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2006 Employee Benefits Seminar

Litigation/Enforcement – The Year's Top ERISA Cases

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1. Proposed New Rule: N.J.A.C. 11:4-58, Department of Banking and Insurance, Division of Insurance

2. *Haddock v. Nationwide Financial Services, Inc.*
   419 F. Supp. 2d 156 (D. Conn. 2006)

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7. *Sereboff v. Mid Atlantic Medical Services*: The Supreme Court Revisits "Equitable" Remedies Under § 502(a)(3)

TAB 1

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Actuarial Services
Prohibition of Discretionary Clauses

Proposed New Rule: N.J.A.C. 11:4-58

Authorized by: Steven M. Goldman, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15(e), 17B:25-18(h), 17B:25-18.1, 17B:26-1h(2), 17B:27-74(e), 17B:27E-10, 17:29B-1 et seq., and 26:2S-12c.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2006-268

Submit comments by October 20, 2006 to:

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The agency proposal follows:

Summary

A discretionary clause is any provision in an insurance policy or contract or an annuity contract that purports to confer on the carrier sole discretionary authority to determine eligibility for benefits or to interpret the terms or provisions of the policy or contract. These types of clauses became popular after the United States Supreme Court decided *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which held that a court should review a decision by a self-funded employee benefit plan without a discretionary clause independently (de novo), not giving deference to the plan administrator. The Court noted that had the plan included a discretionary clause, the

plan administrator's decision could have been overturned only if it was arbitrary and capricious. The Court's ruling applied to all employee group health benefits plans subject to Federal Employee Retirement Income Security Act (29 U.S.C. §§1001 et seq.) (ERISA) regulation, regardless of whether they were offered through insurance or self-funded by the sponsor. The "arbitrary and capricious" standard is a difficult one for consumers to meet when challenging eligibility, benefit or contract interpretation decisions in court. Consequently, carrier decisions are frequently upheld in legal actions involving policies that contain discretionary clauses. Without providing a court the opportunity to fully review a claim, a consumer has little chance of success.

The Department believes that the inclusion of discretionary clauses in policies and contracts - life, health, long-term care and annuity -- may nullify a carrier's promise to pay, and may deny insureds and contractholders benefits to be provided pursuant to the terms and conditions of the policy or contract. Under a discretionary clause, the insured's or contractholder's expectations may become illusory, thereby denying them protections afforded by this State's insurance and other laws. Accordingly, for several years the Department has been disapproving the inclusion of discretionary clauses in all life and health insurance policies and contracts, including disability income coverage policies and contracts; all long-term care insurance policies and contracts; and all annuity contracts.

New Jersey's Health Care Quality Act (HCQA), N.J.S.A. 26:2S-1 et seq., applicable to all insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefits plans in this State, provides that individuals covered under a health benefits plan that uses one or more utilization management features have a right to appeal a denial, reduction or termination of covered services

by a carrier. Each carrier that uses utilization management is required to have a two-stage internal appeal mechanism for the benefit of its covered individuals, and must provide covered individuals with a written explanation of how to access this mechanism. In addition to these internal appeal programs, a covered individual has the right to an external appeal process involving an independent utilization review organization (IURO). The IURO may uphold, reverse or modify the utilization management decision of a carrier, and an adverse decision is binding on the carrier. Because IUROs are able to reverse carriers' medical necessity decisions and arbitrators and courts can reverse carriers on contractual issues other than medical necessity, carriers clearly do not have sole discretion to interpret their policies or contracts, and those policies or contracts that include discretionary clauses are disapproved by the Department.

In 2004, the National Association of Insurance Commissioners (NAIC) adopted Model Act 42, titled "Prohibition on the Use of Discretionary Clauses," the stated purpose of which was "to assure that health insurance benefits are contractually guaranteed, and to avoid the conflict of interest that occurs when the health carrier has unfettered authority to decide what benefits are due." While the New Jersey Legislature has not adopted Model Act 42, the Department has continually rejected the inclusion by carriers of discretionary clauses in health insurance and long-term care policies and contracts on the basis that such clauses are inequitable, unfair, and contrary to this State's laws and public policy.

The proposed new rules codify the Department's long-standing practice of disallowing the inclusion of discretionary clauses in all individual and group life, health and long-term care insurance policies and contracts, and all annuity contracts. Proposed N.J.A.C. 11:4-58.1 sets forth the purpose and scope of the subchapter, and

proposed N.J.A.C. 11:4-58.2 contains definitions used throughout the subchapter. Proposed N.J.A.C. 11:4-58.3 contains the language prohibiting the use of discretionary clauses, but permitting carriers to make an initial interpretation concerning the terms of their policies or contracts so long as that interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction. Proposed new N.J.A.C. 11:4-58.4 would deem any such policy and contract forms currently in use that contain discretionary clauses withdrawn as of January 1, 2007, and bar the delivery, issuance, execution or renewal of those forms.

A 60-day comment period is provided for this notice of proposal; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed new rules will have a favorable impact on consumers. The prohibition on discretionary clauses creates a level playing field, and ensures that consumers have the benefit of a fair and impartial standard of review applied by courts or arbitrators to their policies and contracts, rather than the "arbitrary and capricious" standard applied when a discretionary clause is included in a policy or contract. Application of a de novo standard of review better assures that consumers will be able to receive the benefits for which they have contracted in their policies and contracts. The new rules may have an unfavorable impact on carriers only insofar as it codifies an existing prohibition on the inclusion of discretionary clauses in policies and contracts. Disallowing such clauses removes unfettered discretion from carriers

to interpret the terms and conditions of their policies and contracts, and make determinations regarding the payment of benefits.

Economic Impact

The prohibition of the use of discretionary clauses may have a favorable impact on consumers if a de novo standard of review is applied by a court or other arbitrator in interpreting a policy or contract, instead of an arbitrary and capricious standard, and such de novo review results in payment of benefits that would not otherwise have been paid. Conversely, prohibiting the use of discretionary clauses in policies and contracts could unfavorably impact carriers if they are required to pay benefits that they would not otherwise have paid under old policy and contract forms that contained discretionary clauses. Codifying the Department's current policy of disapproving discretionary clauses will, however, economically benefit insurers by providing general notice of this policy, thereby enhancing the efficiency of the form preparation and filing process.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed new rules are *not* subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that the proposed new rules will result in the generation or loss of jobs.

Agriculture Industry Impact

The proposed new rules will have no agriculture industry impact.

Regulatory Flexibility Analysis

This proposed new rules as described in the Summary above may apply to some carriers that constitute "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rules, however, in prohibiting the inclusion of discretionary clauses in life and health insurance policies and contracts, annuity contracts, and long-term care policies and contracts, would not impose any reporting or recordkeeping requirements on small businesses, would not require small businesses to use any professional services, and places no additional administrative burden on small businesses to comply with the rule. The rules would require carriers to remove discretionary clause language from currently-used policy and contract forms, but the cost for doing so would be minimal. As stated in the Economic Impact above, a prohibition on the use of discretionary clauses in policies and contracts may result in carriers having to pay benefits that they otherwise would not have been required to pay on policy or contract forms introduced years ago that contain discretionary clauses. However, as stated in the Summary, the proposed new rules are codifying the Department's long-standing prohibition on the use of such clauses and must be applied consistently to all carriers issuing life and health insurance policies and contracts, annuity contracts and long-term care policies and contracts in this State to ensure the protection of New Jersey consumers. Thus, no exception can be made for small businesses.

Smart Growth Impact

The proposed new rules will have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Full text of the proposed new rules follows:

SUBCHAPTER 58. DISCRETIONARY CLAUSES

11:4-58.1 Purpose and scope

(a) The purpose of this subchapter is to prohibit the use of discretionary clauses in all life, health and long-term care insurance policies and contracts, and all annuity contracts, to assure that all benefits provided under the policy or contract are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has sole discretionary authority to decide what benefits are due.

(b) This subchapter shall apply to all individual and group health insurance policies and contracts; all individual and group life insurance policies and contracts; all individual and group long-term care insurance policies; and all annuity contracts delivered or issued for delivery in this State.

11:4-58.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Annuity" means a contract not included within the definition of life insurance or health insurance, as set forth in this section, under which an insurer obligates

itself to make periodic payments for a specified period of time, such as for a number of years, or until the happening of an event, or for life, or for a period of time determined by any combination thereof. A contract which includes extra benefits, of the kinds set forth in the definitions of life insurance or health insurance, as set forth in this section, shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State; any person or persons, corporation, partnership or company authorized or admitted to transact the business of life insurance or annuities in this State pursuant to Title 17B of the New Jersey statutes; and an insurance company, health service corporation, hospital service corporation, medical service corporation or fraternal benefit society authorized to issue long-term care insurance in this State.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Discretionary clause" means a clause included in a life or health insurance policy or contract, a long-term care insurance policy or contract, or an annuity contract, that provides the carrier with sole discretionary authority to determine eligibility for benefits under the policy or contract and to interpret the terms and provisions of the policy or contract.

"Health insurance" means a contract or agreement whereby a carrier is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or

because of any expenac relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance includes disability income protection coverage. Health insurance does not include workers' compensation coverage.

"Life insurance" means a policy or contract whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. Life insurance also includes the granting of endowment benefits and optional modes of settlement of proceeds of life insurance, as well as provisions for additional benefits in the event of death by accident or accidental means or in the event of dismemberment or loss of sight, or safeguarding such insurance against lapse or giving a special surrender value, or special benefit or annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract of life insurance or in a policy or contract supplemental thereto. Life insurance does not include worker's compensation coverage.

"Long-term care insurance" means any insurance policy, certificate or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also apply to qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit

societies; health, hospital, or medical service corporations; prepaid health plans; or health maintenance organizations. Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more qualifying events, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding the foregoing, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter.

11:4-58.3 Discretionary clauses prohibited

No individual or group health insurance policy or contract, individual or group life insurance policy or contract, individual or group long-term care insurance policy or contract, or annuity contract, delivered or issued for delivery in this State may contain a provision purporting to reserve sole discretion to the carrier to interpret the terms of the policy or contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State. A carrier may include a provision stating that the carrier has the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

11:4-58.4 Noncomplying forms

As of January 1, 2007, forms previously filed, approved or acknowledged by the Commissioner that contain provisions not in compliance with this subchapter shall be deemed withdrawn and shall not be delivered, issued, executed or renewed.

incregs/bbdisclause

TAB 2

Haddock v. Nationwide Financial Services Inc.

(Civ. No. 3:01cv1552) (SRU)(D. Conn.)

In September 2001, a class of 401(k) plan sponsors filed suit against Nationwide Financial Services, Inc. and Nationwide Life Insurance Co. in connection with revenue-sharing payments received by Nationwide from mutual funds (Qualified Plans 2002-3). Haddock v. Nationwide Financial Services Inc. (Civ. No. 3:01cv1552 (SRU), D. Conn). On February 24, 2006, the district court decided defendant's motion for summary judgment, ruling that 401(k) plan sponsors could continue their lawsuit because a rational fact-finder could conclude that (1) Nationwide's ability to select, remove and replace mutual funds offered to plans under its variable annuity contracts makes Nationwide an ERISA fiduciary, (2) revenue-sharing payments received by Nationwide under its contracts with mutual funds are "plan assets" under a functional approach, and (3) even if the revenue-sharing payments are not plan assets, Nationwide's receipt of the payments still might involve illegal "kickbacks" prohibited by ERISA (sec. 406(b)(3)).

Background – Revenue-sharing – where mutual funds pay fees, including so-called 12b-1 and similar fees, to companies that act as recordkeepers or service providers to defined contribution plans – is common in the retirement services industry. The Labor Department has previously issued guidance that essentially allows revenue sharing by mutual funds, under certain conditions. See DOL Advisory Opinions 97-15A and 16A (May 22, 1997). Under these interpretations, so long as a plan recordkeeper or other service provider does not exercise any discretionary authority or control to "cause" a plan (or a participant) to invest in a mutual fund, the recordkeeper (or other service provider) would not be deemed to violate ERISA's anti-kickback prohibition (under ERISA section 406(b)(3)) by receiving fees from the mutual fund. Many companies in the 401(k) service-provider industry rely on this guidance in receiving revenue-sharing payments as part of their overall compensation for recordkeeping and other plan services.

Plaintiff's ERISA Claims – In their fourth amended complaint, the plaintiff 401(k) plan sponsors alleged that Nationwide's contractual arrangements with mutual funds and its retention of revenue sharing payments from those funds constitute breaches of fiduciary duty and prohibited transactions. The plaintiffs have two theories of liability.

- First, they propose a functional approach to defining ERISA "plan assets" and argue that, under this approach, the revenue-sharing payments are plan assets that Nationwide retained in violation of ERISA.
- Second, they contend that Nationwide engaged in a quid pro quo arrangement with the mutual funds, agreeing to include the mutual funds as investment options for the plans under Nationwide's variable annuity contracts in exchange for the revenue-sharing arrangements.

Nationwide disputed that it has any fiduciary duties as well as the characterization of the revenue-sharing payments as "plan assets."

Fiduciary Status – On the issue of Nationwide's status as an ERISA fiduciary, the court found that a reasonable jury could conclude that Nationwide exercised authority or control with respect to the disposition of plan assets by controlling which mutual funds were available as investment options for plans and participants, even if its control or authority was limited to deleting and substituting funds that were initially approved by the plans.

The court's discussion recognizes the Labor Department's position in Advisory Opinion 97-16A that plan service providers may make changes to a menu of funds offered to plans without assuming fiduciary status, under circumstances where plan sponsors have final authority to determine the plan's investment options through a negative consent process. However, the opinion does not discuss in any detail whether Nationwide's authority under its variable annuity contracts was limited such that it should not become a fiduciary in connection with changes in mutual funds that are available to the plans. Presumably, Nationwide may provide additional evidence at trial with respect to whether it in fact had or exercised fiduciary authority or control in deleting or substituting funds that were initially approved by plans.

Revenue-Sharing Payments as "Plan Assets" – As to whether the revenue-sharing payments are ERISA "plan assets," the plaintiffs argued that (1) they would not have been made, but for the plan's investment through Nationwide, (2) Nationwide did not contract for the plan to receive the payments as compensation, despite the opportunity to do so, and (3) the payments could have been used for the benefit of the plans and participants. Rejecting this "overbroad" test, the court nevertheless adopted a functional test, concluding that "plan assets" could include benefits that a defendant receives (1) as a result of its exercise of fiduciary discretion or authority, and (2) at the expense of plan participants and beneficiaries.

Tested against this two-pronged approach, the court held that the plaintiff's claims should survive because, first, it was alleged that Nationwide received revenue-sharing payments in exchange for offering the mutual funds as investment options to the plans. Further, the payments were at the expense of the plan and participants because the mutual funds charged fees to plans to cover not only their normal fees, but also the revenue-sharing payments they were required to make to Nationwide.

Further, the court held that the plaintiffs' prohibited transaction claims are not entirely dependent on their theory that the revenue-sharing payments are plan assets. Specifically, the court held that a reasonable fact-finder could conclude that the revenue-sharing payments were consideration received by Nationwide from a party dealing with the plans, and thus, potentially, "kickbacks" prohibited by ERISA section 406(b)(3). Finally, the court distinguished Labor Department Advisory Opinions 2003-09A, 97-15A and 16A, noting that those opinions assumed that the revenue-sharing payments were consideration for "actual services," and that the plaintiffs had raised a triable issue

concerning whether Nationwide in fact performed any additional services in consideration for the payments.

Observations – Although only a district court decision, it is significant to recordkeepers and other plan service providers because it challenges common industry practices, which are based on Labor Department guidance holding that, generally, a recordkeeper or other plan service provider does not become a plan fiduciary merely by offering a menu of investment options to plans and making changes to those options from time to time. In addition, the court's decision suggests that revenue-sharing payments could be deemed to be "plan assets" – a legal conclusion that the Labor Department has not reached to date in its advisory opinions. We are also concerned that, like some initial court decisions against directed trustees (Qualified Plans 2003-6 and 2003-10), this opinion may encourage more costly protracted lawsuits against 401(k) plan recordkeepers and other service providers receiving revenue-sharing payments.

TAB 3

Two Significant Company Stock Rulings

This week, the courts handed down two important decisions in ERISA "stock drop" cases. These new decisions – both involving the ESOPs of financially troubled airlines – may help to settle the law on when a fiduciary of an eligible individual account plan designed to invest in qualified employer securities has a duty to rid the plan of those employer securities, as well as on the potential liability of directed trustees. We summarize them below.

DiFelice v. US Airways, Inc.

DiFelice v. U.S. Airways, Inc., No. 1:04cv889 (E.D. Va., June 26, 2006), involved a participant-directed 401(k) plan sponsored by US Airways. The plan included as one of several investment options an investment fund consisting primarily of the publicly-traded stock of the airline's parent holding company. After the airline filed bankruptcy in 2002, a class of participants sued, claiming (among other things) that the airline, as the plan's named fiduciary, had breached its fiduciary duty under ERISA by allowing that company stock to remain as a plan investment option while the airline headed toward bankruptcy. More specifically, the plaintiffs claimed that ERISA's "prudent man" standard of care required the airline to eliminate the company stock fund in view of the increasing risk of a bankruptcy filing by the airline.

In 2005, the district court denied the airline's motion for summary judgment on that claim, reasoning that the claim turned on disputed issues of fact. The court held a six-day bench trial on the claim earlier this year, and heard testimony from 11 fact witnesses and 7 expert witnesses. Based on that testimony and on other documentary evidence, the court concluded that plaintiffs' evidence failed to establish imprudent conduct on the part of the airline.

In reaching that conclusion, the court used modern portfolio theory and efficient market theory as guideposts for applying ERISA's prudent man standard of care. The district court noted as an initial matter that ERISA does not judge the prudence of maintaining a company stock investment option under a plan like US Airways' plan based on the individual risk and return characteristics of the company stock, standing alone. Rather, and consistent with modern portfolio theory, the court held that "ERISA requires that the prudence of selecting a particular investment be viewed in light of its contribution to the risk and return of the entire portfolio, and not in light of its individual risk." On the second point, the court observed that, "[b]ecause the risks facing US Airways were publicly disclosed,[] the unit price of the Company Stock Fund reflected the risk that the Group's bankruptcy filing would diminish or eliminate the value of the shares at all times during the class period." Further, "because investors who assume greater risk are compensated for that risk with the possibility of greater returns, the price of [the Company stock] offered participants a potential return far in excess of other Plan investment options." Finally, the district court observed the many steps taken by US

Airways to provide information to participants about the Plan's investment options, including the company stock fund. Taking these points together, the district court framed the prudence question as "[w]hether, in its role as Plan fiduciary, US Airways provided plan participants with the investment options and the information necessary to allow the participants to construct a diversified portfolio. If these requirements are met, and the record clearly so reflects, US Airways has satisfied its fiduciary duty to act prudently under ERISA when selecting and monitoring the Plan's investment options."

Of the more than 100 ERISA "stock-drop" cases filed to date, DiFelice is only the second to be resolved following a full-blown trial on the merits. The district court's ruling on the merits in DiFelice is likely to shape how other courts apply ERISA's prudent-man standard of care in stock-drop cases, like DiFelice, that involve publicly traded employer securities, a "404(c)" plan with diverse and well-explained investment options, and no allegations of securities fraud or market manipulation. In those circumstances, the standard applied by the district court in DiFelice posits that "a fiduciary may continue to offer employee stock as an investment option in a 401(k) Plan as long as the fiduciary also provides Plan participants, as here, with (1) a range of investment options; (2) true and accurate information regarding the risk/return characteristics of those investment options; and (3) the unfettered ability to trade in and out of those investment options."

Summers v. State Street Bank & Trust Co.

In Summers v. State Street Bank & Trust Co., Nos. 05-4005, 05-4317 (7th Cir. June 28, 2006), a Seventh Circuit panel affirmed a district court decision granting summary judgment for the directed trustee of an employee stock ownership plan sponsored by United Air Lines. The Seventh Circuit's opinion, written by Judge Richard Posner, powerfully rejects the premise of most ERISA stock-drop claims, i.e., that a fiduciary can predict a company's future more accurately than the composite judgment of the marketplace as reflected in the market price of the company's stock.

United Air Lines filed bankruptcy in 2002. At the time, more than half of the airline's stock was held in the ESOP. Participants sued the ESOP's named fiduciary and the ESOP's directed trustee (State Street) claiming that each should have replaced the ESOP's stock with some other security before the airline slipped into bankruptcy. Plaintiffs' principal theory was that both defendants knew or should have known that a bankruptcy filing was highly likely when, in the wake of the September 11, 2001 terrorist attacks, United's CEO wrote a letter warning employees that the airline was "in a struggle just to survive." Like DiFelice, Summers involved no allegation of securities fraud or market manipulation.

Plaintiffs settled their claims against the ESOP's named fiduciary. The district court granted summary judgment for State Street (the directed trustee) based on: (i) the theory an ESOP's directed trustee has a duty to dispose of company stock (absent a

direction to do so) only "upon reliable information that shows an imminent collapse because otherwise a fiduciary could be cajoled into prematurely selling off an employer's securities;" and (ii) a conclusion that the evidentiary record, including the CEO's October 2001 warning letter to employees, gave State Street no such indication of an "imminent collapse." Summers v. UAL Corp., 2005 WL 2648670 (N.D. Ill. Oct. 12, 2005).

Plaintiffs appealed the district court's grant of summary judgment for State Street, perhaps hopeful that the appellate court would see the CEO's warning letter to employees as the kind of evidence sufficient to create a triable issue of fact under the "imminent collapse" standard invoked by the district court. The appellate court, however, took a different tack.

As an initial matter, the court of appeals agreed that a directed trustee has *some* level of fiduciary responsibility with respect to the choice of trust assets, even in an ESOP. On this point, Judge Posner essentially endorsed the standard articulated in the Labor Department's 2004 Field Assistance Bulletin on the Fiduciary Responsibilities of Directed Trustees (Qualified Plans 2004-12) – i.e., a trustee may disobey the named fiduciary's directions when it is plain that they are imprudent.

But when does an ESOP's continued holding of company stock plainly become imprudent? On this question, Judge Posner criticized a key premise of the "imminent collapse" theory for identifying when the duty to sell might be triggered. As Judge Posner saw things, the plaintiffs (and to some extent, the lower court) had assumed that qualitative indicators, such as the CEO's October 2001 warning letter to employees, should have alerted plan fiduciaries that the airline was destined for bankruptcy. "That is wrong," wrote Posner. "After the market 'read' the letter, it valued United stock at $15.05 a share. Had the market thought that United would be bankrupt by the end of 2002, it would not have priced the stock that high in October 2001, . . ." For this and other reasons, "[a] trustee is not imprudent to assume that a major stock market . . . provides the best estimate of the stocks traded on it that is available to him. . . . Thus, at every point in the long slide of United's stock price, that price was the best estimate available to State Street and [the named fiduciary] of the Company's value, [] and so neither fiduciary was required to act on the assumption that the market was overvaluing United."

Having concluded that the Summers plaintiffs built their prudence case on a faulty legal theory, the court of appeals upheld the summary judgment in State Street's favor. But Judge Posner's opinion did not stop there. In obiter dictum, Judge Posner suggested an alternative theory for establishing an ESOP fiduciary's duty to sell company stock. That theory, previewed in dictum in an earlier ESOP decision authored by Judge Posner (Steinman v. Hicks, 352 F.3d 1101 (7th Cir. 2003), Qualified Plans 2003-12), posits that ERISA's duty of prudence "could" require diversification "if the ESOP was the [employees'] principal retirement asset . . . and was entirely invested in the stock of their employer" and if an event, such as a rise in the company's debt-to-equity ratio, materially increased the company' risk of bankruptcy. According to Judge Posner, the "source of

the duty to diversify would not be the trustee's disagreement with the market valuation (their failure to predict the company's impending collapse), but the excessive risk imposed on employee-shareholders by the rise in the debt-equity ratio of the employer's stock as a result, in the example given in Steinman, of a merger and in our case of a plummeting stock price."

Importantly, Judge Posner grounded his possible risk-based duty to diversify in the "prudence" requirement set forth in ERISA § 404(a)(1)(D). But he did not expressly try to reconcile his theory with ERISA § 404(b)(2), which provides that, in the case of an eligible individual account plan, both the diversification requirement in ERISA § 404(a)(1)(C) "and the prudence requirement . . . to the extent it requires diversification" are not violated by the plan's acquisition or holding of qualifying employer securities. Nor did Judge Posner attempt meaningfully to grapple with the publicly-available facts showing that the ESOP was only one of several plans through which United offered retirement income for the Summers plaintiffs.

As obiter dictum, Judge Posner's ruminations about a possible risk-based duty to sell company stock are non-precedential. But they could shape the way that other courts (and other plaintiffs) analyze the duty-to-sell question in cases involving ESOPs or other non-diversified individual account plans.

TAB 4

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

BRIAN LOOMIS, DEBRA COGSWELL, RON WELTE, WAYNE JOHNSON, and ED SALFELDER, individually and on behalf of all those similarly situated

Plaintiffs,

v.

EXELON CORPORATION, WILLIAM BERGMAN in his capacity as Exelon Corporation's Director of Employee Benefit Plans and Programs; COMPENSATION COMMITTEE OF EXELON CORPORATION'S BOARD OF DIRECTORS; M. WALTER D'ALESSIO, ROSEMARIE B. GRECO, RONALD RUBIN AND RICHARD L. THOMAS, all in their capacities as members of the Compensation Committee, EMPLOYEE SAVINGS PLAN INVESTMENT COMMITTEE; RISK OVERSIGHT COMMITTEE OF THE EXELON CORPORATION BOARD OF DIRECTORS; AND SUE LING GIN, JUDGE NELSON A. DIAZ, EDGAR D. JANNOTTA, WILLIAM C. RICHARDSON, PH.D., JOHN W. ROGERS, JR. AND RONALD RUBIN, all in their capacities as members of the Risk Oversight Committee,

Defendants.

06CV4900
JUDGE FILIP
MAG.JUDGE ASHMAN

JURY TRIAL DEMANDED
CLASS ACTION COMPLAINT

COMPLAINT FOR BREACH OF FIDUCIARY DUTY

INTRODUCTION

1. Personal savings accounts, such as 401(k)s, are quickly becoming employees' primary method of financially planning for retirement. For many employees

in the United States today, an employer-provided defined benefit pension awaiting their retirement is a quaint, historical notion.

2. In 401(k) plans, employers provide an opportunity for employees to save their own pre-tax dollars in individual 401(k) accounts. The accounts provide a number of investment alternatives into which employees place a portion of their current income with the hope of earning, over time, a return sufficient to support themselves and their families in retirement.

3. Accordingly, in 401(k) plans, the return on employees' investments is critical. Even seemingly small reductions in a participant's return in one year may substantially impair his or her accumulated savings at retirement.

4. While such reductions in 401(k) accounts' returns may result from market fluctuations, a consistent, albeit rarely discussed, force reducing 401(k) accounts' earnings is the administrative fees and expenses assessed against account balances.

5. The most certain means of increasing the return on employees' 401(k) savings is to reduce the fees and expenses employees pay from their 401(k) accounts.

6. Unlike generalized market fluctuations, employers can control these fees and expenses. Federal law requires them to do so.

7. Under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"), an employer who provides a 401(k) plan for its employees is a "Plan Sponsor." The employer or its agent may also serve as "Plan Administrator," or the employer may appoint a third party to serve as such. Both the Plan Sponsor and the Plan Administrator are fiduciaries of the 401(k) plan. The Plan Administrator performs or contracts for administrative, record-keeping, investment management, and other

services from entities in the financial and retirement industry. ERISA requires that the fees for these services must be reasonable, incurred solely for the benefit of Plan participants, and fully disclosed.

8. For providing various services, third-party plan administrators, record-keepers, consultants, investment managers, and other vendors in the 401(k) industry have developed a variety of pricing and fee structures.

9. At best, these fee structures are complicated and confusing when disclosed to Plan participants. At worst, they are excessive, undisclosed, and illegal.

10. In this action, pursuant to ERISA § 502(a), 29 U.S.C. § 1132(a), Plaintiffs and Class Representatives, on behalf of all similarly situated participants and beneficiaries of the Exelon Corporation Employee Savings Plan, Plan #003, (the "Plan"), seek to recover the losses suffered by the Plan on a plan wide basis and to obtain injunctive and other equitable relief for the Plan from the Plan's fiduciaries based upon their breaches of their fiduciary duties.

11. As set forth in detail below, the fees and expenses paid by the Plan, and thus borne by Plan participants, were and are unreasonable and excessive; not incurred solely for the benefit of the Plan and its participants; and undisclosed to participants. By subjecting the Plan and its participants to these excessive fees and expenses, and by other conduct set forth below, the Defendants violated their fiduciary obligations under ERISA.

PARTIES, JURISDICTION AND VENUE

Plaintiffs

12. Plaintiff and Class Representative Brian Loomis is a resident of Illinois, living and working in the Northern District of Illinois.

13. Plaintiff and Class Representative Debra Cogswell is a resident of Illinois, living and working in the Northern District of Illinois.

14. Plaintiff and Class Representative Gary Welte is a resident of Illinois, living and working in the Northern District of Illinois.

15. Plaintiff and Class Represenative Wayne Johnson is a resident of Illinois, living and working in the Northern District of Illinois.

16. Plaintiff and Class Representative Ed Salfelder is a resident of Illinois.

17. Each Plaintiff and Class Representative is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7).

Defendants

18. Defendant Exelon Corporation is a corporation with its headquarters in Chicago, Illinois. It provides electric and gas utility services to consumers in Illinois and Pennsylvania. It is the sponsor of the Plan within the meaning of ERISA § 3(16)(B), 29 U.S.C. § 1002(16)(B), an administrator of the Plan within the meaning of ERISA § 3(16)(A), 29 U.S.C. § 1102(16)(A), and is the employer and principal of the Plan's administrator and one or more of its members. It is a fiduciary with respect to the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

19. Defendant William Bergman, Exelon Corporation's Director of Employee Benefit Plans and Programs, is the current Plan Administrator within the meaning of ERISA § 3(16)(A), 29 U.S.C. § 1002(16)(A), and is a "named fiduciary" to the Plan within the meaning of ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2). He has responsibility for all matters relating to the Plan except for investments, benefits appeals, and the trust

fund. He is also a fiduciary with respect to the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

20. Defendant Compensation Committee of Exelon Corporation's Board of Directors has the responsibility for appointing, monitoring, and/or removing the Plan Administrator. In this capacity, the Compensation Committee and its members are fiduciaries to the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). The members of the Compensation Committee are Directors M. Walter D'Alessio, Rosemarie B. Greco, Ronald Rubin and Richard L. Thomas.

21. Defendant Employee Savings Plan Investment Committee currently has responsibility for all matters relating to the investments held by the Plan and its participants. The members of the Investment Committee are William Bergman, as Director of Employee Benefit Plans and Programs, Exelon Corporation's Director of Investments, and Exelon Business Services Company's Manager of Accounts Payable. The Investment Committee is a "named fiduciary" to the Plan within the meaning of ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2), and is a fiduciary to the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

22. Defendant Risk Oversight Committee of the Exelon Corporation Board of Directors has responsibility for appointing, monitoring, and removing the members of the Investment Committee. The Members of the Risk Oversight Committee are the independent directors of Exelon Corporation: Sue Ling Gin, Judge Nelson A. Diaz, Edgar D. Jannotta, William C. Richardson, Ph.D., John W. Rogers, Jr. and Ronald Rubin. In this capacity, they are all fiduciaries to the Plan within the meaning of ERISA § (21)(A), 29 U.S.C. § 1002(21)(A).

Jurisdiction And Venue:

23. Plaintiffs seek relief on behalf of the Plan through the mechanisms found in ERISA § 409, 29 U.S.C. § 1109, and ERISA § 502, 29 U.S.C. § 1132. Therefore, this Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1).

24. All Defendants are subject to service of process issued from this Court pursuant to 29 U.S.C. § 1132(e)(1)(2).

25. Venue of this action is proper pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because the injury occurred directly to Plaintiffs in this district where they live and work, because the breaches of fiduciary duty occurred in this district and because the Defendants may be found in this district.

The Plaintiff Class

26. Plaintiffs bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedure, on behalf of themselves and all similarly situated Plan participants and beneficiaries. They seek to represent the following class (the "Class"):

> All persons, *excluding the Defendants, the Committees and/or other individuals who are or may be liable for the conduct described in this Complaint,* who are or were participants or beneficiaries of the Plan and who are, were or may have been affected by the conduct set forth in this Complaint, as well as those who will become participants or beneficiaries of the Plan in the future.

27. Certification of this class is proper under Rule 23(a) because all of its prerequisites are satisfied:

a. **Numerosity.** The members of the Class are so numerous that joinder of all members is impracticable. Although the Plaintiffs do not know the exact number of class members as of the date of filing, there were

23,291 participants with account balances in the Plan at the end of the 2004 plan year.

b. **Commonality.** Common issues of fact and law predominate over any issues unique to individual class members. Issues that are common to all class members include, but are not limited to, whether the Defendants:

i. Charged fees and expenses to the Plan that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants;

ii. Caused the Plan to enter into agreements with third parties which caused and/or allowed the Plan to pay fees and expenses that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants;

iii. Failed to monitor the fees and expenses paid by the Plan and, by such failure, caused or allowed the Plan to pay fees and expenses that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants;

iv. Failed to inform themselves of, and understand, the various methods by which vendors in the 401(k) retirement industry collect payments and other revenues from 401(k) plans;

v. Failed to establish, implement, and follow procedures to properly and prudently determine whether the fees and

expenses paid by the Plan were reasonable and incurred solely for the benefit of Plan participants;

vi. Failed properly to inform and/or disclose to Plan participants the fees and expenses that are, or have been, paid by the Plan;

vii. Failed to inform and/or disclose to Plan participants in proper detail and clarity the transaction fees and expenses which affect participants' accounts balances in connection with the purchase or sale of interests in investment alternatives;

viii. Breached their fiduciary duties by failing to disclose that hidden and excessive fees were and are being assessed against Plan assets and by failing to stop such hidden excessive fees;

ix. Appointed as fiduciaries persons who did not fulfill their fiduciary duties, failed to monitor and/or oversee the performance of those fiduciaries and to ensure that they were fulfilling those duties, and failed to terminate the fiduciaries' appointment after breaches occurred;

x. In charging, causing to be charged or paid, and failing to monitor the fees and expenses of the Plan, failed to exercise the care, skill, prudence, and diligence that a prudent

person would when acting in like capacity and familiar with such matters;

xi. Caused and/or allowed fees and expenses to be paid by the Plan for purposes other than those allowed by ERISA;

xii. By the conduct above and/or by other conduct set forth in this Complaint, revealed in discovery and/or proven at trial, breached their fiduciary and other ERISA-imposed obligations to the Plan, Plan participants, and members of the Class;

xiii. Are liable to the Plan and the Class for losses suffered as a result of the breaches of their fiduciary and other ERISA-imposed obligations; and

xiv. Are responsible to account for the assets and transactions of the Plan and should be charged for any transactions and payments for which they cannot account.

c. **Typicality.** The Claims brought by the Plaintiffs are typical of those of the absent class members because:

i. The Defendants owed the exact same fiduciary and other ERISA-based obligations to each Plan participant and each member of the Class;

ii. The Defendants' breach of those obligations constitutes a breach to each participant and each member of the Class;

iii. To the extent that there are any differences among the Class members' damages, such differences would be a product of simple mathematics based upon their account balances in the Plan. Such minimal and formulaic differences are no impediment to class certification.

d. **Adequacy of Representation.** The Plaintiffs are adequate representatives of the absent class members and will protect such absent class members' interests in this litigation. The Plaintiffs do not have any interests antagonistic to the other class members nor do they have any unique claims or defenses that might undermine the efficient resolution of the class claims. Plaintiffs have retained competent counsel, versed in ERISA, class actions, and complex litigation.

28. Class certification is also appropriate under Rule 23(b) and each subpart because:

a. Pursuant to Rule 23(b)(1)(B), in the absence of certification, there is a risk of inconsistent adjudications with respect to individual class members;

b. Pursuant to Rule 23(b)(2), as set forth above, the Defendants have acted on grounds generally applicable to the Class as a whole;

c. Pursuant to Rule 23(b)(3), as set forth above, common issues of law and fact predominate over any purely individual issues and thus a class action is superior to any other method for adjudicating these claims.

FACTS

The Plan

29. As part of their compensation and benefits, Exelon offers certain of its employees the opportunity to participate in the Plan. The Plan is a "defined contribution plan," as defined in ERISA § 3(34), 29 U.S.C. § 1002(34) and contains an employee stock ownership plan provision. It is also a tax-qualified plan of the type popularly known as a "401(k) plan."

30. Exelon benefits from its sponsorship of the Plan because giving employees the opportunity to participate in the Plan enhances Exelon's ability to recruit and retain qualified personnel, fosters employee loyalty and goodwill, and entitles Exelon to tax advantages under the Internal Revenue Code.

31. Under the terms of the Plan, qualified employees may contribute certain portions of their before-tax earnings to the Plan. Exelon Corporation will match those contributions in varying percentages. Participants are 100 percent vested in their account, including Exelon's matching contribution portion, and amounts are entirely non-forfeitable at all times.

32. Each participant's account is credited with the participant's contributions, the participant's share of Exelon's matching and discretionary contributions, and the Plan's earnings.

33. Participating employees may choose to invest Plan contributions in any of 25 investment options, selected by the Investment Committee and its members. Seventeen of those options are mutual funds, with six of the mutual funds being what are known as lifecycle or target date funds.

34. In addition to the mutual funds, the Plan offers six "collective trusts." Collective trusts such as the ones in the Plan are similar to mutual funds in that they pool money from more than one investor and invest in many different underlying securities. Unlike mutual funds, however, collective trusts are not available to the retail customer, but are available only to institutional investors such as pension plans or large 401(k) plans.

35. The Plan also offers participants the option of investing in the Exelon Stock Fund, a fund that holds Exelon Corporation common stock.

36. By the end of 2005, the Plan had more than $3 billion in assets.

37. Of the more than $3 billion in assets, nearly $2 billion was held in mutual funds. The majority of the mutual fund assets were held in funds managed by Fidelity Management and Research Company. Fidelity Management Trust Company is the Plan's trustee.

Fiduciary Duties Owed To The Plan Under ERISA

38. ERISA §403(c)(1), 29 U.S.C. §1103(c)(1), unambiguously mandates that:

> [T]he assets of a plan shall never inure to the benefit of any employer and shall be held for the **exclusive purposes of providing benefits** to participants in the plan and their beneficiaries **and defraying reasonable expenses of administering the plan.**

(Emphasis added).

39. ERISA §§ 404(a)(1)(A)&(B) of ERISA, 29 U.S.C. § 1104(a)(1)(A) & (B), require that Plan fiduciaries, including Exelon, "shall discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries" and:

a. [F]or the exclusive purpose of:
   i. providing benefits to participants and their beneficiaries;

and

ii. defraying reasonable expenses of administering the plan; and

b. [W]ith the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

40. ERISA § 405(a), 29 U.S.C. § 1105(a), provides that one fiduciary may be held liable for breaches of fiduciary duty committed by another fiduciary where

> (1) the fiduciary "participates knowingly in or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach";
> (2) the fiduciary, by his or her "failure to comply with section 1104(a) of this title in the administration of his specific responsibilities which give rise to his status as a fiduciary" enables "such other fiduciary to commit such a breach"; or
> (3) the fiduciary "has knowledge of a breach by such other fiduciary," and does not make "reasonable efforts under the circumstances to remedy the breach."

41. ERISA § 406, 29 U.S.C. § 1106, prohibits certain transactions between the Plan and "parties in interest." This section provides that unless subject to an exemption as set forth in ERISA § 408, 29 U.S.C. § 1108, a fiduciary

> shall not cause the plan to engage in a transaction ...if he knows or should know that such a transaction constitutes a direct or indirect – sale or exchange, or leasing, of any property between the plan and a party in interest ...furnishing of goods, services or facilities between the plan and a party in interest ...transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan.

29 U.S.C. § 1106(a)(1).

42. For purposes of section 406, a "party in interest" is any plan fiduciary, including the plan administrator, trustee, officer or custodian, any plan services provider, the employer, a relative of any of the above, and certain persons with ownership or leadership roles in any of the above. ERISA § 3(14), 29 U.S.C. § 1002(14).

43. Similarly, a fiduciary (1) shall not "deal with the assets of the plan in his own interest or for his own account"; (2) shall not "act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan" or its participants and beneficiaries; and (3) shall not "receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan." 29 U.S.C. § 1106(b).

44. ERISA §104(b)(1), 29 U.S.C. § 1024(b)(1), requires that the Plan Administrator periodically provide to Plan participants and beneficiaries a summary plan description (an "SPD").

45. ERISA §104(b)(3), 29 U.S.C. § 1024(b)(3), requires that the Plan Administrator at least annually provide to Plan participants and beneficiaries copies of statements and schedules from the Plan's annual report for the previous year, and such additional information "as is necessary to fairly summarize the latest annual report."

46. The schedules and statements that the Plan Administrator annually must provide to Plan participants and beneficiaries specifically include:

> a. [A] statement of the assets and liabilities of the plan aggregated by categories and valued at their current value, and the same data displayed in comparative form for the end of the previous fiscal year of the plan; and
> b. [A] statement of receipts and disbursements during the preceding twelve-month period aggregated by general sources and applications.

See ERISA §103(b)(3), 29 U.S.C. §1023(b)(3).

47. ERISA §104(b)(4), 29 U.S.C. § 1024(b)(4), entitles Plan participants and beneficiaries to receive more detailed information from the Plan Administrator on request:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement,

> trust agreement, contract, or other instruments under which the plan is established or operated.

48. ERISA §103(b)(2)&(3), 29 U.S.C. §1023(b)(2)&(3) mandates that, among other extensive disclosures, Plan fiduciaries must include in the Plan's "Annual Report"

> a statement of [the Plan's] assets and liabilities, and a statement of changes in net assets available for plan benefits which shall include details of revenues and expenses and other changes aggregated by general source and application.

49. ERISA § 404(c) provides to Plan fiduciaries a "Safe Harbor" from liability for losses that a participant suffers in his or her 401(k) accounts to the extent that the participant exercises control over the assets in his or her 401(k) accounts. To be eligible for the protection of this "safe harbor," Plan fiduciaries must, among other things, provide:

> a. an opportunity for a participant or beneficiary to exercise control over assets in his individual account, and
> b. a participant or beneficiary an opportunity to choose, from a broad range of investment alternatives, the manner in which some or all of the assets in his account are invested.

29 C.F.R. §2550.404c-1(b)(1).

50. For a participant or beneficiary to have "an opportunity to exercise control over assets in his individual account," Plan fiduciaries must provide him or her with "the opportunity to obtain sufficient information to make informed decisions with regard to investment alternatives under the Plan." 29 C.F.R. §2550.404c-1(b)(2)(B).

51. The "sufficient investment information" Plan fiduciaries must provide includes:

> A description of any transaction fees and expenses which affect the participant's or beneficiary's account balance in connection with purchases or sales of interests in investment alternatives (e.g., commissions, sales load, deferred sales charges, redemption or exchange fees).

29 C.F.R. §2550.404c-1(b)(2)(i)(B)*(1)(v)*. At least upon request, it must include

> A description of the annual operating expenses of each designated investment alternative (e.g., investment management fees, administrative fees, transaction costs) which reduce the rate of return to participants and beneficiaries, and the aggregate amount of such expenses expressed as a percentage of average net assets of the designated investment alternative.

29 C.F.R. §2550.404c-1(b)(2)(i)(B)*(2)(i)*.

52. ERISA's Safe Harbor Regulations state that the imposition of *reasonable* charges for *reasonable* Plan expenses does not interfere with a participant's opportunity to exercise control over his or her individual account so long as *Plan fiduciaries inform the participant* of such actual expenses:

> A plan may charge participants' and beneficiaries' accounts for the reasonable expenses of carrying out investment instructions, *provided that procedures are established under the plan to periodically inform such participants and beneficiaries of actual expenses incurred with respect to their respective individual accounts.*

29 C.F.R. §2550.404c-1(b)(2)(ii)(A) (emphasis added).

The Fees and Expenses Assessed Against The Plan

53. The Defendants, directly or indirectly, have caused the Plan to purchase services from various plan service providers, including trustee, record-keeping, administration, investment advisory, investment management, brokerage, insurance, consulting, accounting, legal, printing, mailing, and other services.

54. The Defendants have caused the amounts that the Plan pays for these services to be assessed against participants' accounts.

55. The Defendants have caused or allowed these plan service providers to receive payment in at least one of two ways:

a. By direct disbursement from the Plan to the entity providing the service; and/or

b. By receiving, or having the opportunity to receive, "Revenue Sharing" payments comprised of Plan assets distributed between and/or among various service providers.

"Hard Dollar" Payments to Plan Service Providers

56. Payments in the form of direct disbursements from the Plan to participants or an entity providing a service to the Plan are characterized as "Hard Dollar" payments.

57. The Plan discloses to government regulators and Plan participants, in one form or another, Hard Dollar payments made from the Plan to service providers. For example, the Plan disclosed in filings with government regulators covering plan year 2003 that it paid Fidelity Institutional Operations Company for recordkeeping services.

58. Based upon this disclosure, understanding the Plan's record-keeping expense for 2003 *appears* straightforward: The Plan sent a check to Fidelity Institutional Operations Company and, in exchange, Fidelity Institutional Operations Company maintained the Plans' records.

59. However, these disclosed hard dollar expenses are not all of the fees.

Revenue Sharing Payments to Plan Service Providers

60. Revenue Sharing is a common practice in the financial, securities, and investment industry that provides services to 401(k) plans.

61. Industry commentators and analysts consider Revenue Sharing to be the "big secret of the retirement industry."

62. Industry commentators and analysts generally define "Revenue Sharing" as the transfer of asset-based compensation from brokers or investment management providers (such as mutual funds, common or collective trusts, insurance companies offering general insurance contracts, and similar pooled investment vehicles) to administrative service providers (record-keepers, administrators, trustees or consultants) in connection with 401(k) and other types of defined contribution plans.

63. For example, a plan or its agent (a third-party administrator, consultant, or similar fiduciary) seeking to select an investment vehicle (mutual fund, common or collective trust, guaranteed investment contracts, etc. (collectively "Fund")) to be offered to plan participants as an investment option will negotiate an agreement that sets the costs assessed against each dollar invested by specifying the expense ratio and available Revenue Sharing.

64. In Revenue Sharing arrangements, the Plan and the Fund agree upon an asset-based fee that is not the true price for which the Fund will provide its service.

65. Instead, the Fund's agreed asset-based fee includes ***both*** the actual price for which the Fund will provide its service ***and*** additional amounts that the Fund does not need to cover the cost of its services and to make a profit.

66. The additional portion of the agreed-upon asset-based charge is "shared" with Plan service providers or others who do business with the Plan or the Fund.

67. As a result of Revenue Sharing arrangements, Plan service providers or others who do business with the Plan or the Fund receive *both* a Hard Dollar payment from the Plan *and* additional revenue that the Fund "shares" with them.

68. The total fees a Fund charges to a plan can vary widely based upon a number of factors, including without limitation: the amount that the plan invests in the Fund; the level of sophistication of the plan fiduciary negotiating the fee agreement; the plan fiduciary's awareness of Revenue Sharing and inclination to expend effort monitoring Revenue Sharing transfers; the diligence with which the plan fiduciary conducts such negotiations; and the separate financial interests and/or agendas of the plan fiduciary and the Fund as they negotiate.

69. Revenue Sharing is not confined to mutual funds. Common or collective trusts, providers of guaranteed insurance contracts, and private investment pools may enter into Revenue Sharing arrangements in connection with the services they provide to 401(k) plans.

70. Revenue Sharing also occurs between and among brokerage firms, investment managers, fund families and other service providers.

71. When 401(k) plan service providers receive compensation in the form of both Hard Dollar fees *and* Revenue Sharing payments, determining the total amount of fees and expenses that the Plan incurs for any category of services (*i.e.* recordkeeping and administration, investment advisory, trustee, auditing, and accounting, etc.) requires that *both* the Hard Dollar fees *and* Revenue Sharing payments be taken into account.

72. Ascertaining whether the Plan Administrator has fulfilled its fiduciary obligation to ensure that the fees and expenses assessed against the 401(k) Plan are reasonable and incurred solely in the interest of Plan participants requires consideration whether the *total of both* the Hard Dollar *and* Revenue Sharing payments paid for any category of services complies with this standard.

73. Although Revenue Sharing monies arise only as a result of, and in connection with, transactions involving the plan, plan assets and plan service providers; Revenue Sharing is not always captured and used for the benefit of the plan and the participants.

74. When Revenue Sharing is foregone, the plan will not only pay additional hard dollar fees to the plan service providers (since no Revenue Sharing payments are available to offset those Hard Dollar costs), but it will also pay additional money to the Fund, beyond what the Fund would normally charge and keep.

75. Consequently, in determining whether a plan administrator or other fiduciary has fulfilled its obligation to ensure that the fees and expenses assessed against the plan are reasonable and incurred solely in the interest of plan participants, foregone Revenue Sharing must also be taken into account.

76. Such is the case here. The investment managers of the Plan investment options, including at least some of the collective trusts, charged fees to the Plan that included money with which to make Revenue Sharing payments. However, the Defendants failed to capture the available Revenue Sharing and use it solely in the interest of the Plan and the participants and beneficiaries.

77. As a result, when the foregone Revenue Sharing – consisting of millions of dollars – is taken into account, the participants and beneficiaries of the Plan paid unreasonably high fees for the administrative services and/or investment management they received.

Revenue Sharing Arrangements Are Not Disclosed to Plan Participants

78. Revenue Sharing is not disclosed to Plan participants and government regulators, even though it may account for a greater portion of certain categories of service provider payments than do Hard Dollar disbursements to those same providers.

79. Accordingly, industry commentators and experts have dubbed Revenue Sharing payments to be "hidden fees" that are assessed against 401(k) plans and thus reduce plan participants' retirement savings.

80. By entering into, allowing, and/or failing to monitor, discover, and prevent or recover these undisclosed Revenue Sharing arrangements, Exelon and the Committees deprived Plan participants of true and accurate information regarding:

a. How much they are paying in fees and expenses for the Plan;

b. Who is receiving Plan assets through Revenue Sharing;

c. How much service providers are paid in addition to their disclosed, hard dollar fees; and

d. Whether the total amount paid to services providers (*i.e.* disclosed, hard dollar fees *combined with* Revenue Sharing payments) is reasonable and incurred solely for the participants' benefit.

Defendants' Non-Compliance with §404(c)'s Safe Harbor Requirements and Concealment of Their Fiduciary Breaches

81. As set forth above, the Defendants did not disclose, and to this day have not disclosed, the fact that plan service providers were and/or engaging in Revenue Sharing; nor that Revenue Sharing was available for the benefit of the Plan and its

participants, nor the amount of Revenue Sharing payments, made by or to Plan service providers.

82. Plan participants did not have, and do not have, complete and actual knowledge of the fees and expenses being charged to the Plan that reduced their account balances.

83. Thus, Plan fiduciaries, including the Defendants, have not told Plan participants, and Plan participants do not know:

a. the "annual operating expenses" of the investment options in the Plan, as required by 29 C.F.R. §2550.404c-1(b)(2)(i)(B)*(2)(i)*; and

b. the actual expenses incurred with respect to their respective individual accounts, as required by 29 C.F.R. §2550.404c-1(b)(2)(ii)(A).

84. As a result of the Defendants' failure and refusal to provide such information, and the general failure on the part of the Plan fiduciaries to disclose the actual Plan expenses, including available Revenue Sharing, the participants have not been provided with "the opportunity to obtain sufficient information to make informed decisions with regard to investment alternatives under the plan." 29 C.F.R. §2550.404c-1(b)(2)(1)(B).

85. Because the Defendants failed and refused to provide them with this information, and concealed this information from them, the participants have lacked the information necessary to understand and protect their interests in the Plan and/or to have knowledge of, the Defendants' breaches of fiduciary duty.

86. In fact, in their fiduciary roles, the Defendants are the parties with the information necessary to know and understand whether the participants' rights and protections under ERISA are being, or have been, violated.

87. Defendants have an affirmative obligation to provide full and accurate information to the Plan participants regarding the administration of the Plan.

88. Defendants' silence and/or non-disclosure in the face of such a duty to disclose is tantamount to an affirmative misrepresentation.

89. Here, despite the Defendants' duty to disclose full and accurate information regarding the fees and expenses assessed against participants' accounts, on an ongoing basis Defendants failed and refused to disclose to, and inform the participants of:

a. the total amount of fees and expenses reasonable and necessary to operate the plan;

b. the total amount of amount of fees and expenses the Plan actually paid to service providers in the form of Hard Dollar payments and Revenue Sharing;

c. the availability of Revenue Sharing;

d. the true and accurate details regarding the revenues and expenses of the Plan;

e. the true and accurate operating expenses which reduce participants' returns, including both Hard Dollar payments and Revenue Sharing, for each of the Plan's investment alternatives;

f. the true and accurate transaction fees and expenses which affect the participants' account in connection with the purchase or sale of investment alternatives;

g. the amount, when both Hard Dollar Payments and Revenue Sharing are considered, by which the Plan's expenses exceeded those which were reasonable and incurred solely in participants' interests; and

h. other revenue and expense information necessary for the participants to understand and protect their interests in the Plan.

90. Based upon the foregoing, Defendants are not entitled to the safe harbor protections of ERISA § 404(c).

91. Based upon the foregoing, the statue of limitations was tolled on the breaches set forth in this Complaint and did not begin to run until such time as Plaintiffs actually discovered them.

COUNT I:
Breach of Fiduciary Duty – ERISA §502(a)(2)

92. Plaintiffs restate and incorporate the allegations contained in paragraphs 1 through 91 as though fully set forth here.

93. As set forth in detail above, the Defendants owe the Plan, its participants and beneficiaries, and the Class extensive fiduciary duties including, without limitation:

a. To conduct themselves as Plan fiduciaries with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent ERISA professional fiduciary would in operating and administering a 401(k) plan the size and character of the Plan;

b. To perform their duties as fiduciaries with the utmost loyalty and fidelity to the Plan and its participants and beneficiaries, avoiding at all times conflicts of interest, self-interest, and duplicity;

c. To ensure, at all times, that Plan assets "shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the Plan and their beneficiaries and defraying reasonable expenses of administering the Plan;"

d. To track and account for all transactions involving the Plan and Plan assets so as to ensure that Plan assets are retained, managed, and disbursed in compliance with the Plan Document and ERISA;

e. To track and account for all transactions involving the Plan and Plan assets so as to ensure that Plan assets "never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the Plan and their beneficiaries and defraying reasonable expenses of administering the Plan;"

f. To ensure that the fees and expenses incurred by the Plan are reasonable and incurred for the sole and exclusive benefit of Plan participants and beneficiaries;

g. In entering into agreements with service providers to the Plan, to ensure that the payments from the Plan – whether they are direct or indirect – are reasonable for the services provided and made for the sole and exclusive benefit of Plan participants and beneficiaries;

h. In operating and administering the Plan, to establish, implement, and follow procedures to properly and prudently determine whether the fees and expenses paid by the Plan were reasonable and incurred solely for the benefit of Plan participants;

i. In operating and administering the Plan, on an ongoing basis to monitor the payments made by the Plan to service providers – whether they are direct or indirect – are and remain reasonable for the services provided and made for the sole and exclusive benefit of Plan participants and beneficiaries;

j. To inform themselves of, and understand, the various methods by which vendors in the 401(k) industry collect payments and other revenues from 401(k) plans;

k. To inform themselves of trends, developments, practices, and policies in the retirement, financial investment and securities industry which affect the Plan; and to remain aware and knowledgeable of such trends, practices and policies on an ongoing basis;

l. To communicate with Plan participants and beneficiaries regarding the Plan honestly, clearly and accurately;

m. To affirmatively and without request provide Plan participants and beneficiaries with honest, accurate and complete information they need to understand their investments in the Plan; the management, risk, potential returns of such investments, and the fees and expenses incurred in connection with those investments;

n. Upon request, to provide further any information to Plan participants and beneficiaries regarding the operation and administration of the Plan and the expenses incurred in doing so; and

o. To provide honest, accurate and complete information to Plan participants and beneficiaries regarding the costs associated with their various investment choices and directions

p. To appoint fiduciaries who lived up to their fiduciary duties, to monitor and oversee those fiduciaries in the performance of their duties, and to remove fiduciaries who breached their fiduciary duties.

94. As set forth in detail above, the Defendants breached their fiduciary obligations to the Plan, Plan participants and beneficiaries and the Class by, among other conduct to be proven at trial:

a. Causing the Plan to enter into agreements with service providers under which the Plan pays/paid – directly or indirectly – fees and expenses that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants and beneficiaries;

b. Allowing the Plan to pay – directly on indirectly – fees and expenses that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants and beneficiaries;

c. Failing to monitor the fees and expenses paid by the Plan and, by such failure, causing and/or allowing the Plan to pay fees and expenses that were, or are, unreasonable and/or not incurred solely for the benefit of Plan participants and beneficiaries;

d. Failing to inform themselves of trends, developments, practices, and policies in the retirement, financial investment and securities industry which affect the Plan; and failing to remain aware and knowledgeable of such trends, practices and policies on an ongoing basis;

e. Failing to inform themselves of, and understand, the various methods by which vendors in the 401(k) industry collect payments and other revenues from 401(k) plans;

f. Failing to establish, implement, and follow procedures to properly and prudently determine whether the fees and expenses paid by the Plan were reasonable and incurred solely for the benefit of Plan participants;

g. Failing to communicate with Plan participants and beneficiaries regarding the Plan honestly, clearly and accurately;

h. Failing properly to inform and/or disclose to Plan participants the fees and expenses that are, or have been, paid by the Plan;

i. Failing to inform and/or disclose to Plan participants in proper detail and clarity the transactions, fees and expenses which affect participants' accounts balances in connection with the purchase or sale of interests in investment alternatives;

j. Failing to discover, disclose and stop the charging of hidden and excessive fees to the Plan;

k. Failing to appoint fiduciaries who lived up to their fiduciary duties, failing to monitor and oversee those fiduciaries in the performance of

their duties, and failing to remove fiduciaries who breached their fiduciary duties;

l. By the foregoing conduct, failing to exercise the care, skill, prudence and diligence that a prudent person would when acting in like capacity and familiar with such matters.

95. As set forth in detail above, as a result of these breaches, Plaintiffs, the Class, the Plan, and the Plan's participants and beneficiaries have suffered financial losses and damages.

96. Further, as set forth in detail above, the Defendants failed to provide participants and beneficiaries with sufficient investment information to qualify for the Safe Harbor immunity of ERISA § 404(c), 29 U.S.C. 1104(c). Accordingly, the Defendants are liable for participants and beneficiaries' investment losses in the Plan.

97. Pursuant to ERISA § 409, 29 U.S.C. § 1109, and ERISA § 502(a), the Defendants are liable to restore to the Plan the losses it experienced as a direct result of the Defendants' breaches of fiduciary duty and are liable for any other available and appropriate equitable relief, including prospective injunctive relief and declaratory relief, and attorney's fees.

COUNT II:
Other Remedies for Breach of Fiduciary Duty – ERISA §502(a)(3)

98. Plaintiffs restate and incorporate the allegations contained in paragraphs 1 through 97 as though fully set forth here.

99. As an alternative to the causes of action stated in Count I, Plaintiffs seek further relief pursuant to ERISA § 502(a)(3), 29 U.S.C., § 1132(a)(3).

100. Under section 502(a)(3), a participant may enjoin any act which violates ERISA or may obtain other appropriate equitable relief to redress such violations or enforce the terms of ERISA.

101. Defendants are the primary fiduciaries of the Plan and occupy a position of trust and confidence in connection with the Plan, the Plan's assets, and the Plan's participants and beneficiaries.

102. Defendants have exclusive discretion and control over the Plan's assets and are strictly obligated to exercise that control "for the exclusive purposes of providing benefits to participants in the Plan and their beneficiaries and defraying reasonable expenses of administering the Plan."

103. Although *only* Plan participants and beneficiaries are entitled to Plan assets and to the benefit of Plan assets, in the absence of full and candid disclosure from the Defendants, Plan participants and beneficiaries do not know, and have no means of knowing, how their assets have been managed and disbursed.

104. Accordingly, the Defendants occupy the position of a common law trustee in connection with the Plan, its assets, and its participants and beneficiaries.

105. As set forth in detail above, the Defendants have caused and/or allowed the plan to pay – directly or indirectly – excess fees and expenses to Plan service providers.

106. The Defendants, and not the Plaintiffs, are the entities which have and/or should have specific and detailed information regarding how Plan assets have been treated and disbursed in this regard.

107. Accordingly, the Court should order that the Defendants render an accounting of all transactions, disbursements and dispositions occurring in, in connection with, and/or in respect of, the Plan and its assets.

108. The Plaintiffs respectfully request that the Court order that such an accounting include, without limitation, detailed and specific information regarding all fees and expenses incurred by the Plan and/or paid to third parties, whether paid directly by the Plan or indirectly transferred among Plan service providers or other third parties.

109. Plaintiffs respectfully request that to the extent the Defendants do not or cannot account for all such transactions and their property under ERISA, the plan document and other applicable law, the Court surcharge against the Defendants and in favor of the Plan all amounts for which they cannot account.

110. Plaintiffs further seek injunctive and other appropriate equitable relief to redress the wrongs described above, and to cause them to cease in order for the Plan's participants and beneficiaries to receive the full benefit of their retirement savings in the future.

WHEREFORE Plaintiffs, on behalf of the Plan and all similarly situated Plan participants and beneficiaries, respectfully request that the court:

- find and declare that the Defendants have breached their fiduciary duties as described above;
- order the Defendants to make good to the Plan all losses that the Plan incurred as a result of the conduct described above and to restore the Plan to the position it would have been in but for the breaches of fiduciary duty;

- impose a constructive trust on any monies by which the Defendants were unjustly enriched as a result of their breaches of fiduciary duty and/or cause the Defendants to disgorge such monies and return them to the Plan;
- remove the fiduciaries who have breached their fiduciary duties and/or enjoin them from future breaches of ERISA;
- award actual damages to the Plan in the amount of its monetary losses;
- require Defendants to render an accounting as set forth above;
- surcharge against Defendants and in favor of the Plan all amounts involved in transaction which such accounting reveals were or are improper, excessive and/or in violation of ERISA;
- permanently enjoin Defendants from breaching their fiduciary duties in each respect set forth in the Complaint;
- order costs and attorneys fees pursuant to ERISA § 502(g) and the common fund doctrine;
- order equitable restitution or other available equitable relief against the Defendants;
- order the payment of interest to the extent it is allowed by law; and

grant any other and further relief the Court deems appropriate

PLAINTIFFS DEMAND A TRIAL BY JURY OF ALL COUNTS SO TRIABLE.

Dated: September 11, 2006

Respectfully submitted,

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TAB 5

MASSACHUSETTS AND MARYLAND – RECENT HEALTHCARE LEGISLATION

Massachusetts and Maryland recently enacted healthcare legislation that will likely have a significant impact on employers. Maryland's legislation, which is often referred to as "fair share legislation," penalizes very large employers that do not provide a specific level of health benefits to their employees. Massachusetts' law is a comprehensive act that aims to provide universal coverage to all of its residents, which also includes some of the same features of the fair share legislation. Other states are looking at the Massachusetts and Maryland legislation and are likely to draft legislation that incorporates some or all of their features. In particular, several state legislations are considering passing some version of fair share legislation similar to the Maryland act.[1]

Maryland – Fair Share Health Care Fund Act

In January 2006, the Maryland General Assembly passed the "Fair Share Health Care Fund Act" (the "Fair Share Act") over the Governor's veto, becoming the first state to enact such a law. The Fair Share Act requires large employers to pay an assessment to a state fund which supports Maryland's Medicaid program if they do not spend at least a designated percentage of their employees' total wages on employee health care costs. Specifically, a for-profit employer with more than 10,000 employees within the state's borders will be assessed the difference between 8% of their payroll costs and the amount spent on health care insurance costs. In Maryland, the only employer affected is Wal-Mart. (Giant Food and Johns Hopkins University

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[1] Those states include Alaska, California, Colorado, Florida, Georgia, Kansas, Kentucky, Michigan, Minnesota, Mississippi, New Jersey, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Virginia and Wisconsin.

also have more than 10,000 employees but do not have health insurance costs low enough to trigger the payroll assessment.)

Massachusetts Health Care Reform Plan

Massachusetts recently enacted a comprehensive health care reform act (the "Act") intended to make health insurance virtually universal with the Commonwealth's borders. Funding is to come primarily from shifting existing spending on the uninsured away from after-the-fact payments to providers to before-the fact payments to provide coverage for individuals.

Four provisions of the Act directly affect employers. First, the Act includes a fair share provision which authorizes an annual surcharge of up to $295 per full-time employee on any employer with 11 or more full-time employees that does not offer a group health plan to its employees and make "a fair and reasonable premium contribution." Governor Romney used his line-item veto power to strike this provision of the Act. The Massachusetts House and Senate, however, both voted to override his vetoes and to reinstate the "fair share" provision.

Second, the Act imposes a "free rider" surcharge upon any employer with 11 or more employees that does not offer to contribute or arrange for the purchase of health insurance. The surcharge is triggered if an employee, or his or her dependents, individually receives uncompensated services more than 3 times in a year, or, in the aggregate, receives uncompensated health services 5 or more times per year. It appears that even part-time employees could subject an employer to the free rider surcharge. The Act authorizes a state agency to charge employers for these "free riders" between 10% and 100% of the medical bills incurred by them which exceed $50,000.

Third, the new law mandates that employers with 11 or more full-time employees offer cafeteria plans to their employees. It appears that part-time employees and contractors also must be allowed to purchase insurance with pre-tax dollars.

Finally, the Act requires every employer and employee to submit a signed, sworn disclosure form relating to whether the employer has offered to pay or arrange for the purchase of health care insurance, whether the employee has accepted such coverage, and, if the employee has declined coverage, whether the employee has alternative coverage options.

The Act also contains provisions many employers support. For example, the new law imposes a moratorium on the creation of mandated health benefits through 2008. The law also enables HMOs to offer plans that are linked to Health Savings Accounts. Small businesses with fewer than 50 employees may be eligible to offer their employees health care insurance through the Commonwealth Health Insurance Connector ("Connector").

The Connector is a new state entity responsible for connecting individuals and small businesses with health insurance products, as well as certifying and offering products of high value and good quality. The Connector serves as a clearinghouse of sorts and is designed to be one-stop shopping for small businesses and employed individuals who wish to purchase health insurance with pre-tax dollars through the Connector. Small businesses can contribute any amount toward an employee's health insurance purchased through the Connector, and more than one employer may subsidize such an employee's insurance premium. In addition to already-existing state Medicaid programs, the Act also creates a subsidized insurance program for individuals that sets premiums for the program on a sliding scale based on household income.

Finally, the Act requires all residents to obtain insurance coverage or face financial penalties. Currently uninsured residents will have the opportunity to purchase low-cost plans,

some of which are subsidized by the state. Residents who fail to purchase insurance will be assessed financial penalties beginning in July 2007. In the first year, those who do not buy insurance forfeit their personal state tax exemption, and in the second year those who do not buy would have to pay a fine equal to half of the monthly premium cost of an affordable plan.

[Insert hyperlink to Massachusetts Act]

ERISA Preemption

Legal challenges to the Maryland and Massachusetts legislation have centered on the question of whether ERISA preempts the legislation. To trigger ERISA preemption, the state law at issue must "relate to any employee benefit plan." A state law can "relate to" an ERISA-covered plan, and therefore be preempted, in either of two ways: it could make "reference to," or have an impermissible "connection with," an ERISA-covered plan. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96 (1983). A law "references" ERISA plans, most obviously, when it explicitly cites ERISA, but an explicit citation to ERISA is not essential. A law can "reference" a plan when it "acts immediately and exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation." *Cal. Div. of Labor Standard Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). Laws that "reference" ERISA plans are preempted *per se* without regard to whether they might be viewed as consistent or inconsistent with the goals of ERISA. *Id.; see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

The Maryland and Massachusetts legislation appears to have been carefully crafted to attempt to avoid ERISA preemption. Proponents of the legislation rely primarily on the Supreme Court's decision in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645 (1995) to argue that ERISA preemption does not apply. In the past several years, the

Supreme Court has limited the "connection with" analysis by reasoning that, if applied without limitation, nearly any state law could bear some "connection with" a plan in some fashion. In *Travelers*, the Court found that New York's indirect economic regulation of plans through a general tax on hospital charges did not trigger preemption since it did not preclude an employer from having uniform administrative practices or offering similar benefit packages to employees of different states. *Id.*, at 658-59. The Court found that the law did not relate to employee benefit plans, but rather related to hospital charges and had only the "indirect economic effect" of causing insured employers to incur greater costs. *Id.*

Applying the *Travelers'* rationale, proponents of the fair share legislation argue that the law has only an "indirect economic effect" on health insurance choices made by employers. They argue that the legislation does not specifically refer to employee welfare benefit plans and the existence of a plan is not necessary since the law allows an employer to take into account payments made for health services outside the structure of an employer-sponsored plan in order to meet the required level of mandated health care expenditures. Similarly, they argue that employers do not have to adopt a plan to comply with the fair share provisions because they can simply pay the assessment. In short, according to the legislation's proponents, the law does not regulate the benefits available through ERISA-covered plans, mandate eligibility requirements for such plans, or affect the administration of plans.

Proponents of ERISA preemption argue that the Maryland Fair Share Act and, at least, the fair share and mandatory cafeteria plan provisions of the Massachusetts Act would be found to reference an ERISA plan because they will inevitably affect employee benefit plans covered by ERISA. Because of the breadth of the ERISA definition, it would be impossible for an employer to expend significant health care resources on its employees "outside" of its existing

ERISA plan (as suggested by some) without creating another plan or benefit subject to ERISA. *See, e.g., Aloha Airlines v. Ahue*, 12 F.3d 1498, 1503 (9th Cir. 1993) (program of employer-paid physical examinations outside of health plan is covered by ERISA). If a state law's only subject is what ERISA identifies as one of an employer's ERISA plans, then the "existence of ERISA-covered plans is essential to the law's operation" (*Dillingham,* 519 U.S. at 325) and the law has a reference to an ERISA-covered plan.

The legislation also has a "connection with" ERISA-covered plans within the meaning of ERISA § 514. The "connection with" standard requires that a court look to the nature of a state law's effects on ERISA plans and determine whether the law interferes with ERISA's objective of providing a uniform administrative scheme for employers that sponsor plans. *Travelers,* 514 U.S. at 658-59; *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147-48 (2001). The Supreme Court has not hesitated to find that state laws mandating the terms of group health plans "relate to" employee benefit plans, generally through the application of the "connection with" test. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 365 (2002) (mandated external review); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (mandated benefits). The Court has also found that requiring employers to offer coverage under a plan "relate[s] to" a plan. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 127-128 (1992) (preempting local law requiring employers to provide inactive employees on workers' compensation with the same health benefits as active employees).

Importantly, the Supreme Court has recognized that while an indirect economic regulation generally does not force a particular choice on a plan, "there may be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate." *Travelers,* 514 U.S. at 659; *see also Employee Staffing Servs., Inc. v.*

Aubry, 20 F.3d 1038, 1041 (9th Cir. 1994) (if a state law dictates how employers must write their ERISA plans, or attempts to condition a requirement on the existence of an ERISA plan, the law is subject to preemption).

Those who believe that ERISA preempts this type of state legislation argue that it is exactly the kind of state-by-state legislation that ERISA is intended to preempt. Under this view, such legislation is a direct attempt to force employers to provide employee health benefits meeting a state-mandated design, either directly or through a combination of contributions to their own plans plus contributions to a state fund. The "choice" to pay a surcharge or other assessment is no choice at all given its punitive nature.

The "free rider" surcharge provision in the Massachusetts legislation presents a closer question with respect to ERISA preemption. In *Travelers*, the Supreme Court upheld hospital surcharges that appear similar. Importantly, however, the surcharges addressed in *Travelers* did not vary based on whether the employer offered health coverage or not. As such, the "free rider" surcharge might be distinguishable from those previously litigated in that it is more of a penalty designed to force employers to adopt or extend health care plans, rather than a generally-applicable tax designed to fund uncompensated care.

The District Court of Maryland will hear arguments on whether ERISA preempts the Maryland Fair Share Act in mid-June. One can expect a similar ERISA preemption-based challenge to the Massachusetts act as well.

TAB 6

Two New Stock Drop Decisions – Friendly Skies for ERISA Fiduciaries?

Jennifer Eller
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June 30, 2006

This week, courts issued rulings in two separate employer securities cases. The first decision, issued on June 26, involved the stock of US Airways held in a US Airways 401(k) plan. The second, issued on June 28, involved the stock of United Airlines held in an Employee Stock Ownership Plan ("ESOP") sponsored by United. Although favorable to the defendants, the decisions don't necessarily settle the debate over plan holdings of employer securities, and they may raise as many questions as they answer.

On June 26, 2006, the United States District Court for the Eastern District of Virginia decided one of a only a handful of stock drop lawsuits that has made it to trial. In *DiFelice v. US Airways, Inc.*, No. 04-889 (E.D. Va. June 26, 2006) the court held that US Airways did not breach its fiduciary duties under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), by allowing the stock of its parent company, US Airways Group Inc., to remain as a plan investment option in the US Airways 401(k) plan during the period from October 1, 2001 to June 27, 2002.

The US Airways plan was a defined contribution, individual account plan in which participants could direct the investment of the assets in their account among 13 investment options, one of which was comprised of US Airways stock. During the class period, less than 5% of the plan's assets were invested in the company stock fund. During this same time, US Airways experienced financial difficulties resulting from high operating costs and a competitive marketplace that were exacerbated by the terrorist attacks of September 11, 2001.

Under the plan, US Airways was the fiduciary with discretionary authority to select the plan's investment options. US Airways delegated this responsibility to the plan's Pension Investment Committee. The plan did not require a company stock option, and US Airways was free to terminate the company stock fund at any time. The Pension Investment Committee met regularly and obtained advice from outside counsel on continuing the plan's company stock option. Based on this advice, and its review of information about the company and its prospects, the committee concluded that it was prudent to retain company stock as a plan investment option. These findings were reported to the US Airways Board of Directors. The court found that, even though bankruptcy was a risk at all times during the class period, it was never imminent. On June 27, 2002, the Board appointed an independent fiduciary to monitor the company stock fund.

The central question addressed by the court was whether it was prudent for US Airways to retain the company stock option during the class period given the company's financial difficulties. The court rejected the plaintiff's contention that retaining the

company stock option was imprudent because during the class period, it was highly likely that the company would go bankrupt. The court's main reason for rejecting plaintiff's theory was its belief that a prudent fiduciary is one who judges an investment in the context of "its contribution to the risk and return characteristics of a portfolio of investments." Citing modern portfolio theory and the Department of Labor's regulations on prudent investing, the court found that highly risky investments can, in fact, contribute to the diversity of an investment portfolio, thereby reducing the portfolio's overall risk (and boosting return). The court concluded that under ERISA, the prudence of retaining company stock, an admittedly risky investment alternative must be judged "in light of its contribution to the entire portfolio, and not in light of its individual risk."

To judge the "contribution" of US Airways stock under this standard, the court reviewed whether plan participants had the necessary tools to build a diversified portfolio, and found that they did. Specifically, the court found that the 13 investment options under the plan covered the spectrum from low to high risk. Moreover, the court found that US Airways' communications to plan participants about the importance of diversification and the risks of investing in company stock, further enabled participants to construct a diverse portfolio given the available investment options, including company stock.

Although the court's analysis of US Airways' conduct is primarily premised on the role of diversification and participant communications, it also noted in support of its decision the fact that ERISA generally exempts company stock from diversification requirements and places fewer limitations on the holding of company stock in an individual account plan than it does in other types of plans. Bases on this, the court explained that it would be inconsistent with Congressional intent to hold a plan fiduciary imprudent for including company stock in an individual account plan unless the company was no longer viable and the risks of the stock were not fully disclosed to participants.

The court did not, however, include company viability in its concluding roadmap for investment fiduciaries. Rather, the court held that an investment fiduciary for a 401(k) plan with a company stock fund will not be imprudent in continuing to offer company stock so long as (a) the plan offers a range of investment options across the risk/return spectrum, (b) the fiduciary provides participants with accurate information about the particular risk/return characteristics of the company stock, and (c) participants have the "unfettered ability" to diversify out of the plan's investment options, including company stock.

In a footnote, the court distinguished the standard of prudence for retaining company stock as an investment in 401(k) plan from the standard of prudence applicable to ESOPs. Recognizing the "presumption of prudence" applied by some courts in ESOP cases, the court emphasized that, "[u]nlike ESOPs, the prudence of continuing to offer company stock as an investment option in a 401(k) plan will depend largely on the other investment options offered to participants and the participants' ability to diversify their account assets among those investment options."

In a case issued on June 28, 2006, two days after *DiFelice*, the United States Court of Appeals for the Seventh Circuit, in an opinion written by Judge Posner, addressed the issue of whether State Street Bank & Trust Company, as directed trustee of the United Airlines ESOP, acted imprudently in failing to cause the ESOP to sell its United stock. *Summers v. State St. Bank & Trust Co.*, Nos. 05-4005 and 05-4317, 2006 WL 1751888 (7th Cir. June 28, 2006).

The court first found that even as a directed trustee, State Street retained a fiduciary duty not to comply with an imprudent direction to retain the ESOP's holdings in United stock. The court did not, however, accept plaintiff's argument that State Street should have acted on publicly available information to sell the stock. According to the court, all publicly available information about the company was reflected in the stock price, and "it would be *hubris*" for State Street to believe it could predict the company's future better than the market and "preposterous" for the plan's investment fiduciaries to challenge the market's valuation. This assessment of the market's ability to accurately price the stock is the basis of the court's ruling that State Street was not imprudent for failing to cause the sale of United stock from the ESOP.

Although not necessary for its actual holding, in the opinion the court suggests an alternative standard by which to judge the actions of ESOP fiduciaries. The standard suggested by the court is really a variation on the "presumption of prudence" standard articulated in *Moench v. Robertson*, (and cited in both *DiFelice* and *Summers*). The *Moench* court presumed that it is prudent for a plan designed to hold company stock to invest in such stock, but found that the presumption can be overcome by establishing that continued investment in the employer stock would impair the purposes of the trust. The standard suggested by the *Summers* court varies in two ways from the *Moench* standard. First, rather than expressing the circumstances that could impair the trust's original purposes in terms of the condition of the company as an on-going entity, the court expressed the unforeseen circumstances in terms of the risk of owning the stock. This appears to be more a matter of perspective, or economic theory, than a real distinction.

The second distinction, however, is more interesting. Because the *Summers* court assumed that the ESOP holdings were the primary, if not the sole, retirement asset of the ESOP participants, the court felt compelled to recognize a duty to diversify the ESOP's assets to protect participants from the risks associated with holding a single stock. The court recognized that the goal of an ESOP – to invest in a single security – and the goal of protecting ESOP participants from the risks of non-diversification cannot be reconciled. Because of its underlying assumption, the court could not allow the ESOP goal to trump completely trump the goal of diversification. Instead, it suggested a compromise: where ESOP participants do not have substantial other wealth (i.e., are not otherwise holders of diverse portfolios), an ESOP fiduciary should begin diversifying out of company stock "at the point at which an increase in the riskiness of the assets, had it been foreseen, would have induced the creators of the ESOP either to have not created it at all or to have required at least partial diversification." What is distinct about the court's proposed compromise, is not the expression of risk of the *stock* (which is its first variation on the *Moench* standard). Rather, the striking component of the proposed

standard is the premise that action may be required because participant investments are not otherwise diversified. Recognizing the unworkability of this standard in a litigation context, the court went on to question the policy behind the laws governing ESOPs.

These two cases deserve to be studied further to determine the effect the decisions are likely to have on the rest of the stock drop cases now working their way through the courts, and on the actions of plan investment fiduciaries and directed trustees. Initially, however, the cases raise some interesting questions, including (but by no means limited to) the following:

- From a litigation liability standpoint, is it better to hold company stock in an ESOP or as a component of a 401(k) plan?
- What legal standard would apply to judge the prudence of retaining employer stock in an ESOP feature of a 401(k) plan?
- If prudent investment selection keys off of participants' abilities to build a diverse portfolio, is there really a difference between monitoring a single plan investment option and monitoring the range of plan options as a whole? Put another way, so long as a 401(k) plan contains diverse enough investment options to allow a participant to build a diversified portfolio, is there any single option that would be imprudent to select or maintain?
- Should 401(k) plan fiduciaries require participant investment education?
- Must (or may) fiduciaries consider the level of participant investment diversification across (or even outside of) a company's retirement plans?

TAB 7

SEREBOFF v. MID ATLANTIC MEDICAL SERVICES: THE SUPREME COURT REVISITS "EQUITABLE" REMEDIES UNDER § 502(a)(3)

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In Sereboff v. Mid Atlantic Medical Services, Inc., 126 S. Ct. 1869 (2006), the Supreme Court once again grappled with what constitutes "appropriate equitable relief" under ERISA § 502(a)(3). At issue in Sereboff was whether a health plan could sue a plan beneficiary under § 502(a)(3) to recover benefits that were paid on the beneficiary's behalf due to a car accident, following the beneficiary's receipt of a monetary settlement from a third party.

A unanimous Supreme Court resolved a split among the circuits by ruling that health plan fiduciaries may sue under § 502(a)(3) to recover money paid as benefits from plan beneficiaries who receive a settlement or judgment from a third party. The Court's decision has implications for plans and fiduciaries that extend beyond health plan reimbursement cases.

I. Background

ERISA's civil enforcement provisions, codified in § 502, have been interpreted to provide the sole avenue by which plan beneficiaries can pursue claims against ERISA-covered plans and plan fiduciaries, since state law causes of action generally are preempted.[1] ERISA § 502(a)(1)(B) provides beneficiaries with the ability to recover plan benefits, but the remedy under this section is limited *solely* to the payment of plan benefits or a declaration of rights to future benefits. Section 502(a)(1)(B) does not allow beneficiaries to obtain "extracontractual" recovery, such as consequential or punitive damages. Although beneficiaries may seek monetary recovery from plan fiduciaries who breach their fiduciary duties to the plan, § 502(a)(2) provides that any recovery must be paid to the plan as a whole, rather than to individual beneficiaries.[2]

ERISA § 502(a)(3) is a "catch-all" provision which provides that a participant, beneficiary, or fiduciary may sue "(A) to enjoin any act or practice which violates [Title I of ERISA] or the terms of [a] plan, or (B) to obtain *other appropriate equitable relief* to (i) redress such violations or (ii) to enforce any provisions of [Title I] or the terms of the plan." (Emphasis added). According to the Supreme Court's decision in Varity Corp. v.

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[1] ERISA § 514(a) broadly preempts, with certain exceptions, "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute.

[2] Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985). Under ERISA § 409(a), fiduciaries are personally liable to a plan "for any losses to the plan resulting from" such breach, but Russell ruled that any recovery in a § 502(a)(2) case must be paid to the plan as whole.

Howe, 516 U.S. 489, 512 (1996), § 502(a)(3) acts "as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy."

Plan beneficiaries and the plaintiffs' bar have attempted to use § 502(a)(3) as a means of obtaining monetary recovery for amounts greater than the cost of denied plan benefits (e.g., interest on plan benefits), or as individual damages for breach of fiduciary duty. The Court's decision in Varity Corp. allowed beneficiaries to seek individual relief under § 502(a)(3), but it did not resolve the debate as to the scope of "appropriate equitable relief" available to beneficiaries.[3] Whether § 502(a)(3) can be used as a "backdoor" by which plan beneficiaries may obtain extracontractual damages is an issue with which courts continue to struggle, thus making the Supreme Court's decision in Sereboff—as to what constitutes "other appropriate equitable relief"—critically important.

A. The Court's Attempts to Define "Other Appropriate Equitable Relief"

1. *Mertens* Holds Relief Under § 502(a)(3) Is Limited to the Relief "Typically" Available In Equity

The Supreme Court first attempted to define the scope of "other appropriate equitable relief" for purposes of § 502(a)(3) in Mertens v. Hewitt Assoc., 508 U.S. 248 (1993). In Mertens, the Court ruled that the "other appropriate equitable relief" available under § 502(a)(3) comprised "traditional" equitable relief, and did not permit the recovery of legal (money) damages. According to the Court, the relief available under § 502(a)(3) was limited solely to those categories of relief *typically* available in courts of equity, such as declaratory and injunctive relief, mandamus, and restitution.

2. Great-West Further Limited the Scope of § 502(a)(3) Relief

The Court revisited the issue of what constitutes "other appropriate equitable relief" in Great-West Life Ass. Co. v. Knudson, 534 U.S. 183 (2002). In Knudson, an insurance carrier sought to enforce a

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[3] In Varity Corp., supra, the Court held that plan beneficiaries could bring suit under § 502(a)(3) for individual relief based upon a claim that their employer breached its fiduciary duties by intentionally misrepresenting to employees that their benefits would remain secure if they transferred their employment to a newly established subsidiary company. The Court therefore affirmed the lower courts' rulings, and required the employees' reinstatement in the employer's plans.

In Harris Trust and Savings Bank v. Salomon Smith Barney Inc., 530 U.S. 238 (2000), the Court ruled that the universe of potential defendants in a § 502(a)(3) case is not limited, and that a *non-fiduciary* party in interest can be held liable for knowing participation in a prohibited transaction with respect to a plan.

reimbursement provision in an ERISA plan against a beneficiary who had recovered money from the third party responsible for her injuries in a car accident. The beneficiary had settled her case against the tortfeasor, but her portion of the settlement was placed in a "special needs trust" established under California law to provide for her future medical care. Since the settlement awarded the plan only a small portion of the benefits it had paid on her behalf, Great-West sued the beneficiary under § 502(a)(3), seeking injunctive and declaratory relief to enforce the plan's reimbursement provision.

The Court in Knudson, by a vote of 5-4, ruled that despite being cast in traditional equitable terms, the lawsuit sought to "impose personal liability on [the plan beneficiary] for a contractual obligation to pay money—relief that was typically not available in equity." Id. at 210. In so ruling, the Court rejected the argument that because the suit alleged that it sought "restitution," it necessarily sought a remedy that was typically available in courts of equity. The Court held that "not all relief falling under the rubric of restitution is available in equity," and that:

> Where the property sought to be recovered or its proceeds have been dissipated so that no product remains, the plaintiff's claim is only that of a general creditor, and the plaintiff cannot enforce a constructive trust or an equitable lien upon other property of the defendant. Thus, for restitution to lie in equity, the action must seek not to impose personal liability on the defendant, but *to restore particular funds or property in the defendant's possession.* (Id. at 213-14) (emphasis added).

Given that the settlement proceeds at issue in Knudson had been distributed to a special needs trust, the Court held that Great-West's lawsuit to obtain reimbursement from the plaintiff was an action for money damages, and thus could not be asserted under § 502(a)(3).

Following Knudson, courts addressing § 502(a)(3) claims have focused on whether monetary relief is sought, and, if so, whether the money belongs in good conscience to the plaintiff, and whether the money is in the defendant's possession or control. In post-Knudson cases involving health plans asserting subrogation/reimbursement claims, the lower courts split as to the viability of such claims under § 502(a)(3). Compare Admin. Comm. of Wal-Mart Assoc. Health & Welfare Plan v. Willard, 393 F.3d 1119 (10th Cir. 2004), Bombadier Aerospace Employees Welfare benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F. 3d 348 (5th Cir. 2003), and Admin. Comm. of Wal-Mart Assoc. Health & Welfare Plan v.Varco, 338 F.3d 680 (7th Cir. 2003), with Qualchoice, Inc. v. Rowland, 367 F.3d 638 (6th Cir. 2004), and Westaff (USA) Inc. v. Arce, 298 F.3d 1164 (9th Cir. 2002).

B. Sereboff Revisits *Knudson*

To resolve the split in the circuits as to the viability of subrogation/reimbursement claims under § 502(a)(3) in the aftermath of Knudson, the Court agreed to hear Sereboff v. Mid Atlantic Medical Services, Inc., and it issued its decision in May 2006. In Sereboff, a unanimous Court ruled that the plaintiff health plan's claim for reimbursement for benefits paid was viable under § 502(a)(3), since the plan's reimbursement provision established an equitable lien over identifiable funds in the plan beneficiary's control.

1. The Facts Underlying Sereboff

Joel and Marlene Sereboff were covered under a self-funded health plan sponsored by Ms. Sereboff's employer. Mid Atlantic Medical Services, Inc. ("Mid Atlantic") was a fiduciary with respect to the plan. In 2000, the Sereboffs were injured in a car accident. The plan paid $75,000 in medical expenses on behalf of the Sereboffs which were attributable to the car accident. The plan document provided, in pertinent part, that beneficiaries were required to "reimburse [Mid Atlantic] for . . . benefits" from "[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)."

The Sereboffs sued the party responsible for their injuries in state court and received a $750,000 settlement. After the Sereboffs refused to repay the plan for their medical expenses, Mid Atlantic sued the Sereboffs in the District of Maryland on behalf of the employer plan, asserting a claim for reimbursement under ERISA § 502(a)(3), seeking restitution of the disputed settlement funds held by the Sereboffs. The parties agreed that the Sereboffs would place in escrow $75,000 of the settlement proceeds contained in an identified investment account controlled by the Sereboffs, pending resolution of the litigation. The District Court ruled that Mid Atlantic's claim for reimbursement was "appropriate equitable relief" under § 502(a)(3), and that it was entitled to reimbursement of its benefit expenditures. The Fourth Circuit affirmed the District Court's decision.

2. The Court's Decision in Sereboff

Resolving a four-to-two circuit split on how to apply the Knudson decision, Sereboff held that the reimbursement claim asserted by Mid Atlantic was equitable in nature. In contrast to the facts in Knudson, where the plan beneficiary did not control the settlement proceeds, the Court found that the Sereboffs had possession of the disputed proceeds and that the health plan's reimbursement provision created an equitable lien upon settlement proceeds received by the Sereboffs equal to the amount the plan had paid in medical expenses arising out of the accident. According to the Court, these settlement proceeds constituted "specifically identifiable" funds within the possession and control of the Sereboffs that

equity courts would traditionally award to the lien holder. As such, the Court concluded that Mid Atlantic's action to enforce the plan's reimbursement rights qualified as equitable relief under ERISA § 502(a)(3).

The Sereboffs argued that Knudson imposed a strict "tracing" requirement on all recoveries, i.e., that the funds the plan sought to recover must be directly traceable to those that the plan had advanced. Chief Justice Roberts, writing for the Court, rejected the "tracing" argument, finding that the lien asserted by Mid Atlantic was an "equitable lien imposed by agreement" that was codified in the plan document, and which specifically identified settlement proceeds as subject to the lien. The Court noted that under its long-standing precedent with respect to liens imposed by agreement, the fund over which a lien is asserted need not be in existence when the contract containing the lien is executed. According to the Court, the creation of an equitable lien by agreement "allowed [Mid Atlantic] to follow a portion of the recovery into the Sereboffs' hands as soon as the settlement fund was identified, and impose on that portion a constructive trust or equitable lien." Id. at 1875 (internal quotations and alterations omitted).

Although Sereboff does not change the Court's position that § 502(a)(3) only permits the equitable relief that was typically available in courts of equity, it provides a clear roadmap to plans that seek reimbursement of benefit payments.

II. *Sereboff's* Implications for Plans

A. Health Plan Subrogation/Reimbursement Claims

Sereboff recognizes that a healthcare plan may bring suit under § 502(a)(3) to be reimbursed for benefit payments when a beneficiary recovers money from a third party in connection with an injury for which the plan paid benefits, provided that the money at issue is in the beneficiary's possession or control. To take advantage of Sereboff's favorable treatment of such claims, sponsors of health plans should review their governing documents (including summary plan descriptions and reimbursement agreements) to verify that the documents specifically require beneficiaries to reimburse the plan for benefits paid, with such reimbursement to come from any and all recoveries paid by a third party (whether by lawsuit, settlement, or otherwise). Under Sereboff, such language should be sufficient to create an "equitable lien by agreement," which then allows the plan to seek recovery when settlement funds are identified.

Plans also should identify, as early as possible, situations in which third party recoveries are likely (e.g., claims resulting from car accidents), and they should adopt administrative procedures to assert recovery rights before settlements or judgments are paid to beneficiaries. For example, when a third party recovery is a

possibility, a plan should notify the beneficiary and his or her counsel as to the plan's recovery rights and its lien on any settlement or judgment proceeds. Further, the plan should be prepared to file suit under § 502(a)(3) to obtain an injunction requiring the beneficiary to segregate (and hold in escrow) the amount subject to the plan's lien from any third party recovery, pending settlement of the plan's claim or the outcome of litigation that the plan may pursue.

B. Benefit Recoupment Claims

Cases involving the overpayment of benefits to beneficiaries raise a number of legal issues, and a plan's ability to recover overpayments may be tied to the nature of payments that the plan paid—e.g., whether a pension plan paid a lump sum benefit that was too high, or paid monthly pension benefits that were more than what was owed to the beneficiary.

In the case of a lump-sum pension benefit distribution that was, by mistake, in excess of the amount owed under the plan (or an overpayment by a health plan), Sereboff and Knudson support a § 502(a)(3) action by the plan against the beneficiary to recover the amount of the mistaken benefit payment, *provided that* the plan can identify the specific funds in the beneficiary's possession or control against which a constructive trust could be imposed. Identifying such funds may be difficult, however, and the participant could possibly defend against the plan by asserting, among other things, a statute of limitations and/or laches defense.

With respect to cases in which a beneficiary's monthly pension payments erroneously exceed what was owed under the plan, a § 502(a)(3) claim also may be asserted by the plan, subject to Sereboff's and Knudson's requirement that the plan identify the specific funds against which a constructive trust may be imposed. Given the likelihood that pension benefits paid on a monthly basis are spent quickly, a § 502(a)(3) claim by a plan to recover overpayments in such a situation may present significant difficulties. One option that a plan may wish to consider—following consultation with counsel—is to offset its future payment obligations against the amount that it overpaid the beneficiary.

C. Liability for Participation in Breach of Fiduciary Duty Claims

Although Sereboff and Knudson involved health plan reimbursement claims, their holdings (and the holding of Mertens) significantly restrict the availability of monetary damages against defendants in § 502(a)(3) cases, since relief under § 502(a)(3) is limited to that typically available in equity. This is not to say, however, that there is no potential for monetary recovery under § 502(a)(3). Indeed, the Supreme Court has made clear that monetary recovery against a defendant in a § 502(a)(3) case could be accomplished in a case involving "an action for restitution of [a plan's] property (if not already disposed of), or disgorgement of proceeds (if already disposed of), and disgorgement of [a] third person's profits derived therefrom)." Harris Trust & Savings Bank, supra, 530 U.S. at 250-51.

Additionally, the Court has recognized that an "accounting for profits" is a form of equitable restitution available under § 502(a)(3), by which a plaintiff may recover profits produced by the defendant's impermissible use of plan assets, even if the plaintiff cannot identify a particular *res* containing the profits for which recovery is sought. Knudson, supra, 534 U.S. at 215, n.2.

We expect that as the plaintiffs' bar digests the implications of Sereboff and Knudson, complaints for relief under § 502(a)(3) will increasingly assert that they seek equitable relief in the form of equitable restitution, disgorgement, and an accounting for profits.

D. Unresolved Issues

The Court in Sereboff declined to address whether the "make whole" doctrine applied to reimbursement claims asserted by health plans, and we expect that this issue will be litigated in the near future. Under the "make whole" doctrine, an insurer may be barred from obtaining reimbursement of benefits it paid when its insured receives less than a full recovery for his or her injuries. The Sereboffs argued that since they were not fully compensated for their injuries by the tortfeasor's settlement, Mid Atlantic's reimbursement claim—even if equitable—was not "appropriate equitable relief" authorized by § 502(a)(3). The Court refused to consider this argument, finding that it was not raised in the lower courts. Sereboff, supra, 126 S. Ct. at 1877, n.2.

We expect that the interaction of the "make whole" doctrine and the scope of "appropriate" equitable relief under § 502(a)(3) post-Sereboff will be litigated and that courts may reach differing conclusions. To reduce the risk of court rulings that apply the make whole doctrine, plans should review their subrogation/reimbursement provisions to ensure that such provisions clearly state that plan's right to recovery will not be reduced because the beneficiary has not received the full damages claimed.