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Taft-Hartley Report

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Welfare Benefit Plan Overcomes Make-Whole Doctrine in Pursuit of Full Reimbursement

The Western District of Kentucky recently addressed the make-whole doctrine in *Caesars Entertainment Operating Co. v. Johnson*.[1] In *Caesars*, the Plaintiff was a sponsor and fiduciary of a welfare benefit plan ("Plan") that provides a self-funded group health plan for its participants. The Defendant was enrolled in the Plan as a participant when he suffered significant injuries in a car accident. The participant received medical treatment for his injuries that he alleged exceeded $720,000.00 in cost.

The Plan paid $136,479.57 in medical expenses on the participant's behalf as a result of his injuries. The participant ultimately recovered a $225,000.00 settlement from a third party, but declined to reimburse the Plan in full. After the Plan sought reimbursement for its claims paid, the participant asserted the make-whole doctrine to argue that the Plan could not obtain reimbursement because the settlement funds amounted to less than the alleged medical expenses incurred by the participant.

As a result, the Plaintiff filed suit in the Western District of Kentucky seeking a constructive trust, requesting enforcement of its equitable lien by agreement and asserting a claim of unjust enrichment. The issue before the Court was whether the Plaintiff's Summary Plan Description ("SPD") disavowed the make-whole doctrine and contained language necessary to provide it with an equitable lien by agreement.

Under Sixth Circuit precedent, the Plan had to set forth language that was specific to both the Plan's priority and its right to reimbursement even in the case of a partial recovery. In its ruling, the Court granted summary judgment to the Plan, finding that it did have an equitable lien enforceable under ERISA § 502(a)(3) against the settlement fees.

Specifically, the Court held that a self-funded group health plan can claim an equitable lien by agreement over settlement proceeds obtained from a third party, despite the settlement only reflecting a partial recovery by the participant. Importantly, the Court concluded that the Plan invoked language that disavowed the make-whole doctrine because it had explicitly established:

> The Plan's priority to the funds recovered; and
>
> The Plan's right to any full or partial recovery.

The Plan language overcame the participant's claim for protection under the make-whole doctrine and provided the Plan with an equitable lien by agreement against the participant's third party recovery.

[1] *Caesars Entertainment Operating Co. v. Johnson, 2015 U.S. Dist. LE IS 30221 (W.D. Ky. Mar. 11, 2015).*

Review of *Spokeo, Inc. v. Robins*

In February 2014, a U.S. Court of Appeals in California ruled that a Plaintiff had satisfied the "standing" requirement to sue in Federal Court[1]. The U.S. Supreme Court will consider Spokeo's appeal during its October 2015 term. Spokeo is a website that provides users with information about other individuals, including contact data, marital status, age, occupation, economic health, and wealth level. The information is gathered from various sources throughout the web and is not always accurate nor is it confirmed by the individual. The Plaintiff in the case alleged that Spokeo's misinformation about his credit and wealth caused him to remain unemployed. However, he did not offer any specific financial injury. As a result, the Defendant argued that the Plaintiff failed to have standing because he could not show that he actually suffered any injury.

In order to bring a lawsuit in Federal Court, a Plaintiff must have "standing." To do so, a Plaintiff must allege that (1) he "has suffered an 'injury in fact' that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical"; (2) "the injury is fairly traceable to the challenged action of the defendant"; and (3) "it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision."[2] In reversing the District Court's opinion, the U.S. Court of Appeals ruled that the Plaintiff had sufficiently alleged standing to continue with his case because he alleged that there was a statutory

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violation, which the Court found to be satisfactory.

Spokeo appealed the matter to the U.S. Supreme Court and is arguing that a statutory violation of a statute, without an actual recognizable injury, is not enough to satisfy the "standing" requirements. If the U.S. Supreme Court agrees with Spokeo, the equitable remedies available to plan participants may be significantly limited.

Prior to 2011, a participant's damages were limited to the benefits available to him/her under the plan document. However, in 2011, the U.S. Supreme Court significantly expanded the remedies available to plan participants when a fiduciary breaches his/her/its duties.[3] This has resulted in many courts expanding remedies that could be available to participants, including surcharge and disgorgement.

Therefore, if the Court agrees with Spokeo, it would be much more difficult for plan participants to bring surcharge and disgorgement claims against plan fiduciaries. Specifically, many of the surcharge and disgorgement claims having to do with the plan fiduciaries' wrongful acts, rather than the participant's injury. As such, the U.S. Supreme Court's eventual decision could severely limit the claims a plan participant may bring against plan fiduciaries, if it agrees with Spokeo. A ruling from the U.S. Supreme Court should come sometime in 2016.

[1] *Robins v. Spokeo, Inc.*, No. 11-56843 (9th Cir. February 4, 2014).
[2] *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167, 180–81 (2000).
[3] *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 50 EBC 2569 (2011).

Illinois House Says Right-to-Work Not Right for Illinois

The National Labor Relations Act authorizes the right of unions and employers to include a union security clause – a clause requiring membership in the union as a condition of employment — in a collective bargaining agreement. However, a later amendment to the Act, enacted as part of the Taft-Hartley Act in 1947, permits individual "States and Territories" to pass laws prohibiting the use of union security clauses.

States that prohibit the use of union security clauses have become known as 'right-to-work states'. Twenty-five states currently have right-to-work laws on the books, including several states throughout the Midwest such as Iowa, Indiana, Michigan and most recently Wisconsin.

Since taking office, Governor Bruce Rauner has repeatedly said he would like to set up local right-to-work zones: areas of the state where union security clauses would be prohibited. The right-to-work zones in Illinois would be modeled after the local right-to-work laws in Kentucky, which failed to pass a right-to-work law on a statewide basis, but recently had several counties pass local ordinances. Whether the local right-to-work laws are permissible under federal labor law remains a point of contention for many legal experts.

Several unions in Kentucky have challenged the local right-to-work laws on the grounds that the right to prohibit the use of union security clauses is limited to "States and Territories", and therefore does not extend to local governments.

The National Labor Relations Board recently filed an *amicus* brief in the Kentucky lawsuit urging the Court to find the local ordinances impermissible under federal law. Illinois Attorney General Lisa Madigan has also issued a legal opinion indicating that the local right-to-work zones violate federal law.

In May 2015, Speaker of the House Michael Madigan sponsored a statewide bill that would have authorized the right-to-work zones, if approved by the local governments. The Illinois House overwhelmingly rejected the proposal, which received a vote tally of: zero "Yes" votes, seventy-two "No" votes, and thirty-seven "Present" votes, with a handful of Republicans declining to participate in the vote. Governor Rauner and other Republican lawmakers dismissed the vote as simply political theater claiming that the bill was sponsored by the Democratic Speaker with the intention that it would fail.

Illinois Democrats, with the support of many labor unions throughout the state, have argued that the Governor's right-to-work zones are just another attempt to weaken labor unions and would result in lower wages and less safe working conditions for Illinois families. State Rep. Brandon Phelps voiced his opinion during discussion of the bill, emphatically stating, "I wouldn't be here today without my union brothers and sisters."

The defeat of the right-to-work bill is just one of many setbacks Governor Rauner has faced while pushing his "Turnaround Agenda." Most recently, House Democrats passed a whittled down workers' compensation reform bill despite strong opposition from the Governor. Governor Rauner, who has also made worker's compensation reform one of his top priorities, stated that he believes the bill passed by House Democrats "ignores the most important reforms need[ed] for our workers' compensation system." Governor Rauner has also pushed for changes to Illinois Tort laws and for a freeze on property taxes, both of which have been blocked by Democratic lawmakers.

Legal Claims in Bankruptcy

While it may seem counterintuitive, the fact remains that when a Plaintiff in a civil lawsuit files for bankruptcy protection, his/her ability to recover any money in the lawsuit can be dramatically reduced. This is because any civil claims automatically become property of the bankruptcy estate and are subject to the automatic stay. This essentially means that this bankruptcy estate becomes the owner of the claim, which eliminates the Debtor/Plaintiff's ability to control the disposition of the lawsuit. This can be a very powerful tool that is often overlooked by many civil defendants.

Upon the commencement of most bankruptcy cases, an estate is created that is comprised of all property in which the Debtor has an interest.[1] This broad definition of "property of the estate" includes any causes of action and even extends to property that has not been properly disclosed to the Bankruptcy Court and the Bankruptcy Trustee. Property that has been concealed from, and/or not disclosed to, the Court and the Trustee remains property of the estate, subject to the possession, custody and control of the Trustee[2]. The automatic stay imposed while the bankruptcy case is pending applies to all of the Debtor's claims and neither the Plaintiff nor the Defendant can prosecute the case unless the Bankruptcy Court grants a relief from the automatic stay.

Civil claims have monetary value and should be applied for the benefit of the Debtor's creditors in the bankruptcy, which means any action taken by a Plaintiff/Debtor to prosecute a civil case while the bankruptcy case is pending is a violation of the automatic stay. It then becomes the responsibility of the Bankruptcy Trustee to value the Debtor's claim and to take the action that is most beneficial to the estate. The Bankruptcy Trustee has several options and may: 1) abandon the claim back to the Debtor because it has little or no value; 2) sell the claim to anyone willing to purchase it, including to the person or entity defending it; or 3) prosecute the claim on behalf of the estate.

If the Bankruptcy Trustee determines that the Debtor's claim has little or no value, he/she can abandon or relinquish it back to the Debtor, in which case the Debtor is then free to prosecute it. The Trustee may also elect to prosecute the claim him or herself on behalf of the estate, but the estate must assume the costs associated with pursuing the claim. A final option allows the Bankruptcy Trustee to sell the claim and apply the proceeds towards repaying the Debtor's creditors.[3] Oddly enough, this allows a Defendant of the Debtor's claim to purchase the claim from the bankruptcy estate. Provided the sale of the claim is approved by the Bankruptcy Court, the Defendant will then own the claim against itself and dismiss it, or simply let the claim lapse.

In addition to the immediate financial repercussions faced by the individual, bankruptcy filings can have a significant impact on unrelated civil claims. Any Defendant to such claims should always inquire into whether the individual asserting the civil claim has filed a petition in bankruptcy.

[1] 11 U.S.C. § 541.

[2] *See Wieburg v. GTE Southwest Incorporated*, 272 F.3d 302, 306 (5th Cir. 2001) (Trustee is the real party in interest with exclusive standing to assert claims which are property of the bankruptcy estate).

[3] 11 U.S.C. § 363.

We encourage you to contact

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if you have any questions regarding the content within this newsletter.

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2016 Out-of-Pocket Maximums and Transitional Reinsurance Contribution Rates

On February 27, 2015, the Department of Health and Human Services (HHS) issued final regulations on the 2016 Notice of Benefit and Payment Parameters.[1] The regulations address a variety of Affordable Care Act (ACA) benefit provisions for 2016, including ACA out-of-pocket maximums and Transitional Reinsurance Program contribution rates.

Effective for plan years beginning on or after January 1, 2014, the ACA required all non-grandfathered plans to comply with a new annual limit on total participant cost-sharing, also known as an out-of-pocket maximum. Cost-sharing includes any expenditure required by or on behalf of a participant with respect to essential health benefits (EHB), such as deductibles, co-payments, co-insurance and similar charges.

The out-of-pocket maximums for 2015 are $6,600 for self-only coverage and $13,200 for family coverage. Under the final regulations, the 2016 maximum annual out-of-pocket maximums are $6,850 for self-only coverage and $13,700 for family coverage.

More importantly, within the portion of the regulation's preamble, HHS formally adopted a "clarification" to the treatment of family out-of-pocket maximums. Under the final rule, HHS requires plans to "embed" an individual cost sharing limit within the family limit. This means that the self-only out-of-pocket maximum applies even if the participant has self-only coverage or family coverage. For example, if a plan has a family out-of-pocket maximum of $10,000 and an individual in the family has $15,000 in expenses, that individual can only be responsible for cost-sharing up to the ACA maximum of $6,850 in 2016, even though the plan has a $10,000 family out-of-pocket maximum. The HHS clarification is effective for plan years beginning on or after January 1, 2016.

Beginning in 2014 (and continuing for 2015 and 2016), the ACA requires health insurance insurers and self-funded group health plans to pay fees to the Transitional Reinsurance Program. The fees will be used to help stabilize premiums for coverage in the individual market.

The final rule confirms that the 2016 Transitional Reinsurance Fee is $27 per covered life, which includes covered spouses and dependents. Additionally, self-administered, self-insured plans are exempt from the fee for 2015 and 2016. Self-administered plans are those that do not use a third party administrator (TPA) for claims payment, claims adjudication and plan enrollment services. Previous regulations issued in March of 2014[2] clarified the following regarding self-administered status:

- A self-insured plan can still be considered self-administered if it uses a third party's services with respect to pharmacy benefits or ACA "excepted benefits" (e.g., limited scope dental and vision benefits);
- A self-insured plan can still be considered self-administered even if it uses a third party to lease a provider network and provide claim re-pricing services; and
- A self-insured plan can still be considered self-administered if it uses a third party for a *de minimis* amount of services (up to 5%). This means that a third party administrator may be used for up to 5% of the plan's "claims processing or adjudication or plan enrollment for services other than for pharmacy or excepted benefits."[3]

The 2016 final regulations do not change these exceptions regarding self-administered status. For further information regarding annual out-of-pocket maximums or the Transitional Reinsurance Fee, please contact our office.

[1] Federal Register/Vol. 80, No. 39/Friday, February 27, 2015.
[2] Federal Register/Vol. 79, No. 47/Tuesday, March 11, 2014.
[3] *Id.*

Supreme Court to Consider ERISA Reimbursement Case

Oftentimes, plan fiduciaries sue participants who have received erroneous benefit payments or, as is common in cases involving car accidents, have received plan benefits for injuries later compensated by third-party settlements. In some instances, however, the money received from these third-party settlements has already been spent by the participant, or has otherwise dissipated, and is no longer in his or her possession. These cases pose the following question: should the Plan be required to show that it "traced" the money it is seeking back to the participant, or can the Plan simply go ahead and sue a participant to collect funds that may no longer exist? Some courts have ruled that in order to sue a participant to recover benefit payments, the Plan must satisfy a "tracing requirement" by only allowing the Plan to recover benefits that still remain in the possession of the participant or beneficiary. Other courts have rejected the "tracing requirement," finding that ERISA plans can recover overpaid benefits even if those benefits did not remain in possession of the participant or beneficiary. On March 30, 2015, the U.S. Supreme Court agreed to review the requirement of "tracing" for a health plan attempting to recover benefits previously paid to an injured participant who later received a settlement for his injuries.

The Supreme Court will examine the decision of the 11th U.S. Circuit Court of Appeals in *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile,* which upheld a lower court's decision that a Participant must pay back more than $120,000 to the National Elevator Industry Health

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Supreme Court to Consider ERISA Reimbursement Case (*continued from previous page)*

Benefit Plan following a 2008 car accident[1]. The Participant sustained injuries when he was struck by a drunk-driver. He subsequently sued and received a $500,000 settlement from the driver. The Plan paid $120,000 worth of the Participant's claims related to the injuries sustained from the accident. The Participant's attorney made numerous attempts to get into contact with the Plan regarding the reimbursement requirement in the plan documents and eventually gave the Plan a deadline to respond, otherwise he would release the settlement proceeds to the Participant. The Plan never responded and the Participant received approximately $235,000 in settlement proceeds after attorney's fees were deducted. By the time the Plan attempted to recover the reimbursement, the Participant had spent nearly all the money.

The Court found that the summary plan documents gave the Plan a "first-priority claim" to the settlement payment and that the Plan could therefore recover the money paid out, even if the Participant had already spent it[2]. The Participant appealed to the Supreme Court.

The central issue in this case is ERISA's equitable remedies provision, found in Section 502(a)(3), which requires that any lawsuits by plan fiduciaries seek only "equitable relief," 29 U.S.C. §1132(a)(3). Typically, most courts have found that ERISA's catchall remedy authorizing suits for "other equitable relief" includes suits for recovery of "overpaid" medical benefits. The question the Supreme Court must answer in this case is whether a lawsuit by an ERISA fiduciary against a participant can recover an alleged overpayment by the plan seeking "equitable relief" within the meaning of Section 502(a)(3), if the fiduciary has not identified a particular fund that is in the participant's possession and control at the time the fiduciary asserts its claim[3].

The Circuit Courts are split on whether Section 502(a)(3) allows a fiduciary to sue a participant who is no longer in control of the disputed benefit payments. This is often referred to as ERISA's "tracing requirement." In *Montanile,* the Eleventh Circuit sided with the majority of the circuits when it allowed the Plan to bring this kind of lawsuit. In particular, the First, Second, Third, Sixth and Seventh Circuits have all rejected the notion of a tracing requirement, instead finding that ERISA plans can recover overpaid benefits even if those benefits don't remain in the possession of the participant[4]. In appealing the Eleventh Circuit decision, the Participant in *Montanile* is asking the Supreme Court to adopt the minority view in the circuits (namely, the Eighth and Ninth Circuits) and hold that strict tracing rules from equity apply in ERISA actions. Under the minority view, a plan fiduciary must identify the specific funds the participant recovered and then proceed only against that money[5].

Given the deep split between the circuits, it is difficult to predict on which side the Supreme Court will fall. However, it goes without saying that this is an important decision to the future of ERISA Plans with reimbursement provisions. If the decision follows the majority rule, ERISA plans will be able to enforce subrogation and reimbursement provisions to recover overpayments in more cases, and participants and their attorneys will take into account the rights of ERISA plans when they decide whether to pursue litigation or settle with the individuals who caused the participant's injuries. On the other hand, if the decision follows the minority rule, plan fiduciaries will need to examine their procedures for discovering participant's recoveries against third-parties in order to take action more quickly and obtain reimbursement before the funds have been spent by the participant[6].

The case is scheduled to be heard by the Supreme Court next term, which begins in October 2015. If you have any questions, please contact our office.

[1] *Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan v. Montanile*, 593 Fed. Appx. 903 (11th Cir. 2014).
[2] *Montanile*, 592 Fed. Appx at 903.
[3] Deschenaux, Joanne. *Supreme Court to Hear ERISA Reimbursement Case.* Society for Human Resource Management, p. 1, http://wwww.shrm/legalissues (April 1,2015).
[4] *Id.* at 2.
[5] Dyke, Charles and Toni Bitseff. *Supreme Court will decide whether strict tracing rule limits ERISA fiduciaries' ability to sue for recovery of benefit overpayments.* Benefits Law Alert: Nixon Peabody, LLP. (April 1, 2015).
[6] *Id.*

Separation Issues in Qualified Retirement Plans

Due to the financial difficulties faced by many pension plans, the suspension of benefits has become a hot topic among many of J&K's multi-employer clients. As a result, we are often asked to provide recommendations regarding the administration and design of suspension rules, wherein a retiree returns to work either in covered employment or disqualifying employment after he begins receiving benefits from a pension plan. However, another important question is whether or not an initial separation from service occurred as required under the Internal Revenue Code (Code).

It is generally understood that pension plans are, for the most part, not permitted to make in-service distributions to participants under the qualification rules of Code §401(a).[1] Accordingly, participants and administrators are familiar with distributions upon: (1) disability, if available, (2) early retirement, or (3) normal retirement. Given that the purpose of pension plans is to provide income to employees after they are no longer earning wages from active employment, our cultural understanding of retirement causes us to assume a person intends to stop working when they

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Separation Issues in Qualified Retirement Plans (*continued from previous page*)

apply for their pension.

As a result, many administrators do not look beyond the application in determining a participant's intention to retire. However, it may be advisable to perform additional due diligence regarding a participant's intention to remain in the workforce after his "retirement" under a multi-employer plan.

In order to be a qualified plan under Code §401(a), a pension plan is not allowed to make in-service distributions prior to normal retirement age. The IRS has interpreted this requirement to mean that if a plan "distributes benefits to employees 'prior to any severance of employment or the termination of the plan' [the plan fails] to comply with the requirements of Section 401(a) and lose[s] its protected status."[2]

As explained by subsequent Revenue Rulings, the rationale for the holding in Rev. Rul. 56-593 is that pension plans will violate the definitely determinative benefit rules under the treasury regulations if each employee may at any time withdraw some part of the funds stemming from employer contributions[3] that had been accumulated to provide his or her pension benefits.

Therefore, in order to maintain qualified status, a pension fund (defined contribution or defined benefit) may not allow its participants to receive pension benefits prior to normal retirement age until severance from employment, or "separation", occurs. This is often more difficult to determine in a multi-employer plan because the plans do not have general employment information about the participants, only information regarding employment for which contributions are received, i.e., covered employment.

However, many employers seek to retain their best employees after retirement by offering them employment as an estimator or supervisor, which may not require contributions under a collective bargaining agreement. While this practice may be advisable from an employer/employee standpoint, it presents qualification issues under the Code because the employee may never have fulfilled the "separation" requirement.

This is not an often enforced rule and there are no regulatory guidelines for the definition of "separation" under §401. However, there has been noise as of late about the analysis of separation of service rules under Code §409A, which governs non-qualified plans. Under §409A, there are two definitions of separation of service – one for employees and one for independent contractors-based on whether the facts and circumstances indicate that there was a *reasonable expectation* by the parties that no further services were to be required. The general idea is that a separation of service will have occurred if the level of services performed post-separation decreases to no more than 20% of the level of services performed pre-separation in the prior 36-month period.

While not directly applicable to plans qualified under §401, it may be worthwhile to review the due diligence performed at initial benefit determination regarding the separation of service for retirees and to gather additional information regarding the retirees' intentions post-retirement. For assistance with such reviews and recommendations regarding best practices for compliance, please contact our office directly.

[1] *Code §401(a)(36) allows in service distributions after age 62 under a bona fide phased retirement program, or as early as 55 if the age complies with the reasonably representative standard of the industry. IRB 2007-3 (January 16, 2007). 401(k) Plans may also distribute after age 59 ½ or upon financial hardship under §401(k)(2)(B).*

[2] *Carter v. Pension Plan of A. Finkl 7 Sons Co.*, 2010 U.S. Dist. LEXIS 46993 (N.D. Ill. May 12, 2010) (*citing* Revenue Ruling 56-693 *as modified by* Revenue Ruling 60-323).

[3] *Rev. Rul. 73-533*

Review of *Tibble v. Edison International*

On May 18, 2015, the U.S. Supreme Court handed down a decision in one of the most impactful cases for ERISA fiduciaries in recent memory.[1] The Defendant, Edison International, sponsored a 401(k) retirement plan for its workforce, serving approximately 20,000 beneficiaries. Edison had formed an investment committee to assist beneficiaries in the decision making process, a committee which met quarterly to present a selection of possible investment options from which the beneficiaries could choose.

In 1999, Edison added three mutual funds to its proposed investment portfolio, with higher fees than the other available lower-fee mutual funds participants could have chosen. The beneficiaries brought a class action lawsuit arguing that the decision to include the higher-fee mutual funds was imprudent because lower fee alternatives were available.

The District Court granted summary judgment in favor of Edison holding that ERISA's statute of limitations barred the Plaintiffs' claim, as the mutual funds were selected in 1999, more than six years before the complaint was filed. The Ninth Circuit Court of Appeals affirmed, holding that absent a significant change in circumstances making an investment

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Review of *Tibble v. Edison International* (*continued from previous page*)

decision imprudent, an investment decision made outside of ERISA's six year statute of limitations was in fact barred.

As a result, the Supreme Court was tasked with deciding "whether a fiduciary's allegedly imprudent retention of an investment is an action or omission that triggers the running of the 6-year limitations period."[2] ERISA states that no lawsuit may be brought after the earlier of either six years after the date of the last action which constituted a part of the breach/last date on which fiduciary could have cured the breach, or three years from the date of actual knowledge.[3]

It was absolutely clear from the outset of this case that the decision to go with the higher-fee mutual funds was initially made more than six years prior to the lawsuit. However, the Plaintiffs argued that a continuing-violation type theory should apply, which places a continuing duty to monitor investments and remove imprudent ones. The Plaintiffs' argument set forth that the initial selection of the higher-fee mutual funds was imprudent, even though the decision was made at a time falling outside the statute of limitations period.[4]

The Supreme Court arrived at their opinion by examining the source from which ERISA derives much of its fiduciary duty laws: trust law, which imposes a continuing duty to monitor investments and remove imprudent ones. As a result, the Supreme Court held in favor of the Plaintiffs, holding that "the Ninth Circuit erred in not recognizing that under trust law, a fiduciary is required to conduct a regular review of its investment with the nature and timing of the review contingent on the circumstances."[5]

The Supreme Court has now made clear that "a Plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones…so long as the alleged breach of the continuing duty occurred within six years of suit."[6] Since the Ninth Circuit applied the six year statutory bar using the date of the initial investment selection, the Court vacated the decision and remanded it to the Ninth Circuit for rehearing.

"Thus, an allegation that a fiduciary breached the duty to monitor may be timely under ERISA's six-year period of repose, even though the initial selection of the investment occurred outside of that period and ***even though there was no significant change in circumstances*** that would have caused the fiduciary to revisit its initial selection."[7] The decision in this case further illustrates the importance of having plan fiduciaries conduct regular reviews of plan investments and, some would argue, "makes it easier for participants to sue over excessive fees and underperforming funds."[8]

The Court did not provide further insight as to how plan fiduciaries should carry out their monitoring function, or how this would affect computation of damages under ERISA's statute of limitations.[9] However, more concrete guidance regarding these issues is expected now that the statute of limitations issue has been decided.[10]

[1] *Tibble et al. v. Edison International et al.*, Case No. 13-550 (May 18, 2015).
[2] *Id.*
[3] *Id.* (citing 29 U.S.C. §1113).
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] Christopher J. Boron and Nicole A. Diller, *Tibble v. Edison International Decision Finds Ongoing Duty to Monitor Investments in 401(k) Plans*, The National Law Review (June 12, 2015), http://www.natlawreview.com/article/tibble-v-edison-international-decision-finds-ongoing-duty-to-monitor-investments-401.
[8] Chris Murkowski, Tibble v. Edison ruling turns up the heat on plan sponsors, http://ebn.benefitnews.com/blog/ebviews/tibble-vs-edison-ruling-turns-up-the-heat-on-plan-sponsors-2746429-1.html (May 19, 2015); Robert Powell, Court makes it easier to sue over 401(k) retirement plans, http://www.usatoday.com/story/money/personalfinance/2015/05/18/justices-make-it-easier-to-sue-over-401k-retirement-plans/27527625/ (May 18, 2015).
[9] *Id.*
[10] *Id.*

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DOL Proposes Rule to Address Conflicts of Interest in Retirement Advice

On April 14, 2015, the Department of Labor (DOL) issued proposed rules regarding conflicts of interest in retirement advice provided to ERISA plans and IRA owners. Although these rules are unlikely to have a direct effect on multiemployer plans, participants may be indirectly affected if they are considering a rollover to an IRA.

Multiemployer retirement plans are unlikely to be directly affected because Boards of Trustees are already fiduciaries and the investment consultants they use by and large acknowledge fiduciary status. However, multiemployer plan participants who are considering a rollover may be affected to the extent that previously outside advisors did not have to meet a fiduciary standard in advising participants to rollover their account to an IRA.

Currently, an investment advisor to an IRA owner may or may not be a fiduciary. Broker-dealers are generally subject to a "suitability" standard required by the Securities and Exchange Commission (SEC) which is less stringent than the fiduciary standard. Under the proposed rules, any person advising a customer regarding rollover distributions will be subject to the fiduciary standard.

The intent of the regulation is to address perceived abuses by advisors who have a conflict of interest and who steer customers towards high commission products rather than providing advice that is in the best interest of the customer. The DOL previously issued detailed regulations in 2010 using a "rules-based" approach that were later withdrawn in 2011 in response to criticism from brokers, insurance agents, and other affected service providers.

The 2015 proposed regulations are "principles-based" rather than "rules-based". In addition, the proposed rules include several exemptions to address the concerns of the retirement services industry. The proposed rules are subject to a comment period and various notice requirements so that the earliest the proposed rules are likely to become effective is late 2016.

Once the rules become effective, investment advisors will have to meet a fiduciary standard when advising an IRA owner regarding investment decisions. Accordingly, multiemployer plan participants will receive the benefit of the fiduciary standard when outside investment advisors recommend rolling over a plan account to an IRA.