Employee Benefits

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Plaintiff Fails to Present Evidence That He Is Entitled to Severance Benefits

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The United States Court of Appeals for the Third Circuit, applying the heightened arbitrary and capricious standard of review, upholds the plan administrator's finding that the plaintiff employee voluntarily terminated employment without good cause and, therefore, was not entitled to severance benefits.

The plaintiff employee was employed as a "director" with a predecessor company when that company was acquired by another company. After the acquisition, the plaintiff was offered a position with the acquiring company as a "director" and the plaintiff acknowledged that this position was "the same position as he held at [the predecessor company]." The plaintiff accepted the position but voluntarily resigned when, according to the record, he "unilaterally decided to stop performing his duties." Subsequently, the plaintiff applied for enhanced severance benefits under his predecessor company's employee severance plan (the plan), which provided enhanced benefits for those employees who voluntarily terminated employment for "good reason." The acquiring company, acting as the plan administrator, denied the plaintiff's application for benefits and his appeal on the ground that he did not have "good reason" to resign. Thereafter, the plaintiff filed a suit against the predecessor company, the acquiring company, and the plan (collectively, the "defendants") alleging that he was improperly denied severance benefits. The district court affirmed the plan administrator's decision and the plaintiff now appeals the district court's decision.

In considering the plaintiff's appeal, the court must first determine the appropriate standard of review. The parties agree that the plan grants the plan administrator the discretionary authority to construe the terms of the plan and determine eligibility for benefits. The court notes that, generally, such authority necessitates an application of the arbitrary and capricious standard of review. However, in this case, the plaintiff argues that the plan administrator is operating under a conflict of interest. The court notes that the United States Supreme Court has held that a conflict of interest "must be weighed as a 'factor in determining whether there is an abuse of discretion.'" Based on the facts in the record, the court agrees with the plaintiff that there is a conflict of interest. Specifically, the court recognizes that the plan administrator/employer is determining eligibility for benefits and paying benefits disbursed through the plan out of its own funds. This inherent conflict of interest, which often occurs when the plan sponsor is also the plan administrator, requires the use of the "heightened" arbitrary and capricious standard of review. The court notes that this standard is a "sliding scale" in which the degree of scrutiny is intensified to match the degree of the conflict. Here, the court notes that a finding in favor of the plaintiff would cost the acquiring company $156,666 under the plan's provisions. However, the court believes that the "magnitude of the conflict is lessened by the fact that [the acquiring company], as the employer, had 'incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits' that at least partially counter any incentive not to pay legitimate claims."

Thus, the court applies the arbitrary and capricious standard of review but tempers its deference because of the conflict of interest. However, even with this heightened standard of review, the court finds that there is ample evidence in the record to support the plan administrator's decision. The plaintiff seeks to collect benefits under the provision of the plan that provides benefits to employees who voluntarily resign for "good reason." The plan administrator found, however, and the court agrees, that the plaintiff did not resign for good reason as defined by the plan. There is no evidence in the record indicating that there was a material and adverse change in the plaintiff's duties, responsibilities or status with the acquiring company. Moreover, there is no evidence in the record that the plaintiff "was at any time unable to or prevented from continuing with his prior responsibilities." The evidence only establishes that the plaintiff "unilaterally declined to stop performing his duties." Therefore, the court upholds the plan administrator's decision to deny the plaintiff's application for benefits based on the terms of the plan.

This case is *Bader v. RHI Refractories America, Inc.*, No. 01-4486 (3d Cir. Oct. 1, 2004) (unpublished decision). •

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Employee Benefits

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Employer Liable for Delinquent Contributions to Plan After Failing to Keep Adequate Contribution Records

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The United States Court of Appeals for the Sixth Circuit holds that defendants' objection to the calculation of fringe benefit contributions cannot be sustained based solely on the individual defendant's deposition testimony and unsworn statements challenging the calculations.

The plaintiffs are the trustees of a collection fund (the fund), "which centralizes the payments required of employers for various benefits for employees covered" by the applicable collective bargaining agreement (the CBA). The trustees are responsible for collecting fringe benefit contributions from contributing employers and "for allocating those contributions between funds that provide health, pension, vacation and other benefits to eligible employees." The defendant company was a participating employer in the CBA. The defendant individual signed the CBA on behalf of the defendant company as the personal guarantor for wages and other payments required by the CBA. The CBA "specified commercial and residential rates of wages and fringe benefit contributions that were to be paid for each hour worked by covered employees." The CBA also required participating employers to submit periodic reports to the trustees relating to the covered employees' hours of work and the corresponding fringe benefit contributions. And, the CBA provided that the trustees could audit the contributing employers' books and records.

In September 2001, the trustees sought to perform an audit of the defendants' books and records to verify the defendants' contributions to the fund. After its review, the auditor concluded that the defendant company owed $237,452 in delinquent contributions and $47,490.40 in liquidated damages. These delinquent contributions and liquidated damages were the result of numerous payments for work that was covered by the CBA, but was not reported in the defendant company's monthly contribution reports. "The auditor divided the unreported payments by the commercial hourly rate and multiplied the result by the commercial fringe benefit contribution rate." The auditor found that there was no indication in the records that the payments were for residential, rather than commercial, work.

When the individual defendant was deposed regarding the audit, she objected to the audit but initially could not produce any documents to substantiate her objections. Eventually, the individual defendant produced some documents to support her objections and the auditor revised his conclusions based on the additional records. Thereafter, the individual defendant's deposition continued and she continued to object to the audit results. Specifically, the individual defendant claimed that the audit erroneously included management personnel, carpenters and laborers who were not covered by the CBA; that commercial rates had been used for all computations in the audit even though the majority of the work was residential in nature; and that the auditor had inflated the number of total hours. Following the deposition, the trustees filed a motion for summary judgment compelling the defendants to pay the delinquent contributions and liquidated damages. The defendants responded with an unsworn declaration signed by the individual defendant reiterating their objections to the audit. The district court awarded the plaintiffs' motion for summary judgment, including the liquidated damages, in accordance with the terms of the CBA. The defendants appealed the district court's decision.

The court notes that ERISA requires employers contributing to employee welfare benefit plans to make contributions to such plans in accordance with the terms of the plans. Moreover, ERISA requires that "every employer shall . . . maintain records with respect to each of his employees sufficient to determine the ben-

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efits due or which may become due to such employees." If adequate records are not maintained, "ERISA shifts the burden to the employer to produce evidence of the amount of work performed and to rebut reasonable inferences that can be drawn from the plaintiff's evidence." Therefore, "an employer may not escape liability for benefits due under labor agreements by failing to keep records as required by statute."

In this case, the audit findings were based on the records produced by the defendants. The defendants did not produce any evidence to substantiate to the fund their claims "that benefits for many of the hours at issue should have been calculated using the residential rate, that certain employees should not have been included in the computation, or that the total number of hours was too high." The court notes that the auditor's findings are presumed accurate unless contradictory evidence is produced by the defendants. As they did before the district court, the defendants rely solely on the individual defendant's deposition testimony and unsworn statement to argue that there are genuine issues of material fact. The court dismisses this evidence because it is not "affirmative evidence" in support of the defendants' position. Although the defendants point to a case from the Seventh Circuit Court of Appeals in support of their position, the court finds this case is not controlling. Rather, the court relies on a Sixth Circuit Court of Appeals case that held that where an employer failed to keep adequate records it was "liable for all contributions on all hours worked during a period in which it [was] demonstrated that some covered work was performed." Thus, based on the lack of affirmative evidence presented by the defendants, the court upholds the district court's decision granting the plaintiffs' motion for summary judgment.

This case is *Trustees of the Painters Union Deposit Fund v. Ybarra Construction Company et al.,* No. 03-1680 (6th Cir. Oct. 14, 2004) (unpublished decision). •

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Hospital's Claims Against an ERISA Welfare Plan May Not Be Removed to Federal Court

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The United States Court of Appeals for the Third Circuit holds that the plaintiff hospital (the hospital) does not present a federal question claim against the defendant welfare plan (the plan) and, therefore, the case must be remanded to state court.

The plan is an ERISA-governed employee welfare benefits plan that reimburses participants and beneficiaries for out-of-pocket medical expenses. The plan does not provide any medical care itself. The independent consultant (the consultant) "organized a network of hospitals that agreed to accept discounted payments for medical services provided to beneficiaries of group health plans in return for the plans' promise to encourage beneficiaries to use network hospitals." To implement its network system, the consultant entered into a separate agreement with each participating plan and a separate agreement with each participating hospital. As such, around 1995, the plan entered into a "subscriber agreement" with the consultant, which provided "that the discounted rates offered by the hospital will be forfeited unless claims are timely paid." And, in 1996, the hospital entered into "network hospital agreement" with the consultant. Thereafter, in 1999, the hospital provided medical service to two individuals who were "eligible persons" under the subscriber agreement, and the medical services provided to them were "covered services" under the subscriber agreement. The hospital argues that it properly submitted claims and that the plan paid these claims at the discounted rate. However, the hospital argues that because the claims were not timely paid within 30 days of receipt, the plan forfeited the discounted rate. Therefore, the hospital seeks to recover the allegedly forfeited discount from the plan.

In order to recover the funds allegedly owed, the hospital filed a claim in state court against the plan for breach of contract. The plan removed the case to district court and filed a motion for summary judgment. The hospital cross-moved to remand the case to state court. "The parties' motions focused on whether, under the doctrine of 'complete preemption,' the hospital's state law breach of contract claims raised a federal question." The district court granted the plan's motion for summary judgment and denied the hospital's cross-motion to remand. The district court found that the hospital's state law claims were completely preempted by ERISA and, therefore, the claims were properly in federal court. The hospital now appeals the district court's decision.

The court begins its analysis by noting that "[a] civil action filed in state court may be removed to federal court if the claim is one 'arising under' federal law." The court continues to note that "[u]nder the 'well-pleaded complaint' rule, the plaintiff is ordinarily entitled to remain in state court so long as its complaint does not, on its face, affirmatively allege a federal claim." The court concludes that "on its face, the hospital's complaint does not present a federal question." The complaint instead asserts state law breach of contract claims and does not mention ERISA. Further, the "rights or immunities created under ERISA are not elements . . . of the plaintiff's claims." In rebuttal, however, the plan argues that the hospital's claim arises under the "federal common law" of ERISA and, therefore, is properly before the federal court. Therefore, the court dismisses this argument because ERISA federal common law "does not provide an element—essential or otherwise—of the hospital's state law breach of contract claim." Moreover, the court notes that while ERISA federal common law may be a defense to the hospital's complaint, potential defenses "are not relevant under the well-pleaded complaint rule."

The court must continue its analysis, however, because there is an exception to the well-pleaded complaint rule that provides that an action that does not, on its face, raise federal jurisdiction "may be removed if it falls with the narrow class of cases to which the doctrine of 'complete pre-emption' applies." As the court explains, "complete pre-emption recognizes that 'Congress may so completely pre-empt a particular area that any civil complaint raising this select group of

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claims is necessarily federal in character.'" For example, the court notes that any state law cause of action that is within the scope of Section 502(a) of ERISA is "completely pre-empted and therefore removable to federal court." Under this doctrine, the court finds that "this case is removable only if (1) the hospital could have brought its breach of contract claim under Section 502(a) [of ERISA], and (2) no other legal duty supports the Hospital's claim."

The court quickly dismisses the first prong of the test by finding that the hospital could not have brought its claims under ERISA Section 502(a) because the hospital does not have standing to sue under that provision. The court notes that ERISA Section 502(a) only confers standing on participants and beneficiaries. The hospital, however, is neither a participant nor a beneficiary. In addition, the court concludes that even if the hospital could obtain standing through an assignment of a claim from a participant or beneficiary, there is nothing in the record indicating that the two individuals whose claims are in dispute assigned their claims to the hospital. Therefore, without standing, the court concludes that the hospital could not have brought its breach of contract claim under ERISA Section 502(a).

In further support of its conclusion that this case is not removable to federal court, the court finds that "the Hospital's state law claims are predicated on a legal duty that is independent of ERISA." Although the hospital's claims "are derived from an ERISA plan and 'exist only because' of [the plan]," the court finds that the resolution of this case is not dependent on the interpretation of the plan. Rather, the resolution is dependent on the interpretation of the subscriber agreement, which is independent of the plan. Thus, the court concludes that this case is not dependent on ERISA. The court does recognize the "apparent convergence between the Hospital's breach of contract claim and a claim for benefits under §502(a) [of ERISA]." Specifically, as the plan is a reimbursement plan, the plan benefits received by the two individuals whose claims are in dispute is the monies paid to the hospital. Thus, it is the case that "any claims the hospital could have obtained by assignment from [the two individuals] would be for the same amount as the breach of contract claims [at issue]." Further, if the hospital had sued the two individuals for the amount of payment due, the individuals would have been able to bring claims for reimbursement against the plan under §502(a) of ERISA. However, the court finds that "the assurance of an assignment is dispositive of the complete pre-emption question," and no assignments were obtained from the two individuals in this case. Based on the foregoing analysis, the court concludes that this case should be heard before the state court and remands with instructions accordingly.

This case is *Pascack Valley Hospital, Inc. v. Local 464A UFCW Welfare Reimbursement Plan Pascack Valley Hospital, Inc.,* No. 03-4196 (3d Cir. Nov. 1, 2004). •

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Employees Were Not Laid Off When Immediately Rehired by Purchasing Company

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The United States Court of Appeals for the Sixth Circuit holds that employees who were separated from their original employment and immediately reemployed by the purchasing company were not subject to a layoff and, therefore, were not entitled to recover benefits under the "layoff" provision of their pension plan (the plan).

The plaintiffs were employed by the defendant corporation in its Glasgow, Kentucky division when the division was sold to a purchasing company. The plaintiffs became employees of the purchasing company immediately after the sale with no period of unemployment or interruption of wages. Under the terms of the sale, the purchasing company agreed to provide a pension plan equivalent to the existing plan. However, the plaintiffs alleged that there was no agreement to merge the two pension plans in order to guarantee that there would be no change in their pension status. The plaintiffs then filed an administrative claim under the plan seeking to collect pension benefits because they argued that they had been subject to a "layoff" as a result of the sale of the defendant company. The plaintiffs claimed benefits pursuant to two plan provisions. The first provision provided an "immediate vested retirement" benefit to those employees who met certain age and service requirements and "whose active service with the Employer cease[d] by reason of a layoff or a permanent shutdown of the plan at such Location. . . . " The other provision provided unreduced pensions for a three-year period starting with their lay-off date, which the plaintiffs argued was the sale date.

After a hearing on those issues, the plan administrator denied the plaintiffs' claims on the ground that the plaintiffs were not "laid off" when they became employees of the purchasing company immediately after the sale. The plan administrator noted that the terms *layoff* and *permanent shutdown* were not defined in the plan, and therefore, sought to give the terms their "plain meaning." To that end, the plan administrator noted that the plaintiffs never had any period of unemployment or discontinuation of wages; that the purchasing company had assumed the collective bargaining agreement (the CBA) that was in effect prior to the sale of the defendant company; and that the purchasing company implemented a pension plan that was practically identical to the plan. The plaintiffs disagreed with the plan administrator's findings and filed a claim in state court. The defendant company removed the claim to federal court where the district court upheld the plan administrator's decision. The plaintiffs now appeal the district court's decision.

At the outset, the court notes that the parties agree that the plan administrator's decision should be reviewed under the arbitrary and capricious standard of review. Under this standard, the court will determine whether the plan administrator's interpretation of the plan "adhere[s] to the plain meaning of its language as it would be construed by an ordinary person." If the plan administrator presents a rational interpretation of the plan, this interpretation must be upheld even in light of an equally rational interpretation presented by the plaintiffs.

In support of their argument, the plaintiffs look to the definition of *layoff* in *Black's Law Dictionary*. There the term is defined as a "termination of employment at the will of employer. Such may be temporary (e.g., caused by seasonal or adverse economic conditions) or permanent." The court, however, does not consider the dictionary definition is necessary because it finds that the issue presented in this case was already decided in this circuit. In another case with similarly situated plaintiffs, the court held that the "separation of employees from their original employment and immediate employment by the company purchasing the original employer's facility did not constitute a layoff." The plaintiffs attempt to limit this decision to apply only to situations where the successor employer agrees to continue the existing pension plan with no impact on the employees' pension benefits. The court, however, does not believe that decision should be read so narrowly. Rather, the court finds that the crucial fact in that

decision was that there was no interruption of the plaintiffs' employment when they immediately became employees of the purchasing company upon completion of the sale; therefore, there was no layoff. The court also notes that in order to have a successful complaint the plaintiffs must show that the plan administrator's decision was arbitrary and capricious. Lastly, the court notes that the plan's terms support the plan administrator's "interpretation of layoff on a temporary termination of employment." Thus, because the plan administrator's conclusion that the plaintiffs were not laid off is supported by applicable case law and the terms of the plan, the court upholds the decision of the district court and dismisses the plaintiffs' claim.

This case is *Morgan et al. v. SKF USA, Inc.,* No. 03-6152 (6th Cir. Oct. 8, 2004). •

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Tenth Circuit Holds Plaintiffs' Claims for Fraudulent Misrepresentation Not Completely Preempted by ERISA or LMRA

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The United States Court of Appeals for the Tenth Circuit finds that plaintiffs' claims against the defendant employer for fraudulent inducement of early retirement were not ERISA or LMRA claims and therefore should be remanded to state court.

The plaintiffs were employed by the defendant company at its Oklahoma City facility. After a series of financial reversals, the defendant decided to sell off its manufacturing facilities, including the Oklahoma City facility. In February 2001, the defendant entered into a memorandum of agreement (the agreement) with the local union (the union) representing the employees from the Oklahoma City facility. The agreement was a supplement to the applicable collective bargaining agreement (the CBA) and specified how retirement-eligible employees would be financially compensated if the facility were closed or the employees were laid off. The defendant held a number of meetings to discuss the benefits with the eligible employees. At these meetings, representatives of the defendant stated that the offer of benefits under the agreement was a "one-time, non-negotiable, final offer that was a take-it-or-leave-it proposal and that any delay by any employee in accepting the offer would not result in any additional benefit." In reliance on these representations, more than 1,000 eligible employees (collectively, the plaintiffs) accepted the offer to retire and left the defendant company. Thereafter, the defendant entered into an agreement with another corporation that agreed to take over the Oklahoma City facility and hire the remaining employees. The defendant then made another offer, even greater than the first offer, to retirement-eligible employees remaining at the facility. The plaintiffs alleged that they were fraudulently induced into retiring in reliance on the defendant's representations that the offer was a one-time-only offer, and the plaintiffs filed a claim in state court. The defendant removed the case to federal court alleging that ERISA and LMRA completely preempted the plaintiffs' claim, and then sought to dismiss the claim for failure to state a claim. The plaintiffs then moved to remand the case back to state court. The district court denied the plaintiffs' motion and granted the defendant's motion to dismiss, relying exclusively on complete preemption under ERISA. The plaintiffs now appeal the district court's order.

In considering the plaintiffs' appeal, the court must first determine whether the plaintiffs' fraud claims were properly removed to federal court on the basis of "complete preemption" under ERISA. To begin, the court attempts to explain the differences between "conflict preemption" and "complete preemption." The court notes that *conflict preemption* is defined under Section 514 of ERISA. This provision contains an express preemption provision that provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. In contrast, *complete preemption* is a doctrine that provides that if a federal cause of action completely preempts a state cause of action, any complaint that comes from within the scope of the federal cause of action necessarily "arises under" federal law and is thus removable to federal court. In ERISA claims, the U.S. Supreme Court has held that if a plaintiff could, at some point in time, have brought his claim under ERISA Section 502(a), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted by ERISA. The court concludes that the difference between conflict preemption and complete preemption is important because "when the doctrine of complete preemption does not apply, but the plaintiffs state claim is arguably preempted under ERISA Section 514, the district court, being without removal jurisdiction, cannot resolve the dispute regarding pre-

emption. It lacks the power to do anything other than remand to state court where the preemption issue can be addressed and resolved."

Applying these principles to the plaintiffs' claims, the court believes that the district court erred in concluding that complete preemption applied. The court notes that in order to have standing to bring a claim under ERISA Section 502(a), the plaintiffs must be either participants or beneficiaries who "seek to recover benefits due to [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights under the terms of the plan." Accordingly, because the plaintiffs are not seeking to collect benefits under the plan, the court holds that the plaintiffs do not have standing under ERISA Section 502(a). In rebuttal, the defendant contends that the plaintiffs have standing because "but for" the defendant's actions, the plaintiffs would be entitled to the additional benefits under the plan. The court, however, affirmatively rejects the "but for" test as a method of obtaining standing under ERISA Section 502(a). Alternatively, the court also considers the possibility that as former employees the plaintiffs have standing because of a "reasonable expectation of returning to covered employment" or a "colorable claim for vested benefits." Neither party believes that the plaintiffs had a reasonable expectation of returning to work, so this argument is irrelevant. As to whether the plaintiffs had a colorable claim for vested benefits, the court notes that the plaintiffs are not claiming to be entitled to benefits under the terms of the plan as it existed at the time of their retirement; rather, the plaintiffs are seeking damages for the loss of the additional benefits that were offered under the later package. Thus, the court is also able to dismiss the argument that the plaintiffs have standing by virtue of a colorable claim to vested benefits.

Without standing to bring an ERISA Section 502(a) claim, the court concludes that the plaintiffs' claims were not completely preempted by ERISA. Therefore, the court believes that the district court erred by not remanding the case to state court. The court recognizes that its holding may present the "uncomfortable possibility that [the plaintiffs] may lack standing to sue under ERISA, but will then be preempted in state court under [ERISA Section 514] from asserting a state claim, leaving them with no remedy." The court, however, concludes that this is not a concern of the federal judiciary and is not germane to their analysis.

The court must also consider whether the plaintiffs' claims are preempted by LMRA. LMRA "preempts questions relating to what the parties to a labor agreement agreed, and what legal consequences were intended to flow from breaches of that agreement, . . . whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort." The U.S. Supreme Court has held that complete preemption under LMRA does not occur where the plaintiff's complaint was "not substantially dependent upon interpretation of the [CBA] . . . [and did] not rely upon the [CBA] directly." The defendant argues that the plaintiffs' claims are an attempt to vindicate their rights under the agreement, which modified the existing CBA. However, the plaintiffs argue, and the court agrees, that their claim is not based on any violation of contractual rights under the agreement or the CBA, but rather is a suit to vindicate their right not to be defrauded. Thus, the court concludes that the plaintiffs' state law claims are not completely preempted by LMRA.

Accordingly, the court reverses the decision of the district court and orders the plaintiffs' claims to be remanded to state court.

This case is *Felix et al. v. Lucent Technologies*, No. 30-6112 (10th Cir. Oct. 26, 2004). •

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WASHINGTON UPDATE

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IRS Announces Cost-of-Living Increases Applicable to Pension Plan Limits

On October 20, 2004, the Internal Revenue Service (IRS) announced cost-of-living adjustments (COLAs) that will increase the dollar limits on benefits and contributions for many retirement plans for 2005. The most important new limits are summarized below:

- The maximum annual benefit a participant may receive from a defined benefit plan under Internal Revenue Code (code) Section 415(b)(1)(A) increases from $165,000 to $170,000 in 2005.
- The maximum annual contribution made on behalf of a participant to a defined contribution plan account under Code Section 415(c)(1)(A) increases from $41,000 to $42,000 in 2005.
- The maximum amount of annual compensation that may be taken into account for a participant in a tax-qualified retirement plan increases from $205,000 in 2004 to $210,000 in 2005.

- The amount of compensation used in the definition of *highly compensation employees* for nondiscrimination testing purposes under Code Section 414(q)(1)(B) increases from $90,000 in 2004 to $95,000 in 2005.
- The amount of compensation used to define a *key employee* in a top-heavy plan under Code Section 416(i)(1)(A)(i) increases from $130,000 to $135,000.

In addition, the following limits will increase statutorily in 2005:

- The maximum amount of a participant's elective deferrals for a Code Section 401(k) or 403(b) plan increases from $13,000 to $14,000, with the same adjustment made for annual compensation deferrals under Code Section 457(b) plans.
- The dollar limit for "catch-up" contributions for participants aged 50 and over in plans other than Simple 401(k) or Simple IRA plans increases from $3,000 to $4,000. For Simple 401(k) or Simple IRA plans, the maximum amount of "catch-up" contributions for participants aged 50 and over increases from $1,500 to $2,000.

Details and text of the IRS' announcement regarding COLAs can be found in IRS News Release IR-2004-127. •

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Sixth Circuit Finds Plaintiff's Resignation Prevents Award of Severance Benefits

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The United States Court of Appeals for the Sixth Circuit finds that a plan administrator did not act arbitrarily and capriciously when it denied severance benefits to an employee who voluntarily left employment between the time he received WARN Act notices of his future involuntary termination and the date of his actual termination.

The plaintiff was employed as a salaried manufacturing supervisor at the defendant employer's Ohio facility (the facility). As a salaried employee, the plaintiff was a participant in the severance plan sponsored by the defendant employer (the plan). In November 2001, the plaintiff received his WARN Act notice that his employment would terminate in January 2002 because the facility would be closing. However, prior to his scheduled termination date, the plaintiff resigned from his position with the defendant to take another job. At the time he was offered the new job, the plaintiff inquired about his eligibility for plan benefits and was told he would not be eligible if he resigned before his termination date. Nonetheless, after his resignation, the plaintiff sought to receive benefits from the plan. The plan administrator denied the plaintiff's application after finding that the plaintiff did not meet the eligibility requirements under the plan. The plan administrator found that the plaintiff had not been "involuntarily terminated" but instead had "voluntarily resigned" from his position with the defendant. After an appeal, the plan's appeals committee upheld the plan administrator's decision and the plaintiff filed suit in district court. The district court granted summary judgment to the defendant upholding the administrative decision to deny benefits to the plaintiff.

In considering the plaintiff's appeal, the court applies the arbitrary and capricious standard of review because the plan gave the plan administrator the discretion to interpret the terms of the plan and determine eligibility for benefits. Under this standard, the court will uphold the plan administrator's decision if it is based on a reasonable interpretation of the plan. The plaintiff argues that the plan administrator's decision was not reasonable because it impermissibly added an element to the eligibility requirements under the plan. The plan provides benefits to eligible employees who are "involuntarily terminated" by the defendant for any of the following reasons: (1) facility closure; (2) sale of all or any part of an employer; (3) permanent reduction in workforce; or (4) permanent position elimination. The plan also provides, however, that benefits will not be paid to an otherwise eligible participant (1) "who is offered alternative employment at any facility or place of business of the employer"; (2) "who is offered alternative employment with a successor employer to commence promptly following termination"; or (3) "whose termination of employment is not due to one or more of the reasons set forth in [the previous section of the plan]."

The plaintiff argues that he met the conditions of the plan, but that the plan administrator had impermissibly added a "must stay" element to the plan. He stresses that under the plain language of the plan he was involuntarily terminated when he received the WARN Act notice, and that the plan does not require a participant who receives a notice of effective termination "to remain at his job to retain his 'involuntarily terminated' status." The defendant responds by noting that the plan administrator has consistently followed a three-part analysis to determine whether similarly situated participants were entitled to benefits. First, the plan administrator determined "whether the participant was 'involuntarily terminated.'" Second, if the answer to the first question was *yes*, then the plan administrator determined whether the participant was "involuntarily terminated" for a reason set out in the plan. Third, if that question was answered in the affirmative, then the plan administrator determined whether any of the exclusions listed in the plan applied. Applying this process to the plaintiff's situation, the defendant argues that the plan administrator properly

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concluded its analysis after determining that the plaintiff did not meet the first element. The defendant believes that the plaintiff's termination occurred on the date he resigned, which is the day he actually left, not the date he received the letter of his future termination.

The court recognizes that the plan does not define the phrase *involuntarily terminated*. However, the court believes that the plan administrator used a "reasonable interpretation" of the plan's language. Because the plan grants the plan administrator the discretion to interpret the terms of the plan, the court believes that it must uphold a reasonable interpretation. Moreover, the court believes that the plan administrator's interpretation comported with the purposes underlying the plan which, as a severance plan, included providing "employees with a buffer agreement against the privations which so often attend unforeseen layoffs." Therefore, the court upholds the plan administrator's decision and affirms the district court order granting summary judgment to the defendant.

This case is *Farmer v. The Square D Company,* No. 03-3733 (6th Cir. Oct. 22, 2004) (unpublished decision). •

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District Court Granted Inadequate Deference to PBGC's Selection of Termination Date for Involuntary Termination

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The United States Court of Appeals for the Sixth Circuit concludes that the district court gave inadequate deference to the Pension Benefit Guaranty Corporation (PBGC) in selecting the involuntary termination date for the pension plans of an employer filing for bankruptcy.

Prior to its filing for bankruptcy, the defendant employer was a leading producer of steel products. The defendant employer was formed by two mergers in 1998 and 1999, through which the defendant became the sponsor and administrator of four defined benefit plans covered by ERISA. Two of the plans (the plans) provided benefits to participants represented by the defendant steelworkers union (the union), and those plans included "shutdown benefits," for which the union had made a number of concessions in collective bargaining sessions to obtain. These shutdown benefits were "enhanced early retirement benefits for certain workers who were affected by a facility shutdown or business cessation." Unlike other retirement benefits, such benefits usually are not funded in advance and they tend to be very expensive because they are enhanced benefits that may be paid for many years before the participants become eligible for their normal retirement benefits.

Following the defendant's mergers, PBGC became concerned about the defendant's financial condition and it began to negotiate a series of agreements to mitigate the risks associated with a possible bankruptcy. In spite of the mergers and the agreements with PBGC, the defendant filed for voluntary bankruptcy on April 2, 2001. During the bankruptcy proceedings, the defendant employer received approval to sell substantially all of its assets pursuant to a court-supervised bidding process. While the defendant employer was able to locate a principal buyer who intended to hire 2,500 of the defendant's employees, this buyer did not want to assume liability for the defendant's plans. Therefore, the defendant employer and the defendant union entered into a shutdown agreement in April 2002 specifying that the sale of the defendant employer would constitute a "shutdown" under the plans. While the bankruptcy proceedings were progressing, PBGC was going through its administrative process to determine whether to involuntarily terminate the plans. In this administrative process, which is the same for each case in which involuntary termination is considered, PBGC determined that the plans were underfunded, and that if the plans terminated with shutdown benefits, the amount of unfunded liabilities for the plan would increase by almost $96 million. With this information, PBGC concluded that, if the plans were not terminated preshutdown, "PBGC's long run loss [could] reasonably be expected to increase unreasonably." Thus, PBGC determined that the plan should be terminated and that the termination date should be set prior to shutdown so as to avoid this increased liability. PBGC then issued notices to the plans and the union, and published notices in the newspaper where the defendant's facilities were located, indicating that it was seeking to have the plans terminated and to have June 14, 2002 established as the plans' termination date.

On the same day the notices were issued, PBGC filed an action against the defendant to terminate the plans and have June 14, 2002 as the termination date. The defendant union responded by disputing the date of plan termination and asking for a termination date of August 17, 2002—the day after the closing of the asset sale. The district court agreed to the plans' involuntary termination but rejected PBGC's termination date, and accepted the defendant union's proposed termination date. With this termination

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date, the plans' participants are entitled to shutdown benefits. PBGC appealed the district court's decision.

Before the court reviews the specific facts of this case, it considers the role of PBGC, which is a federal corporation in our nation's pension benefit insurance system. The court notes that ERISA established PBGC in order to "administer the single-employer pension plan termination insurance program," and "to guarante[e] the payment of certain minimum pension benefits to pension plan participants in the event that a covered plan terminates with insufficient assets to pay the benefits in full." The court also comments that PBGC "receives no funds from general tax revenues." If a "plan terminates with insufficient assets to pay guaranteed benefits, the PBGC typically becomes the trustee of the plan, takes over the assets and liabilities of the plan, and pays benefits to plan participants." PBGC has the ability to institute involuntary termination proceedings if it determines that a plan will be unable to pay benefits when due and "when PBGC faces an unreasonable increase in liabilities with respect to the plan even if the plan is not terminated." When PBGC institutes such proceedings, the termination date becomes significant because that date will mark the date on which benefits for plan participants will cease to accrue. Moreover, when the termination is involuntary and involves a bankrupt employer, a later termination date will mean that PBGC will have little chance of recovering anything from a bankrupt employer, while an earlier termination date could give PBGC the right to recover substantial assets from that same employer, based on its higher net worth at an earlier time. However, PBGC does not have the authority to unilaterally set an involuntary termination date. Rather, if the plan administrator disputes PGBC's proposal date, the district court shall set the termination date.

With this background, the court considers PBGC's request of an earlier termination date. The court notes that while there are no statutory guidelines, the courts generally have considered two factors when setting termination dates in involuntary proceedings: (1) the expectations of the participants and (2) the financial implications of the termination for PBGC. The court recognizes that the district court did, in fact, consider these factors, but finds that the district court improperly concluded that the termination date should be the date proposed by the defendant union.

With regard to the first factors, the district court determined that the fact that the benefits at stake in this case were "shutdown benefits," as opposed to "traditional pension benefits," was significant because shutdown benefits generally would only arise if the employer collapsed financially, which is the same reason involuntary termination would be imposed. Therefore, participants eligible for shutdown benefits should be able to reasonably rely on those benefits even if a termination occurs. The district court further reasoned that the participants' reliance in the benefits was "strong" because, after entering the shutdown agreement, the participants were only waiting for their shutdown benefits to vest following the bankruptcy court's approval of the sale. Therefore, the district court determined that "the PBGC's notice to the participants did not 'presumptively terminate the participants' reliance interests' in shutdown benefits." The court, however, disagrees with the district court's assessment of the participants' reliance based on PBGC's notice of termination and termination date. The court finds that after the participants received PBGC's notice that it intended to terminate the plans on June 14, 2002, the participants "no longer had a justifiable expectation in the accrual of vested pension rights." In addition, the court finds it was improper for the district court to characterize the participants' reliance interests prior to receiving PBGC's notice as "strong." The shutdown agreement, which presumably was the basis for the participants' reliance, was contingent on the bankruptcy court approving the sale, and that approval was given approximately one month after PBGC issued its notice. Therefore, the court disagrees with the district court's assessment of the first factor in setting a termination date.

As to the second factor, the court determines that the district court "failed to give appropriate deference to [the] PBGC's conclusion that it faced an unreasonable increase in its liabilities if the court selected a termination date after 'shutdown.'" While the district court concluded that PBGC did not present sufficient evidence of the impact of the additional liabilities and noted that, at the time of its determination, PBGC had a multibillion dollar surplus, the court finds that PBGC is not required to produce such evidence and that it is not proper to take PBGC's financial situation into account. Rather, the court notes that ERISA specifically authorizes PBGC to terminate a plan "when the possible long-run loss of [the PBGC] with respect to the plan may reasonably be expected to increase unreasonably if the plan is not terminated," and that determination was made in this case. Thus, because the court concludes that the participants' reliance interests were extinguished by PBGC's notices and because PBGC claimed to have a significant financial interest in the earlier termination date, the court concludes that the district court should have chosen a termination date that served the interests of PBGC. Accordingly, the case is remanded with instructions to follow the court's opinion.

This case is *Pension Benefit Guaranty Corporation v. Republic Technologies International, LLC et al.,* No. 03-4494 (6th Cir. Oct. 1, 2004). •

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Plaintiff's Agreement With Prior Business Partners Is Not an ERISA Plan, District Court Concludes

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The United States District Court for the District of Minnesota determines that an employer is not liable for providing notice under the Consolidated Omnibus Budget Reconciliation Act (COBRA) because the employer was not the plan administrator and the employer is not liable for interference with the plaintiff's ERISA rights because there was no ERISA plan.

The plaintiff was a one-third owner of the defendant company, with the other individual defendants owning the other two-thirds of the company. When the business relationship between the plaintiff and the individual defendants broke down, the parties entered into negotiations to buy out the plaintiff's interest in the company. Prior to the plaintiff's resignation on November 16, 2002, the parties managed to agree on and sign a redemption and settlement proposal (the proposal), which provided that the parties would enter a final binding agreement in the future. However, there was a breakdown in negotiations and the parties were never able to agree on the final binding terms of the agreement. The proposal provided, in part, that the company would "pay for and continue (directly as a consultant or through COBRA reimbursement) all group insurance benefits that [the plaintiff] currently receives until the earlier of November 1, 2003, or the date he takes a new job." In fact, however, the plaintiff's health coverage, which was provided through and administered by a third-party administrator, was terminated beginning in January 2003. The plaintiff filed several federal and state law claims against the defendants. The defendants filed a motion for summary judgment pertaining to the plaintiff's COBRA and ERISA claims.

The court notes that the plaintiff has presented two COBRA/ERISA issues on which the defendants seek summary judgment. First, the plaintiff argues that the defendant company violated COBRA when it failed to provide him with timely notice of his rights under COBRA. The court recognizes that COBRA requires that qualified beneficiaries be notified of their "option of receiving self-paid continuation coverage for eighteen months after a qualifying event which would otherwise result in termination of coverage," and that termination of employment is a qualifying event that triggers COBRA rights. This notice requirement must be fulfilled by the designated plan administrator. All of the parties agree that the defendant company was not the plan administrator of the relevant health care plan. Rather, the plan designated a third-party administrator. Therefore, the court concludes that the third-party administrator was required to provide the plaintiff with notice under COBRA. Because the third-party administrator is not a party to this lawsuit, the court determines that the plaintiff's claim fails as a matter of law.

The plaintiff presents a second argument in which he alleges that the defendant company "unlawfully interfered with his ERISA rights by informing [the third-party administrator] that he had resigned from the company, and by instructing the office manager [at the defendant company] to cancel [the plaintiff's] benefits after his resignation." The court notes that in order for the plaintiff's claim—which is characterized as an ERISA Section 510 interference claim—to survive summary judgment, the plaintiff must show that there was "(1) prohibited (adverse) employer action (2) taken for the purpose of interfering with the attainment of (3) any right to which [the plaintiff] is entitled." The plaintiff argues that he had a statutorily protected right to the maintenance of his benefits by the third-party administrator and that the defen-

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dant company's actions leading to the third-party administrator's termination of his benefits constituted discrimination against him for the purpose of interfering with his ERISA rights.

The court explained that a critical element necessary to the plaintiff's claim is that he have a right to health benefits under an ERISA plan. While it is undisputed that the plaintiff had (and may still have) the right to continued coverage under COBRA, the court must determine whether he has any rights under an ERISA plan. The court determines that any such rights would have to stem from the proposal. Therefore, the relevant inquiry is whether the proposal is an ERISA plan. The court notes that "[a]n agreement between employer and employee regarding post-employment benefits may be an ERISA plan even if it only pertains to one employee." However, an arrangement governing just one employee will be "met with particularly careful scrutiny." Such an arrangement will be governed by ERISA if the providing of those benefits "necessitate[s] an ongoing administrative scheme." Moreover, an arrangement is more likely to be deemed an ERISA plan if it grants discretionary authority regarding the timing, amount or form of payment. In applying these principles to the proposal, the court concludes that it is not an ERISA plan. The proposal does not include any discretionary authority and there is no ongoing administrative scheme. The proposal simply requires regular payments of a fixed amount, as well as a continuation of benefits for one year or until the plaintiff finds a new job. Because the court concludes that the proposal was not an ERISA plan, the plaintiff does not have an ERISA right and his claim under ERISA is therefore dismissed.

This case is *Plante v. Foster Klima & Company, LLC et al.,* No. 03-3553 (D. Minn. Sept. 30, 2004). •

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Other Recent Decisions of Significance

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Baker et al. v. Kingsley et al. (The plaintiffs were employees of a now-bankrupt corporation when it was taken over and the individual defendants were named as the directors. In anticipation of a shutdown of the facility where the plaintiffs were employed, the defendants negotiated an extension of the existing collective bargaining agreement (the CBA). The extension agreement (the shutdown agreement) promised to pay union members, including the plaintiffs, certain severance and retention wage supplements if they worked to the end of the shutdown agreement or until the actual shutdown of the facility. After the shutdown, the plaintiffs alleged that the defendants failed to pay the wage supplements specified in the shutdown agreement and that this failure violated the Illinois Wage Act. The plaintiffs also alleged that the defendants violated their fiduciary duties under ERISA by failing to give "reasonable advance notice" of the likely termination of their health plan (the plan) and by failing to fund the plan. The district court dismissed the ERISA claim and remanded the Illinois Wage Act claim. The court determines that the Illinois Wage Act claim is completely preempted by Section 301 of the Labor-Management Relations Act (LMRA) and thus should not have been remanded to state court. In considering the ERISA claim, the court first focuses on whether the defendants violated a duty to give advance notice of the termination of the plan. While the defendants did indicate in their bankruptcy filing that the plan would be terminated, the plaintiffs argue that the defendants knew well before the bankruptcy filing that the plan would have to be terminated and that the defendants should have warned the plaintiffs of this risk of termination. The defendants respond by noting that there is no fiduciary duty owed to plan participants in terminating a plan, and that it follows that there is never a fiduciary duty to inform plan participants of a risk of plan termination. The court agrees with the defendants' position. Moreover, the court notes that its case law has established that while there is a fiduciary duty not to mislead participants or misrepresent the terms or administration of the plan, "the lack of a specific warning that welfare benefits are terminable would not alone create a breach of fiduciary duty." Alternatively, the plaintiffs argue that the defendants' general statements about the general economic well-being of the corporation affirmatively misled the plaintiffs into believing that the plan would continue. The court concludes that these general statements are not sufficient to create a breach of fiduciary duty, especially in light of the fact that there is no allegation that the defendants intended to deceive the plan participants. The court then considers the plaintiffs' argument that the defendants violated ERISA by failing to fund the plan. The plaintiffs argue that the plan's terms required long-term funding for the plan. The court finds that the defendants have not demonstrated that the plaintiff's interpretation of the plan was incorrect as a matter of law, and thus declines to dismiss the claim. Finally, the court considers whether the district court was correct in concluding that while the defendants were fiduciaries with respect to the administration of the plan, they were not fiduciaries with respect to the funding and investment of the plan. The court, however, does not believe that "at this early stage in the litigation" it is possible to conclude that the plaintiffs will be unable to state a claim which would entitle them to relief. Therefore, the court reverses the district court's dismissal of the plaintiffs' ERISA claim only insofar as it is based on a fiduciary duty to fund the plan.) Nos. 01-1071 and 04-1096 (7th Cir. Oct. 27, 2004)

Miller v. Terramite Corporation (The plaintiff's employment with the defendant corporation was terminated. The defendant asserted that the termination was motivated by the plaintiff's skill, seniority and the recommendations of the plaintiff's supervisor. In contrast, how-

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ever, the plaintiff believed his termination was due to his age and disability. The plaintiff filed a four-count complaint in state court alleging: (1) breach of contract; (2) wrongful termination on the basis of age discrimination in violation of West Virginia law and public policy; (3) wrongful termination on the basis of disability discrimination in violation of West Virginia law; and (4) wrongful denial of retirement benefits that he would have received if he had not been terminated 45 days before his benefits vested. The defendant removed the action to federal court asserting that the fourth count stated a federal claim under ERISA. Following discovery, the defendant filed a motion for summary judgment. The plaintiff responded by opposing summary judgment on all of the claims except for the contract claim. The plaintiff did not seek to dismiss the ERISA claim even though discovery had revealed that he had received all that was due to him under his retirement plan. Rather, the plaintiff sought to amend his ERISA argument to claim that the defendant discriminated against him with regard to medical benefits. A month later, the plaintiff sought to voluntarily dismiss the ERISA claim and remand the entire action to state court. Thereafter, the district court granted summary judgment in favor of the defendant and denied the plaintiff's request to voluntarily dismiss the ERISA claim. The plaintiff now appeals the district court's decision. In his appeal, the plaintiff argues that the court should have freely granted a request for "dismissal with prejudice," even though such a request was never made until presented to this court. The court, however, does not believe that the district court abused its discretion in concluding that the plaintiff's attempt to dismiss the ERISA claim was untimely and would waste judicial resources. The court notes that the district court based its decision on the fact that after discovery the facts revealed that the plaintiff had no evidentiary basis for his ERISA claim. Alternatively, the plaintiff asserts that even if the district court properly dismissed the plaintiff's ERISA claim, it should have remanded the remaining issues to state court rather than exercise supplemental jurisdiction over the claims. The court believes that although the district court did not specifically delineate its reasons for exercising supplemental jurisdiction, its reasons "are evident from the [district court's] expression that [the plaintiff's] request to dismiss the ERISA claim and to remand the entire case to state course would waste judicial resources." Finally, the court considers the plaintiff's argument that the district court erred in granting summary judgment on the merits of his state-law age and disability discrimination claims. Here, the court concludes that the district court properly dismissed the claims because the plaintiff was unable to set forth a prima facia case of discrimination under the tests set forth in West Virginia case law. Therefore, the court affirms the decisions of the district court.) No. 03-2449 (4th Cir. Oct. 4, 2004)

Cicio v. Does et al. (In this case, the court must reconsider a prior decision after the outcome of the U.S. Supreme Court case *Aetna Health Inc. v. Davila.* In *Aetna*, the U.S. Supreme Court declared that "any state-law cause of action that duplicates, supplements, or supplants the [ERISA] civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted." The court concludes that this Supreme Court decision "fatally undermines" its prior panel decision in this case. Here, the plaintiffs brought a state-law malpractice claim against a physician and the health care plan. This claim would "have, in effect, supplemented [an ERISA] remedy by providing, had it succeeded, compensation beyond the value of the services to which the plaintiff thought herself entitled and consequential and perhaps putative damages." The court notes that neither of the defendants was actually providing medical care to the plaintiff. Therefore, based on the decision in *Aetna*, the court concludes that the plaintiff's state-law malpractice claim was completely preempted by ERISA and the plaintiff's motion to remand to state court is dismissed.) No. 01-9248 (2d Cir. Sept. 23, 2004) •