



FIDUCIARY EXCEPTION TO THE ATTORNEY CLIENT PRIVILEGE WHEN SEEKING ADVICE REGARDING PLAN INVESTMENT OPTIONS

by Timothy M. Iannettoni and Kimberly J. Ruppel



The fiduciary exception to the attorney client privilege can pose significant problems for plan fiduciaries who operate under the misconception that their communications with either in-house or outside counsel are protected by the attorney-client privilege. This misconception could lead to awkward situations for both fiduciaries and their attorneys, and in some instances may even jeopardize the outcome of a litigation. With a significant amount of recent litigation focusing on who can be considered

a fiduciary and what is considered a fiduciary activity, this article provides guidance regarding what communications with counsel may or may not be protected as privileged.

In an ERISA plan, plan fiduciaries owe a duty of loyalty to the plan participants and beneficiaries similar to that of a trustee to its beneficiaries and a board of directors to its shareholders.

A person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. 1002(21)(A).

Courts have relied on two different theories for applying the fiduciary exception in the ERISA context. The first theory is based on the duty of disclosure, requiring a fiduciary to disclose material information, including matters communicated by a fiduciary with its attorney, to all plan participants. The second theory is premised on the notion that because the fiduciary acts for the ultimate benefit of the plan participants, the participants are the “real” clients. Thus, any advice concerning the administration and management of the plan is ultimately advice for the benefit of the plan participants, which the participants are entitled to know.

Settlor Function vs. Plan Administration

When a fiduciary is said to be exercising its settlor function, any advice fiduciaries may receive in relation to this function has been held to be privileged and thus not subject to the fiduciary exception. The Supreme Court has held that “employers or other plan sponsors are

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EDITOR

Kimberly J. Ruppel, Bloomfield Hills
248.433.7291 • kruppel@dickinsonwright.com

CONTRIBUTORS

Aaron V. Burrell, Detroit
313.223.3118 • aburrell@dickinsonwright.com

Jane M. Feddes, Ann Arbor
734.623.1653 • jfeddes@dickinsonwright.com

Timothy M. Iannettoni, Detroit
313.223.3142 • tiannettoni@dickinsonwright.com

Benjamin M. Sobczak, Detroit
313.223.3094 • bsobczak@dickinsonwright.com

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generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans,” and that “when the employers undertake those action, they do not act as fiduciaries, but are analogous to the settlors of a trust.” *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443-44

(1999); see also *Lockheed Corp. v. Spink*, 517 U.S. 882, 891 (1996). As explained by the Supreme Court in *Jacobson*, the rationale behind limiting the exception in the settlor context is based on trust law, in that the fiduciary who creates, adopts, and modifies the plan is acting as a settlor of a trust and its actions are not considered to be taken for the benefit of the plan participants.

In contrast, actions relating to the administration of the plan, specifically, how to invest and allocate plan assets, are subject to the fiduciary exception. *United States v. Mett*, 178 F.3d 1063, 1065 (9th Cir. 1999) (explaining that the trustee is not the real client and is not entitled to the privilege when it seeks advice regarding plan administration). In a more recent case concerning allegations of breach of fiduciary duties resulting from investing in mutual funds with high investment management fees and inferior returns, the plaintiffs sought discovery of all documents relating to the investment of the plan funds, including communications with counsel. *David v. Alphin et. al.*, 2010 U.S. Dist. LEXIS 102278 (D.N.C. 2010). The court there held the fiduciary exception applied and required the fiduciary to produce all documents concerning plan administration, including communications with counsel regarding investment of plan assets.

With the increase in challenges to plan's investment decisions, plan fiduciaries are well advised to keep the above concepts in mind when seeking advice regarding initial investment selection and modifications, and choosing investment managers.

UNITED STATES SUPREME COURT UPDATE

Cigna Corp. v. Amara, No. 09-804 (argued November 30, 2010)

The United States Supreme Court is expected to issue its decision before the end of the term in a case concerning the standard for measuring harm to ERISA plan participants and beneficiaries resulting from alleged inconsistencies between a summary plan description and the full plan document. A ruling here will resolve a split in the circuits as to what standard should be applied to determine whether the SPD or the plan should control. For example, the Sixth Circuit holds that the SPD controls where there is a conflict between the two documents. See, *Haus v. Bechtel Jacobs Co.*, 491 F.3d 557 (6th Cir 2007). However, in the Second Circuit, a plaintiff must show that he or she was "likely to have been harmed" due to the inconsistent SPD. See, *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103 (2nd Cir 2003). The *Amara* plaintiffs argued in favor of the "likely harm" standard; whereas the defendants argued that detrimental reliance was required. The Court's decision will determine the burden of proof applicable in ERISA benefit class action suits as well as have an impact on the level and type of information included in a summary plan descriptions. Stay tuned for further developments.



SELECT CIRCUIT COURT DECISIONS

by Aaron V. Burrell, Jane M. Feddes and Benjamin M. Sobczak / edited by Kimberly J. Ruppel

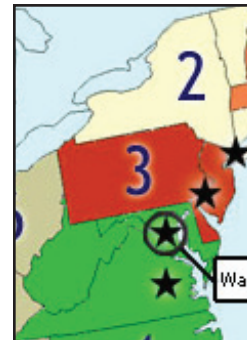
Third Circuit

Miller v. American Airlines, Inc., No. 10-1784, 2011 U.S. App. LEXIS 1462 (3rd Cir. Jan. 25, 2011).

The plaintiff, an airline pilot, suffered a psychotic episode while on duty and was later admitted to a hospital for treatment. As a result, the plaintiff's FAA medical certification, required for all commercial pilots, was revoked. Based on the diagnosis of a brief reactive psychosis and information supporting disability from his own occupation, the plan approved payment of LTD benefits. Four years later, because medical records indicated that the plaintiff was asymptomatic, although his diagnoses remained the same, the plan terminated the plaintiff's LTD benefits.



The Court found the plan's determination arbitrary and capricious because the records that prompted the termination of benefits did not differ in any material aspect from the records the plaintiff submitted before termination. Further, the court found that the plan erred by basing its decision in part on the plaintiff's failure to obtain his FAA medical certification when the plan's terms did not require the plaintiff to do so.



Fourth Circuit

Duperry v. Life Ins. Co. of North Am., No. 10-1089, 2011 U.S. App. LEXIS 1399 (4th Cir. Jan. 24, 2011).

Long term disability benefits were denied here because the plaintiff, who had been diagnosed with rheumatoid arthritis, osteoarthritis, and fibromyalgia, provided only subjective evidence of her purportedly disabling pain and fatigue. The court, applying the abuse of discretion standard, reversed the plan's decision and followed the lower court's reasoning that a plan administrator cannot "simply dismiss such subjective complaints of pain out of hand, especially where there is objective medical proof of a disease that could cause such pain."



Further, the defendant argued that an award of benefits should be limited to the “own occupation” period because it had not yet considered the plaintiff’s claim under the “any occupation” standard. The court disagreed, finding that the evidence in the administrative record established that the plaintiff’s inability to work was not connected to any particular duty of her occupation. Thus, the court affirmed an award of benefits up to the date of the lower court’s decision instead of remanding to the defendant.

Sixth Circuit

Soloman v. Medical Mutual of Ohio, No. 09-4152, 2011 U.S. App. LEXIS 213 (6th Cir. Jan. 4, 2011).

The plaintiff sought treatment for her cocaine addiction and utilized a website (not maintained by the defendant) to attempt to locate an in-network treatment provider. However, the outdated website’s information was inaccurate and the plaintiff sought treatment at a provider that had been removed from the network. Despite subsequently being warned that her treatment was not covered, the plaintiff spent nearly two months at the out-of-network facility. The defendant determined that certain services were not medically necessary, that she did not obtain pre-approval for the services that were medically necessary, and that her treatment was considered “residential” but not in-patient, and thus not covered beyond the first two days of her stay.

The plaintiff argued for application of *de novo* judicial review because an independent reviewing physician made the final decision regarding her claim. The court disagreed and held that the independent reviewing physician merely made “medical necessity” finding which was not a decision regarding coverage. Therefore, the defendant was entitled to the discretionary review. The court upheld the defendant’s determination as a rational interpretation of the plan.



Union Security Ins. Co. v. Blakeley, No. 09-4368, 2011 U.S. App. LEXIS 2911, (6th Cir. Feb. 15, 2011).

This case presented the not uncommon scenario of a dispute over life insurance proceeds between the children of the deceased and the deceased’s purported fiancée where no beneficiary had been designated. In that situation, the policy provided that proceeds would be paid first to a surviving spouse, and if none, to a domestic partner, and thereafter to the deceased’s children. In this case, the deceased’s

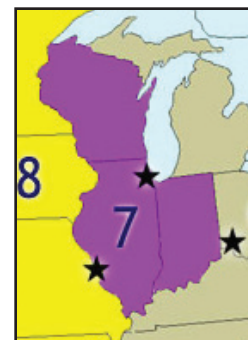
fiancée claimed entitlement to the proceeds as a “domestic partner,” arguing that state law should be applied to establish her status as such. The Sixth Circuit found that although “domestic partner” was not expressly defined in the policy’s general definition sections, the plan listed criteria for determining whether a domestic partner was an insurable life under the plan. As a result, the Court held that beneficiary status must be determined by application of the plan documents rather than by state law and remanded for consideration of whether the fiancée satisfied the plan criteria to be considered a domestic partner.

Seventh Circuit

Comrie v. IPSCO, Inc., No. 10-2393, 2011 U.S. App. LEXIS 3417 (7th Cir. Feb. 18, 2011).

Under the top-hat plan at issue here, if any high level executive was involuntarily terminated within two years of a change in control, they would be eligible for benefits that were calculated based on “compensation” which expressly excluded bonuses.

Here, the issue was whether stock-linked income was properly considered as a bonus or as compensation for the purpose of determining the amount of benefits owed. The court first determined that even though the plan administrators were not fiduciaries, the arbitrary and capricious standard still applied to the plan’s decision because the plan expressly conferred discretion on the administrative committee. The court upheld the administrative committee’s decision that, because the amount of stock-linked income plaintiff received was discretionary, it should not be considered as compensation.

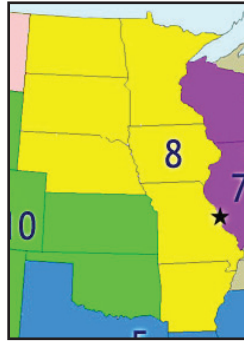


Eighth Circuit

Wrenn v. Principal Life Ins. Co., No. 09-3658, 2011 U.S. App. LEXIS 3962 (8th Cir. Mar. 2, 2011)

A fifteen-year-old was admitted into the hospital for forty days for treatment related to severe malnutrition as a result of anorexia nervosa. Although the plaintiff argued that the focus of the hospitalization was the child’s calorie intake and limitations on her physical activity in order to increase her body weight, the plan denied coverage beyond the policy’s ten day for mental health inpatient services.

Applying the abuse of discretion standard, the court noted that for the plan to reasonably deny the plaintiff's hospital charges, "substantial evidence had to support its determination that the primary focus of her hospitalization was mental health treatment, i.e., treatment designed to alter her behavior." Overturning the defendant's decision, the court held that there was "insufficient evidence to support the determination that [the child's] mental health was the *primary* focus of the hospitalization."

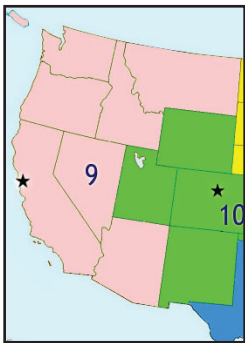


Ninth Circuit

Salomaa v. Honda Long Term Disability Plan, 2011 U.S. App. LEXIS 4386 (9th Cir. March 7, 2011).

In this LTD claim based on chronic fatigue syndrome ("CFS"), the defendant denied the plaintiff's claim based on a "lack of objective physical findings." The plaintiff disputed that CFS could be objectively verified and provided a neuropsychologist's report which stated that there was no evidence of malingering, and that his IQ test supported the diagnosis of CFS. Applying the arbitrary and capricious standard

of review, the court found that the defendant was unreasonable to demand objective tests for a condition that is not objectively verifiable. Further, the majority focused on the fact that each of the plaintiff's examining or treating providers concluded that he was disabled, a position that was soundly criticized by the dissent. Because the defendant also changed its reasons for denying benefits and failed to engage the plaintiff in a meaningful dialog as to the type of evidence that might better support his claim, the court held that the defendant abused its discretion.



ERISA LITIGATION & EMPLOYEE BENEFITS COUNSELING

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Dickinson Wright ERISA Attorneys



Deborah L. Grace
248.433.7217
dgrace@dickinsonwright.com



K. Scott Hamilton
313.223.3041
khamilton@dickinsonwright.com



Cynthia A. Moore
248.433.7295
cmoore@dickinsonwright.com



Sherry D. O'Neal
313.223.3871
soneal@dickinsonwright.com



Francis R. Ortiz
313.223.3690
fortiz@dickinsonwright.com



Kimberly J. Ruppel
248.433.7291
kruppel@dickinsonwright.com

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