DrinkerBiddle

ERISA Litigation

April 2012

In This Issue

The principal ERISA litigation attorneys at Drinker Biddle collectively have over 100 years of ERISA litigation experience. We pride ourselves on the breadth of our experience and our understanding of the substantive law that underlies this highly specialized form of litigation.

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 to address cases and legal developments that make a difference to our clients and 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 between the articles is that each has a point that matters to our clients, and not just to us as practitioners.

In this issue of our newsletter we begin with an article that should be of significant interest to hospitals and other health care providers. It involves a recent federal court decision limiting a hospital's ability to recover from a self-funded employee benefit plan. The case demonstrates how important it is for health care providers to review their admission documentation, and to implement policies and procedures that maximize their likelihood of getting paid for their services.

Our second article addresses the fiduciary exception to the attorney-client privilege, and provides food for thought for benefit plan sponsors and fiduciaries about what they should consider when picking up the phone to contact their attorneys.

Our final article focuses on "church plans," which, in the absence of an election to be covered by ERISA, are typically governed by state laws. Recent court cases highlight the reasons why it is important for churches and other entities affiliated with churches to consider whether it makes sense for their plans to affirmatively elect to be governed by ERISA.

We hope you enjoy our newsletter and invite your questions and comments.

Court Limits Hospital's Rights to Recover Through Assignment

By Joseph C. Faucher
(310) 203-4052
Joe.Faucher@dbr.com

On March 2, 2012, a federal district court in South Carolina issued a ruling in *Medical University Hospital Authority vs. Oceana Resorts, LLC*, that should cause hospitals and other health care providers to think seriously about the policies and procedures they have in place for pursuing payment for their services, and carefully review the documents they use in admitting patients.

Stephen Showers was an employee of Oceana Resorts. Oceana sponsored a self-funded health plan. Mr. Showers sought medical treatment at the Medical University of South Carolina (MUSC). As part of the admission process, Mr. Showers signed a consent form that contained language assigning benefits "... under any insurance policy [he] may have" and directing "... any insurance company or other party to make payment of such benefits to [MUSC]." The consent form went on to authorize MUSC and Mr. Showers' doctor "... to collect benefits from any responsible third party through whatever means may be deemed necessary ..."

MUSC proceeded to render treatment to Mr. Showers, but when it submitted the bills for its services to the third party administrator for Oceana's plan, the claim was denied on the grounds that the hospital's services were excluded from coverage under the plan because they were "experimental" or "investigational."

MUSC sued Oceana and the health plan. The defendants moved to dismiss the claims (or in the alternative, for summary judgment). The defendants argued that MUSC lacked standing to pursue the claim, because the Oceana plan contained a provision that precluded participants from assigning benefits under the plan to any third person.

The defendants also argued that the consent form that Mr. Showers signed contained language that only assigned benefits "under any insurance policy" that he had. Oceana's self-funded health plan was not an "insurance policy" and so, according to the defendants, even if the plan had allowed an assignment of benefits, the consent form was ineffective to reach Mr. Showers' benefits (since they were not provided under an "insurance policy").

MUSC argued that the plan included an "implicit assignment" of benefits to health care providers. That is, because "network providers" (such as MUSC) were required to submit claims for payment to the plan's third party administrator, the plan itself provided an implied assignment of benefits to network providers. The court disagreed. It distinguished between Mr. Showers and the plan, and stated "MUSC is arguing that the implicit assignment was given by the Plan, not Mr. Showers." It concluded that "[a]n arrangement whereby the Plan sets up a default payment structure to provide payments to a medical provider would not constitute an assignment ..."

MUSC also argued that even if there was no implied assignment as a result of the plan's payment structure, the consent form provided a valid assignment from Mr. Showers. The court again found in favor of Oceana and the Plan, noting that unambiguous antiassignment provisions in ERISA plans are valid and enforceable, and that in light of the anti-assignment provision, "... only the Plan [and not one of its participants] may designate an alternative recipient for payments." On the basis of these findings, the court concluded "[b]ecause the Plan clearly prohibited Mr. Showers from assigning his Plan benefits, Mr. Showers' attempted assignment to MUSC was ineffective and cannot serve as the basis for derivative standing."

The court then shut the door on MUSC, finding that its consent form "... does not cover assignments to self-funded employee benefits plans" such as Oceana's, and granted the motion for summary judgment by Oceana and its plan.

It is too soon to tell whether this district court case will survive the scrutiny of the appellate court. And, the decision by a district court in South Carolina is not binding on courts in other jurisdictions. However, for the time being, the case is "on the books," so hospitals and other health care providers should consider taking steps to prevent a similar outcome.

First, health care providers should review the forms used during their admission and patient intake process, and take note of any language that may limit the scope of an assignment of health benefits. For example, language that limits an assignment to rights under "an insurance policy" should be extended to rights under any employee benefit plan and any other source of benefits to which the patient may be entitled.

Second, health care providers — particularly hospitals — should have policies in place that enable them to recover even if a plan contains an anti-assignment provision. In this regard, the MUSC case is somewhat unusual, because it appears that MUSC only claimed to be entitled to recover because of its claimed status as Mr. Showers' assignee. Health care providers often confirm coverage in advance for the services to be provided with the insurance carrier or, in the case of a self-funded plan such as Oceana's, with the plan's third party administrator. The act of confirming coverage (through a telephone call to the insurer or administrator, for instance) provides a basis for the health care provider to argue that a separate, independent basis for the health care provider's standing exists. In other words, when the health care provider independently confirms that the services to be rendered are covered by the plan, it may trigger a claim that is independent of, and that does not rely upon, any rights that may exist under the ERISA plan. Because the health care provider's rights in that circumstance are not dependent upon the plan, it would not need to demonstrate that the plan participant assigned its rights under the plan.

Confidentiality Has Its Limits: The Fiduciary Exception to the Attorney-Client Privilege

By Michael A. Vanic
(310) 203-4049
Mike.Vanic@dbr.com

Navigating the heavily regulated world of employee benefit plans is difficult. As a result, benefit plan fiduciaries — such as trustees and committee members — often work closely with their attorneys to help them fulfill their duties and keep their plans running properly. Many, and perhaps most, of those fiduciaries may think that all of their communications with their attorneys are confidential.

But not all communications between plan fiduciaries and their attorneys are privileged from disclosure. The so-called "fiduciary exception" prevents ERISA fiduciaries from asserting the attorney-client privilege against their plan participants and beneficiaries in certain circumstances. Fiduciaries should know *before* they speak with their attorneys whether the participant/beneficiary can be privy to the privileged communication. The purpose of this article is to highlight the issue, and to give fiduciaries a basic understanding of both the attorney-client privilege and this important exception.

Attorney-Client Privilege Basics

The attorney-client privilege applies only to communications between an attorney and a client in confidence for the purpose of obtaining or providing legal assistance for the client. The purpose of the privilege is to insure open disclosure between client and attorney. When that purpose ends, the privilege ends as well. So, for example, non-legal business advice is not privileged. Nor are communications

that are not made "in confidence" privileged. (For that reason, when attorneys wish to maintain the confidentiality of a communication, they often excuse persons other than the client from the room.)

Unless the communication meets all those requirements — between an attorney and client, in confidence, and for the purpose of providing legal assistance — it is not protected from disclosure. In the context of communications between the attorney and the plan fiduciary, the fiduciary exception to the attorney-client privilege may apply.

Fiduciary Exception Basics

Many courts have recognized that ERISA "abounds with the language and terminology of trust law." Consequently, courts often turn to trust law concepts when deciding ERISA disputes. One of those concepts — the fiduciary exception to the attorney-client privilege — came into use well over a century ago in the trust context, and by the 1980s, federal courts began to apply the concept in ERISA cases. To gain a better sense of when the fiduciary exception applies, it helps to understand why courts have applied it. Courts have followed two primary approaches:

Duty of Disclosure

Some courts focus on an ERISA fiduciary's obligation to provide full and accurate information about plan administration to the plan participants. In a sense, those courts consider one policy consideration (the duty of full disclosure) to be more important than a competing principle (the sanctity of attorney-client communications).

The Real Client

Other courts have essentially concluded that, when an ERISA fiduciary is focused on administering the plan, the fiduciary is not the "real" client. Instead, the ultimate beneficiaries of the advice are the plan participants themselves, and thus, those participants, rather than the fiduciary, are the real clients for the purpose of the attorney-client privilege. Under this approach, the fiduciary never enjoyed the privilege in the first place.

The Exceptions to the Fiduciary Exception

Not all actions related to a plan taken by a person who is otherwise a fiduciary, however, are fiduciary in nature. As a result, there is an "exception to the exception." Courts have recognized two types of situations in which the fiduciary exception does not apply. The first exception is the "settlor exception." The second is the "liability exception."

Settlor versus Fiduciary Functions

The settlor exception to the fiduciary exception distinguishes between fiduciary functions and "settlor" functions. Courts often ask "which hat" a person is wearing. When performing fiduciary functions (i.e., exercising discretionary authority or discretionary control respecting plan management, or any authority or control regarding management or disposition of plan assets, rendering investment advice for a fee or compensation, or having discretionary authority or responsibility regarding plan administration), a person wears the "fiduciary hat." When performing other functions, they are wearing a "settlor hat."

If a person wearing his fiduciary hat seeks advice from an attorney regarding plan administration, he is engaged in a fiduciary function. If a dispute subsequently arises between the fiduciary and the participants, the fiduciary may not be able to protect the communication from disclosure to the participants.

However, persons who might otherwise be a plan fiduciary may seek advice about issues that do not directly involve the administration of the plan. The Supreme Court has held that adopting, forming, modifying and terminating an employee benefit plan are non-fiduciary, settlor functions. When persons — including persons who are otherwise fiduciaries — seek legal advice about those non-fiduciary functions, the advice they receive is generally subject to the "settlor exception."

Pre-Decisional versus Post-Decisional Advice -- the Liability Exception

The "liability exception" recognizes that when a fiduciary seeks the advice of counsel because he anticipates claims against him by the participants, he cannot be compelled to disclose that advice to the plan beneficiaries. That is, when the fiduciary consults with counsel about his own liability, the communication is protected. The key issue here is whether the advice is "pre-decisional" or "post-decisional."

Generally, "pre-decisional" advice relates to fiduciary action that is part of the ordinary administration of the plan. For example, advice about a participant's

benefit claim is often "pre-decisional." "Pre-decisional" advice is generally subject to disclosure to the participants. "Post decisional" advice is rendered after the plan action, when fiduciaries are warranted in seeking confidential advice from counsel, even if that confidential advice involves plan administration issues.

Conclusion

Benefit plan fiduciaries should not assume that all of their communications with their attorneys are confidential for all purposes. The issue is subject to a fairly complex analysis. At a minimum, before communicating with counsel, fiduciaries should ask "what is the purpose of the communication?" and "who is benefiting from the communication?"

Asking these questions may help fiduciaries recognize, in advance, which communications are more likely to be discovered and which communications are more likely to be maintained in confidence from the participants.

The ERISA Church Plan Exception—The Courts Throw a Curve

By Mark E. Furlane
(312) 569-1332
Mark.Furlane@dbr.com

Joseph C. Faucher
(310) 203-4052
Joe.Faucher@dbr.com

Introduction

Most private sector employee benefit plans are subject to ERISA. Plans sponsored by churches and church-related entities are not covered by ERISA, unless an election is made to have ERISA coverage. (The Department of Labor takes the position that this election can only be made for retirement plans, not health and welfare plans. Courts and the Internal Revenue Service have not always agreed with that position.)

There are advantages and disadvantages to electing ERISA coverage. ERISA coverage requires compliance with the participation, vesting, and funding requirements of ERISA and the prohibited transaction provisions of ERISA and the Internal Revenue Code.

One significant advantage to ERISA coverage for the church or church-related entity that sponsors the plan is that ERISA significantly limits liability. ERISA preempts state law remedies like punitive damages, pain and suffering, and consequential damages. Moreover, jury trials are typically not available for claims relating to ERISA-governed plans.

In 1980, ERISA was amended with respect to the types of organizations that could sponsor a "church plan." Congress amended the statute to allow church plans to cover employees of related tax-exempt agencies that were controlled by or associated with a church, or a convention or association of churches. ERISA§ 3(33)(c)(i) provided for a plan established for the employees of an organization other than a church (or a convention or association of churches) to be considered a "church plan," where the organization was controlled by or associated with the church, and the plan was established and maintained by an organization, the principal purpose of which was to administer or fund the plan. We refer to this method as the "committee approach."

Until fairly recently, church-related organizations--including certain schools, hospitals, and charitable organizations--often operated under a belief that their plans that did not follow the committee approach were governed by ERISA. Conversely, plans that followed the committee approach would be considered church plans, and therefore exempt from ERISA regulation. This belief appeared to be warranted by the language of ERISA.

However, recent court decisions make it imperative for church and church-related organizations that want their plans to be covered by ERISA to review their plans' status and determine whether they should affirmatively elect ERISA coverage. Given the recent trend in the cases, plans

established for the benefit of church-related organizations that have not affirmatively elected to be governed by ERISA are vulnerable to a determination that they are, in fact, church plans subject to state law. That, in turn, potentially exposes plans, plan sponsors, and fiduciaries to the full range of remedies that are not otherwise available in the context of ERISA-governed plans.

Recent Decisions Affecting The Scope of The Church Plan Exception

A series of recent court decisions including *Rinehart v. Life Ins. Co. of North America* in the Western District of Washington, has forced church-related organizations to rethink whether their plans are governed by ERISA.

In that case, Rinehart was an employee of a hospital that was founded by a religious order of Catholic nuns. The hospital sponsored a long-term disability insurance plan. Rinehart became disabled and began receiving benefits under the plan. When the insurance company subsequently terminated his benefits, he sued the insurance company, alleging several state law based theories of relief — and no claims under ERISA. The insurance company argued that the plan was governed by ERISA and, therefore, that ERISA preempted the Plaintiff's claims.

The *Rinehart* court focused almost exclusively on whether the hospital was "controlled by" or "associated with" the Catholic Church, and concluded that it was both controlled by and associated with the Church. Essentially, the court concluded that as long as the hospital was controlled by or associated with the Church, it was irrelevant whether it followed the committee approach or not. Because the court also determined that there was no election for ERISA coverage, it was a church plan. Therefore, the court held that ERISA did not apply to the plan and could not preempt Rinehart's state law claims or state law remedies for those claims.

Until *Rinehart*, many plans operated on the assumption that they were ERISA plans simply because they intentionally did not follow the committee approach and operated the plans as if they were governed by ERISA. Since *Rinehart*, several federal district courts have followed its reasoning, making the committee approach all but irrelevant to those courts' analysis of whether a plan is a church plan or not.

A Lesson To Be Learned

Rinehart, and cases following its reasoning, almost invariably lead to the conclusion that plans sponsored by church-related entities are church plans, unless an affirmative election for ERISA coverage has been made. As mentioned above, while the Department of Labor takes the position that the election is only available to retirement plans, and not welfare plans, courts in cases since Rinehart have largely rejected that position — thus opening the door to allow welfare plans to elect ERISA coverage.

Notwithstanding the DOL's position on the subject, sponsors of these plans should not assume that the ERISA election is not available to their welfare benefit plans. Indeed, the vast majority of benefit claim cases arise in the context of welfare benefit plans, such as health, life and disability plans. Consequently, church related entities such as hospitals and schools should engage in a serious review of both their retirement plans and their welfare plans, and determine along with their counsel whether they should elect ERISA coverage (assuming they have not already done so). If they conclude ERISA coverage is beneficial, and no election has previously been made, they should make the election.

Employee Benefits & Executive Compensation News & Notes

New Practice Group Member

Drinker Biddle is proud to announce the addition of Bradford P. Campbell, a former Assistant Secretary of Labor, to the national Employee Benefits & Executive Compensation Practice Group. Brad, who played a key role in every significant ERISA retirement and health reform of the prior decade, focuses his practice on ERISA Title I issues, including fiduciary conduct and representation of financial service providers. Brad joins our Washington, D.C., office as a member of the Practice Group and a key player contributing to the recently organized Financial Services ERISA Team.

Brad was on a team of attorneys who wrote an amicus brief on behalf of the American Benefits Council, the National Association of Manufacturers and the Chamber of Commerce in support of Siemens in a case before the 3rd Circuit regarding the applicability of ERISA's spinoff and anticutback rules. Last month the 3rd Circuit decided in favor of Siemens.

Recent Webinar Series

Joe Faucher recently presented a two-part webinar on the fundamentals of ERISA Fidelity Bonds and Fiduciary Liability Insurance. To hear a recording of the webinars and obtain a copy of the presentations, visit: http.//www.drinkerbiddle.com/ERISAWebinarFeb292012.

Employee Benefits & Executive Compensation Practice Group

Drinker Biddle's Employee Benefits and 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 like Health Care Reform.

For questions regarding ERISA and employee benefits litigation, please contact:

David R. Levin
(202) 230-5181
David.Levin@dbr.com

Joseph C. Faucher
(310) 203-4052
Joe.Faucher@dbr.com

Mark E. Furlane
(312) 569-1332
Mark.Furlane@dbr.com

Brian A. Coleman
(202) 842-8868
Brian.Coleman@dbr.com

Michael A. Vanic
(310) 203-4049
Mike.Vanic@dbr.com

Employee Benefits & Executive Compensation Practice Group Chair

Howard J. Levine
(312) 569-1304
Howard.Levine@dbr.com

DrinkerBiddle

Employee Benefits & Executive Compensation Practice Group

CALIFORNIA | DELAWARE | ILLINOIS | NEW JERSEY | NEW YORK | PENNSYLVANIA | WASHINGTON DC | WISCONSIN