The purpose of this newsletter is not just to focus on the current “hot topics” in the world of ERISA litigation. Rather, our goal is also to address cases and legal developments that make a difference to our clients and to how they operate their businesses and their employee benefit plans. Sometimes we write about cases that we handle. Sometimes we write about recently filed or decided cases handled by others. The common thread among the articles is that each has a point that matters to our clients and not just to us as practitioners.

Reading a good litigation newsletter shouldn’t be like passing a traffic accident on the road. As to the accident, you look at it, you’re thankful that it didn’t happen to you, and you don’t give it a second thought. In our ERISA Litigation newsletter, our goal is to present you with “the second thought”—learning from a case how to minimize the risk of having the same litigation filed against your plan.

In keeping with that goal, two of the articles in this edition address cases demonstrating why plan sponsors need to keep an eye on the fees that their service providers charge and ask questions of those service providers if they don’t understand the compensation they are receiving. Our third article focuses on a soon-to-be decided case by the United States Supreme Court that may determine whether and how much health plans can recover when their participants are injured by third persons. We conclude that article with some concrete suggestions that plan sponsors can take to maximize their chances of recovery.

We hope you find these articles helpful, and we invite your comments and questions.
When people are injured in accidents, they generally turn to their employer’s health plan to cover their medical expenses. Then they may consider suing whoever caused their injuries. Recognizing this, most sponsors of well-drafted self-funded welfare benefit plans include reimbursement and subrogation provisions that expressly give the plan the right to full reimbursement for medical expenses paid by the plan on behalf of an employee/participant from any funds recovered by that employee from the person who caused the employee’s injuries. These provisions often exempt the plan from any responsibility for any portion of attorney’s fees paid to the participant’s attorney regardless of whether the participant is “made whole” by the recovery. Most U.S. Circuit Courts of Appeal that have considered this issue have upheld these provisions when challenged by injured employees and their attorneys.

Those courts (the Fifth, Seventh, Eighth, Eleventh and DC Circuit Courts of Appeal) have stressed the primacy of an ERISA plan’s express language in governing the rights, obligations and expectations of the participants, fiduciaries and plans regarding benefits and ERISA’s primary purpose to protect contractually defined benefits.

Two circuits, however, have gone in a different direction—the Third Circuit (see US Airways, Inc. v. McCutchen, 663 F.3d 671 (3rd Cir. 2012) and, more recently, the Ninth Circuit (see CGI Technologies and Solutions, Inc. v. Rose, 683 F.3d 1113 (9th Cir. 2012).

In CGI and US Airways, the courts focused on the perceived “unfairness” of requiring participants to reimburse their plans for the benefits they received, since the participants were not made whole in their litigation against third parties who caused their injuries. In the process, those courts invented a potential “hardship” exception to reimbursement provisions in plan documents. Whether the exception applies can only be resolved by litigating the hardship on a case-by-case basis at significant additional expense.

Relief from the decisions in CGI and US Airways, however, may be on the way. On June 25, 2012, the U.S. Supreme Court agreed to consider the Third Circuit’s decision in US Airways. The question to be decided by the Court is whether the Third Circuit correctly held that ERISA §502(a)(3) authorizes courts to use equitable principles such as the “make whole” doctrine and the “common fund” doctrine to rewrite plan provisions that give the plan an absolute right to full reimbursement. (The “common fund” doctrine essentially requires parties that enforce subrogation rights—like the employee benefit plans in these cases—to share in the expense of obtaining the recovery.) Of course, the Supreme Court’s resolution of that question will directly affect the Ninth Circuit’s holding in CGI and the holdings on this issue in the other appellate courts.

We think the courts in CGI and US Airways got it wrong and that the Supreme Court should reverse the US Airways decision. Here’s why:

With limited exceptions, ERISA does not mandate what kind of benefits employers must provide if they choose to have an ERISA benefits plan. Employers have much leeway to design welfare plans as they see fit. While a subrogation provision may be deemed to affect the level of benefits conferred by the plan, ERISA leaves that issue to the employer that establishes the plan. ERISA does not bar subrogation or reimbursement clauses, and they are commonplace in well-drafted plans. Furthermore, they serve the important purpose of ensuring that the plan administrator preserves the plan’s assets for the benefit of all plan participants.
CGI and *US Airways*, however, essentially rewrite the plans over the objection of the employers that establish the plans and the fiduciaries who administer them. They also elevate the interests of a single participant over the interests of all other participants. This is because the plan as a whole and all other participants benefit by reduced costs resulting from enforcement of the reimbursement/subrogation provisions of the plan. And, when courts mandate a hardship exception to the plan’s express reimbursement provisions, the plan’s fiduciaries are put in the untenable position of having to act contrary to the terms of the plan based on factors extraneous to the plan and beyond the fiduciary’s control.

The United States Department of Labor (DOL) has weighed in on the *US Airways* case by filing an amicus brief in the pending Supreme Court proceeding. The DOL’s brief pretends to strike a sort of middle ground. First, the DOL takes the position that plans should be able to enforce provisions requiring reimbursement, in part because the reimbursement obligation is part of a “quid pro quo” for receiving plan benefits immediately, even though a third party is responsible for the participant’s injuries. However, the DOL does not support plan provisions that purport to exempt plans from having to share in the expense—that is, attorneys fees—incurred in recovering from a third party. As the DOL puts it, “…the beneficiary is effectively conducting litigation on behalf of the plan, and the plan, rather than exercising its subrogation rights to vindicate its own interests, decides to stand aside and accept that valuable benefit of representation from the participant.” Thus, from the perspective of the DOL, reimbursement provisions are fine, as long as they are written the way the DOL would like.

Unless and until the Supreme Court states otherwise, plans should be drafted or continue to be drafted to include reimbursement and subrogation provisions. Ideally, plans should also expressly state that they are not subject to the make whole doctrine and the related common fund doctrine. Plans should also provide, as a condition of receiving benefits, that if a participant’s injury is caused by a third party, the participant agrees in writing to:

1. Provide the plan with a written notice of any claim made against the third party or its insurer to recover money damages as a result of the injury or illness;

2. Reimburse the plan for benefits paid by the plan from any recovery received by the participant, including any recovery from any uninsured or underinsured motorist coverage the employee may have;

3. Reimburse the plan without reduction for any attorney’s fees by or for the participant, and regardless of whether the participant has been made whole by the recovery;

4. Waive any defense to full reimbursement of the plan from the recovery, including any defense that the participant has not been made whole by the recovery or that participant’s attorney’s fees and costs are required to be paid from the amount of the recovery;

5. Keep any recovery separate from, and not co-mingled with, any other funds and agree that the portion of any recovery required to satisfy the lien of the plan will be held in trust for the sole benefit of the plan until such time as it is delivered to the plan;

6. Execute a lien in favor of the plan for the full amount benefits paid by the plan;

7. Notify the plan, in writing, of any recovery within a specified (short) number of days after the recovery;

8. Direct any legal counsel retained by participant and any other person acting on participant’s behalf to hold that portion of the recovery to which the plan is entitled in trust for the sole benefit of the plan and to comply with and facilitate the reimbursement to the plan of the monies owed to it; and,

9. Agree that if reimbursement is requested, but is not received by the plan, the amount of the benefits paid may be deducted by the plan from any and all further benefit payments to, or on behalf of, the participant until the plan’s reimbursement is resolved.

If the Supreme Court were to rule that the Third and Ninth Circuits got it right—that there is a hardship exception to a plan’s subrogation and reimbursement provision—plan sponsors could amend their plans to provide that no benefits can be paid for any injury or illness caused by a third party unless and until the participant or beneficiary agrees in writing to waive any “make whole” or “common fund” defense against recovery. This waiver could also be added to the claim form used by employers, if it is not already on the form.
Why It Is Necessary to Watch Over Your Service Providers

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Sometimes the real lesson to be learned from a litigation case has little to do with the court’s holding. Take for example a recent decision by the U.S. Court of Appeals for the Sixth Circuit—Guyan International, Inc. v. Professional Benefits Administrators, Inc.

The holding of the case itself is fairly obvious—a third party administrator breached its fiduciary duty by engaging in what the court described as a “classic case of self-dealing” and had to reimburse the plans for its breach. The lesson for plan fiduciaries, however, doesn’t appear in the holding. It’s that the plan fiduciaries could have paid the price if they had not monitored the TPA’s conduct, learned of the self-dealing, and taken action.

In Guyan, the defendant was a third party administrator, Professional Benefits Administrators (PBA), that was hired to administer and pay benefits for health plans sponsored by the plaintiffs. Like many such contracts, the contract between PBA and the plan sponsors required PBA to establish separate accounts for each plan sponsor, notify the plan sponsors of the amounts needed to pay claims, and pay health care providers out of the account attributable to each plan sponsor. PBA, however, commingled monies that were contributed by several sponsors (and therefore earmarked for their own plans), and used those monies for its own purposes. As the court stated, “when PBA received too many complaints from medical providers or Plan participants, PBA would withdraw funds from its main, commingled account and put that money into the respective Plaintiff’s separate account to pay the claim(s) in question.” Predictably, PBA fell short in paying the claims, and several employers sued PBA claiming that it breached its fiduciary duty under ERISA. The court agreed.

Once it reached the fairly obvious conclusion that PBA was a fiduciary because it exercised authority over plan assets, it was a short leap to the conclusion that it breached its fiduciary duties.

What is not so obvious is that before filing this lawsuit, the plan sponsor plaintiffs (in the role of plan fiduciaries) needed to recognize that something was amiss—and then do something about it. Plan fiduciaries are obligated to monitor the conduct of their service providers, including other fiduciaries. Failing to take the proper steps to monitor those other fiduciaries and service providers is in itself a breach of fiduciary duty.

The obligation of the fiduciaries was to have proper procedures in place to reasonably monitor PBA, to document their monitoring activities, and—if they discovered that something wasn’t right—to take appropriate action. Apparently, in Guyan, the plan sponsors, wearing their fiduciary hats, took seriously this duty to monitor. If they hadn’t, however, they could just as easily been “on the other side of the ‘v’” in the caption title of the case—as defendants in a lawsuit by plan participants.

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Undisclosed Fees in the Health Plan Setting, and the Potential Danger to Health Plan Sponsors

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In recent years, the Department of Labor has put an increased focus on compensation paid to retirement plan service providers, which has culminated in an additional regulation under ERISA §408(b)(2). That regulation, which took effect July 1, 2012, requires fiduciaries and covered service providers to “covered plans”—meaning most retirement plans—to provide written disclosures of all of the direct and indirect compensation they receive in connection with their work for those plans.

The DOL reserved part of the regulation—29 C.F.R. § 2550.408b-2(c)(2)—for future guidance on disclosure requirements for welfare plans. As one recent court decision shows, however, a lack of transparency regarding service provider fees is already an issue for welfare plans as well as retirement plans.

The issue came to a head in two recent decisions—Burroughs Corporation, et al. v. Blue Cross Blue Shield of Michigan and Hi-Lex Controls Inc., et al. v. Blue Cross Blue Shield of Michigan. In those cases, a U.S. District Court in Michigan found that Blue Cross Blue Shield of Michigan (BCBSM) engaged in breaches of fiduciary duty and prohibited transactions in connection with the compensation that it received from the Burroughs and Hi-Lex health plans. Burroughs and Hi-Lex had identical administrative services contracts with BCBSM engaged in breaches of fiduciary duty and prohibited transactions in connection with the compensation that it received from the plans’ assets, because the administrative service contract did not disclose the amount of the fees or how they were calculated.

Having concluded that BCBSM was a fiduciary relative to the plan, the court went on to analyze whether it had breached its fiduciary duty and engaged in prohibited transactions in connection with its billing practices. It made short work of the prohibited transaction claim:

“[ERISA § 406 (b)(1) prohibits a fiduciary from ‘deal[ing] with the assets of the plan in his own interest or for his own account.’ This is plainly what Blue Cross did when it unilaterally determined the amount of Disputed Fees to keep as part of its administrative compensation and collected those fees from plan assets. Because Section [406](b)(1) sets forth ‘an absolute bar against self dealing’ by a fiduciary, Blue Cross is liable.”

The Burroughs and Hi-Lex decisions are significant in their own right, because they resulted in a finding of a prohibited transaction against a major insurance company acting as claims administrator. Assuming that
other administrative service contracts issued by Blue Cross entities contain similar provisions, the potential for more cases like Burroughs and Hi-Lex looms large.

What may not be so immediately obvious, however, is the lesson that sponsors of self-funded health plans should take from the decision in these cases.

Specifically, if it was a prohibited transaction for BCBSM to receive the purportedly “hidden fees” from these plans, one might argue that, if the plan fiduciaries had not taken action to address the prohibited transaction, it would have been a breach of their own fiduciary duties. This is because fiduciaries are obligated to understand the fees that are being charged to their plans and to determine that they are reasonable.

With more and more awareness that service providers may have hidden fees, it may not be enough for fiduciaries to argue that they were unaware of the fees charged because they were not clearly explained by the service provider. Plan fiduciaries may want to provide questionnaires to their service providers inquiring about all the fees—direct and indirect—that are being charged to the plan and/or its participants.
Employee Benefits & Executive Compensation Practice Group

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