Proskauer

newsletter

September 2013
in this issue

For the latest insights on developments in the world of employee benefits, executive compensation & ERISA litigation, visit our blog at www.erisapracticecenter.com.

A report to clients and friends of the firm

Edited by **Stacey C.S. Cerrone** and **Russell L. Hirschhorn**

Editor's Overview

Health care issues make the headlines once again in this month's ERISA Litigation Newsletter. Tzvia Feiertag first provides practical and timely tips for insured ERISA health plan sponsors on managing medical loss ratio rebates. Next, Todd Mobley comments on the post-DOMA world and the impact of the Supreme Court's decision finding that same-sex marriages will be recognized for purposes of federal laws. As always, be sure to review our monthly recap of interesting rulings, filings and settlements where the commentary on health care continues. We also highlight decisions addressing proper defendants in claims for benefits, statute of limitations, issues pertaining to fiduciary status, class actions, standing and retiree health care benefits.

Year Two of Medical Loss Ratio Rebates: Five Tips for Insured ERISA Health Plan Sponsors*

By Tzvia Feiertag

The Affordable Care Act's medical loss ratio ("MLR") rule requires health insurance companies (but not self-insured plans) in the group or individual market to provide an annual rebate to enrollees if the insurer's MLR falls below a certain minimum level. Generally, this means that health insurance companies in the individual and small group markets must spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities, and health insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities.[1]

---

* Originally published by Law360. Reprinted with permission.

[1] The large group market is generally defined as employers who employ 101 or more employees; although, in some states, it is defined by state insurance law as employers who employ 51 or more employees.

Health insurers that failed to meet the MLR standards for 2011 were first required to pay rebates in 2012. Health insurers that failed to meet the MLR standards for 2012 were required to pay rebates by August 1, 2013.[2] In addition, health insurers were required to send notice to group policyholders and to all employees who participated in affected plans during 2012 informing them of any rebates.

To help clarify the rules on how rebates are treated under the Employee Retirement Income Security Act of 1974 ("ERISA"), the U.S. Department of Labor ("DOL") issued Technical Release 2011-04 ("TR 2011-04"). Plan sponsors maintaining fully-insured ERISA-covered group health plans (and plan fiduciaries) should keep these rules in mind as they consider their options for managing any MLR rebates.

Here are five tips to consider in the decision-making process.

Do Not Assume You Can Use The Entire MLR Rebate For Corporate Purposes

TR 2011-04 clarifies that insurers must provide any rebates to the "policyholder" of an ERISA plan. Any rebates paid to an ERISA-governed plan may become plan assets, subjecting the policyholder and plan sponsor to special obligations concerning the treatment of the rebates (as explained further below). If the rebates are plan assets, then any individual who has control over the rebates (including a plan sponsor) is a "fiduciary" under ERISA and must act accordingly.

In situations where a plan or its trust is the policyholder (which is typically not the case for ERISA-covered group health plans), the DOL's position is that MLR rebates are generally plan assets and the plan sponsor may not retain any of the rebates.

Where the employer is the policyholder (the more typical case for an ERISA-governed group health plan), the employer may, under certain circumstances, retain some or all of the MLR rebates. In these situations, the DOL will look to the terms of the documents governing the plan, including the insurance policy. If the governing documents are unclear, then the DOL will take into consideration the source of funding for the insurance premium payments. Under this analysis, the amount of a rebate that is not a plan asset (and that the employer may therefore retain) is generally proportional to the amount that the employer contributed to the cost of insurance coverage. For example, if an employer and its employees each pay a fixed percentage of the cost (*e.g.*, employer pays 80% of the premium; employees pay 20% of the premium), a percentage of the MLR rebate equal to the percentage of participants' cost (*i.e.*, 20% in the example) would be attributable to participant contributions and would be plan assets. Based on this

---

[2] On March 1, 2013, the Department of Health and Human Services (HHS) issued a final rule that amends the MLR rule. HHS adjusted the MLR calculation to include premium stabilization amounts, a change HHS stated will improve accuracy. In future years, the final rule extends the annual MLR reporting deadline from June 1 to July 31 and the rebate disbursement deadline from August 1 to September 30, effective for the 2014 MLR reporting year, to allow the deadlines to be after all the premium stabilization payments and receipt amounts are determined.

guidance, some employers amended their plans last year to clarify how premiums are divided between employer and participants.

Determine The Population That Will Receive An Allocation Of The Rebates And Pick A Reasonable, Fair And Objective Allocation Method

Any MLR rebates that are considered plan assets must be handled according to ERISA's general standards of fiduciary conduct. ERISA's prohibited transaction and exclusive benefit rules require that plan assets be used solely for the benefit of participants and beneficiaries (or to defray reasonable plan administrative expenses). As long as the plan fiduciary (*e.g*., the plan sponsor) adheres to these standards, it has some discretion when deciding to whom the rebate should be allocated.

As a general rule, TR 2011-04 states that the MLR rebate should be provided to individuals who were enrolled in the plan during the determination period (for the recently issued rebates that would be the 2012 calendar year). However, TR 2011-04 provides that if a plan fiduciary finds that the cost of distributing shares of the MLR rebate to former participants approximates the amount of the proceeds, the fiduciary may decide to distribute the portion of the MLR rebate attributable to employee contributions to current participants using a "reasonable, fair, and objective" method of allocation. The administratively easiest method may simply be to divide the employee portion of the rebate by the number of recipients. However, a fiduciary may decide to apply a more rigorous methodology (*e.g.*, prorate the rebate by the number of months of participation in 2012, "weight" the rebate to account for greater employee contributions for family tiers, etc.) as long as it is impartial and in the best interest of participants.

TR 2011-04 also provides that if a plan has multiple benefit options, the MLR rebate that constitutes plan assets and is attributable to one benefit option cannot be used to benefit enrollees in another benefit option.

Consider Tax Consequences When Deciding How To Use MLR Rebates

As explained above, the MLR rules require insurers of group health plans to pay rebates directly to the policyholder. The policyholder is then responsible for ensuring that employees covered by ERISA group health plans benefit from the rebates to the extent they contributed to the cost of coverage. Once a plan fiduciary decides who will receive MLR rebates attributable to plan assets, it must then determine the form and tax consequences of the distribution.

Last updated in March 2013, the Internal Revenue Service (IRS) issued a set of frequently asked questions at http://www.irs.gov/uac/Medical-Loss-Ratio-(MLR)-FAQs addressing the tax treatment of MLR rebates. The rebates' tax consequences largely depend on whether employees paid their premiums on an after-tax or a pre-tax basis. Generally, when employees contribute to the cost of coverage on a pre-tax basis, MLR rebates should be returned to employees in the form of a premium reduction or a cash payment, both of which are treated the same way for tax purposes. For example, if an employee's pre-tax premium contribution is $100 per month, and the employee receives a $10 premium

reduction that month, the pre-tax contribution will be reduced to $90 and the remaining $10 would be wages not reduced from the employee's pay and would be included in income and subject to taxes and withholding. Likewise, if the $10 rebate was treated as a direct cash payment, it would also be included in income and subject to taxes and withholding. However, if the employee portion of the premium is paid by the employee on an after-tax basis, MLR rebates that are distributed as a reduction of future premiums or cash will not be subject to federal income tax (unless the employee deducted the premiums to which to the rebates relate on the employee's tax return).

If distributing cash payments to participants is not cost-effective (*e.g.*, the payments would be *de minimis* amounts, or would have tax consequences for participants), the fiduciary may apply the MLR rebate toward a benefit enhancements.

Use The MLR Rebates That Are Plan Assets Within Three Months Of Receipt

Under ERISA, plan assets generally must be held in trust until appropriately expended (or they could be sent to an insurer to provide benefits). In reliance on Technical Release 92-01 ("TR 92-01"), many group health plans receiving MLR rebates do not maintain trusts because they are insured plans where premiums are paid by the employer (including employee payroll deductions) directly to the insurer and all benefits are paid by the insurers.

In TR 2011-04, the DOL provides that prior relief under TR 92-01 applies to MLR rebates that are plan assets, and the DOL will not assert a violation of ERISA's trust requirement against plans receiving MLR rebates that do not otherwise maintain a trust so long as such rebates are used within three months of receipt by the policyholder to provide refunds or pay premiums.

Establishing a trust is an administratively cumbersome task. Employers wishing to avoid the need for a trust to hold MLR rebates that are plan assets should consider disposing of such rebates quickly upon receipt as provided in TR 2011-04.

Document Any Decisions Regarding How MLR Rebates Were Used

The determination of whether the MLR rebates constitute "plan assets" (such that employees are entitled to a share) and how and to whom that portion should be allocated is a fiduciary function that may be subject to the DOL's scrutiny on audit or a challenge by a participant. Thus, plan sponsors should document their treatment of the MLR rebates (*e.g.*, how the recipient population was determined, why a certain allocation method was selected, and the time and form of the rebate distribution) and, as appropriate, amend any written plan document and summary plan description to reflect the decisions made. Lastly, while plan participants will receive general information from the health insurers about the MLR rebates, the plan sponsor should notify participants of the decisions made with respect to the use and allocation of those rebates.

Proskauer's Perspective

TR 2011-04 contains many helpful rules and clear constraints as to how MLR rebates may be used by fully-insured ERISA group health plans. Nevertheless, there are still many decisions that plan sponsors and fiduciaries have to make to ensure that they are acting prudently and impartially and for the exclusive benefit of plan participants and beneficiaries.

* * *

To ensure compliance with requirements imposed by U.S. Treasury Regulations, Proskauer Rose LLP informs you that any U.S. tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

The Post-DOMA World Relating to ERISA-Governed Employee Benefit Plans[*]

By Todd Mobley

As a result of the U.S. Supreme Court's decision in *United States v. Windsor*, 133 S. Ct. 2675 (2013), in which the Court held that Section 3 of the federal Defense of Marriage Act ("DOMA") was unconstitutional, same-sex marriages will be recognized for purposes of federal laws, protections, and obligations. Because the Court did not go so far as to require states to permit same-sex marriage or recognize same-sex marriages entered into in other jurisdictions, there are many open issues that require resolution (either through government guidance or the courts) to provide employers with certainty concerning the administration of their ERISA-governed employee benefit plans.

A federal district court in Pennsylvania issued the first reported post-*Windsor* decision relating to ERISA plan benefits. As discussed below, the district court concluded that a deceased employee's same-sex spouse was entitled to a surviving spouse benefit under a profit-sharing plan, even though the couple was married in a foreign jurisdiction (Canada) and resided in a state that does not allow same-sex marriage (Illinois) but recognizes out-of-state same-sex marriages under its civil union law. *Cozen O'Connor, P.C. v. Tobits*, No. 2:11-cv-0045-CDJ (E.D. Penn. July 29, 2013).

DOMA and The Court's Decision in Windsor

Under Section 3 of DOMA, the terms "marriage" and "spouse" were defined to exclude same-sex married couples for purposes of interpreting federal statutes,

[*] Originally published by Bloomberg, BNA. Reprinted with permission.

rules, and regulations.[1] As a result, same-sex married couples were denied more than 1,000 federally-protected rights and obligations, including Social Security benefits, automatic pension death benefits, pre-tax employer-provided health benefits, and exemption from the federal estate tax for surviving spouses.

Windsor involved a couple — Edith Windsor and Thea Spyer — who registered as domestic partners in 1993 (when New York City extended that right to same-sex couples) and later lawfully married in Ontario, Canada in 2007. After their wedding, Windsor and Spyer returned to their home in New York City. Thea Spyer passed away in 2009. At that time, New York recognized same-sex marriages entered into under the laws of other jurisdictions; it did not permit same-sex marriage until 2011.

DOMA barred Windsor from qualifying for the marital exemption from the federal estate tax due upon Spyer's death. After paying $363,053 in estate taxes, Windsor sought a refund from the Internal Revenue Service ("IRS"). Because she could not be deemed a "surviving spouse" in the eyes of the federal government (per DOMA), the IRS denied Windsor's claim for a refund. Windsor commenced a refund suit in the Southern District of New York and argued that Section 3 of DOMA violated her constitutional guarantee of equal protection under the law, as applied to the federal government through the Fifth Amendment.

The District Court ruled in Windsor's favor. It held that Section 3 of DOMA was unconstitutional and ordered the IRS to refund the estate taxes paid by Windsor, with interest. The Second Circuit affirmed the District Court's judgment, and the Supreme Court granted certiorari.

The Supreme Court agreed (in a 5-4 decision) that Section 3 of DOMA was unconstitutional. The Court explained that marriage traditionally has been defined by and regulated under the laws of the States and that the federal government has deferred to state law when it comes to determining the contours and incidents of marriage. As such, although the rights and obligations stemming from marriage historically have been uniform within each State's boundaries, those rights and obligations may differ from State to State, subject to certain constitutional baselines. Section 3 of DOMA, however, rejected this "long-established precept" and, as a consequence, same-sex married couples were denied the rights accompanying federal recognition of their marriage.

Cozen O'Connor, P.C. v. Tobits

The *Cozen* case involved a couple — Jean Tobits and Sarah Ellyn Farley — who married in Toronto, Canada in 2006. Farley was subsequently diagnosed with cancer and passed away in September 2010. Farley, who had been working at Cozen O'Connor since 2004, was a participant in Cozen's profit sharing plan. The plan provided that, upon the death of a participant, a death benefit would be paid in the form of a qualified pre-retirement survivor annuity to the participant's

[1] DOMA did not prohibit States from permitting or recognizing same-sex marriages. At the time of writing this article, same-sex marriage is legal in thirteen states and the District of Columbia.

spouse or, if the spouse waives the right to receive the benefit, the death benefit would be paid to the participant's designated beneficiary. The plan further provided that if there is no spouse or designated beneficiary, the benefit would be paid to the participant's parents.

Following Farley's death, both Tobits and Farley's parents requested payment of the death benefit. In response to the competing requests, Cozen commenced a suit in federal court and asked the court to decide who the proper beneficiary was under the plan. The court explained that the case ultimately was dependent on whether, under the language of the plan, Tobits was Farley's spouse.

Because the plan did not define "spouse," the court looked to ERISA and the Internal Revenue Code (i.e., federal law) for guidance, since the issue before the court was whether Tobits was a surviving spouse for purposes of a spousal benefit mandated by ERISA and the Code.[2] Under this analysis, the court concluded that, following *Windsor*, these federal laws must acknowledge same-sex marriages recognized under any of the States' laws — "*Windsor* makes clear that where a state has recognized a marriage as valid, the United States Constitution requires that the federal laws and regulations . . . acknowledge that marriage." Since the marriage between Tobits and Farley was recognized by Illinois as a marriage under its civil union law (even though the marriage occurred in Canada), the court ruled that, pursuant to the terms of the plan (as interpreted under federal law), Tobits was Farley's surviving spouse and entitled to the preretirement survivor annuity.

Proskauer's Perspective

It is unknown whether other courts might be willing to find in favor of same-sex spouses if a plan's choice-of-law provision designates a state that does not permit (or recognize) same-sex marriage or if the couple resides in a state that does not itself allow same-sex marriage. It also will be interesting to see whether other courts apply *Windsor* retroactively (to a death that occurred prior to the date of the *Windsor* decision) like the court did in *Cozen.*

[2] The plan document provided that the plan was to be construed and enforced according to ERISA, the Code, and the laws of Pennsylvania (to the extent that Pennsylvania's laws were not preempted by ERISA). The court disregarded the provision making reference to Pennsylvania law (which does not recognize same-sex marriage) based in its finding that ERISA preempted Pennsylvania law entirely.

Rulings, Filings, and Settlements of Interest

First Post-Windsor ERISA Decision

By Howard Shapiro

> In the first reported ERISA decision post-*Windsor*, the U.S District Court for the Eastern District of Pennsylvania held (in *Cozen O'Connor, P.C. v. Jennifer Tobits*) that a same-sex spouse is to be treated as the decedent's lawful spouse for purposes of entitlement to death benefits under a retirement plan. In reaching its decision, the court relied on *Windsor* and reasoned that ERISA and the Internal Revenue Code (Code) provide the definition of spouse; ERISA and the Code incorporate valid state law; and, under Illinois' civil union statute, Illinois recognizes lawful same sex marriages solemnized in other jurisdictions.

The pension plan document defined spouse as a person to whom the participant was married for more than one year. The plan document did not address the issue of same-sex marriage. The court held that if the plan is silent as to the definition of spouse, the court will look to ERISA and the Code to determine who can be a spouse. The court then held that, post-*Windsor*, the term spouse is no longer unconstitutionally restricted to members of the opposite sex, but now includes same-sex spouses in otherwise valid marriages.

The facts in *Cozen* make the court's decision interesting in certain respects. Of particular note is that the participant died prior to the *Windsor* decision, and it is also noteworthy that the couple lived in a civil union state (as opposed to a state that allows same-sex marriage). Query whether the court's decision would have been different had the couple lived in a state that does not recognize same-sex unions of any kind.

Proskauer's DOMA Task Force continues to monitor developments in this area. Look out for future blog posts as additional cases are decided and government guidance is issued.

The Impact of Windsor on Social Security Benefits and FMLA Rights

By Roberta Chevlowe

> In light of the U.S. Supreme Court in *United States v. Windsor*, which struck the Defense of Marriage Act (DOMA) provision limiting marriage to opposite sex spouses, the government agencies have been working on updating guidance in a number of areas. Two recent updates are noteworthy:

Social Security Benefits — The Social Security Administration has started processing applications for Social Security benefits from same-sex spouses. Apparently, for now, only those couples residing in states where same-sex marriage is recognized will be entitled to the benefits. SSA has instructed its employees to hold other claims. SSA has stated that it is continuing to work with the Justice Department to interpret the *Windsor* decision (presumably

with regard to couples residing in other states). Access the internal SSA guidance here.

FMLA Rights — The DOL has updated its Fact Sheet regarding FMLA rights to include same-sex spouses in the definition of "spouse." The definition interprets "spouse" based on the state law in which the employee resides. (http://www.dol.gov/whd/regs/compliance/whdfs28f.htm.) This residency requirement stems from the DOL's FMLA regulations (issued prior to *Windsor*), which state that marriage for FMLA purposes is determined by the state of residence. Unless and until the DOL issues further guidance on this issue, this means that FMLA rights only have to be provided to those same-sex married couples residing in states where their marriage is recognized. See our Client Alert regarding the *Windsor* decision's impact on the FMLA for a further discussion of this issue.

IRS Adopts a "Place of Celebration" Rule in Implementing the U.S. Supreme Court's Windsor Decision

By Roberta Chevlowe

> On August 29, 2013, the U.S. Department of the Treasury and the Internal Revenue Service issued important guidance for employers and employees relating to the impact of the *Windsor* decision on employee benefit plans. In Revenue Ruling 2013-17, the agencies ruled that a same-sex couple legally married in any jurisdiction will be recognized as spouses by the IRS for federal tax purposes even if the couple resides in a jurisdiction that does not recognize the validity of their marriage. This "place of celebration" rule is welcome news for employers and other benefit plan sponsors, who may now administer their benefit plans in a uniform manner with regard to same- and opposite-sex married couples. (The Ruling confirms, however, that *unmarried* domestic partners and civil union partners will not be recognized as married for federal tax purposes, whether the partners are the same or opposite sex.). See our Client Alert discussing the impact of *Windsor* on employee benefit plans.
>
> Although the Ruling is technically effective on a prospective basis as of September 16, 2013, it may be relied on by affected taxpayers on a retroactive basis for purposes of filing original, amended or adjusted tax returns, as well as claims for credits or refunds of overpaid taxes, provided that the applicable limitations period has not expired (i.e., generally, three years from the date the return was filed).
> The IRS has updated its website to include FAQs providing guidance for *employees* on how they may recover federal income taxes paid on the value of health coverage provided to a same-sex spouse and on the premiums paid for such coverage on an after-tax basis. The FAQs also offer guidance for *employers* regarding refunds for Social Security and Medicare taxes paid on income imputed to employees for health benefits provided to same-sex spouses, and on the circumstances in which employers may make adjustments for overwitheld income taxes.

With regard to qualified retirement plans, the FAQs make clear that legally married same-sex spouses must be recognized as spouses for purposes of all federal tax rules applicable to qualified retirement plans.

The agencies intend to issue additional guidance relating to cafeteria plans and also on how *Windsor* and the IRS Ruling will apply to qualified retirement plans and other tax-favored arrangements for periods prior to the effective date of the Ruling.
Employers and plan sponsors need to consider carefully how to interpret the Ruling in the context of their various benefit plans and overall employment and HR policies. In addition, employers and plan sponsors should watch future guidance for how the Ruling impacts legal compliance under ERISA, COBRA, HIPAA (including HIPAA privacy), PPACA (health care reform), and other related federal and state laws affecting employee benefit plans.

Oklahoma's Challenge to Health Care Reform's "Employer Mandate" May Proceed

By Brian Neulander and James Napoli

> A federal district court recently ruled that, at the pleadings stage, Oklahoma established standing to pursue its suit to bar enforcement of the Affordable Care Act's ("ACA") shared responsibility penalty provisions. *Oklahoma ex rel. Pruitt v. Sebelius*, No. CIV-11-30, 2013 WL 4052610 (E.D. Okla. Aug. 12, 2013).

ACA contains a shared responsibility provision (also known as the "Employer Mandate") under which, effective for 2015, large employers (those that employ 50 or more full-time equivalent employees) have to pay a shared responsibility payment if they do not offer minimum value, affordable coverage to their full-time employees. 26 U.S.C. § 4980H. As discussed in our May 31, 2013, blog post, there are two different penalties that could apply depending on whether an employer either (a) offers no health care coverage to at least 95% of its full-time employees or (b) offers full-time employees coverage that is unaffordable or does not provide minimum value. In either case, at least one full-time employee must qualify for a premium tax credit subsidy to purchase health insurance through a health care exchange before penalties apply.

Under ACA, health insurance exchanges are generally required to facilitate the purchase of health care coverage. If a state fails to set up its own exchange, the federal government steps in and creates a federally facilitated exchange. To date, Oklahoma has not created its own exchange.

In its suit, Oklahoma argues that ACA's text regarding the calculation of Employer Mandate penalties is tied to exchanges "established by the State" and that, because Oklahoma has no "State" exchange, the Employer Mandate did not apply to large employers in Oklahoma. Oklahoma also argued that the IRS's rule expanding the definition of "exchange" to include both state and federally facilitated exchanges was beyond the scope of its

authority.

Under the legal theory being pursued in the Oklahoma suit, individuals would not be eligible for federal premium subsidies for coverage purchased through a federally facilitated exchange. Moreover, because the penalties under the Employer Mandate are triggered by a full-time employee receiving a federal premium subsidy, employees working in states that default to the federally facilitated exchange could not trigger any penalties. There are currently thirty-three states that have chosen not to establish a state-run exchange and that have defaulted to the federally facilitated exchange. Consequently, the stakes are high with respect to the merits of *Oklahoma ex rel. Pruitt v. Sebelius.*

Seventh Circuit: Insurance Companies Are Proper Defendants In Suits For ERISA Benefits

By Jacklina Len

> The Seventh Circuit held that a health insurer that makes benefits determinations and pays benefit claims, rather than the health plan itself, is a proper defendant in an action for benefits under ERISA Section 502(a)(1)(B). In *Larson v. United Healthcare Ins. Co.*, No. 12-1256, 2013 WL 3836236 (7th Cir. July 26, 2013) (unpublished), plan participants filed an ERISA class action against six health insurance companies, alleging that they were improperly required to pay co-payments for chiropractic care. While recognizing that plans are "normally" the proper defendant in a claim for benefits because plans normally owe the benefits, the Seventh Circuit ruled that a health insurer is a proper defendant in cases where it decides all eligibility questions and also owes the benefits due to participants. In the end, however, plaintiffs' claims failed because there was nothing in the plans that precluded co-payment charges for chiropractic services.

Georgia Federal Court Holds that Continuing Course of Conduct Did Not Extend Statute of Limitations Period for Fiduciary Breach Claim

By Jacklina Len

> In *Stargel et al. v. SunTrust Banks Inc. et al.*, No. 1:12-cv-03822, (N.D. Ga. Aug. 8, 2013), a Georgia federal judge dismissed a putative class action against Suntrust Banks. Among the claims it dismissed was a fiduciary breach claim based on defendant's failure to remove its own allegedly underperforming funds in its 401(k) plan. More specifically, plaintiffs alleged that the initial selection of the funds was imprudent because they under-performed and charged high fees. Nowhere did plaintiffs allege that the funds performed worse over the course of the putative class period. The court concluded that the statute of limitations on this claim ran in 2004, seven years after the funds were first made available to employees. Repeated failures to remove the investments from the choices available to employees under the plan did not, according to the court, extend the statute of limitations period.

Third Circuit Concludes That Insurer Did Not Breach its Fiduciary Duties in Paying Benefits Through A Retained Asset Account

By Joseph Clark

> The Third Circuit recently found that while a life insurance company acts as a fiduciary in choosing to use a retained asset account to distribute benefits, it did not breach its fiduciary duties in making that choice. When an insurer creates a retained asset account as the method by which it will distribute benefits, it does not initially deposit any funds; rather, it credits the account with the benefits. The insurer does not transfer funds into the account until a beneficiary writes a check, at which point the insurer transfers funds to cover the check. Prior to payment, the beneficiary's balance earns interest at a predetermined rate, but the insurer is free to invest the retained assets for its own benefit.

Plaintiff Connie Edmonson, the recipient of life insurance benefits from her late husband's policy, filed a class action against Lincoln National Life Insurance Co., arguing that Lincoln breached its fiduciary duties by: (i) using a retained asset account to pay benefits, and (ii) investing the retained assets for its own profit. She sought disgorgement of the difference between what Lincoln earned by investing the retained assets and the interest she received.

In a case of first impression within the Third Circuit, the Court held that while Lincoln was a fiduciary insofar as its choice to use a retained asset account (i) represented a "discretionary act of plan management or administration" and (ii) "involved exercising authority or control over plan assets," it did not breach its fiduciary duties. *Edmonson v. Lincoln Nat'l Life Ins. Co.*, 2013 WL 4007553 (3d Cir. Aug. 7, 2013). First, the Court rejected Edmonson's argument that Lincoln's use of the retained asset account was not entirely in her interests. It reasoned that Lincoln did not directly gain any financial benefit from its decision, since Edmonson could have immediately written a check for the entire balance. Second, the Court found that "Lincoln was not managing or administering the plan when it invested the retained assets," and concluded that Lincoln completed its duties by establishing the retained asset account. Third, the Court determined that the retained assets were not plan assets. Once it created the retained asset accounts, Lincoln simply remained obligated to honor checks drawn on the accounts and pay interest at the stipulated rate.

Notably, just two days later a Massachusetts federal court relied heavily on *Edmonson* in finding that (i) an insurer acted as a fiduciary in choosing to use a retained asset account to pay benefits, but (ii) it did not breach its fiduciary duties in making that choice. *Vander Luitgaren v. Sun Life Assurance Co. of Canada*, 2013 WL 4058916 (D. Mass. Aug. 9, 2013).

No Fiduciary Status For 401(k) Plan Service Provider

By Brian Neulander

> The Third Circuit affirmed dismissal of plaintiff Nicholas Danza's claims that Fidelity breached its fiduciary duties and engaged in prohibited transactions by charging excessive service fees for reviewing and qualifying Domestic Relations Orders (DROs) for a 401(k) plan. *Danza v. Fidelity Management Trust Co.,* 2013 WL 3872118 (3d Cir. July 29, 2013) (unpublished). Danza filed suit after Fidelity charged him $1,200 — pursuant to the plan's fee schedule — to review his non-standard DRO, claiming that this amount was unreasonable and violated ERISA. In rejecting plaintiff's claims, the Court reasoned that: (i) Fidelity engaged in an arms-length transaction, and not as a fiduciary or party-in-interest, in negotiating its fee arrangement with the plan, and (ii) Fidelity's fiduciary status was limited to reviewing and qualifying DROs.

Rule 23 Requirements are "Heightened" for Proposed Class Settlements

By Brian Neulander

> In *Rodriguez v. Nat'l City Bank*, — F.3d —, 2013 WL 4046385 (3d Cir. Aug. 12, 2013), the Third Circuit refused to certify a proposed class for settlement purposes to amicably resolve mortgage discrimination claims because those claims failed to satisfy Rule 23 under the Supreme Court's recent ruling in *Dukes v. Wal-Mart*. Rejecting plaintiffs' contention that a lesser showing under Rule 23 should be required to accommodate settlements, the Court concluded that Rule 23's requirements demand "heightened" attention in the context of proposed class action settlements, and that "sufficient unity" must be established to bind the absent class members to the decisions of the named plaintiffs. Thus, the general policy in favor of voluntary settlements did not trump the "rigorous analysis" required to certify a class. In so ruling, the Court followed prior Supreme Court precedent. Applying the commonality and typicality standards as articulated in *Dukes*, the court concluded that, just as in *Dukes*, where statistical analyses of individual store managers could not sustain claims of company-wide discrimination claims, so too plaintiffs' claims that individual loan officers discriminated against certain groups of borrowers could not be certified for class treatment because there was no showing of a common practice and common harm.

Chiropractors Lack Standing Under ERISA to Assert Claims For Benefits

By Aaron Feuer

> A federal district court in New Jersey recently dismissed claims asserted by a putative class of chiropractors seeking to enjoin the procedure used by UnitedHealth to determine the necessity of certain treatments administered by in-network physicians, finding that they lacked standing to assert their claims. *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 2:11-cv-00425-ES-CLW (D.N.J. August 1, 2013). The plaintiffs claimed that they had an assignment of the right to reimbursement for services and that this qualified them as a "participant or beneficiary" under ERISA. The court determined that

the plaintiffs had no standing to enjoin UnitedHealth's procedure because they were no longer in-network providers and thus would not be impacted by the procedure in the future. (The plaintiffs' claims arising from assignments made while the plaintiffs were in-network were subject to arbitration and not part of the lawsuit.) The court also rejected a second proposed class to challenge UnitedHealth's overpayment recoupment procedures. The court found the named plaintiffs lacked typicality under Rule 23(a) since none of the named plaintiffs had made voluntary repayments, which constituted a significant component of the challenged policy.

Sixth Circuit Concludes That CBAs Vested Retirees Contribution-Free Health Benefits, Despite Side Letters To The Contrary

By Joseph Clark

> The Sixth Circuit affirmed a district court's decision granting a permanent injunction in favor of M&G Polymers, USA LLC retirees who sought vested lifetime health care benefits. *Tackett v. M&G Polymers USA, LLC*, 6th Cir., No. 12-3329, Aug. 12, 2013. In December 2006, M&G announced that it would begin requiring retirees to contribute to the cost of their health benefits. Certain retirees commenced a lawsuit, arguing that the changes violated ERISA because "the promise of a 'full Company contribution towards the cost of [health care] benefits' in the CBAs provided them with a vested right to receive health care benefits in retirement without making any contributions." M&G argued that a series of side letters that purported to allow the company to cap its contributions to the retirees' health benefits applied to the CBAs because: (i) the side letters had been consistently agreed to with the union since 1991; (ii) internal union conversations indicated that some union members believed the side letters applied; and (iii) the SPD explicitly set forth a contribution cap. Nevertheless, the Court found that the side letters did not apply, in part because separate, collectively bargained "Pension, Insurance and Service Award Agreements," which were distributed to all class members and described the benefits they could expect to receive, did not contain any "capping" language. The Court also found that the side letters had not been distributed to all of the class members.

The Court also rejected plaintiffs' cross-appeal. Plaintiffs had argued that the district court erred by ordering retirees who were previously enrolled in the pre-2007 plan to be enrolled in the current plan. The Court reasoned that retirees' whose health benefits are vested may be subject to "reasonable changes" in benefits, provided the changes are "reasonable in light of changes in health care." According to the Court, the 2007 changes to the health care plan, which included an "increase in the maximum out-of-pocket limit from $500 to $4,000 per family," were not unreasonable.

Equitable Exception To Excuse Interim Withdrawal Liability Payments Rejected

By Aaron Feuer

> A federal district court in New Jersey recently declined to apply an equitable exception to excuse an employer's failure to pay interim withdrawal liability payments while it challenged the demand for withdrawal liability. *Nat'l Integrated Grp. Pension Plan v. Black Millwork Co.*, 2:11-cv-05072-KM-MAH (D.N.J. August 1, 2013). After making one withdrawal liability payment, the employer initiated arbitration to challenge the plan's demand for withdrawal liability and made no further payments. Notwithstanding ERISA's "pay now, dispute later" statutory withdrawal liability rules, the employer argued that the court should apply an equitable exception to this mandate. In particular, the employer argued that the court should invoke, like the Fifth and Seventh Circuits have done, equity to excuse an employer's failure to pay interim withdrawal liability when an employer could show: (i) severe financial hardship, and (ii) the fund's claim is frivolous and not colorable. The district court, observing that the Third Circuit had previously expressed skepticism regarding whether a court could apply such an equitable exception, concluded that even if the Third Circuit were to adopt such an equitable exception, the employer had not shown that the plan's claim was frivolous.

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits, Executive Compensation & ERISA Litigation Practice Center. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

For more information about this practice area, contact:

Stacey C.S. Cerrone
504.310.4086 –scerrone@proskauer.com

Amy R. Covert
212.969.3531 – acovert@proskauer.com

Russell L. Hirschhorn
212.969.3286 – rhirschhorn@proskauer.com

Robert W. Rachal
504.310.4081 – rrachal@proskauer.com

Myron D. Rumeld
212.969.3021 – mrumeld@proskauer.com

Howard Shapiro
504.310.4085 – howshapiro@proskauer.com