EPSTEIN BECKER GREEN

ERIC

BENEFITS LITIGATION UPDATE

A Publication From Epstein Becker Green & The ERISA Industry Committee

Summer 2017 Issue 14

Message from ERIC President and CEO Annette Guarisco Fildes:

Welcome to the Summer edition of *Benefits Litigation Update*, brought to you by The ERISA Industry Committee (ERIC) and the law firm Epstein Becker & Green.

With a new Administration and executive branch, we are already seeing changes to the judiciary, with numerous new judges already nominated and confirmed, and a new Justice on the Supreme Court already participating in and writing decisions. Plan sponsors must be vigilant of change, and prepare for the future by minimizing litigation exposure, while also maximizing strategy and tactics. ERIC represents member companies in all aspects of employee benefits policy, including legislative action, administrative and regulatory activity, and judicial proceedings, where our Legal Committee weighs in on important cases via amicus briefs.

This BLU issue covers a number of eclectic issues that are all of importance to plan sponsors, including forum shopping in ERISA cases, patent exclusivity for biologic medications, 401(k) litigation, and much more. Some of the cases were big wins for employers, while others are likely to cause you some heartburn – but even for those that are disappointing, it's always better to be informed!

Some of the cases in this edition stood out as important warnings for plan sponsors – for instance, a case that demonstrated the risks of not having a fully fleshed out SPD, and one that delves into plans' agreements with service providers. I hope you will find all of these cases as interesting and informative as we did.

We are greatly appreciative of the Epstein Becker & Green experts who partnered with us to put together this edition of the BLU. If you would like more information, or to contact any of the authors or presenters, please do not hesitate to do so.

EXECUTIVE EDITORS

James Gelfand
jgelfand@eric.org

Gretchen Harders
gharders@ebglaw.com

John Houston Pope
jhpope@ebglaw.com

Adam C. Solander
asolander@ebglaw.com

ERIC will hold a conference call discussing cases addressed in this issue on **Wednesday, August 2, 2017** from 2:00 to 3:30 pm EST.

ERIC members and trial members can register for the call by clicking here. If you are a prospective member and would like to participate in the call, please contact ERIC at (202) 789-1400 or by email at memberservices@eric.org.

FEATURED ARTICLE

The Importance and Difficulty of Controlling Venue in ERISA Litigation

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Employment, Labor & Workforce Management practices at Epstein Becker Green

Venue matters. Like many civil cases, the selection of the place to file suit in an ERISA case may be a decisive factor in determining the case's outcome. Before *MetLife v. Glenn*, 554 U.S. 105 (2008), the hodge-podge of approaches to applying the abuse of discretion standard in the various federal circuit courts meant the ability to file in one district rather than another could make all the difference to a plaintiff's success in a benefits denial review lawsuit.

The guise of uniformity under *Glenn*, however, may not have a lasting impact. The seeming uniformity imposed by *Glenn* further diminished last year, when the U.S. Court of Appeals for the Second Circuit broke ranks with its sister circuits. In *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), the court declared that any deviation from the claims procedures set forth by the Department of Labor (DOL Regulations § 2560.503-1) could result in the loss of deferential review. In every other jurisdiction, however, a "substantial compliance" standard excuses any noncompliance that does not actually prejudice a claimant.

Post *Halo,* the federal district courts in the states within the Second Circuit—New York, Connecticut, and Vermont—became destination venues for plaintiffs in need of breaking down the deference that might otherwise stand in the way of winning a benefits lawsuit. Employers would be wrong to think that it is not a problem for their benefit plans if they have few, or no, participants or beneficiaries in those states and their plans are administered across the country.

Unlike most statutes, ERISA contains its own venue provision. Section 502(e)(2) of ERISA (29 U.S.C. § 1132(e)(2)) specifies that suits may be brought in the district:

> (1) where the plan is administered;
>
> (2) where the breach took place; or
>
> (3) where a defendant resides or may be found.

The first two of these venues are easy to locate. The summary plan description (SPD) will inform participants where the plan is administered. The place where the breach occurred could be that same location (if the decision to deny benefits was made there) or, as the cases have held, will include the location where the participant or beneficiary expected to receive the benefits at the time of his or her application. With the exception of retirees or former employees who have moved since their employment ended, these two venues will be captured, by and large, by the locations of a plan sponsor's business operations.

The third venue option, however, presents a huge opportunity for plaintiffs to engage in forum shopping. Every one of those nine words seems to contain a potential for mischief. Consider what it means to "reside" or "be found" for a corporate defendant. Those broad terms might be read to encompass any jurisdiction in which service of process might be accomplished, meaning anywhere the company does business. Of course, the reach extends even further when one considers that ERISA itself provides authority for nationwide service of process.

On top of the breadth of these words, exactly who or what may be "a defendant" is undefined in ERISA. Section 502(a)(1)(B) of ERISA says who can bring suit, but does not specify who should be sued. Section 502(d)(2) of ERISA states that only the plan is liable for a money judgment to pay benefits. It would therefore seem that a plan is the only logical candidate to be a "defendant," though the courts also have allowed either the plan administrator or claims administrator to be named, in lieu of the plan, because they may direct the plan to make that payment of benefits. As a result, courts have allowed participants to proceed even if they name only one of the three potential defendants – the plan, the plan administrator, or the claims administrator – as the sole defendant in their suits for benefits.

Thus, a self-funded health plan administered in Texas, for Texas-based employees, might hire a national insurance company as its third-party administrator and find itself subjected to a lawsuit in a Connecticut federal court because the insurer (who acts as the claims administrator) is headquartered there. If this sounds a bit farfetched, consider this statement from a newsletter published by a plaintiff's firm with a national ERISA benefits practice:

> In most ERISA benefits cases today, at least one of the defendants will likely be a nationally-operating insurance company, such as Unum, Hartford, MetLife, or Cigna. Because these companies operate nearly everywhere in one name or another, they may be "found" there.

Jeremy Bordelon, *Venue and Forum Issues in ERISA Benefits Litigation*, ERISA & DISABILITY BENEFITS NEWSLETTER, July 2015, at 1 (*available at* www.buchanandisability.com). The Tennessee-based firm that published this article recently brought a claim in federal court in Connecticut on behalf of a South Carolina resident against a plan administered in New Jersey, based on the claims administrator's presence in Connecticut. We have seen other firms hopping on the bandwagon to file suits in the Second Circuit, where deference might be overturned under Halo, even though the claims arise in jurisdictions where deference will be enforced under the substantial compliance doctrine.

The risk of forum shopping is not news. One law professor looked at statutes with nationwide service of process, like ERISA, and observed the following: "[A] plaintiff may select a particularly inconvenient forum in the hope of improving the settlement value of its case, or a forum with a comparatively slow or quick docket so as to suit its perceived settlement needs. Likewise, a plaintiff may select what it perceives to be a more plaintiff-friendly forum." Rachel M. Janutis, *Pulling Venue Up By Its Own Bootstraps: The Relationship Among Nationwide Service Of Process, Personal Jurisdiction, And §1391*(c), 78 ST. JOHNS L. REV. 37, 74 (2004). The incentive simply grew with decisions, such as Halo, that confer particular, distinct advantages on those who sue in particular venues.

The counterweight to this naked forum shopping should lie in the venue transfer provision, 28 U.S.C. § 1404(a). That statute allows a Court to transfer a case to another district "[f]or the convenience of parties and witnesses" and "in the interest of justice." Unfortunately, the years of litigation over Section 1404(a) have developed multi-factor tests that fit awkwardly with ERISA benefits litigation. Since benefits cases mostly turn on an administrative record that can be transmitted electronically, with little to no discovery and no live witness testimony, they share little with the considerations that have dominated the question of venue in other types of cases for decades. Plugging traditional factors into the existing test may leave the Court with one non-neutral factor—the plaintiff's choice of forum—and it ends up weighing against transfer. *See, e.g., Robertson v. Standard Ins. Co.*, 2014 U.S. Dist. LEXIS 173939 (D. Or. Dec. 16, 2014).

If the evidence of forum shopping is strong, that constitutes an "interest of justice" to vindicate. Plaintiffs' counsel, however, may try to cover their tracks with plausible evasions. For example, in one pending case, plaintiff's counsel

asserted that he brought the suit in the Connecticut federal court based on its friendlier approach (relative to other potential venues) to the role that out-of-state counsel, specially admitted for the case, can take. Essentially, this constituted a cost-savings rationale because he could rely less on local counsel (who may demand money up front) and take on more of the work himself. The Court recently accepted this justification and refused to transfer the case because, while the factors seemed to weakly favor transfer, they failed to do so "clearly and convincingly." Whether or not that particular rationale carries the day in that particular case, a number of federal districts employ pretrial procedures that raise the cost of litigating in that forum (such as mandatory in-person mediation and required in-person appearances at other conferences) and therefore could provide a seemingly legitimate, cost-based reason to avoid that district.

How, then, do plan sponsors avoid the scourge of forum shopping? Regulating venue starts with the plan itself. A plan should designate one or more specified venues for all benefits litigation. The one federal appellate court to consider the question so far enforced a forum selection clause in a benefit plan, so long as it is reasonable. *Smith v. Aegon Companies Pension Plan*, 769 F.3d 922 (6th Cir. 2014), *cert. denied*, 136 S. Ct. 791 (2016). The lower courts in other Circuits remain split on the issue. Although the majority favor enforcement, those courts that have refused to enforce designated venues have been entertaining suits by residents of their own District, see, e.g., *Dumont v. Pepsico, Inc.*, 192 F. Supp. 3d 209 (D. Me. 2016), but not by forum-shopping, out-of-District interlopers. During the Obama Administration, the DOL sided with participants opposing the enforcement of venue provisions; that position may be revised or revisited by the current Administration.

Another approach would be to use the plan document to identify one proper party to be named in any suit for benefits (such as the plan) and to state clearly that no other defendant may be sued to obtain relief. By shrinking the universe of potentially liable parties (for example, taking a TPA acting as the claims administrator out of the equation), the potential venues should correspondingly shrink. This approach has not yet been tested in the courts, but it is consistent with the Supreme Court's endorsement of plan-dictated limitation periods placed on benefits litigation in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013). Both involve using the plan to create more specific rules governing litigation in an area that ERISA has left vague and undefined. The plan approach possesses the additional advantage of not confronting the venue provision of ERISA directly, which has been part of the objection of courts refusing to enforce venue selection clauses. Rather, it helps to regulate venue indirectly by limiting where a court may conclude the defendant "may be found." *See, e.g., Waeltz v. Delta Pilots Ret. Plan*, 301 F.3d 804, 808 (7th Cir. 2002).

Either, or both, of these approaches also should be accompanied by disclosure of these litigation-related plan rules in the communications regarding the determination of any benefit claim. In the area of plan-imposed limitations periods, the emerging trend seems to require the plans to disclose the information on limitations in the determination letters if the period is to be enforced. *See, e.g., Santana-Diaz v. Metropolitan Life Ins. Co.*, 816 F.3d 172 (1st Cir. 2016); *Mirza v. Ins. Adm'r of Am., Inc.,* 800 F.3d 129 (3d Cir. 2015); *Moyer v. Metropolitan Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014). Best practices would call for similar disclosures in these instances, where a future suit by the claimant may be impacted significantly by the plan's designation of a particular forum or a single proper party.

While this discussion has focused on benefits litigation, venue provisions have been enforced in fiduciary duty litigation as well. These favorable outcomes provide yet another good reason to use venue provisions and should be factored into the selection of venue.

Takeaways

- A failure to address venue in plan documents may expose a plan to suit in unexpected venues, unrelated to the claim, the claimant, or the plan, which have been selected by claimants for forum shopping reasons to increase their chances of winning in court.
- Venue selection provisions in a plan provide a substantial counterweight to forum shopping and are the best tool available to steer a case out of a "shopped" forum.
- Proper party designations under the plan also may assist with controlling distant venue exposure.
- Any provision placed in the plan to regulate how a claim is litigated in court should be disclosed in the claim determination communications.

NOTEWORTHY PENDING CASE

What's With GICs? – Is Any Plan Investment Reasonable?

By Michelle Capezza, Member of the Firm in the Employee Benefits and Health Care and Life Sciences practices at Epstein Becker Green

Adding to the litigation surrounding 401(k) fees is the class action lawsuit, *Insinga v. United of Omaha Life Insurance Company* (case number 8:17-cv-00179), filed May 26, 2017, in the United Stated District Court for the District of Nebraska. In this case, Mr. Insinga, a participant in the Safe Auto Insurance Company 401(k) Plan, sued on behalf of all participants and beneficiaries of defined contribution plans who had funds invested in the United of Omaha guaranteed investment contracts (GICs) as of May 26, 2011. He asserted that the insurer of the GIC was a plan fiduciary who breached its duty of loyalty. The breach, he claimed, was the result of such violations as not specifying the minimum rate of return or methodology to determine the guaranteed interest rate of the investment and setting the rate for its own benefit, retaining the margin, and charging excessive fees or collecting excessive compensation. Further, he asserted that the insurer engaged in prohibited transactions by dealing with the GIC in its own interest for its own account and setting the crediting rate for its own benefit. In sum, Mr. Insinga asserted that the insurer "improperly exercised its discretionary authority to maximize its own compensation and retain large profits rather than crediting the participants and beneficiaries of the plans with appropriate returns." Among his claims, Mr. Insinga seeks to hold the insurer personally liable as a plan fiduciary for his loss of retirement benefits.

The complaint noted that Mr. Insinga directed the majority of his plan 401(k) account to be invested in the GIC. It also asserted that the 401(k) plan documents and fee disclosure materials provided to Mr. Insinga failed to disclose that the insurer retains the spread between credited interest rates provided to plans and its actual earnings. While GICs may provide a worthwhile option for plan participants who seek to diversify their investment choices for their plan accounts and preserve principal, participants may not realize that GICs are fixed income investments and may not be appropriate for the majority of the account's investment. Further, GICs are not designated as investments that would qualify as qualified default investment alternatives and they are not meant to provide high returns. GICs are also not risk-free, and the issuer can default or become insolvent. Moreover, GICs are designed to have inherent restrictions on withdrawals and transfers. Thus, it is possible that Mr. Insinga's complaints may have their root in a lack of understanding regarding how GICs operate as an investment for his 401(k) assets.

Takeaways

Regardless of the outcome of this case, plans sponsors and fiduciaries should take note and confirm their selection, monitoring, and communication processes for such investments. Plan fiduciaries should evaluate GICs and stable value products as they would review and monitor any plan investment that is offered to participants, determine whether it is prudent to make it available in a plan's investment lineup, and ensure that the fees and expenses of the investment are reasonable. It is also important to provide plan participants with understandable communications regarding these investments so that they can evaluate whether, and to what extent, to include such options in their plan account investment portfolio.

NOTEWORTHY DEVELOPMENTS

Third Time is the Charm: Fourth Circuit Finally Finds in Favor of 401(k) Plans' Fiduciaries

By Christopher Lech, Associate in the Employment, Labor & Workforce Management and Litigation & Business Disputes practices at Epstein Becker Green

The everlasting saga of the Nabisco spinoff, which has lasted almost twenty years, is coming to an end—at least with respect to the stock drop litigation brought by RJR Nabisco, Inc.'s employee, Richard Tatum ("Tatum"), against RJR's 401(k) plan (the "Plan"). On its third trip to the United States Court of Appeals for the Fourth Circuit, and almost fifteen years since the lawsuit commenced, the appellate court has affirmed the district court's decision. The court held that the fiduciary's breach did not cause the losses because a prudent fiduciary *would have* made the same divestment decision, at the same time and in the same manner. *Tatum v. RJR Pension Investment Committee*, 855 F.3d 553 (4th Cir. Apr. 28, 2017).

Going back to the beginning, in 1999, with RJR's spinoff of its Nabisco food-related operations, the Plan's investment options included a fund that held stock only in Nabisco's post-spinoff parent. RJR's pension investment committee decided that holding investment funds consisting solely of shares in an unrelated corporation was ill-advised. As a result, in January 2000, the Plan divested the Nabisco funds, and forced participants whose accounts held interests in them to move their money elsewhere. This lead to Tatum bringing a class action against RJR and its various committees, alleging that they breached their fiduciary duties under ERISA. The breach, Tatum alleged, occurred when RJR divested Nabisco stock from the Plan "on an arbitrary timeline without conducting a thorough investigation[,]", which "caused substantial loss to the Plan." *Tatum IV*, 761 F.3d 346, 355 (4th Cir. 2014)

The first time on appeal, the Fourth Circuit reversed the district court's decision because the Plan's documents did not mandate divestment of Nabisco Funds and did not preclude Tatum from stating a claim for breach of fiduciary duty. *See Tatum II*, 392 F.3d 636, 637 (4th Cir. 2004). On remand, after a four week bench trial, the district court held that the Plan breached its fiduciary duty of procedural prudence by divesting Nabisco Funds "without undertaking a proper investigation" because the investment committee failed to sufficiently deliberate and consult with appropriate independent advisors. It was, however, possible that a hypothetical, prudent fiduciary *could have* made the same decision. *Tatum III*, 926 F. Supp. 2d 648, 651 (Md. D. N.C. 2013).

The second time on appeal, the Fourth Circuit decided that precedent mandated a breaching fiduciary prove by a preponderance of the evidence that a hypothetical prudent fiduciary *would have,* not *could have*, reached the same decision. *Tatum III,* 926 F. Supp. 2d at 651, *cert. denied*, 135 S. Ct. 2887 (2015). Noting that the district court's review under the proper standard might lead to the same result, the determination was left to the district court to conduct. Surprisingly, the district court reached a different conclusion. Straying from its previous determination, the district court explained that a prudent fiduciary *would have* divested the Nabisco Funds in the same manner and at the same time that RJR did. *Tatum V,* 2016 U.S. Dist. LEXIS. 19536, at *88–89 (M.D. N.C. Feb. 18, 2016).

This led to the case being heard for the third time by the Fourth Circuit and the third time was the charm. The Fourth Circuit affirmed the district court's decision in favor of the Plan's fiduciaries. And, to top it off, a few weeks later, the Fourth Circuit denied Tatum's petition to have the case reviewed *en banc*. *Tatum*, 16-1293 (4th Cir. May 26, 2017). Notably, the Fourth Circuit rejected an argument that different standards should apply to investment and divestment decisions relying on the Supreme Court's reasoning in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014). Further addressing *Dudenhoeffer*'s support of the efficient market hypothesis, the Fourth Circuit clarified that the heightened would have standard does not require fiduciaries to "predict the future."

Despite our previous analysis that "the Fourth Circuit made it very difficult, if not impossible, for the fiduciaries to avoid personal liability," (*see* prior analysis in *Benefits Litigation Update*, Fall/Winter 2014), this decision provides a glimmer of hope for plan fiduciaries that the heightened would have standard can be satisfied. However, as also previously stated, plan fiduciaries should observe caution. The difficult task of proving that a prudent fiduciary "would have" come to the *same*, *exact* investment decision will not be easy and it is better to avoid having to prove this at all.

Takeaway

If there is one thing that *Tatum* teaches us, it is that it is better to take proactive steps to avoid the harrowing possibility of being involved in a lengthy stock drop litigation examining every step of the plan fiduciaries' process. Accordingly, plan fiduciaries should continue to establish plan procedures for investment decisions, follow "procedural prudence" by strictly adhering to the plan terms, analyze each investment decision carefully, seek the advice of investment consultants, and document the decision-making process.

Northrop Grumman Settles Decade Long Fee Litigation with 401k Plan Participants

By Cassandra Labbees, Associate in the Employee Benefits Practice at Epstein Becker Green

In June 2017, Northrop Grumman agreed to a $16.75 million settlement with participants over ERISA breach of fiduciary duty allegations involving excessive fees in a consolidated class action tiled *In re Northrop Grumman Corporation ERISA Litigation*. (C.D. Cal., No.2:06-cv-06213-AB-JC). Over a decade ago, two sets of participants sued Northop Grumman Corporation ("Northrop") plan fiduciaries and argued that the Northop Grumman Savings Plan and the Northrop Grumman Financial Security Savings Plan (collectively referred to herein as the "Plans") were charged excessive administrative and investment manager fees and that the Plan fiduciaries failed to exercise discretion in the selection, monitoring, and retention of Plan assets. The district court eventually allowed the

complaint of excessive administrative fees to proceed, with the plaintiffs alleging that the Plan paid excessive administrative fees to Northrop for services performed by Northrop employees. Plaintiffs argued that Northrop was made aware in 2006 by consultants that the fees charged for Northrup services were above those generally paid for the services rendered but Northrop did not reduce or eliminate the costs.

Under the June 2017 settlement, the Northrop Grumman Savings Plan class members will receive 85% of the payment and the Northrop Grumman Finance Security and Savings Program class members will receive the remaining 15%. The settlement will cover a period between September 28, 2000 and May 11, 2009. This settlement does not apply to a separate class action, which is still pending, making similar allegations for actions by Northrop from 2010 onward.

Takeaway

Given the significant growth in plan fee litigation, plan sponsors are under additional pressure to properly monitor the fees that are charged to their plans and be able to show that those fees are reasonable. Also, if the plan is paying administrative fees directly to the plan sponsor for record keeping or administrative services, extra caution should be taken to ensure that fiduciary duties are not violated and that any fees that are received from the plan are in line with the market.

Trinity Lutheran Church v. Comer: The Parameters of the Church Plan Exemption under ERISA

By Gretchen Harders, Member of the Firm in the Employee Benefits practice at Epstein Becker Green

On the heels of the Supreme Court's June 5, 2017 decision that employee benefit plans maintained by church-affiliated hospitals were exempt from ERISA, *see Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652 (2017), the Court on June 26, 2017 also held that the exclusion of a church from participation in a state-funded government program for nonprofit organizations violated the First Amendment.

In *Trinity Lutheran Church of Columbia, Inc. v. Comer,* 198 L. Ed. 2d 551 (2017), the Supreme Court held that by denying a generally available benefit solely on account of religious identity, the Missouri Department of Natural Resources' policy violated a church-affiliated organization's right to the free exercise of religion under the First Amendment. This case was brought by the Trinity Lutheran Child Learning Center, a Missouri pre-school and daycare center, which was later merged with Trinity Lutheran Church and operates on church property. Missouri's Department of Natural Resources offers a program called the Scrap-Tire Program, which offers grants to qualifying nonprofit organizations that install playground surfaces made from recycled tires. The program explicitly excludes any applicant owned or controlled by a church, sect, or other religious entity in reliance on the Missouri Constitution. The Supreme Court found that the program expressly discriminated against otherwise eligible nonprofit organizations by disqualifying them from a public benefit solely because of their religious character. This resulted in a penalty against *Trinity Lutheran Church* by not permitting the pre-school and daycare center to participate in a public-funded program solely because of its status as a church.

This decision does not address the church plan exemption under ERISA for employee benefit plans established and maintained for employees by a church. However, *Trinity Lutheran Church* involved a nonprofit pre-school and daycare center serving the community that was merged into a church and operates on church property. In *Stapleton*, the Supreme Court unanimously found that Congress intended that the church plan exemption under ERISA include plans adopted by principal-purpose organizations, even if not established by the church to which the principal-purpose organization is affiliated. Both cases arguably could be read to expand church-affiliated nonprofit organizations' rights to avail themselves of the benefits available to churches under the First Amendment and ERISA.

Takeaway

Though not an ERISA case, *Trinity Lutheran Church* raises the question of what rights should be accorded a church entity under the First Amendment that operates principally as a nonprofit organization. This could have an indirect effect on the parameters of the church plan exemption under ERISA as expanded under the *Advocate Health Care Network* decision to church-affiliated nonprofit organizations.

NOTEWORTHY RECENT DECISIONS

Rhea v. Allen Ritchey, Inc. Welfare Benefit Plan: Is an SPD Enough to Enforce Subrogation After a Medical Liability Settlement?

By Adam Greathouse, Health Policy Associate, The ERISA Industry Committee

In a recent decision by the Fifth Circuit (*Rhea v. Allen Ritchey, Inc. Welfare Benefit Plan, No. 16-41032, 5th Cir. 2017*), the Court decided that a plan's summary plan description (SPD) sufficed as an enforceable plan document through which a plan administrator can obtain reimbursement from a beneficiary.

In *Rhea*, the plaintiff was a beneficiary of the Plan through her husband, an Allen Ritchey employee. She underwent surgery and claimed injury from medical malpractice. The Plan covered over $70,000 of her medical expenses, and through her malpractice action, she received a settlement that was in excess of $70,000. The Plan sought reimbursement under the SPD's language stating that in the instance a third-party caused injury for which a beneficiary received a settlement or other recovery, the beneficiary would pay back any benefits received from the Plan. There was also a clause stating that attorneys' fees could be recovered if the Plan had to file suit to recover third-party settlement funds.

The SPD was the only Plan document, even though it referenced a separate "official Plan Document." Rhea claimed that the SPD was not ERISA-compliant and refused to reimburse the Plan for the medical expenses it covered as a result of the alleged medical malpractice. She sued the Plan seeking a declaratory judgement that she did not owe the Plan any reimbursement. The Plan countersued under ERISA. The magistrate judge as well as the district court judge found in favor of the Plan and also awarded attorneys' fees.

Under ERISA, plans are required to provide SPDs to beneficiaries that must "reasonably apprise [plan] participants and beneficiaries of their rights and obligations under the plan." ERISA also requires plans to "be established and maintained pursuant to a written instrument."

Rhea's first argument was that the SPD and the written instrument had to be separate documents; however, the Court cited numerous cases where an SPD was found to suffice as a written instrument when there was no other plan document. Her next argument was that the SPD did not provide enough detail on how the Plan was funded or how it could be amended, a requirement under ERISA. The Court rejected this argument because "ERISA does not require written instruments to set forth complex procedures," and the SPD had a brief discussion on both funding and amendment procedures. Rhea's third argument was that the SPD was never adopted as the written instrument, but the Court stated that typically when an SPD is the only written instrument, courts assume that it is the written instrument. Rhea's final argument was that since the SPD referenced an "official Plan Document" that did not exist, the Plan lied to her and should not be able to enforce the SPD as the written instrument. The Court referenced a Second Circuit decision in which it was found that if an SPD refers to a non-existent written instrument, the SPD can be enforced as the governing text. Since she could not prove that the Plan made intentional misrepresentations or that the misrepresentation caused her harm, this argument failed. Lastly, the lower court had awarded the Plan attorneys' fees, which are reviewed for abuse of discretion at the appellate level in ERISA cases. The Court found that awarding attorneys' fees was appropriate given that the plaintiff "act[ed] in bad faith when she moved to deny the Plan a recovery to which it [was] contractually entitled."

Takeaway

In good news for plan sponsors, an SPD can function as both the SPD and the written instrument for the plan in the absence of a plan document. Accordingly, plan sponsors should carefully review their SPD provisions, their accuracy and how they relate to the written instrument.

Hannan v. Hartford: Support for Plan Service Providers and Sponsors in Setting Plan Costs

By Sharon Lippett, Member of the Firm in the Employee Benefits practice at Epstein Becker Green

Employer plan sponsors and service providers to employee benefit plans subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA") should be pleased with the Second Circuit's April 25, 2017 decision in *Hannan v Hartford*, 2017 U.S. App. LEXIS 7436 (2d Cir. Apr. 25, 2017). The Second Circuit held that Hartford Financial Services, Inc., the insurer of an ERISA life insurance plan sponsored by Family Dollar Stores Inc., was not a fiduciary of the plan. The court also held that Family Dollar had not breached its fiduciary duties or engaged in a prohibited transaction.

At the heart of this case was the Family Dollar Stores, Inc. Group Insurance Plan (the "Plan"), which automatically enrolled all Family Dollar employees in basic life insurance and offered supplemental insurance. The plaintiffs alleged that the Plan enrollment materials represented that Family Dollar would pay the cost of basic life insurance coverage, while the cost of supplemental coverage, which was "surprisingly affordable" and "without high cost", would be borne by the employees electing such coverage.

Plaintiffs originally brought a class action alleging that Family Dollar overcharged employees for the Plan's supplemental coverage for the purpose of subsidizing Family Dollar's costs for the basic coverage. Plaintiffs also alleged that Family Dollar and Hartford violated ERISA by breaching their fiduciary duties, failing (as co-fiduciaries) to remedy each other's breaches and participating in prohibited self-dealing. The district court dismissed these claims in March 2016.

On appeal, plaintiffs challenged the dismissal of their fiduciary and co-fiduciary claims with respect to alleged misrepresentations in the enrollment materials and their prohibited transaction claims with respect to self-dealing by Hartford and Family Dollar. Plaintiffs alleged that Hartford was a Plan fiduciary because it exercised discretionary control over the assets of the Plan (for example, control over payroll deductions for the supplemental coverage when it negotiated the contract terms and then shared in the premiums). The Second Circuit concluded that the complaint did not sufficiently allege that Hartford had or exercised any discretionary authority over the Plan or its assets with respect to setting the contract terms. The court explained that the complaint identified only Hartford's negotiation conduct and no pre-existing relationship with the Plan or post-contract exercise of discretionary control as its basis for alleging Hartford's fiduciary liability.

While intentional misrepresentation about an ERISA plan may be a fiduciary breach, the court upheld the dismissal of the breach of fiduciary duty claim against Family Dollar because the complaint did not identify any material misrepresentations or omissions. The court reasoned that the statement that basic life insurance was non-contributory was not false or misleading and that Family Dollar accurately disclosed the cost of supplemental coverage. The court further noted that Family Dollar had no obligation to disclose how it would apply proceeds from the supplemental coverage premiums and that the complaint did not "plausibly and in a non-conclusory way" allege that the statement of the premiums as "affordable" and "without high cost" was not true.

The court also found that the complaint failed to state a prohibited transaction claim against Family Dollar or Hartford. The court reasoned that Family Dollar's use of cost-reduction strategies to minimize its costs in providing basic and supplemental coverage under the Plan was not a prohibited self-dealing transaction. With respect to Hartford, the court stated that the complaint failed to allege that Hartford engaged in a prohibited transaction because, under ERISA, the prohibition on such transactions applies to fiduciaries and Hartford was not a fiduciary.

Takeaways

For service providers who do not exercise control over plan assets, Hannan v. Hartford is helpful as it supports their long-held position that they are not fiduciaries. For ERISA plan sponsors, this decision affirms that sponsors have the discretion to establish the price of coverage under an ERISA plan and to apply employee premiums to reduce sponsor costs. The court's dismissal of the misrepresentation claim also should mitigate sponsor risks related to employee communications.

UPDATE Biologics and Biosimilars: *Amgen v. Sandoz*

By Gretchen Harders, Member of the Firm in the Employee Benefits practice at Epstein Becker Green

In an eagerly awaited decision, on June 12, 2017, the US Supreme Court in *Amgen Inc. v. Sandoz Inc.*, 137 S. Ct. 1664 (2017), ruled in favor of the biosimilars industry under the Biologics Price Competition and Innovation Act ("BPCIA") by allowing biosimilars to be sold in the market even if advance notice is given to the biologics reference

product sponsor prior to FDA approval. Biosimilars are basically generic forms of biologics that are similar to the more costly brand name biologic drugs, but are not considered to have any meaningful clinical differences with brand name biologics.

The Federal Circuit decision in *Amgen v. Sandoz* is discussed in more detail in the Spring 2017 BLU Issue. The Federal Circuit held in favor of the biologic patent sponsor Amgen by finding that the 180-day advance notice requirement to the biologics reference product sponsor under the BPCIA did not commence until the biosimilar received FDA approval. The biosimilar industry criticized the decision as effectively providing the biologics reference product sponsors an additional 180 days of exclusivity for the biologic.

The Supreme Court disagreed with the Federal Circuit holding and interpreted the BPCIA to allow the 180-day advance notice to commence before FDA approval is received. It reasoned the language of BPCIA provides that advance notice only be given prior to commercial marketing and the biosimilar applicant may provide the notice before or after FDA licensing.

Takeaway

The opportunity for employer plan sponsors to offer biosimilars as a plan benefit may accelerate following this Supreme Court decision in favor of faster commercialization of biosimilars. As a lower cost drug alternative, employer plan sponsors have a further incentive to reach out to their specialty pharmacy providers and/or pharmacy benefit management organizations on the availability of biosimilars.

About Epstein Becker Green

Epstein Becker & Green, P.C., is a national law firm with a primary focus on health care and life sciences; employment, labor, and workforce management; and litigation and business disputes.

About ERIC

The only national association advocating solely for the employee benefit and compensation interests of America's largest employers on the federal, state, and local levels.

Please send questions, comments, and related requests to James Gelfand, Gretchen Harders, John Houston Pope, or Adam C. Solander.

Information published in the BENEFITS LITIGATION UPDATE is not intended to be, nor should it be considered, legal advice. The views expressed herein are those of the authors, and are intended to stimulate consideration and discussion. They do not reflect the position of The ERISA Industry Committee or Epstein Becker Green. Please consult your attorney in connection with any fact-specific situation under federal law and the applicable state or local laws that may impose additional obligations on you and your company.

© 2017 Epstein Becker & Green, P.C.