This edition of our ERISA litigation newsletter focuses largely on our plan sponsor clients. First, we discuss the Supreme Court’s April 16, 2013 decision in *US Airways v. McCutchen*. The decision clarifies the law relating to plans’ rights to reimbursement from their plan participants, and our article provides practical advice that plan sponsors should consider in light of the decision.

Our next two articles tackle two separate issues that were the subject of the recent decision by the U.S. Ninth Circuit Court of Appeals in *Tibble v. Edison International*. The first is the need to consider share classes of the investment options that are offered to plan participants. The second involves the practice of “revenue sharing.”

Our last article is geared toward benefit plan service providers, and gives some practical pointers about things to do – and not do – when service providers discover they may have made a mistake in handling a client’s plan.

We are proud to announce that Theodore M. Becker has joined our Employee Benefits & Executive Compensation Practice Group. Ted, who is based in our Chicago office, has established a national practice in ERISA and Employee Stock Ownership Plan (ESOP) litigation and earned a reputation as a “big case” litigator. He has been involved in a number of multi-million dollar cases on both sides of the aisle.

Ted represents corporate plan sponsors and ERISA plan fiduciaries, both in litigation matters and regulatory agency investigations. He has handled some of the highest profile lawsuits involving ESOPs and has also defended health care companies and insurers in actions under ERISA and other federal and state laws, including claims for breach of fiduciary duty and prohibited transactions, improper plan termination, denial of benefits, breach of contract, securities fraud, and unfair competition. Ted has also defended companies and their directors and officers in litigation involving noncompetition covenants, alleged misappropriation of customer lists and trade secrets, and confidential and proprietary information, including actions for injunctions.

We are thrilled to welcome Ted, and look forward to being able to offer his unique insights and skills to our clients.
The Supreme Court Rules: Equitable Defenses May Not be Used by Participants to Rewrite and Defeat Plan Reimbursement Provisions

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In our November 2012 ERISA Litigation Newsletter, we discussed a split among the several federal Courts of Appeals with respect to the ability of employee benefit plans to recover reimbursement for medical expenses paid for participants who are injured by third parties. More specifically, some courts (the Ninth Circuit and Third Circuit) had held that when plans sought reimbursement from participants who recover – through a settlement or a judgment – against a person who injured them, participants could apply “equitable defenses” to defeat clear plan provisions providing for reimbursement. However, the Fifth, Seventh, Eighth, Eleventh and DC Circuits had all held that equitable defenses could not trump the plan document. As we predicted in our November article, on April 16, 2013, the Supreme Court resolved the split between the Circuits by holding in US Airways, Inc. v. McCutchen that equitable defenses cannot override an ERISA plan’s express reimbursement provision.

Like most ERISA health plans, the Plan in US Airways was obligated to pay any medical expenses a participant incurred as a result of a third party’s negligent actions, but in turn, the Plan was entitled to reimbursement if the participant later recovered money from the third party or the participant’s own insurer. After McCutchen recovered, he refused to reimburse the Plan, raising two equitable defenses. First, he claimed that the plan was not entitled to reimbursement because he had not been made whole (i.e., the total amount of his damages exceeded the amount of his recovery). Second, he relied upon the “common fund” doctrine, under which the plan would have had to share the costs the participant incurred to get the recovery. Consequently any reimbursement to the Plan would be reduced by a portion of the fees that he had to pay to his attorney. The District Court rejected both arguments and entered judgment for the Plan. The Third Circuit reversed, concluding that the suit was for “appropriate equitable relief” under ERISA §502(a) (3). It determined that, despite the clear plan provision mandating reimbursement, the principle of unjust enrichment should “serve to limit the effectiveness” of the plan’s reimbursement provision. The Third Circuit concluded that full reimbursement to the Plan would leave McCutchen with less than full payment for his medical bills, resulting in a “windfall” if the Plan was reimbursed, since it had not contributed to the costs of obtaining the third party recovery.

The Supreme Court held that reimbursement provisions in a plan create an “equitable lien by agreement.” In the words of the Court, “[t]he agreement itself becomes the measure of the parties’ equities; so if a contract abrogates the common-fund doctrine, the insurer is not unjustly enriched by claiming the benefit of its bargain.” In so ruling, the Supreme Court reiterated its prevalent theme of the preeminence of the plan document. ERISA “is built around reliance on the face of written plan documents” and “the plan, in short, is at the center of ERISA.” The Court emphasized that its decision “fits lock and key with ERISA’s focus on what a plan provides.”

The Department of Labor argued that “when it comes to costs incurred, the terms of the plan do not control.” The DOL acknowledged in its brief, however, that plan provisions should typically be enforced, and the Court rejected the DOL argument that the common-fund rule has a “special capacity to trump” a full reimbursement provision in a plan. “But if the agreement governs, the agreement governs. The reasons we have given … for looking to the contract’s terms do not permit an attorney’s-fees exception.”

The case, however, was not a complete victory for the Plan. The Court’s Opinion had a second part. The Court held that the common-fund doctrine applied to the US Airways plan, because the Plan was silent as to the allocation of attorney’s fees. The Court referred to the silence as a “contractual gap” and stated “in those circumstances, the common-fund doctrine provides the appropriate default.”
The lessons from *US Airways* are straightforward and generally favorable to plans. Express reimbursement provisions in plans are enforceable and cannot be supplanted, overridden or trumped by equitable defenses. If the plan addresses the common-fund issue explicitly, the plan provisions will govern. If the plan rejects application of the common-fund doctrine, a court cannot impose it. If the plan accepts the common fund doctrine, it will be applied. Last, if the plan is silent about the common-fund doctrine, the common-fund doctrine will be deemed to apply.

Shortly after the Supreme Court issued its ruling in the *US Airways* case, the Supreme Court vacated the Ninth Circuit’s ruling in *CGI Technologies and Solutions, Inc. v. Rose*. In the *CGI* case, the Ninth Circuit – like the Third Circuit – had ruled that equitable defenses can trump clear plan provisions. The Supreme Court vacated that ruling and remanded to the Ninth Circuit in light of the ruling in *US Airways*. The plan in the *CGI* case rejected both the common fund doctrine and the make whole doctrine. Presumably, the Ninth Circuit will now rule that the plan provisions trump any equitable defenses.

Of course, it is for each plan sponsor to decide whether or not the plan should include a provision that it will be entitled to full reimbursement (even if the participant is not made whole) or share in the attorney’s fees and costs of the underlying litigation. *US Airways* simply makes clear that a well drafted plan will control, as it should, the rights and duties of the plan fiduciaries and the participants in regard to reimbursement to the plan.

Mike Vanic has approximately 30 years of experience in ERISA litigation, involving both retirement plans and welfare benefit plans and representing single-employer, multi-employer, government and church plans, plan sponsors, fiduciaries and service providers in a wide range of ERISA claims including fiduciary breach, denial of benefits, service provider malpractice, withdrawal liability and other qualified plan and non-qualified deferred compensation matters.

Joe Faucher has been litigating cases in federal and state courts since 1988. His litigation practice focuses heavily on ERISA and employee benefits matters, including claims for breach of fiduciary duty against retirement plan fiduciaries, claims for benefits against retirement plans, disability insurance plans, health insurance plans and life insurance plans and claims against surety bond companies. Joe has also represented numerous benefit plan service providers, such as third party administrators, actuaries, registered investment advisers and insurance carriers. In addition to his litigation practice, Joe actively counsels clients regarding risk management and insurance coverage issues, and, in the employee benefit context, helps clients comply with applicable Department of Labor regulations.

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**Tibble Part 1: What Tibble Tells Us About Revenue Sharing**

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On March 21, 2013, the U.S. Court of Appeals for the Ninth Circuit issued its decision in *Tibble v. Edison International*, one of the most closely watched decisions in the ERISA litigation world during the past several years. The trial court decided most of the issues in *Tibble* in favor of the defendants and the Court of Appeals has now affirmed all of the District Court’s decisions with regard to those issues – although not always for the reasons articulated by the District Court.

In this article, we address just one of the significant aspects of *Tibble*: the issue of revenue sharing and how plan sponsors and fiduciaries should deal with it.

From 1997 until December 2006, the Edison 401(k) Plan stated that “[t]he cost of administration of the Plan will be paid by the Company.” Beginning in 1999, the menu of investment options was expanded in the Plan in response to collective bargaining negotiations with the union representing many of the Edison employees. Some of the mutual funds that were added as investment options transferred a portion of their fees to the Plan’s administrative service provider, Hewitt. In turn, Edison received a credit on its bills from Hewitt. Thus, the “revenue sharing” payments reduced the amount that Edison would otherwise have had to pay to Hewitt. The revenue sharing arrangement was disclosed by Edison in connection with collective bargaining negotiations and in the Plan SPDs. In December 2006, the Plan language was formally amended – consistent with how the Plan fiduciaries were already interpreting the Plan – to provide that “[t]he costs of administration of the Plan, net of any adjustments by service providers, will be paid by the Company.”

The Plaintiffs claimed that Edison violated the Plan prior to its amendment because it benefited from the revenue sharing payments. Edison argued that the pre-2006 Plan language did not foreclose revenue sharing, that the Plan conferred “full discretion to construe and interpret [its] terms and provisions” upon the Plan fiduciaries, and that the fiduciaries had always interpreted the Plan to mean...
that Edison would pay the invoices that Hewitt submitted – after Hewitt applied the revenue sharing payments.

Edison argued that the court should defer to the Plan fiduciaries’ interpretation of the Plan unless that interpretation was arbitrary or capricious.

The Court of Appeals concluded that the fiduciaries’ interpretations of the Plan were entitled to deference since the Plan gave them discretion to interpret its terms.

In applying the abuse of discretion standard, the *Tibble* court relied heavily on evidence showing that revenue sharing was not hidden from participants, was expressly discussed between Edison and union negotiators, and was referred to in SPDs.

Plaintiffs in *Tibble* also argued that it was a prohibited transaction for Edison to receive the “benefit” of lower administrative costs as a result of revenue sharing. The argument was based on ERISA§406(b)(3), which provides: “A fiduciary with respect to a plan 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.” In a somewhat controversial decision, the trial court viewed Edison not as a unified corporate entity, but in terms of its constituent parts and decided that since the fiduciary that selected the mutual funds that provided the revenue sharing was different than the fiduciary that received the benefit of the revenue sharing, no prohibited transaction occurred. This aspect of the trial court’s decision was, and remains, controversial for the obvious reason that both fiduciaries were affiliated with Edison, albeit with different constituent parts.

The Ninth Circuit declined to adopt the trial court’s reasoning, but nevertheless upheld the decision in favor of Edison on different grounds. Relying on a DOL regulation and advisory opinion that allows fiduciaries to be reimbursed for out-of-pocket expenses they incur, the court concluded that discounts on Hewitt’s invoices constituted “reimbursement” rather than “consideration.” Therefore, applying those revenue sharing payments to the administrative expenses did not violate §406(b)(3).

Although Edison prevailed with respect to the revenue sharing issues, there are still lessons to be learned from the case, and about revenue sharing in general.

First, plan fiduciaries need to understand how revenue sharing works. The DOL’s 408b-2 regulation now requires service providers to disclose all of their direct and indirect compensation in writing, and fiduciaries are obligated to make sure they have received disclosures from all of their service providers – and to demand that service providers who fail to disclose do so. Failing to take the required action violates the regulation and may trigger a prohibited transaction. In short, prudent fiduciaries will take steps to know who is paying compensation (including revenue sharing), how much is being paid, and who is receiving the payment. Then, fiduciaries must determine if the total compensation is reasonable.

Second, it may be risky for a plan sponsor or fiduciary to rely on the *Tibble* trial court’s decision that there was sufficient distinction between the fiduciary making the investment decision and the fiduciary benefiting from the revenue sharing. The DOL vigorously objected to the lower court’s conclusion in that regard, arguing that 406(b)(3) is intended to prohibit transactions where fiduciaries make plan investment decisions that result in the company receiving an economic benefit from a third party. The Ninth Circuit did not embrace the district court’s analysis, stating: “we reserve for another case whether the lower court’s control determinations are defensible…” Thus, it is likely safer for plan fiduciaries to assume that committees that they appoint to oversee plan investments may be treated collectively, as an extension of the plan sponsor itself.

Third, it matters what the plan says about who, as between the plan and the sponsor, is responsible for paying the plan’s administrative costs. Had the Edison Plan provided that the Plan, and not Edison, was responsible for the Plan’s administrative expense, these issues would likely have been avoided completely. If, as in *Tibble*, the employer pays those costs – but pays them only after applying any revenue sharing to the service provider’s bills – the plan should say so expressly in order to minimize any issue of plan interpretation.

Finally, in all cases, sponsors should review their plan language, and make sure that it clearly provides that the fiduciaries have discretion to interpret the plan terms. Absent that clear grant of discretion, courts may not defer to their interpretation of the plan terms, in which case the court, rather than the plan fiduciaries, will determine the appropriate interpretation of the plan.
Tibble Part 2: What Fiduciaries Need to Know About Share Classes

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Mutual funds may offer multiple share classes, including “institutional” share classes and “retail” share classes. As those names imply, institutional share classes are typically available to institutional investors – such as larger retirement plans. Institutional shares are less expensive than their retail share counterparts, which are often available to individual investors and small plans.

In Tibble, the plan offered retail shares, rather than institutional shares, of three mutual funds. The institutional share classes of the funds were in the range of 24 to 40 basis points (i.e., .24% to .40%) cheaper than their retail share class counterparts. According to the court, there were “no salient differences in the investment quality or management.” In other words, while in some cases there may be features associated with retail share classes that make them suitable for a particular plan, there was no evidence that was the case in Tibble. Plaintiffs alleged that, in failing to investigate and ultimately offer lower-priced institutional shares, the fiduciaries acted imprudently.

At trial, the defendants argued that the amounts invested in those funds fell below the minimum investment required for institutional shares. During the trial, however, expert witnesses for both sides testified that mutual fund companies can and often do waive or reduce the minimum investment requirement when requested to do so by investors like larger retirement plans.

On appeal, Edison argued that it relied on its investment adviser to determine which share classes to offer. Reliance on expert advice is helpful – but the reliance must be reasonable. In Tibble, the court noted that fiduciaries are required to (1) probe the expert’s qualifications, (2) furnish the expert with reliable and complete information and, importantly, (3) make certain that reliance on the expert’s advice is reasonably justified under the circumstances.

According to the court, the fiduciaries in this case fell short on this final point – reasonable reliance. Showing reasonable reliance requires fiduciaries to assess the advice they receive, and in the court’s words, “question the methods and assumptions that do not make sense.” Expert witnesses on both sides of the case testified that a reasonable investor would have reviewed all available share classes and the relative costs of each when selecting a mutual fund. This required Edison to show that its investment adviser engaged in a prudent process in considering share classes. The court noted that if Edison had presented evidence of the specific recommendations the adviser made to the fiduciaries, the scope of the investment adviser’s review, and whether the investment adviser considered both retail and institutional share classes, the outcome may have been different. But because no such evidence was presented, the court stated that it had “…little difficulty agreeing with the district court that Edison did not exercise the ‘care, skill, prudence, and diligence under the circumstances’ that ERISA demands in the selection of these retail mutual funds.”

While fiduciaries must engage in a reasonable process in evaluating the expense of their investments, the law does not require them to always select the least expensive investment option. Fiduciaries may take many factors into account in deciding which investments they will offer to their participants. Expense is just one of those factors. The issue comes down to whether fiduciaries perform a prudent analysis and are prepared to explain why a more expensive option was selected if a less expensive version of the same fund is available.

Ultimately, fiduciaries should ask relevant questions, get answers to those questions, and document the process throughout. Tibble, and many other cases, make clear that a fiduciary cannot simply “rubber stamp” a consultant’s conclusions or advice.
Service Providers: Tread Carefully Before You Agree to “Fix” a Mistake

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Employee benefit plan service providers sometimes make mistakes. When they do, they are sometimes tempted to “fall on the sword,” and agree to fix the problems that flow from those mistakes. For example, if a service provider has made a mistake that affects a plan’s qualified status, the service provider may offer to assist or represent clients before the Internal Revenue Service (“IRS”) during an audit or in the course of preparing a voluntary compliance program application pursuant to the IRS Employee Plans Compliance Resolution System (“VCP”). Service providers may also wish to reimburse their clients for any sanctions, costs and/or penalties that are imposed, and any additional professional fees (such as attorney and accountant fees) the client might incur due to the service provider’s mistake. There are right ways and a potentially costly wrong way to go about volunteering to rectify these errors.

Naturally, service providers want to “do right” by their clients. It is not always evident at the outset what the cost of an error might be. That is because the ultimate cost of correcting a mistake is often at least partially out of the service provider’s control. In our example, the IRS is likely to have a significant impact on how long the process takes, the amount of any penalties, and the professional fees that may be incurred during the correction process. Often, service providers carry errors and omissions (“E&O”) insurance because, as the Supreme Court has stated, “People make mistakes. Even administrators of ERISA plans.”

Some service providers may balk at notifying their insurance carrier of claims that their clients make against them. They may believe that the cost of correcting the mistake, and if necessary, paying the costs of an attorney to help the client navigate through a correction program, will be less than their insurance deductible. They may also conclude that notifying their insurance carrier will only cause their insurance premiums to increase. Only in the rare case would it make sense for service providers to avoid notifying their insurance carrier when clients make claims against them. This is true for several reasons.

First, E&O policies typically require the insured to notify the insurance carrier of claims within a reasonable time, sometimes within a specified period following receipt of the claim. And, most policies will not provide coverage for expenses that are incurred — such as attorney fees — before the claim is made to the insurance carrier. A failure to timely notify the insurer of the claim may even relieve the insurer of the obligation to cover the claim at all.

Second, E&O policies often exclude coverage for claims arising out of a contract, unless the claim would exist in the absence of a contract. In other words, if the service provider enters into an agreement to pay the costs associated with correcting a plan error before notifying its insurance company of the claim (and giving the insurance company an opportunity to investigate the claim), the insurance company may be justified in refusing to pay the claim. While the impact could be minor if the cost of correction is relatively low, service providers rarely know with certainty if that will be the case early in the process.

Finally, even if it is likely that a claim is within the deductible, the service provider may be required to notify the carrier that the claim was made during the annual renewal process. So, there may be little to gain — and much to lose — by not notifying the insurer at the time the claim is made, regardless of the likelihood that the claim can be resolved within the deductible.

We recommend that service providers carefully review their E&O coverage to ensure that it meets their needs and that coverage limits are adequate. This should be done at least annually. When evaluating how much coverage you need, resist the temptation to think you need minimal coverage just because you have never been sued.

Heather is part of the Los Angeles office of the firm’s Employee Benefits & Executive Compensation Practice Group. Her practice focuses on assisting public and private sector plan sponsors, third party administrators and other pension service providers in all aspects of employee benefit, including qualified retirement plan and health and welfare issues. She also assists plan sponsors in connection with qualification of state domestic relations orders, Department of Labor and Internal Revenue Service audits, complying with fiduciary responsibilities, reporting and disclosure matters, and drafting qualified, non-qualified and welfare benefit plan documents.

Plan Sponsor Webinar on May 15, 2013

On May 15, 2013, Joe Faucher and Heather Abrigo in our Los Angeles office will be conducting a webinar titled “Lessons from Defendants: How Plan Committees can Avoid Being Sued for Fiduciary Breach under ERISA.” This webinar will address some of the latest ERISA court decisions and focus on ways that Plan Committees and other fiduciaries can manage risk and avoid litigation. If you would like to take part in this webinar, please click here: www.drinkerbiddle.com/register/lessons-from-defendants.
Employee Benefits & Executive Compensation Team

Drinker Biddle’s Employee Benefits & Executive Compensation team has been helping clients throughout the United States achieve their business and human resources objectives in this increasingly complex area since the Employee Income Retirement Security Act (ERISA) was passed in 1974. With more than 40 dedicated benefits and compensation lawyers and other professionals across the country, we’ve been guiding our diverse client base and successfully navigating this technically challenging and highly regulated area with a keen eye on the business trends that will affect our clients’ businesses. The issues we continue to tackle include the increasing globalization of business and its employees, societal changes such as longevity and the financial planning challenges it creates, uncertainty about the economy and sweeping legislative changes such as Health Care Reform.

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