



# Employee Benefit Plans in the New Administration

## Employee Benefits in the New Administration

ROBERTO SCALESE: Good afternoon. The Association of Corporate Counsel and SmartPros Legal and Ethics welcome you to today's webcast, Employee Benefit Plans in the New Administration.

*[The instructions provided here were intended for attendees of the live webcast when it was originally broadcast. You may submit questions and comments regarding the content of this course using the Questions and Comments link on the left side of your screen below the video.]*

Our presentation today will be moderated by Timothy Rogers. He is a senior attorney with the Employment Law and Benefits Section of Southern California Edison Company. Mr. Rogers will introduce our speakers today. Take it away, Tim.

TIMOTHY ROGERS: Hi. Good day, everyone, and welcome to today's ACC webcast. I will get right to it. There are a lot of interesting and practical topics for us to discuss today, so after some brief introductions and a few logistical items, we will proceed.

First a little bit about today's webcast subject. ERISA, in my experience, for many years was something of an esoteric kind of niche area which was rather mysterious and somewhat sedate. Present company excepted, it probably interested few attorneys and fewer corporate types, but I think needless to say those days are gone. There are Supreme Court cases of great import coming down one after another significantly impacting employee benefit plans and their administration and the companies who sponsor them; 401(k) litigation has received widespread attention, fee disclosure regulations and/or legislation are on the horizon, and health care legislation is the stuff of daily conversation and keen public interest.

So we are fortunate, today, to have three esteemed and leading ERISA and employee benefits practitioners, each of the law firm of Crowell and Moring in Washington, D.C., shed some light and perspective on these high-profile topics.

Leading today's presentation is Tom Gies. He is the founding partner of Crowell and Moring's Labor and Employment Practice Group in Washington, D.C. Tom leads the firm's ERISA litigation team and has broad experience on issues involving retirement and 401(k) plans, including representing the respondents in the *LaRue* case, one of the Supreme Court cases that will be discussed today. Tom is a frequent lecturer and a member of the faculty of PLI's national ERISA litigation program.

After Tom, the next speaker will be Florence Prioleau. She practices legislative advocacy before Congress and federal agencies on behalf of private companies, trade associations and municipal governments on diverse issues, including health care reform. Ms. Prioleau was an assistant director of the domestic policy staff at the White House during the Carter administration and has extensive congressional staff experience.

The next speaker is William Flanagan. As counsel for the firm, he specializes in employee benefits matters with over 25 years of experience with ERISA. He provides counseling and representation on a full range of ERISA issues, including health care reporting and coverage, including COBRA and HIPAA. He has represented clients before the Department of Labor in numerous prohibited transaction exemption and advisory opinion proceedings and began his ERISA career with the Department of Labor's Office of the Solicitor in the Planned Benefit Security Division, where he was an assistant counsel for regulation.

Now I'm not sure that I've done complete justice to the presenters' very impressive biographies, but because we have a lot of ground to cover, I'm going to proceed at this point, and if the audience can bear with me while I go over a few more important housekeeping items.

The first one is regarding questions. *[The instructions provided here were intended for attendees of the live webcast when it was originally broadcast. You may submit questions and comments regarding the content of this course using the Questions and Comments link on the left side of your screen below the video.]*

Another housekeeping item is survey. Another matter which is very important today to the ACC and to the Employment and Labor Law Committee is the evaluation form which you have been asked to complete. *[The instructions provided here were intended for attendees of the live webcast when it was originally broadcast. If you are taking this course for CLE credit, you may complete an evaluation form when you obtain your certificate.]* We would appreciate it if you would take a few

moments to complete that form at the end of the presentation. As you may expect they are very important; they are reviewed continually so that we can improve these webcasts and the ACC can continue to be a superior resource in this respect.

Please note finally that the webcast is being recorded and will be made available on the ACC Web site. And so with that, I will hand it to Roberto at this point.

ROBERTO SCALESE: OK, thank you, Tim.

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Thank you. Back to you, Tim.

TIMOTHY ROGERS: OK, Tom will lead off with a discussion of the *Glenn* and *Kennedy* cases entitled The Supreme Court's Latest ERISA Double Play, and as a sports fan, I am all ears.

TOM GIES: Thank you Tim. Good day, everyone. I'm going to try to cover the court's three latest decisions, *Glenn*, *Kennedy*, and *LaRue*, in reverse chronological order. It may be a little unusual but I think they make more practical sense when considered in this way and, at least in my view, taking them in this approach is also probably a matter of reverse order of importance, perhaps to save the best for last.

So with that let's start with *Kennedy*. You see the factual context in the court's holding there on your slides. Many of you involved in plan administration find this to be a perennial issue of dealing with the consequences of a divorce. It is a straightforward answer from the Supreme Court in the sense that it is good news in that it now, I think it's pretty clear, that plan administrators are removed from at least one aspect of family law disputes. The court's opinion reaffirms the plan documents rule, and as a generalization it is safe to say that plan administrators are now free to rely on whatever documentation has been called for by the plan and/or the summary plan description and rely on that, and not have to get into a situation as was presented in *Kennedy* of having to look behind that and see if in collateral family law dispute litigation some change in the beneficiary's intention or the participant's intentions were actually made.

I think a couple of other observations about *Kennedy* are important. First, it may not change at all the outcome of who actually gets the money. If there is a dispute between divorced spouses or beneficiaries or children or other heirs, all this decision does is take the ERISA plan out of that fight. There can very well be, and I think there quite surely will be, continued litigation in state family law courts over whether or not the money can go to the person that is supposed to get it under the terms of the plan. In one of the ironies of ERISA, those kinds of claims are almost surely not pre-empted if they are not brought against the plan, the plan sponsor or anybody else in plan administration. That's, I think, the most important heads-up about the decision.

The second is the decision makes no change at all in the administration of QDROs, so for those of you familiar with that, this does not change that. The decree at issue in this case was not a QDRO.

The other thing that I find interesting about *Kennedy*, from a lawyering point of view, is sort of the starting point for Justice Souter. His opinion, a unanimous opinion, may actually be a harbinger of something that we may see in subsequent cases.

Justice Souter took it as a given that it was a bad thing to impose additional costs on plan administrators in this, at least in this idea, and although you will not find a lot of it explicitly in the opinion, I think it is fair to say that this court's opinion recognizes that consistent with the notion of the importance of encouraging voluntary adoption and maintenance of employee benefit plans, the court here, I think, was pretty easily convinced that it was not a good idea to force plans to spend a lot of resources and time to go into essentially what are more prosaic family law disputes. Whether or not this really will be a harbinger of other cases obviously remains to be seen, but I think it is a tip of a hat to voluntary adoption principle.

I think the other thing to say about the *Kennedy* opinion, and this is not news to any of you who work in this area, as with almost any other ERISA case, it's all about the plan language and it's even more about participant communications. So those

of you who want to stay out of the family courts ought to make sure that your plans are written in a way that provides you the maximum discretion to interpret the plan documents consistent with the court's holding, and I think participant communications about how the plan works and what doesn't happen in the event of a divorce is also something that plan administrators should consider doing.

I think then we can move on to *Glenn*. I think most of us agree that *Glenn* is of much greater significance than *Kennedy*, at least in terms of the volume of ERISA litigation that will be either generated or extinguished. Clearly *Glenn* is going to generate more litigation than it's going to extinguish. As with *Kennedy*, this is a fairly familiar fact pattern. The case involved a benefit claim denial, and this is the situation that we see a lot, where the employer and/or an insurance company arguably have a financial incentive to deny the claim.

If you practice in this area regularly, I recommend that you read both Breyer's and Scalia's opinions carefully. You can then decide for yourself whether you think the decision has had any real change in the law, and if so, what it is. One of the handouts that we have also posted goes into a more lengthy discussion of those opinions than I have time to present today, so that's also available in your materials.

I share Justice Scalia's frustration about the outcome here. I think that the majority's articulation of a new test, or rather a reaffirmation of the *Firestone* test, is really nothing more than an invitation for more facts and circumstances evaluations, which in turn begets more litigation. And I think it's fair to say that for a lot of cases, depending on where you are, in which parts of the country, this might really be an effective end of the arbitrary and capricious standard we've been operating under since *Firestone*.

So to be more specific about my own take, I think it's going to be harder for plans to be able to take advantage of the abuse of discretion standard. Since the decision came down, the circuit courts have taken a different view of what the decision means, which is often the case.

As you see there, a couple of courts have affirmatively said that it's the end of the sliding scale test. I think it's clear that *Glenn* is the end of the causation element that was used by some courts. The Second and the Third Circuits have both said that they have abandoned their prior standard. I think the big question is whether or not the outcome in most of these cases really would have been different under the prior articulation and that I think is an open question. I think the biggest takeaway is that we're going to have additional discovery in these cases regarding the conflict. The Supreme Court's opinion lays out the road map frankly for plaintiff's lawyers to try to discover whether or not the conflict of interest is significant enough that it ought to require *de novo* review, and almost all the time that means, of course, reversal of the denial of the benefit claim.

The challenge, I think, in this case, and in light of this case, is that the Supreme Court's majority opinion says, "Put in as many of the conflict walls, trip wires, and processes that you can." Those trip wires and processes give you a much better argument that the financial conflict of interest had no impact on the decision. If you are new to this area you probably ought to read the Seventh Circuit's opinion in *Jenkins v. Price Waterhouse*. It's a classic Judge Easterbrook opinion. And my final reaction, I guess, to *Glenn* is that in reading these cases, it's apparent to me that the courts are going to continue to be very carefully scrutinizing the medical evidence used by the claims reviewers and others involved to see whether or not, in sort of a plain old-fashioned "does it pass the smell test?" sense, does the decision seem to hold up?

Let's talk about *LaRue* for a few minutes. The facts there are set forward. It is a pretty easy case factually. The person claimed that he tried to get his investments reallocated and that didn't happen and as a result his account balance was depleted. The Supreme Court's holdings also are very straightforward. The court holds that these individual claims can be brought. They do not have to be brought on behalf of a plan, and it's not limited to nefarious conduct by people, the alleged hypothetical trustee who takes the money and moves to Aruba. Any mistake, any error, even if it's not nefarious, will give rise to one of these claims. It's probably a Pyrrhic victory because on remand the plaintiff ended up losing, but the rest of us get to live with the consequences, which is part of the fun of doing this.

As you see, I think it's clear to say that the Supreme Court really backed away from its decision in *Russell*. You also see there that an open question is whether or not these claims, many of them at least, should be viewed as claims for benefits under § 502(a)(1)(B), which is something we will talk about later.

Some consequences: I think it's obvious that these claims for damages, there'll be lots of them. Is it death by thousand cuts? I don't know. The implications, as you see there at the bottom of that slide, any mistake ranging from enrollment issues to blackout dates to plan terminations, if mistakes are made it is possible that you could face litigation for those kinds of things. I think you also need to be cognizant, if you have not thought about this already, in terms of the implications on the

availability and cost of fiduciary insurance. We will talk about the implications on claims for damages later on.

Some open legal issues to talk about, briefly. Despite what you may have read, in my opinion, the standing issue has not yet been resolved. There is a District Court case called *Bendaoud*, which is cited in your materials, that I think correctly makes the distinction between mootness, statutory standing, and constitutional standing, and I think that's an open issue, as is the impact of the chief justice's concurrence in terms of whether or not these can be viewed as benefit claims. As I said, measuring damages is probably the biggest issue of all that you are going to see in these cases.

We should talk a bit about preventative measures. I've set out some of them there on this slide. This is all about, of course, being as clear as you can in what you have in writing and what you communicate to participants about how plan investments, how enrollment decisions, how blackout dates, how withdrawals, how all of those things will be managed. You've got to be much more sensitive if you haven't thought about it recently, about record-keeping. My experience is that stuff happens in HR and benefit plan administration, and without anybody being nefarious, mistakes do happen. And I think the main consequence of this case is that those mistakes make it more likely than not that you're going to end up defending lawsuits for which there frankly may not be much of defense.

Communication to plan participants and beneficiaries about how all of this works is very important. Selection and monitoring of service providers to try to minimize the number of mistakes is also important in implementing the appropriate procedures to try to minimize mistakes. We say all of these things in light of two legal rules that we ought to mention briefly.

First is that not every mistake would actually be a breach of fiduciary duty because mere clerical mistakes are not, and there may be a question in some of these cases as to whether or not the entity involved in making the alleged mistake is a fiduciary, in which, if that's not the case, it may lead to a different array of plaintiffs and defendants if there is litigation.

So that's a few minutes on those cases. I'll now turn it over to Florence to talk about the pending health care reform matters.

FLORENCE PRIOLEAU: Thank you, Tom. Anyone who has been reading just about any newspaper recently knows that health care reform is a priority of the Obama administration and of the leaders in the U.S. Congress. Health care reform is a moving target at the moment however because legislative proposals are in the process of being shaped by the relevant congressional committees, and we don't really know yet the specifics of what will emerge in the form of legislation. So I'm going to try to give you a sense of the issues on the table from the perspective of the business community.

Though health care reform has been elusive, it has been suggested that the economic crisis indeed may be the catalyst that will propel us toward a meaningful health care reform act. The increasing numbers of people who are losing their jobs in the economic downturn are joining the ranks of the uninsured, thus making health care reform, some have argued, more than just a necessity but in actuality a human need. So where is all of this talk leading? Looking at this issue from the perspective of business stakeholders in the health care reform process will require some understanding of the context of the ongoing debate. So in the 10 minutes that I have, I will briefly discuss first an overview of President Obama's approach to health care reform, secondly, activity in congress, third, a focus on some of the issues that have garnered both support and opposition from the business community, fourth and finally, an outlook for accomplishing reform in this congress.

To those of you who may have an accessible employer-sponsored health plan—and I assume that's most of us on this call—and are reasonably healthy, the health care system may seem just fine, but a recent *Time* magazine cover story suggests that's not the case for many Americans. Some of the stats were shocking in fact, in terms of revealing how healthy we Americans are compared to citizens of other countries, particularly in light of what we spend on health care in this country, and I note that expenditures on health care are the only category in which the U.S. ranks number one.

Just to focus on a couple of other facts, we're first in spending, yet 45.6 million people are uninsured. We live shorter lives, have higher infant mortality rates, and die from cardiovascular disease more often than our counterparts in the other industrialized nations that you see here. Stats like these will provide a real-world picture against which health care reform will be measured.

Growing out of the campaign rhetoric, a consensus has developed around the need to address three overarching problems: first, inadequate coverage, secondly soaring costs, and third, less than acceptable quality of care. And so, my discussion of the issues will fall into those three categories.

During the campaign, candidate Obama set down a marker on health care reform. He articulated what he thought then were

the principles for meaningful reform, and since assuming the presidency, he has reiterated those principles. While there are advocates who favor scrapping the current system, the consensus seems to be that meaningful reform can be achieved building on the current system.

First, coverage. The problem, according to the Senate Finance Committee, which has been holding hearings and is one of the primary committees of jurisdiction in the Congress for writing health care legislation, according to their statistics, in addition to the 46 million Americans who are uninsured, 25 million are underinsured. The cost of caring for those folks is shifted largely to people with insurance. These folks with insurance pay higher doctor's costs, pay higher insurance premiums, etc., to make up for uncompensated care provided to people without insurance.

On the issue of coverage, Obama's view is that we start with universal coverage for children by expanding existing programs that make more people eligible. Once you address that, people at higher incomes who don't have an employer-sponsored coverage plan, and as I said, who don't qualify for a government program, would seek to buy coverage through a newly created vehicle called a National Health Insurance Exchange. The exchange would offer an array of preapproved private plans and a public benefit option. And by "public benefit option," that's simply a government-sponsored plan that would be an alternative to the private plan. Some have suggested that the public benefit plan could be fashioned after the plan available to federal employees.

Under the Obama principle, large companies would be required to offer health care to their employees or contribute a percentage of their payroll to the exchange if they choose not to offer coverage. Small companies would be exempt.

With respect to the problem of affordability and cost, again according to the Senate Finance Committee, the rate of increase in health care spending is spiraling out of control and has been. They project that by the year 2017, health expenditures are expected to top 20% of gross domestic product or 4.3 trillion dollars per year. So some of the possible solutions that have been discussed to address the cost and affordability issue are listed on this slide. As a fundamental concept, though, universal coverage will address the uncompensated care problem and end the cost shifting that I mentioned a few minutes ago that forces doctors to charge higher costs to those with health insurance, forces those who have health insurance to pay higher premiums, etc. There are an array of tax credits that have been discussed to help small businesses offset premium costs to provide employee coverage. More competition in the insurance market has been one of the issues that has also been discussed broadly.

Quality. I won't go into detail here. There are a number of things that can be done to improve quality. Eliminating health disparities is one that you see mentioned here. The administration's approach has been described as brilliant because they have compared it to the previous Clinton approach, in which President Clinton attempted to write all the details of a health reform bill. President Obama has set forth his principles, he has reserved \$600 billion as a downpayment against reform, and he has left the details to be worked out by Congress.

This next slide simply lists some of the key players in the Obama administration. You'll see their names mentioned in the press frequently.

There are a number of congressional committees that have jurisdiction over various elements of health care reform. I've mentioned those here.

It is worth noting that a number of businesses and private industry stakeholders are coming on board this time with the need for health care reform. For example, the private insurance industry, who, with their Harry and Louise commercials back in the '90s were very instrumental in defeating the Clinton proposal, they are now calling for comprehensive health care reform. These are some of the reforms in the system that they believe are worthy of attention. But they're not totally on board. I'll just talk about two of their biggest objections, that is, the objections from the business community. One is the issue of mandates. Obviously if universal coverage is a goal of health care reform, one can't expect that to occur spontaneously. Thus employer mandates would require that all employers above a certain level, mainly larger employers, would offer insurance to their employees. If they don't offer insurance, as I said before, if they don't play, they pay. They would pay an assessment.

Then we come to the issue of whether employees would be required to accept coverage. There's also discussion of an individual mandate. That mandate would require that every individual buy insurance. There is a plan in Massachusetts that has been in effect for two years, a reform plan, which seeks universal coverage through an individual mandate so that people who don't buy insurance are subject to penalties. I will add here that there are some exceptions to that general plan.

Secondly, a very controversial part of the discussion involves the public plan option, which I mentioned earlier. The idea that the government would sponsor a health insurance plan that would compete in the market with private plans has raised very vigorous opposition from the health insurance companies, who argue that a public plan would in effect drive private insurers out of the market and would be unfair competition because of the government backing. Obama supports a public plan, as does Kennedy on the Senate Health Committee [and] Rangel on the Ways and Means Committee.

The costs associated with health care also include the costs of tax benefits designed to encourage health care coverage. I list a few of those benefits here and their cost to the treasury. These benefits, these deductions, credits and such might change under health care reform and in fact The Washington Post carried an editorial recently which proposed that some of these benefits should be cut back as unnecessary.

In terms of outlook for completion of a bill, I will say initially that it's anybody's guess. The president's goal is to pass a bill by December, end of this year. House leadership [and] Senate leaders are working hard on a plan which they say they are prepared or will be prepared to reveal later this month, moving to mark-up in July, and have a bill on the House and Senate floor by August—I think that remains to be seen.

Finally, health care reform received a jump start when the stimulus legislation was passed, because a number of changes related to health care, including health IT funding to promote electronic medical records, increases in Medicare funding, increases in the Children's Health Insurance Program, were also enacted in the stimulus bill. In addition, COBRA changes were enacted in the stimulus bill, and this is probably a good segue into Bill Flanagan's part of the presentation.

WILLIAM FLANAGAN: Thank you, Florence. Good afternoon, everybody. Whereas Florence is looking in her crystal ball and trying to figure out what's going to happen in health care reform, I think it's safe to say that the most important concrete legislative achievement of the Obama administration so far has been the American Recovery and Reinvestment Act of 2009, or the stimulus bill, and it did include the COBRA premiums subsidy provisions that I am going to briefly speak about today. It is provisions with the best of intentions to allow people to continue to be able to afford health care after they have lost their employment, but I think, as Florence has indicated, in the health care area, once again with COBRA, the Obama administration and Congress have focused on employers as the source of the solution for these types of problems.

I know most of you are probably familiar with the COBRA subsidy program. I've included a couple of slides here just setting forth the basics, and I won't go into them in any detail, but I will say that the issue of eligibility for the COBRA subsidy continues to be perhaps the thorniest issue presented in this area. It's important to note that the subsidy rules don't change the underlying COBRA eligibility rules. Therefore, for example, if an employee is involuntary terminated from employment for gross or willful misconduct, under traditional COBRA analyses, that individual is not entitled to COBRA benefits. The stimulus package does not change that at all. So someone terminated for gross or willful misconduct is not eligible for COBRA and therefore is not eligible for the subsidy. It's a surprisingly simple concept that we run into that people have problems with.

Going on, the 35% payment that an eligible individual must make is accompanied by a 65% payment by the person to whom premiums are payable under COBRA continuation coverage. In most situations that the folks on this call are involved in, I would say that individual responsible for the 65% payment is the employer. Therefore, as we note, the person to whom those premiums are payable, in most situations, will be the employer. In the case of self-insured plans covered by COBRA or insured plans that are covered by COBRA, this does raise some coordination issues, especially between the employer and the insurance company, where the employer historically has not really been involved at all in COBRA administration. The employer—many of you will now find yourselves having to determine not only who is eligible, whether they have paid their premium, [but] how to go about paying your portion of your premium and how to recover that portion through offset of the payroll tax process.

There are a couple of issues that I just want to raise to you folks today, the first being that under guidance provided by the IRS and DOL, once an eligible individual pays his or her 35%, they are guaranteed coverage, whether or not they should be eligible or not. The IRS is going to work that out through the audit process after the fact.

Second, what is an involuntary termination? Many times you will negotiate a termination with an employee and everyone will agree that it is a voluntary resignation. The IRS has said that they will look at the facts and circumstances of each individual situation to determine whether an involuntary termination has occurred. So there's no guarantee that what you and your employee call it will actually be what the IRS and Department of Labor ultimately deem it to be.

Third, complete notice, and this is something that is really a trap for the unwary. The Department of Labor has said that any

COBRA notice that goes out, whether the individual becomes eligible for COBRA through an involuntary termination or through any of the other qualifying events in COBRA, if that notice does not contain all of the Department of Labor's mandatory and now model notices for the COBRA subsidy program, that notice will be deemed to be incomplete and will not be sufficient to start the running of the various COBRA notice and election period limitations. It's something that a lot of people are not aware of. They'll look at someone who has gone through a divorce or has a dependent child who has reached the age of majority, and they have not received notice, even though it's totally inapplicable to them, the notice will not cause the election period to start running.

The final point I would like to make, evolving issues, deals with the Department of Labor's new administrative appeals process. It's an expedited process. Individuals are allowed to apply through the filling out of a form and providing certain documentation. The department will tell them within 15 days whether they have been wrongly denied COBRA subsidy coverage. It's interesting because the IRS, on the other hand, has said that an employer must never deny COBRA subsidy coverage unless the individual involved has specifically and irrevocably waived that coverage or that subsidy eligibility. So there's tension between what the two agencies are saying. It is left to be worked out. The Department of Labor has said the employers will be dragged into this process in one way, shape, or form, but haven't told us exactly how as yet. So that's a very quick thumbnail sketch of the COBRA issues, and I will turn it over to Tom to talk about some very hot topics in litigation these days.

TOM GIES: Thank you, Bill. We're going to spend the next eight or ten minutes on two topics, each of which could justify more than an hour. What I'll try to do here is give you the benefit of what we're seeing in these cases in terms of how to get rid of them as quickly as possible from a litigator's point of view and better yet avoid them in the first place. On these issues there are more details in the printed materials, the handouts, that were also posted.

Let's start with the stock drop litigation. You may wonder what these things are; well they all involve some sort of business event that causes the company's stock price to drop. Corporate fraud like Enron [and] WorldCom, restatement of corporate earnings for some reason, downturn in the industry sector, problems with a big product, threatened bankruptcy, whatever it might be. When the stock drops, and of course we are presuming here that the company's stock is an investment alternative in the plan, the plaintiff's lawyers are not very far behind. I think you should care; most of you, if you are publically traded, may have already had the pleasure of having one of these cases before. There's a lot of money at stake, there have been significant settlements, and the second wave is a result of last year's financial meltdown. I think it is going to be a much bigger wave even for employers that are not in the financial services industry.

What you see here, very quickly, are the typical theories the plaintiffs make in these cases. The big two we find are claims of violation of ERISA's prudence rule and allegations of misrepresentations and failures to disclose material information. The defenses that are typically asserted by folks like us are set forth on that slide. The most important, probably, merits defense is the presumption of prudence. The leading case there is a case called *Moench* out of the Third Circuit, which is cited in that handout. The impact of Section 404(c), the safe harbor, remains a hotly contested issue. There you should, if you haven't yet, look at the Fifth Circuit's decision in *Langbecker v. EDS*.

The takeaway, I think, for many of you here is the Department of Labor simply doesn't agree with the employer community on this very important issue. The obvious practice pointer, of course, is to try to take the maximum advantage of this safe harbor defense in careful plan design and plan administration. There is some good news in some of these cases, I think. More defendants are being able to get out of the case on motions to dismiss and that's good for all kinds of obvious reasons. The courts have come around to pretty much a consensus that the mere fluctuation in the stock price isn't enough. There's increasing deference to plan design decisions where the plan says that the company stock is a mandatory investment, and finally the presumption of prudence is one that's increasingly being argued at the pleading stage.

Now for those of you who are not litigators, you may have heard a little bit about a Supreme Court case a couple years ago called *Bell Atlantic v. Twombly* that a lot of us use in a variety of litigation contexts to argue that the plaintiff's complaint does not say enough, and the case ought to be dismissed at the motion to dismiss stage. *Twombly* and these merits arguments and some of the other procedural arguments we're talking about are made increasingly in these cases to try to get rid of as many claims as possible at the motion to dismiss stage for pretty obvious reasons.

As we litigate more and more of these cases, my own reaction is that the game is now really turning on a combination of, I guess, four factors: standing, causation, class certification, and damages theories. And we'll talk a little bit about a couple more of those in a little bit, but I think another thing that you might want to have to think about, that you might not have thought about before, is this last bullet point. Do you have an obligation or should you consider or do you need to be a plaintiff yourself? And here I'm talking about the securities lending situation, the planned-for British Petroleum suit,

Northern Trust, there's been litigation brought against State Street, there's been litigation brought against Morgan Stanley, Chase, involving allegations that the fiduciaries and/or administrators involved in the plan have, through aggressive, unreasonable, unwise financial practices, caused a loss to the plan, and that's caused many fiduciaries of plans and plan sponsors to be thinking about bringing their own lawsuits and becoming plaintiffs. [This is] probably not something you had thought of until the financial meltdown.

Let's talk a little bit about some of these other theories in litigation. You should look, when you have one of these cases, very carefully to determine whether people suffered any actual losses and what exactly is the damages theory. This is where I think *LaRue* is likely to spawn a lot of litigation, including *Daubert* challenges, as to the viability of plaintiffs' damages theories where the alleged losses and damages claims may or may not mesh with traditional measures of proving loss, particularly in light of the recent market decline.

I mentioned class certification. One of the interesting things about *LaRue* is that in addition to the developing law in other areas on class certification, there's now a better basis than there was before to argue that these claims should not be certified as a class in the first instance; that in many respects, they are all individual claims for damages for which class certification is not appropriate.

I would leave you with this thought. If you could read just one case—it's actually three opinions—but it's the *Merck* case referred to at the bottom of that page. We've got a citation in the materials. It's got something for everybody. Time doesn't permit me to go through all the issues that come up in the case but it involves who ought to be a defendant, it involves standing, it involves class certification, it involves causation, and it involves the presumption of reasonableness and damages theories. If you spend a few minutes with those opinions, you'll go to the head of the class in learning what some of these hot button issues are.

Let me say a couple of words finally about this, about trying to prevent these claims in the first place—everybody's goal of course. Procedural prudence is obviously the watchword here. Everything you can do to beef up what you may already be doing to demonstrate that you exercise procedural prudence in deciding whether or not company stock should be an investment. Choice is something that is quite important. You see the other things there. The Pension Protection Act of 2006, that safe harbor can be very valuable. You need to understand that to try to take advantage of it, and I think maybe most important on that list is to make sure that you've got compliance with the technical requirements of Section 404(c).

The last thing to say, I suppose, you'll see some other preventive measures there. The last thing to think about, I guess—and a lot of companies have already thought about this; if you haven't, you might want to think about it—is: Should stock be an investment at all? Many companies have decided not to do that any longer. I would think, and you'll hear more about this from Bill later, that the political winds are changing, have changed, and there's a lingering concern that many of us have, in part because of the political change and in part because of the tenacity of the plaintiffs' lawyers and just the facts, that maybe company stock is just too risky to have in a retirement plan in today's environment. The new leaders within the Department of Labor have stated publically, for example, that they think there ought to be an annuity option in a 401(k) plan, which would be a sea change in the way most of us understand 401(k) plans to operate. My point here is simply to say that it now is probably a good time as the second wave of cases start to wash over us, to think about that issue if you have not already done so.

Let me say a couple of words about excessive fee cases. This is one of these deals where I would say if you could just read one decision, *Hecker v. Deere* is the one to read. [It is a] Seventh Circuit decision, very pro-employer. The Seventh Circuit affirmed the trial court's grant of a motion to dismiss. Everyone involved in this, we all were holding our breath to see which way this would come out. The four key aspects of the decision are set forth on that slide, and I think that's pretty straightforward, but that certainly is not the end of the story. I think you would be most premature to declare victory with respect to this type of claim; they really are just starting. The petition for rehearing is on file in the Seventh Circuit. There's more than a dozen other cases pending. The next one up might be in the Eighth Circuit involving a case with Wal-Mart; no guarantee that other courts will take the same view that the Seventh Circuit has.

Significantly, I think, the Department of Labor is against the employer community on important issues here, including the scope of § 404(c), and I think the new administration is probably not likely to be very sensitive to the views of the employer community on this issue. I think that this question of what's going to happen to 401(k) plans is one of the top three to five political issues in Washington, maybe right up there close behind health care reform—the issues that Florence has just talked about—and I completely abdicate any idea of giving you any crystal ball about what's likely to happen. Instead I'm going to turn it over to Bill to talk about the fee disclosure legislation that's already been introduced.

WILLIAM FLANAGAN: Thanks, Tom. It is interesting to note that while these issues are taking up a lot of litigation activity in courts throughout the country, both the Department of Labor and Congress are looking at the very same issues as well.

I was reading the other day a statistic that indicated the class action lawsuits filed in 2008 and the first quarter of 2009 involving stock drop and excessive fee issues would total, if granted damages, in excess of \$18 billion. And that, coupled with the general drop in the value of everybody's 401(k) account, and the belief that there are hidden fees or hidden costs that the average plan and plan participant don't know anything about, that are affecting their retirement stability, has led to a flurry of activity both at the regulatory and legislative level.

The Department of Labor, in 2008, proposed regulations that would have required extensive reporting of fees charged by all service providers, not just in the case of 401(k) plans but in all plans in general. Those fees would be both the direct kind of fees everybody can quantify and indirect payments such as discounts, rebates, things of that nature. This regulation was proposed to implement a requirement in ERISA that service providers receive no more than reasonable compensation for the services that they provide to plans, and there was a thought that if there could be further disclosure of those fees, perhaps plan fiduciaries and plan participants might be able to better monitor what their plans are being charged and perhaps get better service for the fee they are paying or lower fees for the service they are receiving. These are parallel to requirements that the department has already implemented in the reporting and disclosure area as part of the annual Form 5500 plan reporting process that has been in place under ERISA.

These regulations were never finalized. A final regulation was prepared and sent to OMB but then was caught in the change of administrations, and now, as far as anybody can tell, those final regulations are in limbo. They do not appear, interestingly enough, on the department's 2009 regulatory agenda.

To fill that gap, Congress has come in and is becoming very interested in the area of 401(k) fees. They had been interested before. Some people, especially Senator Harkin, had been critical of the Department of Labor's proposal and made that criticism known in a public letter to the department, and now he and Senator Cole from Wisconsin have introduced the Defined Contribution Fee Disclosure Act of 2009. At the same time in the House, Representative Miller from California and Representative Andrews from New Jersey have introduced the 401(k) Fair Disclosure for Retirement Security Act. It's that bill that is getting, I think, most of the action right now. The House has held committee hearings about that bill, and I'll just go through very quickly what some of the specifics of that bill are, because they would require a fee change in the way fees are dealt with by 401(k) plans.

First the bill; it's very, very specific. There is a detailed list of the different types of fees that would have to be disclosed to a plan sponsor or plan fiduciary before that plan sponsor or fiduciary could sign a contract for any kinds of services that involve investment management under a 401(k) plan.

Second, there would need to be a description or disclosures about so-called free services. Oftentimes an advisor will offer you, as all of you know, a bundled fee, where you pay a one-time fee and there are certain other services that are provided, and some of those services are denominated as free or without charge. This provision of the bill would require those things to be unbundled so that the plan sponsor or plan fiduciary would have a chance to see where those costs are otherwise being absorbed.

Third, and perhaps the most revolutionarily, the bill would require direct disclosure of fee information to plan participants. The Department of Labor has been interested in that area for years but has never in its regulatory proceedings introduced anything that would require direct disclosure to plan participants. The Miller-Andrews Bill would do that, both with respect to overall annual fees and the fees being charged to each investment option available under the 401(k) plan.

As I said there, the House has held hearings, the Senate has not on this, but there are certain themes that come out of these, and there are several other bills circulating, and the Department of Labor's initiative, that I think you should be aware of.

First is the idea that transparency of the investment management fees will lead, in one way, shape or form, to lower fees and better services. It should be noted that all of the bills being thought about right now deal only with 401(k) plans and only with investment management fees. So health plans and services provided, for example, by managed care entities, would not be affected.

Second is the idea of direct disclosure to plan participants. It is a relatively revolutionary provision and would be something

that would really change things. Query whether participants would know what to do with this information.

Third, there is the idea out there that fees being charged currently are excessive, and this is important not only from the investment manager point of view but from the employer point of view. Certainly an investment manager that was viewed as either charging excessive fees or not providing the information would, under all of these bills, be subject to some sort of penalties. But at the same time, since the employer would have the burden of providing information to participants and choosing the investment manager, there could be residual liability there, making it easier, in terms of litigation, to prove that the plan sponsor or fiduciary was imprudent, for example, in choosing an investment manager who charged fees that were higher than others.

A closing note: I will just say that yesterday, in testimony before a Senate committee, the SEC chairman Mary Shapiro noted that the SEC is going to open a regulatory project dealing with mutual fund 12b-1 fees. Those are fees that would be covered by this legislation, and that's now become a regulatory priority at the SEC as well. I'm certain that this is not the last we've heard of these things, and that they will be continuing to occupy both a lot of Congress's and the agencies' time in 2009. And I'll hand it back to Tim Rogers.

TIMOTHY ROGERS: Well, thank you. That was a tremendous amount of material that we went over, and I think in really quick and efficient fashion. And in fact we've covered so much ground that I'm in disbelief that I do not see that we have many questions at this point from our attendees, so I would just encourage those attendees who are with us to use the questions box on their control panel to follow up or ask a question of our speakers. As we committed to, we have some time here at the end, and so if you could please do that. And I'm going to take advantage, though, as moderator, since I don't see anybody asking anything, to ask a question that I have; first a comment and then a question.

One is, I think the focus on litigation is really important, because as an ERISA practitioner, I think it's perhaps easy to get kind of bogged down in the regs and in the statute, and ignore sometimes at our peril the developing case law. Now is a really bad time to get in that mode. So with that in mind, on the *MetLife*—and I guess I'd pose this question to Tom—you mentioned about the Supreme Court's majority opinion indicated that the structural conflict could be minimized through the establishing of certain firewalls and trip wires and what have you. And in my view, I understand the concept, but they didn't seem to go long on specifics. One of the specifics they offered was to—for example, it would be helpful if there could be some kind indication that inaccurate decision-making was penalized. I've got a number of problems with that. I don't know what inaccurate decision-making is, other than after the fact, and I'm not sure what kind of penalty is being suggested, but do you have any thoughts about those issues, Tom?

TOM GIES: Well I agree with you that there's not much guidance in the opinion. I think our clients have tried to be practical about it. I think there are some common sense rules that would govern how far you would reasonably go. That's one comment.

Another comment I would make is that I think the real problem is with these independent medical reviewers. When you litigate these cases and when you read them, when you see that there are some sort of a bounty or strong financial incentive for the independent reviewers to deny the claims, that's the worst fact pattern from the litigator's point of view. I don't have any silver bullet on how to fix that, except that it might be that companies who use those reviewers could think more thoughtfully about structuring the compensation to avoid it having look like it is [set up so that] you get paid more if you deny the claims.

TIMOTHY ROGERS: Tom, a quick follow-up. It seemed like the Supreme Court was most critical of the kind of employers who do this on a self-funded basis as opposed to third-party administrators, although obviously the case itself dealt with the third-party administrative context, so do you see any relative advantage of an employer doing this more in-house as opposed to by virtue of third-party administration?

TOM GIES: I really don't. Either you're self-insured or you're not, and so that is going to dictate that, I think. I think if it is done all internally on a self-insured basis, I think you have to be candid because it's so, that somebody's going to second-guess the decision and claim you were financially motivated to do so, and just be prepared, I think, because I try to suggest in my remarks, to look separately at the merits of the claim. Many of these, when you read the cases, the court concludes by saying, "You know what? Whether there is a conflict or not, this really wasn't a close case on the facts therefore we're not going to overturn the decision." Bill, what would you add to that answer?

WILLIAM FLANAGAN: I was just going to say, Tim, that I have seen a couple of cases where judges have, at the appellate level, remanded to the district court level for a specific discussion of whether there were these firewalls or protective

procedures in place. I think that there is some affinity for that, anyone who knows about what used to be the banking industry anyway, where they had Chinese walls set up. But if you can, I think, make a colorable argument that you have a separate decision-making process, that might be something you would want to include in your pleadings or in your responsive pleadings, certainly at the very outset of litigation.

TIMOTHY ROGERS: Florence, I had a question for you. As you said, the health care reform is changing virtually day by day in some respects, but I believe over the weekend there was some kind of report that, perhaps it was Senator Kennedy's kind of proposal, might be to include some type of, I believe, short-term disability or some kind of disability benefit component. Have you seen that and do you think that that's a likely element as part of this reform?

FLORENCE PRIOLEAU: Well, interesting, I was talking to a health reporter just yesterday about that who was trying to get a copy of that. It's a white paper that Senator Kennedy, who chairs the Health Committee, is apparently circulating but didn't intend for it to be disclosed publically. So no, I haven't seen it. I don't know about the disability. I've heard that it includes a public plan, as I described. It includes also an expansion of certain government programs, such as the Child Health Insurance Program, to include more low-income children and would increase the age of eligibility. It also includes mandates. So there are bits and pieces that people have apparently revealed, but I have not seen anything about the disability part of that proposal.

TIMOTHY ROGERS: OK, thank you. I think we're getting toward the end of our program, if I'm not mistaken. Roberto, is that correct?

ROBERTO SCALESE: We are indeed, Tim.

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This concludes our program. Thank you again, and have a great day.

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