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Employee Benefits for Employers — Winter 2019

A Note from the Editor

As we all prepare for the end of 2019, we are excited to present the Litigation Edition of *Employee Benefits for Employers*. Our lead piece, by John Sulau (Greenville), provides an insightful analysis of the most recent revisions to the ERISA Claims Procedure regulations, asking whether the amendments have finally sounded the death knell for the "substantial compliance" doctrine in ERISA disability claims. Our second article, by Katelyn Harrell (New Orleans), summarizes the results of several recent class certification battles in Georgia, New York, North Carolina, and South Carolina involving claims purportedly brought on behalf of ERISA plans under ERISA § 502(a)(2). Our featured lawyer is Robert Rachal, from our New Orleans office, who discusses his 30 years in ERISA law, as well as his reasons for joining Jackson Lewis. As always, we offer concise summaries of employee benefits developments to help you stay abreast of this rapidly changing field and highlight the recent activities and upcoming or recorded events of our practice group members. We hope you enjoy this edition, and please watch for our upcoming 2020 editions.

— Robert Wood

Has DOL Put Final Nail In Coffin of 'Substantial Compliance' Doctrine for Disability Claims?

By John W. Sulau

In recent years, administrators of short- and long-term disability plans have found the "substantial compliance" doctrine less effective as a shield from liability. Indeed, following court decisions that categorically rejected the doctrine, such as *Halo v. Yale Health Plan, 819* F.3d 42 (2d Cir. 2016), the ERISA plaintiffs' bar appears emboldened to attack a "substantial compliance" defense.

Even while several courts have declined to adopt the *Halo* court's opinion, regulations enacted in 2018 requiring administrators to "strictly adhere" to the claims procedures they prescribe likely will end the doctrine's usefulness, at least for disability claims.

ERISA's 2002 Amended Regulations

At the heart of recent challenges to the substantial compliance doctrine lies ERISA's amendments to the claims procedure regulations (29 C.F.R. § 2560.503-1) that took effect in 2002. The preamble explains that the purpose of the amendments was "to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims." See ERISA Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70,246 (Nov. 21, 2000). The preamble also states that the amendments were "necessary to guarantee procedural rights to benefit claimants."

The 2002 Regulations impose tougher consequences for an administrator's failure to adhere to the Regulations' deadlines for rendering decisions. If an administrator misses the deadlines, the claim will be "deemed exhausted" and the claimant may sue when the relevant deadline expires. The preamble explains the intent was "to clarify that [the] procedural minimums … are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference."

Finally, the preamble states, "Inasmuch as the regulation makes substantial revisions in the severity of the standards imposed on plans, we believe that plans should be held to the articulated standards as representing the *minimum procedural regularity* that warrants imposing an exhaustion requirement on claimants." (Emphasis added.) This sets the stage for challenges to the substantial compliance doctrine.

Halo Decision and Subsequent Second Circuit Decisions Interpreting 2002 Regulations

The *Halo* court rejected a medical benefit plan's argument it was entitled to the "arbitrary and capricious" standard of review despite its technical violations of the Claims Procedure Regulations.

The plan claimed it substantially complied with the Regulations, even though it untimely denied the plaintiff's claim by a matter of days and it did not explain the denial, among other details the

Regulations require. The district court agreed with the plan that it substantially complied with the Regulations, concluding that, despite the plan's technical violations, the "substance and timing of its denials of Halo's claims were sufficient to indicate that [the plan] had exercised its discretion," as granted by the plan's governing documents. The district court applied the "arbitrary and capricious" standard of review.

The U.S. Court of Appeals for the Second Circuit vehemently disagreed. It focused on the 2002 amendments' provision that a plan's "[f]ailure to establish and follow reasonable claims procedures" leads to the "deemed exhaustion" of the claim. The Second Circuit also noted that the Regulations establish the minimum standard a plan must meet in claim administration. The Court reversed the district court's application of the arbitrary and capricious standard and held that, when a plan "fails to comply with [the Regulations], the plan's decision denying a claim should not be entitled to deference in court" unless the plan can show its failure was "inadvertent and harmless."

Understandably, plan administrators were alarmed by the ruling. Their worry intensified when the U.S. District Court for the Southern District of New York cited *Halo* to find *de novo* review applied to a denial of a claim for long-term disability benefits because the claims administrator failed to show, in the court's judgment, "special circumstances," as required by the Claim Review Regulations, to extend its 45-day time period to decide the plaintiff's appeal. *See Salisbury v. Prudential Ins. Co. of Am.*, 238 F. Supp. 3d 444 (S.D.N.Y. 2017).

Many circuit courts declined to follow this bright-line rule, although some limited their application of the substantial compliance doctrine under the 2002 amendments.

Other Circuits' Interpretations of 2002 Regulations' Effect on Substantial Compliance

The U.S. Court of Appeals for the Seventh Circuit recently narrowed, but stopped short of eliminating, the substantial compliance doctrine for disability claims subject to the 2002 Regulations. In *Fessenden v. Reliance Std. Life Ins. Co.*, 927 F.3d 998 (7th Cir. 2019), the Court held that an administrator's failure to adhere to the Regulations' 45-day deadline for deciding on the plaintiff's appeal mandated *de novo* review. The administrator gave its decision 53 days after it received the appeal. The Court explained that the "'substantial compliance' exception does not apply to blown deadlines" because "a deadline is a bright line."

The Court nevertheless rejected the plaintiff's argument that it should follow *Halo* and eliminate the substantial compliance doctrine altogether. The Court explained that, in its view, the doctrine was not implicated because it does not apply to violations of regulatory deadlines and the court need not disturb its jurisprudence invoking the doctrine to excuse other minor or technical regulatory violations.

In *Price v. UNUM Life Ins. Co. of Am.*, 2018 U.S. Dist. LEXIS 42976 (D. Md. Mar. 14, 2018), *aff'd*, 746 F. App'x 231 (4th Cir. 2018), the plaintiff sued two days before Unum gave its decision to deny his appeal. Unum's decision was issued within the properly noticed 45-day extension period permitted by the Regulations, but the plaintiff alleged the decision was untimely and required *de novo* review. The court concluded Unum fully complied with the Regulations. In addition, the court explained that, even if Unum had not "strictly compl[ied] with the regulatory time limits, … such procedural violations [would]

not automatically strip Unum of its discretionary authority to make claim determinations." When an administrator fails to provide a timely claim decision, the court explained, the claim is "deemed exhausted" under the Regulations and the claimant may sue without fully exhausting administrative remedies. Accordingly, the court concluded an administrator's untimely but "reasoned decision" was entitled to abuse of discretion review, so long as the administrator, during the delay, otherwise took "'steps commensurate with the exercise of its discretion as delineated in the [p]lan.'" As the delay followed the plaintiff's refusal to provide certain information requested by Unum, the court concluded "any delays associated with Unum's attempt to obtain this information does not show that it failed to substantially comply with ERISA's procedural requirements."

In *L.M. v. Metro. Life Ins. Co*., 2016 U.S. Dist. LEXIS 168463 (D.N.J. Dec. 2, 2016), the court declined to adopt *Halo's* sweeping abandonment of the substantial compliance doctrine. The court said it would have come to the same conclusion even if were to adopt the *Halo* analysis, as it found the plan administrator's "brief delay" of one or two days in deciding the plaintiff's appeals "amount[ed] to an inadvertent and harmless deviation and [did] not trigger a *de novo* review." The court also found persuasive the administrator's establishment of "procedures in full conformity with" ERISA's Regulations.

District courts in Louisiana and Utah also have declined to abandon the substantial compliance doctrine in cases subject to the 2002 Regulations. See *Van Bael v. United HealthCare Servs*., 2019 U.S. Dist. LEXIS 3678 (E.D. La. Jan. 8, 2019); *Joel S. v. Cigna*, 356 F. Supp. 3d 1305 (D. Utah 2018).

On April 1, 2018, additional amendments to the Claims Procedure Regulations took effect that significantly limit the substantial compliance doctrine in claims for disability benefits. If the 2018 amendments were applied to the cases discussed above, their outcomes may have been different.

2018 Regulations

The aim of the 2018 Regulations appears to be ending the substantial compliance doctrine for disability claims by requiring administrators to "strictly adhere" to the prescribed claims procedures. As amended, the Regulations allow a claimant to end the administrative process unilaterally because of any perceived error by the administrator. Such a claimant may sue for a court decision on whether the alleged error occurred and, if it did, whether it was "*de minimis*," as the Regulations define the term. The court must weigh several factors to decide whether the error was *de minimis*, including prejudice to the claimant, whether the administrator acted in good faith, and whether the error was isolated or systemic. If the court finds the error occurred and was not *de minimis*, the claim is "deemed exhausted" under the Regulations, and the claimant may proceed with litigation before the administrator has decided the claim. In such cases, the majority of federal circuits would apply a *de novo* standard of review, regardless of whether the plan or insurance policy grants sole discretionary authority to the administrator to make claims decisions under the plan.

The 2018 Regulations also mandate that, before issuing an appeal determination that relies on "new or additional evidence" or a "new or additional rationale" supporting the administrator's initial denial of the claim, the administrator must provide the new evidence or rationales to the claimant "sufficiently in advance" of the deadline for the

appeal decision so the claimant has "a reasonable opportunity to respond prior to that date." The Regulations do not limit the administrator's obligation to provide the new or additional evidence or rationales. They also do not adjust the time in which the administrator must provide a decision to account for the required additional communications between the parties.

It is not difficult to foresee how an administrator, caught up in extensive back-and-forth discussions with a claimant regarding new or additional evidence or rationales considered by the administrator, could easily miss the deadline for the appeal decision. The administrator would have the unenviable choice of risking a violation of the Regulations by deciding the appeal before the claimant gets around to submitting his response, or by delaying its decision until receipt of the claimant's response beyond the deadline for its decision. The Regulations provide no guidance or offer any relief in such a scenario. Courts that previously declined to abandon completely the substantial compliance doctrine under the 2002 Regulations likely would have had to do so had the 2018 Regulations' "strict adherence" directive applied to the claims before them.

Courts have yet to publish decisions applying the 2018 Regulations, but their decisions will almost certainly deal with plan administrators more harshly than under the 2002 Regulations.

Administrators should train all employees responsible for the day-to-day administration of claims regarding ERISA's regulations, focusing particularly on the regulatory requirements for deadlines. Extensions of deadlines should be employed carefully, if not sparingly, and with an eye toward ensuring strict compliance with all regulatory mandates. All extension notices should be in writing and clearly state:

1. The original deadline;
2. The extended deadline;
3. The basis for the extension;
4. An explanation of why the extension is needed for reasons beyond the administrator's control; and
5. Any unusual problems or circumstances with the claim.

Administrators also should review their claims-handling procedures to ensure that the procedures satisfy ERISA's requirements, so they can show to a judge, if necessary, they take their obligations seriously and have established procedures intended to comply with ERISA. Such a demonstration may help establish that any violation of the 2018 Regulations was *de minimis*.

ERISA Class Actions under ERISA § 502(a)(2)

By Katelyn Harrell

Courts in Georgia, New York, North Carolina, and South Carolina in the past months have provided some insights on certification of proposed classes with claims on behalf of a plan arising under ERISA § 502(a)(2). While courts readily certify classes where the plaintiffs seek recovery on behalf of the plan in which the plaintiffs are participants, they do not uniformly grant certification without analysis.

Berry v. Wells Fargo & Co.

A South Carolina court granted class action status to a former Wells Fargo financial adviser's suit alleging the company failed to comply with ERISA provisions by failing to fund its Performance Award Deferral Plan and Performance Award Contribution Plan and by requiring employees to forgo vested benefits if they violated non-compete provisions in their employment contracts after they left the company. *Berry v. Wells Fargo & Co.*, 2018 U.S. Dist. LEXIS 220095 (D. S.C. Oct. 9, 2018). The plaintiff sued in his individual capacity under ERISA § 502(a)(3) and on behalf of the Plans under ERISA § 502(a)(2).

The defendants argued the plaintiff did not have standing to pursue a claim under 502(a)(3) because the relief he sought was prospective when his alleged harm was retrospective. To have standing under 502(a)(3), a plaintiff must demonstrate, among other things, that "it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." In addition, a court may reform plan terms under ERISA § 502(a)(3) and order that benefits be paid "under the plan as reformed." *CIGNA Corp. v. Amara*, 563 U.S. 421, 440 (2011). The court ruled that a declaration that the Deferral Plan be reformed was appropriate because, under *Johnson v. Meriter Health Servs. Emp. Ret. Plan*, 702 F.3d 364, 369 (7th Cir. 2012), "a declaration is a permissible prelude to claim for damages, that is, for monetary relief for a concrete harm already suffered." The court ruled the plaintiff demonstrated he suffered an injury that was capable of redress by the court and he and those similarly situated to him had standing to pursue the 502(a)(3) claim.

The defendants argued that the plaintiff's class claim under 502(a)(2) must fail because the class did not include current members of the Deferral Plan. The defendants argued that because a 502(a)(2) claim "redounds to the benefit of the plan as a whole, it is brought in a representative capacity and must abide by procedural safeguards to ensure that the interests of all beneficiaries are protected." A plaintiff bringing suit in a representative capacity on behalf of a plan in an ERISA case, they argued, must "take adequate steps under the circumstances properly to act in" that capacity. Although current members of the Deferral Plan have not experienced harm, the defendants argued that their interests must be considered by the class. In response, the plaintiff noted that ERISA does not require all plan participants be included in a proposed class because not every participant will have suffered a loss and typically only participants whose plan accounts lost money due to a breach will be included in a class. The plaintiff also noted current Deferral Plan participants do not have a protectable interest in participating in an illegal plan. Therefore, to the extent the Deferral Plan is adjudged to be in violation of ERISA, current members have no protectable interest in maintaining that violation, the plaintiff argued. The court agreed with the plaintiff and held the plaintiff's proposed class definition to pursue 502(a)(2) claims was proper.

Henderson v. Emory Univ., et al.

The plaintiffs, participants and beneficiaries of two retirement plans sponsored by Emory University (Emory University Retirement Plan and the Emory Healthcare, Inc. Retirement Savings and Matching Plan), were granted their motion for class certification in a case against the university for alleged breaches of fiduciary duties under ERISA. *Henderson v. Emory Univ., et al.*, 2018 U.S. Dist. LEXIS 180349 (N.D. Ga. Sept. 13, 2018).

The defendants opposed class certification, arguing that the plaintiffs lacked standing to represent the proposed class and failed to meet the requirements of Rule 23.

Regarding standing, the court held that, because the plaintiffs sufficiently alleged concrete and particularized injuries in their complaint, they had standing to bring the suit. The court said the defendants' presentation of deposition testimony demonstrating that the plaintiffs did not know whether they suffered an injury merely indicated that the plaintiffs "might not fully grasp the complex factual and legal issues involved in the case." The court also ruled that, despite the plans' participants investing in different funds, the class representatives had standing to seek relief on behalf of the plans and their participants "even if that relief 'sweeps beyond [their] own injury.'"

Regarding the requirements of Rule 23, the defendants argued the plaintiffs were improper class representatives under Rule 23(a) because statute of limitations issues existed that would affect the plaintiffs' ability to meet Rule 23(a) commonality and typicality requirements. They also argued that adequacy issues existed because the proposed class representatives had a limited understanding of their own claims. However, because the plaintiffs had not "abdicated their role in the case beyond that of furnishing their names as plaintiffs," the court held they demonstrated that they and their counsel would adequately prosecute the action.

The defendants also argued that intra-class conflicts existed under the plaintiffs' theories of recovery. However, the court noted, no theory of recovery would go against the interests of any individual class member and each theory, if proven, would show the plans were in violation of ERISA requirements. The court concluded that no participant would have a legal interest in maintaining investments that ran afoul of ERISA and, therefore, there was no demonstrable intra-class conflict.

The defendants finally argued that, because the relief the plaintiffs sought was "individualized monetary relief," they were limited to certification under Rule 23(b)(3). The court noted that the recovery sought was for losses to the plans, rather than for individualized monetary damages. Therefore, it ruled, the suit could proceed under Rule 23(b)(1)(B).

Beach v. JP Morgan Chase Bank

Class action status has been granted to plaintiffs bringing a putative class action on behalf of the JP Morgan Chase 401(k) Savings Plan alleging JP Morgan and several related defendants breached their duties of loyalty and prudence by including funds with excessive fees in the Plan's investment options. *Beach v. JP Morgan Chase Bank, N.A.*, 2019 U.S. Dist. LEXIS 97946 (S.D. N.Y. June 11, 2019).

The defendants argued the plaintiffs lacked standing with respect to funds in which no plaintiff invested. Rejecting that argument, the court concluded that, "because the alleged harms are premised on the process defendants used

to manage the Plan, the claims involve similar inquiries and proof, and thus implicate the same set of concerns. Plaintiffs have class standing to pursue the claims on behalf of the absent class members, including those who invested in … funds offered by the Plan in which none of them invested."

The defendants also argued that, because three of the named plaintiffs signed agreements to arbitrate claims in the suit, they were inappropriate class representatives. The court held that, because the defendants engaged in the litigation, they had waived their right to compel arbitration and, as a result, the plaintiffs were not bound by the arbitration agreements. Thus, it ruled the unenforceable agreements could not preclude plaintiffs from representing the proposed class.

The defendants argued the plaintiffs were not able to meet Rule 23(a)'s typicality requirements because one of the proposed class representatives was not a member of the proposed class. The court agreed with this argument. It held the proposed class representative could not be appointed as a class representative.

The defendants also argued the class definition must be narrowed to ensure the plaintiffs' investments were typical of the class members' investments, as some potential plaintiff only invested in funds when those funds had no fees or reasonable fees. The court agreed and held the class definition must be narrowed to exclude members who invested in the subject funds only when the funds had no fees or reasonable fees.

Defendants argued the plaintiffs were not adequate class representatives because they could not explain some of the details related to their claims. The court rejected this argument. The court held the plaintiffs knew enough about the case to act as class representatives because they had general knowledge of their claims.

The court held that, because the Plan-wide relief sought by the plaintiffs to recover losses sustained by the Plan and enjoin future violations would bind the Plan and all Plan participants even without class certification, the class was properly certified under Rule 23(b)(1)(B).

Peters v. Aetna Inc.

A court has denied a motion for class certification of a class of plaintiffs alleging under ERISA Section 502(a)(2) that Aetna engaged in a fraudulent scheme with subcontractors, whereby plan participants were caused to pay subcontractors' administrative fees because the defendants misrepresented the fees as medical expenses. *Peters v. Aetna Inc.*, 2019 U.S. Dist. LEXIS 53613 (W.D. N.C. Mar. 29, 2019).

The court held the proposed class failed to meet the commonality requirement of Rule 23(a)(1) because the evidence indicated that, rather than harming the participants, the Aetna-Optum contracts saved plans and their participants millions of dollars.

Recent Developments

Supreme Court to Decide on ERISA Causation Burden

After a similar Tenth Circuit case was dismissed last year, the U.S. Supreme Court is finally poised to decide which party has the ultimate burden of proof regarding whether an ERISA fiduciary's breach of fiduciary duty caused losses to the plan in *Brotherston v. Putnam Invs., LLC*, 907 F.3d 172 (1st Cir. 2018) (Sup. Ct. Dkt. 18-926). The Court has asked the Solicitor General to weigh in. In taking up review of the case, the Court presumably will resolve a deep circuit split on whether the plaintiff must definitively prove a plan loss was caused by the fiduciary's breach of fiduciary duty as part of its case in chief, or whether the burden of proof shifts to the fiduciary to disprove causation when the plaintiff has proven breach and a *prima facie* case of loss. The Sixth, Ninth, Tenth, and Eleventh Circuits hold that participants bear the full burden of proving loss caused by a breach of fiduciary duty; the First, Second, Fourth, Fifth, and Eighth Circuits hold that once a participant establishes a *prima facie* breach of fiduciary duty case, the burden of persuasion shifts to the fiduciary to disprove that its conduct caused the loss.

ERISA Preemption Defense Found Unavailable to Health Care Provider

A state law breach of contract claim was not preempted by ERISA, the Sixth Circuit has held. *K.B. v. Methodist HealthCare - Memphis Hospitals*, 929 F.3d 765 (6th Cir. 2019). The claim was brought by a class of individual insureds alleging Methodist Health Care Memphis Hospitals overcharged them for services. The plaintiffs claimed contracts their insurers had with the hospital provided set rates and prices for certain services. They claimed the hospital breached its contractual duties to insureds when it charged them higher prices than the negotiated contract amounts.

The Court rejected the lower court's determination that, because the plaintiffs' breach of contract claim involved an analysis of coverage rights under an ERISA plan, it was preempted under ERISA thus making the case removable to federal court. The Court explained that the plaintiffs' claim did not trigger the ERISA complete preemption doctrine, which it must in order to support removal, because the complaint of the provider's excessive cost of services did not involve a denial of coverage or benefits claim. The plaintiffs' claim rested on contracts the hospital negotiated with insurers, not on the terms of any ERISA plan. Thus, the claim arose from a legal duty independent of ERISA and was not removeable to federal court.

For health care providers facing claims of excessive cost brought by ERISA plan participants who are provided services through contracts negotiated with plan insurers, the Sixth Circuit's ruling on ERISA preemption is significant. Without a complete preemption defense, health care providers may have to fight breach of contract claims over billing practices in state court.

$30 Million Award for ESOP Trustee Fiduciary Breach Affirmed

The Fourth Circuit has upheld a liability determination of almost $30 million against an ESOP Trustee in *Brundle v. Wilmington Trust, N.A.*, 919 F.3d 763 (4th Cir. 2019). The Court affirmed the finding that the Trustee breached its ERISA fiduciary duties in negotiating the ESOP's purchase of the corporate owner's stock at rates well above a reasonable fair market value.

The Circuit Court agreed the record indicated the Trustee did not sufficiently evaluate at least four "red flags" that should have alerted a reasonably prudent fiduciary that closer scrutiny of the valuation the Trustee relied on was warranted. Noting that it was the Trustee's burden to prove its affirmative defense that the ESOP sale was for "adequate consideration," the Court held the evidence supported the conclusion that the Trustee was primarily acting to benefit the owners of the company, rather than the interest of ESOP participants.

The result in *Brundle* reflects the lack of guidance from the DOL on evaluating the concepts of "fair market value" and "adequate consideration" (which are inherently imprecise terms) in ESOP transactions. The DOL issued proposed regulations more than 30 years ago, but they were never finalized. While courts often consult the proposed regulations for guidance, the absence of a final rule handicaps predictability for those involved in structuring and evaluating ESOP transactions. *Brundle* may increase DOL scrutiny of ESOP transactions with similar deal structures.

Majority of Circuits Reject 'De Facto' Administrator Theory for ERISA Statutory Penalty Liability

Joining the majority of circuit courts, the Third Circuit has held that ERISA does not permit statutory penalties to be assessed against an individual under a "de facto" administrator theory, affirming dismissal of a plan participant's claim against the director of the plan. *Bergamatto v. Bd. of Trs. of the Nysa-Ila Pension Fund*, 933 F.3d 257 (3d Cir. 2019). The director was not the named plan administrator, as defined by ERISA. The participant had asked the director for information, which he claimed he did not receive. He argued the director was liable under 29 U.S.C. § 1132(c), which provides that "a plan administrator who fails or refuses to comply with a request for information which the administrator is required by law to provide to a participant or beneficiary within 30 days is subject to a penalty of $100.00 per day." The participant argued the director acted as a "de facto" administrator because he performed some duties consistent with that role and "never disavowed" he was the plan administrator or redirected his document requests elsewhere. Based upon U.S. Supreme Court precedent "quite forcefully" warning the lower courts not to create new ERISA remedies not articulated by congress in the Act, and Third Circuit precedent holding 29 U.S.C. § 1132(c) is a "penal provision" that must be narrowly and strictly construed, the Third Circuit affirmed the dismissal of this claim, joining a majority of circuits that have rejected the concept of statutory penalty liability as a "de facto administrator."

Fifth Circuit Adopts 'Clear Repudiation' Rule for Accrual of Limitations Period

In resolving a dispute over how to determine the accrual date for benefit miscalculation claims, which often involve circumstances where there has not been a formal claim and appeal determination on the benefit amount issue, the Fifth Circuit Court has concluded the district court properly followed decisions from other circuits applying the "clear repudiation" rule, a version of the "discovery rule" applied in other contexts for establishing when the statute of limitations begins to run. *Faciane v. Sun Life Assurance Co.*, 931 F.3d 412 (5th Cir. 2019).

The Court also agreed with the district court that, although the plan administrator apparently did not use mailing conventions that provide proof of delivery by the carrier, the plan administrator's contemporaneously recorded notes about the mailing and contents of a letter advising the

claimant of the amount of his monthly benefit overcame the claimant's unsupported denial of the letter's delivery. The Court held that, as this letter clearly repudiated the claimant's belief that he was entitled to a larger benefit, the date of the letter marked the accrual date of that claim for purposes of calculating the limitations period.

Tenth Circuit Clarifies 'Functional Fiduciary' Status

In *Teets v. Great-West Life*, 2019 U.S. App. LEXIS 25671 (10th Cir. 2019), a class action lawsuit under ERISA involving a class of 270,000 people who invested in Great-West's Key Guaranteed Portfolio Fund (a stable value fund) through over 13,000 employer-sponsored 401(k) plans, the Tenth Circuit has affirmed the district court's opinion that Great-West, as an investment fund manager, was not a functional fiduciary, concluding the plaintiffs failed to offer evidence that Great-West had actually exercised its right to impose a 12-month deferral on transferring a plan's withdrawal of assets from the Fund, or that any plan had ever been deterred from withdrawing from the Fund because of the deferral provision. Absent such evidence, the Court concluded the plaintiffs had not demonstrated Great-West had ever "actually exercised" authority or control over plan assets.

The Court's opinion is worth a close reading. For parties involved in administration of certain aspects of ERISA plans, this opinion provides a thorough analysis of the circumstances under which such a party may be deemed a "functional fiduciary" even though it is not specifically identified as a fiduciary under the relevant plan documents. For plan sponsors or named fiduciaries seeking relief against third parties involved in plan administration, this opinion demonstrates the significant burden of proof such a plaintiff bears in obtaining equitable relief under ERISA.

Review of Venue Selection Decision Favorable to Plan Sponsors Denied by Supreme Court

On October 7, 2019, based upon a forum selection clause in the controlling plan document, the U.S. Supreme Court denied a plan participant's petition for review of the lower court decisions upholding transfer of a case alleging a breach of fiduciary duty. *Robertson v. U.S. District Court for the E.D. Penn. et al.*, No. 18-1341.

Jackson Lewis attorneys Ashley Abel and John M. Nolan III are among the counsel that represented the Pfizer Retirement Committee and Fidelity Executive Services in this action brought by a participant in the Pfizer Consolidated Pension Plan. The participant originally sued in the Eastern District of Pennsylvania. Pfizer and Fidelity moved to have the case tried in the Southern District of New York based on a forum selection clause in the Plan. Both the Eastern District and the Third Circuit upheld the transfer.

The participant filed a petition for a writ of certiorari asking the Supreme Court to weigh in. Pfizer and Fidelity argued ERISA allows plans covered by ERISA to incorporate venue selection clauses into the governing plan document, and that the findings of the Eastern District and Third Circuit are in line with other circuits' holdings on the issue. Robertson argued ERISA allows participants to sue in any of three venues, i.e., "where the plan is administered, where the breach occurred or where the defendant plan resides," none of which apply to the Southern District of New York in this case.

The Supreme Court's rejection of the petition for certiorari leaves the decisions of the lower courts intact. This should be noted by plan sponsors who wish to incorporate venue selection clauses in their plan documents.

Featured Lawyer:

New Orleans-based ERISA Litigator **Robert W. Rachal** has spent nearly 30 years litigating high-stakes ERISA cases. A veteran of dozens of class actions around the country, he's known among his peers as a keenly analytical problem-solver and an excellent strategist. He joined Jackson Lewis in March 2019 and maintains a busy schedule as a speaker and writer.

What is one of your favorite parts about your employee-benefits practice?

I like working with clients to develop the best defenses for a case. Listening to clients to understand the realities of their business and the transaction at issue lets me translate their business realities into what I hope can be strong legal defenses. I like that creative part of developing strategy and legal defenses, often on new or novel issues.

What was it that led you to join Jackson Lewis?

In a sense, I grew up as a lawyer in a labor and employment boutique of about 20 lawyers. I feel like I've come home, except now I have the resources of a firm with more than 950 lawyers and offices nationwide. Here, I can work on a broad range of cutting-edge ERISA and fiduciary litigation issues. I especially like working with colleagues I've known for 20-plus years.

How your experience in complex ERISA litigation affected you as a person?

It gives me some humility, and hopefully, a little bit of wisdom — because it forces me to consider all sides of complex facts and issues.

Media ...

- **Suzanne G. Odom** authors "More Opportunities and Pitfalls Face Employers Providing Employee Benefits in 2020," published by *Upstate Business Journal*.
- **Dorothy McDermott** authors "Pension Benefit Guaranty Corporation's Early Warning Program," published by *Bloomberg Tax & Accounting*.
- **Teresa Burke Wright, Caroline H. Cheng, and Kellie M. Thomas** author "Employers Face New Penalties Under Washington, D.C.'s Commuter-Benefit Law," published by *SHRM*.
- **Joshua Rafsky** comments on the implications of the IRS' final rule that relaxes several existing restrictions on taking hardship distributions from defined contribution plans in "IRS Final Rule Eases 401(k) Hardship Withdrawals, Requires Amending Plans," published by *SHRM*.
- **Joy M. Napier-Joyce** comments on the implications of the Retirement Security Preservation Act of 2019, legislation to protect the retirement security of American workers in closed defined benefit plans in "Senate bill looks to modernize frozen DB non-discrimination rules," published by *Pensions & Investments*.
- **Joy Napier-Joyce** discusses the implications of the ERISA Advisory Council examining the retirement plan audit process in "Audit changes spark concerns of new burdens," published by *Pensions & Investments*.
- **Gina Roccanova** and **Donald Sullivan** discuss their recent move to the firm's San Francisco office in "Jackson Lewis Expands SF Team With 2 From Meyers Nave, Wilson Elser," published by The *Recorder*.
- **Gina Roccanova** and **Donald Sullivan** comment on joining the firm's employee benefits and traditional labor law practices in San Francisco in "Jackson Lewis Lures Benefits, Labor Pros In Calif.," published by *Law360*.
- **Adam Cantor** comments on joining Jackson Lewis' expanding Employee Benefits practice, and his 20 years of experience helping employers navigate executive compensation and benefits issues in "Jackson Lewis' Growing Benefits Practice Adds New Principal," published by Law360.
- **Johnny Wentzell** authors "U.S. House of Representatives Passes Bipartisan Retirement Reform Legislation," published by *Upstate Business Journal*.
- **Paul Friedman** authors "EBSA Missing Participant Investigations Triggered by Failure to Take Distributions," published by *SHRM*.
- **Roxanne Nydegger** authors "New mandatory electronic VCP submissions add to IRS online filings," published by *The 401(k) Handbook* (page 2).
- **Miriam Schindel** comments on why she decided to make the move to Jackson Lewis' Employee Benefits practice in "Jackson Lewis Adds Benefits Pro From Hinman Howard," published by *Law360*.

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Honors ...

The Best Lawyers in America 2020 Honors Jackson Lewis Attorneys

We are pleased to announce more than 210 attorneys throughout the firm's locations have been recognized in the 2020 Edition of The Best Lawyers in America, a publication that has become universally regarded as a definitive guide to legal excellence. The Best Lawyers lists are compiled based on an exhaustive peer-review evaluation.

1. Ashley B. Abel
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3. Brian P. Goldstein
4. Carla D. Macaluso
5. Joy M. Napier-Joyce
6. Suzanne G. Odom
7. Andrew C. Pickett
8. Robert W. Rachal
9. Charles F. Seemann III
10. Stephen M. Silvestri
11. René E. Thorne*
12. John Wentzell, Jr.
13. Stephanie O. Zorn

* "Lawyer of the Year" designation

Jackson Lewis Attorneys Recognized as the Nation's Most Powerful

We are pleased to announce that Jackson Lewis attorneys have been named "Most Powerful Attorneys" of 2019 by Human Resource Executive magazine, including benefits attorney René E. Thorne. Produced in partnership with Lawdragon, the list recognizes employment lawyers who stand out for their ability to guide employers through constantly evolving workplace laws.

Webinars

- *Creating Executive Compensation Arrangements that Comply with California Law* Yana Johnson and Shannon Bettis Nakabayashi hosted Jackson Lewis webinar (recording)

Upcoming Seminars ...

January

- ***Defined Contribution Investment Litigation Update,*** Robert Rachal presents at the ABA Labor Section's Employee Benefits Committee Midwinter Meeting

March

- ***Avoiding the Next Wave of ERISA Class Action Litigation,*** Joy Napier-Joyce and Charles Seemann present at the Jackson Lewis Corporate Counsel Conference.

For more on what our attorneys are up to in the coming months, go to jacksonlewis.com/events.