, e.g., Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251, 1255-56 (2d Cir. 1996). In McCauley, the Second Circuit concluded that this standard was inconsistent with Glenn. It held that, following Glenn, "a plan under which an administrator both evaluates and pays benefits claims creates the kind of conflict of interest that courts must take into account and weigh as a factor in determining whether there was an abuse of discretion, but does not make de novo review appropriate." Id. at 133. The Court concluded that the abuse of discretion standard applied "even where the plaintiff shows that the conflict of interest affected the choice of a reasonable interpretation." Id. The Second Circuit suggested that, where circumstances indicated a higher likelihood that the conflict affected the benefits determination, such as where a plan administrator had a history of biased claims decisions, the conflict of interest would prove more important; it would be less important where the administrator had taken "active steps" to reduce potential bias. Id. at 133, quoting Glenn, 128 S. Ct. at 2351. The Court held that, in the case at hand, defendant's "history of deception and abusive tactics," as evidenced in prior cases and news reports, provided evidence that it was influenced by a conflict of interest. Id. at 137.

Although beyond the scope of this summary, it is worth noting that there are a substantial number of new decisions from federal district courts in New York that address the scope of permissible discovery on conflict of interest issues following Metropolitan Life Ins. Co. v. Glenn. In some instances, the district courts have allowed substantial discovery on this issue. See, e.g., Strope v. Unum Provident Corp., 2009 U.S. Dist. LEXIS 19383 (W.D.N.Y. Mar. 11, 2009) (permitting discovery of administrator's claims manual, compensation and recognition programs for claims personnel, and number of claims handled by personnel who evaluated plaintiff's claim); Burgio v. Prudential Life Ins. Co. of America, 253 F.R.D. 219 (E.D.N.Y. 2008) (permitting discovery regarding plan sponsor's past relationships with physicians reviewing LTD application, financial incentives paid claim reviewers, and sponsor's contracts with third party vendors); Hogan-Cross v. Metropolitan Life Ins. Co., 568 F. Supp. 2d 410 (E.D.N.Y. 2008) (permitting discovery, including depositions, regarding approval and termination rates for LTD claims, statistics for long term disability claims and compensation of persons involved in evaluating claim). But see Rubino v. Aetna Life Ins. Co., 2009 U.S. Dist. LEXIS 27373 (E.D.N.Y. Mar. 31, 2009) (holding that structural conflict of interest created by defendant's role as insurer and claims administrator failed to justify discovery outside of administrative record).

Paneccasio v. Unisource Worldwide, Inc., 532 F.3d 101 (2d Cir. 2008)
(Breach of Fiduciary Duty, Early Termination of Pension Benefits, Preemption of Claims Relating to Top Hat Plan)

Plaintiff Eugene Paneccasio, a participant in a "top hat" deferred compensation plan, appealed from the district court's order granting summary judgment for defendants. At issue was the early termination of the Plan, which Paneccasio argued was a breach of fiduciary duty that unlawfully denied him Plan benefits. Paneccasio also argued that the terms of his elected early retirement package ("ERP") superseded defendants' termination rights over the Plan by guaranteeing him future benefits, and that defendants were equitably estopped from terminating the Plan based on Paneccasio's reliance on the ERP brochure language. Paneccasio also sought to reassert his state law claims. The Second Circuit rejected Paneccasio's arguments, and affirmed the district court.

First, the Court noted that Paneccasio's breach of fiduciary duty claim could not survive because the Plan was a top hat one and therefore was exempt from the fiduciary responsibility provisions of ERISA under 29 U.S.C. § 1101(a)(1). The Court next found that the plan administrator's decision to terminate the Plan was not arbitrary and capricious since it was supported by evidence that lower interest rates and fewer plan participants had had an adverse impact on defendant's finances. The Court also rejected Paneccasio's equitable estoppel claim. Noting that such claims can only be applied in "extraordinary circumstances," the Court found that Paneccasio's reliance on an implicit guarantee of continued benefits in an ERP brochure was unsupported, and his claim of detrimental reliance was unreasonable. The Court interpreted the Plan's disclaimer and reservation of rights to give defendants the right to terminate Paneccasio's deferred compensation plan.

Finally, the Court rejected Paneccasio's argument that his state law claims were not preempted by ERISA because the Plan was a top hat plan. The Second Circuit held that, although top hat plans are exempt from some ERISA requirements, they are still subject to ERISA administration and enforcement provisions. Here, each of Paneccasio's state law claims explicitly referenced the Plan, and each was tied to the Plan's termination. Because these claims all "related to" the Plan, each claim was preempted by ERISA.

Rahm v. Halpin (In re Halpin), 566 F.3d 286 (2d Cir. 2009)
(Liability of Employer for Unpaid Plan Contributions)

Debtor William Halpin was the president and sole shareholder of Halpin Mechanical & Electrical, Inc. ("HM&E"). A collective bargaining agreement and other plan documents required both employer and employee to contribute to various ERISA funds. Halpin failed to contribute to these funds, and ultimately both he and HM&E filed for bankruptcy. During the bankruptcy proceedings, plaintiff-trustees moved to (1) render the unpaid employer contributions non-dischargeable, and (2) hold Halpin personally liable for these unpaid contributions. The bankruptcy court ruled against the trustees, and the district court affirmed, holding that the unpaid contributions were not plan assets.

The Second Circuit agreed, citing Department of Labor interpretations stating that "employer contributions become an asset of the plan only when the contribution has been made." Guided by principles of property and trust law, as well as sister circuit and Supreme Court decisions, the Court held that the "unpaid employer contributions were not assets of the plans." Halpin was therefore not a fiduciary to those unpaid contributions and was not personally liable for these losses. The Court noted that, although the parties could have contracted around this result, the relevant documents did not contain language suggesting any such intention.

Slupinski v. First Unum Life Ins. Co., 554 F.3d 38 (2d Cir. Jan. 23, 2009)
(Award of Attorney's Fees to Successful Claimant)

Plaintiff Zbigniew Slupinski was injured in a car accident while on a business trip overseas and required significant and ongoing medical treatment. The district court found that defendant First Unum had improperly terminated Slupinski's LTD benefits, but declined to award Slupinski attorney's fees or prejudgment interest. Slupinski later appealed these adverse rulings, and the Second Circuit reversed and remanded.

Reviewing the five Chambless factors, the Court upheld the district court's conclusion that there was no common benefit to the plan participants (Chambless factor five). The Court noted, however, that attorney's fees may be awarded even when the fifth Chambless factor does not weigh in favor of the plaintiff. It held that the district court erred in its evaluation of the first and fourth Chambless factors. The Court determined that First Unum had the requisite culpability to meet the first Chambless factor. It highlighted the district court's findings that two medical reports relied on by First Unum—stating that Slupinski could return to work—were either not credible or inaccurate. Further, the "voluminous" medical evidence contradicted and outweighed any conclusion that First Unum's reliance on the two medical reports was reasonable, and procedural deficiencies increased the degree of First Unum's culpability, including mischaracterizations and inconsistent treatment of medical reports.

The Court also found error in the district court's conclusion that the fourth Chambless factor— the relative merits of the parties' position—did not weigh overwhelmingly in favor of Slupinski. The Court cited the district court's own findings that evidence in favor of Slupinski's disability was "overwhelming," and that First Unum relied on reports that had "little value." The district court also mistakenly suggested that Slupinski could prevail on this factor only if First Unum's position was frivolous. Rather, the Court of Appeals explained, "[t]he position taken by a defendant in violation of ERISA need not descend to the level of frivolity in order to be sufficiently

culpable to weigh in favor of awarding fees to the ERISA claimant." Id. at 50. The Second Circuit also concluded that the need to compensate Slupinski (who had been out of work and unpaid by First Unum for almost ten years) and the remedial purpose of ERISA favored an award of prejudgment interest.

Wiener v. Health Net of Connecticut, Inc., 07-4651-cv, 2009 U.S. App. LEXIS 3542 (2d Cir. Feb. 23, 2009)
(Arbitrary and Capricious Claims Decision, Standard for Determining Futility of Remand)

Plaintiffs appealed the district court's decision that Health Net's denial of growth hormone therapy (GHT) for their minor child was arbitrary and capricious but that remand was futile because an independent claims reviewer had determined that Food and Drug Administration ("FDA") guidelines for use of GHT in children were not satisfied here. The policy excluded coverage of GHT unless it was "medically necessary and appropriate." After Health Net denied the claim, the Weiners filed an external appeal with the State of Connecticut, which forwarded the appeal to IPRO, an independent reviewer. IPRO recommended that Health Net's decision be affirmed because plaintiffs' child did not satisfy the "FDA standards" for use of GHT in children.

The Second Circuit affirmed the holding that the denial of coverage was arbitrary and capricious because Health Net had failed to resolve a discrepancy in the treating physician's records, which variously indicated that the child had a growth rate in the 25th and the 10th percentiles. The Court of Appeals stated that Health Net could "easily" have resolved this discrepancy by calling the doctor and that its failure to do so rendered its decision "without reason." However, the Second Circuit reversed the lower court's ruling that remand would be futile because the Wieners had failed to establish that their son was eligible for GHT under the "FDA standards" described in IPRO's decision. The Court concluded that it was unclear that the FDA standard defined what was "medically necessary" under the policy, that the administrative record did not address what the FDA standard was, and that Health Net had not determined that failure to meet that standard would establish that GHT was not medically necessary in this case. The Court held that IPRO was not the plan administrator and "therefore could not make this determination *ex nihilo*" and remanded the case so that Health Net could address these issues on remand.

Young v. General Motors Inv. Mgmt. Corp., 2009 U.S. App. LEXIS 9792, 46 Employee Benefits Cas. (BNA) 2278 (2d Cir. May 6, 2009)
(Duty to Diversify Investments, Excessive Fees)

Plaintiffs alleged that retirement plan managers had breached their fiduciary duty by investing in "risky" undiversified single-equity funds. The Second Circuit held that, pursuant to 29 U.S.C. § 1104(a)(1)(B), which requires a fiduciary to "diversify the investments of the plan so as to minimize the risk of large losses," plaintiffs' failure-to-divest claim could only survive if it alleged a failure to divest across an entire retirement plan. The Court of Appeals affirmed dismissal because plaintiffs alleged only a failure to diversify individual funds within the larger plan.

Plaintiffs' excessive fee allegation likewise failed to state an actionable claim. The Court applied the standard for excessive fees under the Investment Company Act, and determined that the claims did not allege that the "fees were excessive relative 'to the services rendered.'"

II. DISTRICT OF CONNECTICUT DECISIONS

Amara v. CIGNA, 534 F. Supp. 2d 288 (D. Conn. 2008)
(Remedies for Improper Notices and Disclosures In Violation of § 204(h))

Judge Kravitz considered the appropriate remedies for a class of CIGNA employees stemming from his ruling that CIGNA violated ERISA's requirements regarding the notices and disclosures to be provided to employees in connection with the transition from a defined benefit to a cash balance retirement plan.

The Court previously held that the manner in which CIGNA implemented the transition to the cash balance plan was unlawful because of its materially misleading notices and disclosures. Based on CIGNA's statements in its publications that all early retirement benefits would be protected and its failure to warn of "wear away" of pension benefits, the Court ordered the CIGNA Plan to reform its records to reflect that all class members must now receive accrued "A+B" (defined benefit and cash balance) benefits. It also ordered CIGNA to supply accurate § 204(h) notices to all members of the Class, including rehires, and to issue an updated and corrected Summary Plan Description for Part B and "new, accurate" benefit election notices. Noting that the remedy issues were "complex, difficult and enormously important," Judge Kravitz sua sponte stayed his decision so that the parties could seek review in the Court of Appeals. More to come on this case next year.

Collins v. Southern New England Telephone Co., 617 F. Supp. 2d 67 (D. Conn. 2009)
(Preemption Standards Following Travelers)

Plaintiff Aaron Collins sued his former employer for racial discrimination under Title VII and the Connecticut FEP, intentional infliction of emotional distress, breach of contract and promissory estoppel. Southern New England Telephone Company moved to dismiss all but the Title VII claim on grounds of ERISA preemption. In a lengthy opinion, Judge Haight considered the standards applied by the Second Circuit to preemption analysis following the Supreme Court's decision in N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. See Gerosa v. Savasta & Co., 329 F.3d 317 (2d Cir. 2003); Hattem v. Schwarzenegger, 449 F.3d

423, 431 (2d Cir. 2006) (noting that since Travelers "there has been a significant change in preemption analysis that necessitates revamping our overbroad view of its scope"). Judge Haight followed the test set forth in Hattem that "a law relates to an employee benefit plan, within the meaning of [the preemption clause], if it has a 'connection with' or 'reference to' such a plan." 449 F.3d at 428. The Court explained that, when evaluating a state law for a "reference to" ERISA, a judge should consider (1) whether "the state law act[s] immediately and exclusively upon ERISA plans," and (2) whether "the state law require[s] an ERISA plan as a critical element of a cause of action" or if it functions independent of the ERISA plan. Further, "[w]hen the only way in which a claim 'relates to' an ERISA-governed plan is in the determination of the amount of damages, those factors should not be fatal to a claim." When examining a state law's "connection to" ERISA, Judge Haight stated, a judge should consider (1) whether "the state law single[s] out ERISA plans, entities, or actors, or [if it is] a law of general applicability," (2) whether "the state law force[s] ERISA plans or actors to make a specific choice, or act in a certain manner, either directly or indirectly through irresistible economic incentives," (3) whether "the state law impose[s] significant administrative burdens or acute economic effects on ERISA plans or actors," and (4) whether "the state law conflict[s] with a remedy that is already exclusively provided by ERISA . . . in a way that frustrates congressional intent." Judge Haight concluded that the five claims challenged by SNET were not preempted by ERISA and therefore survived the motion to dismiss.

Fenwick v. Merrill Lynch & Co., 570 F. Supp. 2d 366 (D. Conn. 2008)
(Statute of Limitations, Standing, Remedies)

Plaintiffs Fenwick and Fisher were participants in Advest Inc.'s retirement plan, and brought this action under ERISA Sections 502(a)(1)(B), (a)(2), and (a)(3) on behalf of themselves and other individuals who had been or would be denied benefits under the plan. Plaintiffs alleged that the plan violated minimum vesting standards and that defendants had failed to provide a summary plan description ("SPD"). Defendants argued that plaintiffs' claims were time-barred and that plaintiffs did not have standing to assert them.

Judge Eginton held that plaintiffs' Section 502(a)(1)(B) claim was not barred by the relevant six-year statute of limitations. Defendants argued that the statute of limitations began to run when plaintiffs first enrolled in the plan and received notice of the forfeiture provision. The Court disagreed because plaintiffs had never received a SPD. Without the SPD, plaintiffs did not have full knowledge of the plan's terms, and therefore did not have "notice that the terms of [the plan] repudiated their entitlement to accrued benefits." Id. at 372. The Court held that the statute of limitations therefore began to run when plaintiffs terminated their employment in 2005. It similarly found that plaintiffs' Sections 502(a)(2) and (a)(3) claims were not time-barred by the applicable three-year statute of limitations.

Defendants also argued that plaintiffs did not have Article III standing because ERISA did not provide them with a remedy under Sections 502(a)(1)(B), (a)(2), and (a)(3). The Court held that plaintiffs had standing because the Plan allowed them to recover accrued benefits if the forfeiture provisions were found to be invalid or unenforceable.

The Court granted defendants' summary judgment motion on plaintiffs' Sections 502(a)(2) and (a)(3) claims. It concluded that the gravamen of plaintiffs' requests for reformation or an injunction under Section 502(a)(3) was for monetary compensation, not equitable relief, the sole remedy available under that provision. The Court also concluded that, although Section 502(a)(2) holds a fiduciary liable to the retirement plan, "[p]laintiffs may not utilize section 502(a)(2) to seek damages on their own behalf rather than on behalf of [the plan]." Id. at 375. Further, the Court held that plaintiffs could not show that the plan suffered asset losses, which distinguished the Fenwick plan from that in LaRue v. DeWolff, Boberg & Assocs., Inc., 128 S. Ct. 1020 (2008).

In a subsequent ruling, **Fenwick v. Merrill Lynch & Co.**, 2009 U.S. Dist. LEXIS 31032, 46 Empl. Benefits Cas. (BNA) 2221 (D. Conn. Apr. 9, 2009), the Court considered plaintiffs' amended complaint, which alleged that the Administrative Committee breached its fiduciary duty by failing to ensure that defendant's defined benefit plan was ERISA-compliant. The Court rejected defendants' argument that plaintiffs' claim for breach of fiduciary duty was improper under ERISA Section 502(a)(1)(B). It held that, under Varity Corp. v. Howe, 516 U.S. 489 (1996), Section 502(a)(1)(B) provides an injured beneficiary with a remedy for breach of fiduciary duty. Defendants sought to limit Varity to claims arising from the interpretation of plan documents, but the Court rejected this "restricted reading," and denied defendants' motion to dismiss this claim.

The Court did dismiss plaintiffs' claim that defendants had improperly failed to distribute a summary plan description. Plaintiffs failed to allege that they had *requested* a SPD, therefore falling short of the "obligation to amplify their complaint with allegations rendering their claim plausible."

Frishberg v. Deloitte & Touche Pension Plan, 3:07-cv-1081, 2008 U.S. Dist. LEXIS 65343 (D. Conn. Aug. 26, 2008)
(Statute of Limitations, Exhaustion of Administrative Remedies)

Plaintiffs Frishberg and Teitel were retired employees of defendant Deloitte & Touche, USA LLP, who alleged that the defendant plan did not properly credit them for service prior to their participation in the plan. Plaintiffs brought their claims under ERISA Section 502(a)(1)(B), alleging a wrongful denial of benefits. Defendants moved to dismiss on the grounds that Frishberg's claim was untimely and Teitel had failed to exhaust administrative remedies.

Judge Droney concluded that Frishberg's claim was likely time-barred by the applicable six-year statute of limitations,

which the Court found began to run in 1998 when Frishberg's claim for benefits was first denied. The Court also found that equitable tolling was not appropriate because the plan did not fraudulently conceal Frishberg's right to sue after the denial of his administrative appeal. The Court noted that the ERISA regulation that led to equitable tolling in Veltri v. Building Service 32B-J Pension Fund, 393 F.3d 318 (2d Cir. 2004), was not enacted in 1998, and the defendant plan therefore acted in conformity with then-applicable ERISA regulations. The Court denied defendants' motion to dismiss, however, because the facts forming the basis of its conclusions were found outside the materials permitted for consideration of such a motion. Judge Droney held that Teitel's failure to exhaust administrative remedies required dismissal of his claim.

Frulla v. CRA Holdings Inc., 596 F. Supp. 2d 275, (D. Conn. 2009)
(Breach of Fiduciary Duty in Connection with Plan's Financial Deterioration, Failure to Act)

Plaintiff Robert Frulla brought this action on behalf of himself and other similarly situated parties, alleging various breaches of fiduciary duty under ERISA, including failure to act, failure to disclose, engaging in imprudent transactions, and failure to appropriately appoint and monitor fiduciaries. The welfare benefit plan ("Plan") at issue provided retiree participants with health care and life insurance benefits. Frulla's allegations stemmed from activities which allegedly occurred from 1996 to 2005, including the sale of CRA's revenue-producing subsidiaries through various transactions ("Transactions"), the distribution of proceeds from the Transactions, the creation of a capped trust fund for payment of Plan benefits, the use of funds from that trust to purchase life insurance, and the subsequent financial deterioration of the Plan. Defendants CRA Holdings Inc. and the CRA Holdings Inc. Employee Welfare Benefit Plan moved to dismiss Frulla's claims, arguing, *inter alia*, that Frulla's ERISA claims failed to state a claim upon which relief could be granted and were time barred. Judge Hall denied their motion in its entirety.

Frulla's failure to act claims included defendants' alleged failure to investigate potential outcomes of the Transactions and alleged failure to pursue and secure additional funding for the Plan. Although ERISA does not provide minimum funding requirements for welfare benefit plans, defendants were contractually obligated to fund the Plan pursuant to a settlement agreement from prior litigation. The Court found that this obligation may have imposed a fiduciary duty on defendants to ensure that the Plan was adequately funded. Similarly, the Court found that defendants may have had a fiduciary duty to investigate outcomes and protect the Plan, depending on the extent of their knowledge of the outcome of the transactions.

As to Frulla's failure to disclose claims, defendants argued that they complied with ERISA's limited disclosure requirements and that the information at issue was immaterial. The Court disagreed, first stating that the question of a fiduciary's obligation to communicate accurate information applied when "a plan's financial condition is deteriorating and both the cause of the deterioration and the fact of its existence are concealed from plan participants." 596 F. Supp. 2d at 285. Further, the Court reasoned that Frulla might be able to prove that disclosure could have enabled the plan participants to protect their interests in the plan. The Court therefore found that Frulla properly stated a claim for failure to disclose.

The Court concluded that Frulla had properly pleaded knowing omission of material facts, and that the determination of defendants' compliance with ERISA's disclosure obligations was "a fact-specific inquiry inappropriate for resolution at this stage." Id. at 288. The Court also declined to view defendants' public disclosure of the transactions as evidence of non-concealment, again finding that Frulla was entitled to proceed to discovery. Finally, the Court held that Frulla did not discover his injury until he was informed by letter that the Plan was in financial trouble and that he was required to make monthly contributions to sustain it. Based on ERISA's "discovery" rule, the applicable six-year statute of limitations therefore began to run in April of 2005, and Frulla's claims were not time-barred.

Haddock v. Nationwide Financial Services Inc., 570 F. Supp. 2d 355 (D. Conn. 2008).
(Breach of Fiduciary Duty by Fellow Fiduciary, § 409(a))

Plaintiffs were trustees of five employer-sponsored, participant-directed 401(k) plans. Defendant Nationwide was chosen by the Plans' administrative service providers as the Plans' investment provider, with responsibility for selecting certain mutual funds to be available for investment by the Plans and the participants. The lawsuit arose out of Nationwide's receipt of income from mutual funds that it called "service contract payments" or "revenue sharing payments." Nationwide received these payments based on the percentage of assets the Plans and its participants invested in the mutual funds through Nationwide. The Trustees contended that no services were performed in exchange for these payments and that they were actually made in exchange for Nationwide's offering those funds as investment options to the Plans and the participants. In its Answer, Nationwide asserted counterclaims for contribution, indemnification and breach of fiduciary duty by the Trustees. The basis for these claims was defendant's contention that the Trustees had the ultimate responsibility for purchasing annuity contracts and making changes to investment options, and that they knew of the revenue-sharing payments and received cost savings from these payments. Nationwide also alleged that the Trustees breached their fiduciary duties by ratifying or being recklessly indifferent to the revenue sharing payments and that, if Nationwide was found to be a fiduciary of the Plans, it was entitled to seek damages on behalf of the participants.

The Trustees moved to dismiss all of the counterclaims. Judge Underhill held that he was bound by the Second

Circuit's decision in Chemung Canal Trust Co. v. Sovran Bank/Maryland, 939 F.2d 12, 18 (2d Cir. 1991), that ERISA permits claims for contribution or indemnity among co-fiduciaries and that this decision was not affected by Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), which dealt with plaintiffs' remedies against a third party non-fiduciary who participated in the underlying breach, not a fiduciary's rights against its fellow fiduciaries for a breach of trust. Judge Underhill also concluded that the right to seek contribution and indemnification was not an additional right of action (which might run afoul of the holding of Gerosa v. Savasta & Co., 329 F.3d 317 (2d Cir. 2003), that the Court "was no longer free to fill in unwritten gaps in ERISA's civil remedies" following Mertens). Rather, he concluded, the right to seek contribution and indemnification was "a procedural device, implicit in the common law of trusts, for fairly distributing costs among all culpable parties regardless of whom the plaintiff chooses to sue directly for the breach of trust." Although he concluded that Nationwide was not precluded as a matter of law from asserting these counterclaims, Judge Underhill held that Nationwide was prohibited by the law of trusts from seeking contribution because only it received a benefit (the revenue sharing payments) from the breach of trust: "[t]o allow it to seek contribution for those damages would permit it to retain some of the benefit of its breach, which is contrary to the law of trusts." Judge Underhill also held that the counterclaim for breach of fiduciary duty failed to state a claim for relief because it did not allege any losses or harm arising from the Trustees' alleged breach, an essential element of such a claim under 29 U.S.C. § 1109(a).

Kruk v. Metropolitan Life Ins. Co. and Pechiney Plastic Packaging, Inc., 3:07-cv-01533, 2009 U.S. Dist. LEXIS 46454 (D. Conn. May 26, 2009)
(*Discovery Relating to Conflict of Interest*)

In an earlier decision, Judge Covello concluded that MetLife should have obtained additional information before denying plaintiff Kruk's claim for long-term disability benefits and remanded the matter to allow it to do so. On remand, MetLife concluded that Kruk had a psychological disability but not a physical one; it also placed the claim under "high review status" because the monthly benefit exceeded $5,000. Back before the district court (Judge Haight) Kruk filed discovery requests to (1) obtain a copy of MetLife's claims handling manual, (2) depose the claims and medical personnel who denied her claim, and (3) investigate the relationship between MetLife and its reviewing doctors.

Judge Haight addressed this discovery issue based on the Second Circuit's analysis of MetLife v. Glenn in McCauley v. First Unum Life Ins. Co., 551 F.3d 126 (2d Cir. 2008). He noted that other courts had concluded "that one appropriate avenue for discovery is to identify a conflict of interest." Id. at * 11. Judge Haight required MetLife and plaintiff's former employer, the plan administrator, to produce any document that satisfied the language of 29 C.F.R. § 2560.503-1)(m)(8)(iv) (any "statement of policy or guidance with respect to the plan [and] concerning the denied treatment option or benefit for the claimant's diagnosis," without regard to whether it was relied upon) but not all internal operating guidelines concerning the manner in which the company reviewed appeals of LTD claims.

Judge Haight also granted plaintiff's motion to compel responses to an interrogatory that sought the identity of "every medical and/or health care professional that MetLife had review" the plaintiff's LTD application, a statement regarding why MetLife considered review by this person appropriate, the reviewers' employment status and qualifications, and information about how often the reviewers had rendered an opinion for MetLife. The Court found these issues "wholly appropriate" because they could be directly relevant to questions of conflict of interest.

Judge Haight also held that Kruk should be allowed to depose a representative of the Plan Administrator, Pechiney, but should limit her inquiry to whether or not the determination was affected by a conflict of interest or departed from standard procedures for decisions regarding LTD claims. The Court also allowed Kruk to depose three doctors or health care professionals retained by MetLife to review her file, limited to the issue of whether their review departed from standard procedures or whether they had a relationship with MetLife or Pechiney "that would call their medical evaluations into question."

Parillo v. FKI Industries, Inc., 608 F. Supp. 2d 264 (D. Conn. 2009)
(Vesting of Retiree Medical Benefits)

Plaintiffs were alleged beneficiaries of a post-retirement welfare benefits plan, for which defendant FKI retained responsibility. Plaintiffs claimed that FKI denied them vested health benefits and argued that the intent to vest could be inferred from plan provisions and discussions during labor negotiations. FKI argued that there was no agreement to vest the benefits, and that the terms of the plan and other documents manifested no intent to vest. Judge Arterton held that plaintiffs could not prove there was an agreement for vesting because they did not identify specific language in the relevant plan documents which could be "reasonably capable of being interpreted as an intent to vest the medical benefits." The Court noted "that courts cannot 'infer a binding obligation to vest benefits absent some language that itself reasonably supports that interpretation.'" 608 F. Supp. 2d at 267 (quoting Joyce v. Curtiss-Wright Corp., 171 F.3d 130, 135 (2d Cir. 1999)).

Rebaudo v. AT&T, 582 F. Supp. 2d 250 (D. Conn. 2008)
(Equitable Relief Under Section 502(a)(3), Remedies under Section 510)

Plaintiff Rebaudo alleged that AT&T Services terminated him three weeks before his retirement in order to deprive

him of his retirement benefits. Judge Squatrito construed his complaint as alleging a claim under ERISA Section 510, made enforceable through Section 502(a)(3). AT&T moved to dismiss on the ground that the complaint improperly sought money damages. The Court noted that Rebaudo did not ask it to impose a constructive trust or equitable lien so that he could recover participant funds or property in AT&T's possession; he sought relief from "past, present and future economic loss" that he claimed AT&T had inflicted on him. Accordingly, the Court concluded that Rebaudo sought "a classic remedy at law: compensatory damages for AT&T's premature termination of his employment," which were unavailable under Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). Although it appeared unlikely that Rebaudo would be able to allege a viable cause of action for equitable relief, Judge Squatrito nonetheless granted him leave to file a second amended complaint.

Smith v. Champion International Corp., 573 F. Supp. 2d 599 (D. Conn. 2008)
(*Transferable Skills Analysis, Subjective Complaints, Arbitrary and Capricious Claim Denials*)

Fourteen former employees of Champion International Corporation challenged nonpayment of long term disability benefits. Plaintiffs included salaried and hourly workers, whose LTD benefits were covered by different plans. Champion contracted with CORE, Inc., to assist in managing the LTD program, but Champion retained full and sole authority for determining eligibility. In a lengthy opinion, Judge Droney granted Champion's motion for summary judgment as to three plaintiffs for failure to exhaust administrative remedies, rejecting plaintiffs' argument that review by Champion would be futile. Notably, the Court found that the denial letters Champion issued provided sufficient notice of the right to further review even though they "may not have strictly complied with all ERISA requirements."

Turning to the merits, Judge Droney found that his review was subject to the arbitrary and capricious standard and that plaintiffs had not identified good cause to expand review beyond the administrative record. The Court concluded, however, that the denial of benefits was arbitrary and capricious as to nine plaintiffs, essentially because of common problems relating to Champion's use of a "transferable skills analysis" ("TSA"). The Court concluded that the TSA was an inadequate basis for determining whether plaintiffs were vocationally qualified to work at "any occupation," including because defendant (1) did not obtain sufficient information about plaintiffs' work histories and instead relied on brief job descriptions, (2) unreasonably treated certain identified "other functions" as higher order "skills" (a work activity that requires the exercise of significant judgment); (3) failed to consider the side effects of prescription drugs, pain, a limited ability to remain seated for an extended period of time, and plaintiffs' ages in determining whether they could reasonably adapt to a new occupation; and (4) failed to consider whether the alternate occupations it identified still existed in the national economy. The Court also found improprieties with regard to individual claims, including disregarding subjective evidence of pain, denying full and fair review by not making available a copy of the TSA, lack of evidence that claimants could sustain a level of exertion on a daily basis, and failing to consider that available positions would have required an unreasonable amount of training.

Judge Droney concluded that remand to the administrator for further review would be an unnecessary formality with regard to four plaintiffs because the lack of residual vocational capacity was "so clear" and the TSAs were "so unreasonable." The Court requested further briefing as to the appropriateness of a remand with regard to three plaintiffs and remanded the claims of two plaintiffs for reevaluation. The Court denied summary judgment with regard to the final plaintiff because of ambiguities in the record regarding her work capacity.

Taylor v. United Techs. Corp., 3:06-cv-1494, 2009 U.S. Dist. LEXIS 19059, 46 Empl. Benefits Cas. (BNA) 1935 (D. Conn. Mar. 3, 2009)
(Prudent Person Standard with respect to Financial Management)

In an eight-count complaint, plaintiffs alleged various breaches of fiduciary duty with respect to defendants' administration and management of an employee benefit plan. These allegations included the decision to have a stock fund hold cash, offering funds with high fees and expenses, making misleading statements with respect to those fees and expenses, offering actively managed investment options, and failing to capture float. In granting defendants' motion for summary judgment on all counts, Judge Eginton held that defendants acted according to the prudent man standard, and that plaintiffs failed to offer evidence that defendants otherwise acted in violation of ERISA provisions.

The Court noted that, although at times defendants could have chosen a more favorable alternative, "[t]he prudent person standard does not require the fiduciary to take any particular course of action even if another approach seems preferable." 2009 U.S. Dist. LEXIS 19059, at *24. The Court also found that plaintiffs' allegations of misleading statements and nondisclosure were unsupported, in part because plaintiffs failed to establish the materiality of the nondisclosure of certain fees. Specifically, the Court noted that "in the context of securities law, several district courts within this Circuit have concluded that sub-transfer agent fees do not affect the share price and therefore are not material to an objectively reasonable investor." Id. at *36.

Addressing plaintiffs' allegations that a fee-offset arrangement created a conflict of interest which required disclosure, the Court stated that "the fact that a fiduciary's action or decision incidentally benefits an employer does not necessarily mean that the fiduciary has breached his duty." Id. at *37-38. Here, the Court concluded, defendants did not breach their fiduciary duty because their "decisionmaking process turned on considerations of the participants' and beneficiaries' best interests rather than the incentive of the fee discount." Id. at *38.

Tritt v. Automatic Data Processing, Inc. Long Term Disability Plan Administrator, 2008 U.S. Dist. LEXIS 41208 (D. Conn. May 27, 2008); 2008 U.S. Dist. LEXIS 98327 (D. Conn. Dec. 1, 2008)
(Venue, Remedies, Statute of Limitations for § 502 Claims, Discovery)

Plaintiff Suellen Tritt, a former employee of Automatic Data Processing, Inc. ("ADP"), received long term disability benefits for 24 months pursuant to ADP's Long Term Disability Plan. After unsuccessfully seeking additional benefits through 10 years of administrative appeals, Tritt brought this action alleging violations of her rights under ERISA.

Judge Droney denied defendants' motion to transfer venue, finding that, although some factors weighed in favor of transfer to the District of New Jersey, "Congress purposefully enacted a broad venue provision for ERISA cases," and Tritt's choice of forum was due "significant deference." 2008 U.S. Dist. LEXIS 41208, at *6. The Court concluded, however, that the relief Tritt sought under Section 502(a)(3) was duplicative and inappropriate, and warranted dismissal. The equitable remedy that Tritt sought under Section 502(a)(3) was equally available to her under her Section 502(a)(1)(B) claims. The Court stated that, although a party may bring claims under both provisions when there is a risk that the Section 502(a)(1)(B) claims will fail, here no such risk existed.

Addressing the parties' cross-motions for partial summary judgment on Tritt's ERISA Section 502(c) claim, the Court held that Connecticut's one-year statute of limitations under its civil penalty statutes was the most appropriate limitation period because it most closely represented a penal provision. The Court found that Tritt's Section 502(c) claims were time-barred under the one-year limitation period. It rejected Tritt's argument that equitable tolling was appropriate, finding that Tritt could have exercised reasonable diligence to determine her right to sue once defendants failed to respond within 30 days to the document request she filed on June 17, 1997.

In a subsequent decision, 2008 U.S. Dist. LEXIS 98327, Judge Droney held that the 1986 Plan and 1991 SPD, which were in effect when Tritt first applied for benefits, controlled the standard of review for her Section 502(a)(1)(b) claim. Neither the 1986 Plan nor the 1991 SPD reserved the right to alter the benefits plan after a beneficiary became disabled, which meant that Tritt became vested in the 1986 Plan at the time she was allegedly disabled in 1991. And, although the 1986 Plan and the 1991 SPD gave ADP the power to amend the plan, this did not equate to a grant of discretionary authority. The Court concluded that, under the 1986 Plan, the standard of review was therefore *de novo*.

The Court also held that, because ADP determined benefit eligibility and paid out those benefits, a "clear" conflict of interest existed that expanded the scope of review beyond the existing administrative record. Judge Droney held that this conflict of interest also warranted additional discovery "to determine whether an actual conflict of interest influenced ADP's denial of benefits, and whether there might be 'good cause' to expand the scope of review beyond the administrative record for some other reason." 2008 U.S. Dist. LEXIS 98327, at *9-10. The exact form of additional discovery was not specified.

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Questions or Assistance?

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