Proskauer

newsletter

A report to clients and friends of the firm

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

June 2014
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.

Editor's Overview

In this month's issue, our authors address severance benefit claims and ERISA disclosure requirements. In our first article, Joe Clark addresses whether a plan administrator should conduct an independent investigation into the reasons for an individual's termination of employment before deciding a claim for severance. In our second article, Ira Bogner and Adam Scoll address the steady stream of new ERISA-related disclosure and reporting obligations being imposed on plan fiduciaries.

As always, the Rulings, Filings, and Settlements of Interest contains an interesting array of topics, including statute of limitations, beneficiary designations, ERISA's Whistleblower provisions, deferential review plan language, fiduciary status of 401(k) Plan service providers, coverage of same-sex spouses and ACA issues.

View From Proskauer: Investigating and Deciding Severance Benefits Claims*

By Joseph Clark

Plan administrators charged with administering Employee Retirement Income Security Act-governed severance plans are often confronted with the question of whether they should conduct an independent investigation into the reasons the employer-plan sponsor terminated an individual's employment before deciding whether to grant or deny the individual's claim for severance benefits. The decision to conduct such an investigation, and, the breadth of such an investigation, may have consequences in the event of litigation.

This article provides some guidance to plan fiduciaries in evaluating claims for severance benefits.

Many severance plans provide that an employee is ineligible for benefits if terminated "for cause" and define cause as, among other things: neglect in performing one's duties, misconduct, or unsatisfactory performance. A threshold question for those charged with

---

* Originally published in Bloomberg, BNA. Reprinted with permission.

the responsibility for deciding severance benefit claims and appeals is thus whether the employee was in fact terminated "for cause." Whether and, if so, how "for cause" is defined is controlled by the terms of the plan.[1] What is required of plan fiduciaries under these circumstances? May they accept the employer's stated reason for the employee's discharge? Must they conduct an independent investigation into the reasons for the employee's discharge? Somewhat surprisingly, there are relatively few reported decisions addressing whether a plan fiduciary has an obligation to conduct an independent investigation into an employer's reasons for discharging an employee.

As a preliminary matter, in deciding whether an investigation is warranted, it is important to be mindful of the fact that severance plan participants, like all other ERISA plan participants, are statutorily entitled to a "full and fair review by the appropriate named fiduciary of the decision denying the claim."[2] This means that a plan administrator must "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination."[3] Moreover, pursuant to ERISA §503(1), participants must be provided "adequate notice in writing . . . setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant."

Is An Investigation Warranted?

Where a plan fiduciary is in possession of credible evidence that an employer terminated an employee for cause, courts have generally concluded that there is no requirement that a plan fiduciary conduct an independent investigation into the reasons for the employee's discharge from employment. For example, in *Estate of Schwing v. Lilly Health Plan*,[4] the U.S. Court of Appeals for the Third Circuit held that a plan fiduciary may reasonably rely on information obtained from the employer in deciding whether to deny a claim for severance benefits on account of an individual being terminated for cause. There, a sales employee was terminated for falsifying call data. Although the employee denied that he had ever admitted any wrongdoing, and argued that he was fired as an act of retaliation, the plan administrator determined that the employee was ineligible for severance benefits because he was terminated for misconduct. The Third Circuit concluded that there is no requirement that a plan administrator faced with an issue of who is to be believed must conduct an independent investigation into a claimant's arguments, and that, in this case, there was ample evidence of the employee's misconduct to support the denial of his claim for severance benefits.

Similarly, the U.S. Court of Appeals for the Sixth Circuit held that if a plan's language clearly identifies the conduct that will render an individual ineligible for severance benefits, and the employer presents evidence that a terminated employee engaged in

---

[1] *Fahrner v. United Transp. Union Discipline Income Prot. Program*, 645 F.3d 338, 51 EBC 1720, 2011 BL 117641 (6th Cir. 2011) (stating that the language of the plan provides the starting point for determining whether an employee/participant was terminated from employment for cause and thus whether he is entitled to benefits under the plan)

[2] ERISA § 503(2)

[3] 29 C.F.R. §2560.503-(1)(h)(2)(iv)

[4] *Estate of Schwing v. Lilly Health Plan*, 562 F.3d 522, 46 EBC 2370, 2009 BL 79732 (3d Cir. 2009)

such conduct, a plan administrator need not investigate further before denying benefits. In *Fahrner v. United Transp. Union Discipline Income Prot. Program*,[5] an employee was terminated for insubordination after he failed to comply with his employer's requests that he provide certain information after he took a medical leave of absence. The court observed that the plan administrator was provided with information that the employer compiled during its evaluation of whether to terminate the employee, and determined that this constituted sufficient evidence that the employee failed to comply with his employer's procedures and instructions. The plan administrator was thus found to be justified in denying plaintiff's claim for severance benefits.

A plan administrator may not, however, "cherry-pick the evidence it prefers while ignoring significant evidence to the contrary."[6] In *Mohammed v. Sanofi-Aventis Pharmaceuticals*, an employee was terminated for improperly purchasing equipment with employer funds. The plan administrator denied his claim for severance benefits based on an oral summary and memorandum from the employer. The administrator wasn't presented with and didn't review the employee's appeal letter. In the court's view, this rendered the plan administrator's decision arbitrary and capricious, and the court remanded the case to the plan administrator for further consideration.

Privilege Considerations

ERISA's claims regulations provide that a participant is entitled to all "documents, records, and other information relevant to the [employee's] claim for benefits."[7] This includes any information considered or relied upon as part of the plan fiduciary's determination. Accordingly, a plan administrator who denies a claim for severance based on a report of an internal investigation conducted by the employer may subject that report, and the underlying investigation, to discovery. In order to avoid this risk, the administrator may prefer to conduct its own investigation, rather than subject to discovery a report that the employer otherwise intends to keep confidential.

Proskauer's Perspective

The guiding principle to be drawn from the relatively sparse case law is that, in deciding whether to grant or deny an individual's claim for severance benefits, plan fiduciaries should be able to reasonably rely on credible evidence—without conducting an independent investigation—that an individual's employment was terminated for cause. But administrators need to be sensitive to the risks of exposing to discovery any information on which it relies, even if that information emanates from the employer.

---

[5] *Fahrner v. United Transp. Union Discipline Income Prot. Program*, 645 F.3d 338, 51 EBC 1720, 2011 BL 117641 (6th Cir. 2011)

[6] *Mohammed v. Sanofi-Aventis Pharms.*, 2009 U.S. Dist. LEXIS 119871, at *42 (S.D.N.Y. Dec. 22, 2009)

[7] 29 C.F.R. §2560.503-1(h)

Death, Taxes and …ERISA Disclosure Regulations?*

By Ira G. Bogner and Adam Scoll

There are few sure things in life, and although it is probably safe to say that ERISA disclosure regulations would not be considered one of them, there has certainly been a steady stream of new ERISA-related disclosure and reporting obligations being imposed on plan fiduciaries.

The latest installment from the U.S. Department of Labor came out on March 12, 2014, in the form of a proposed amendment to its final regulations under Section 408(b)(2) of ERISA (commonly referred to as the "necessary services exemption"). The proposed amendment, if finalized in its current form, would require covered service providers to furnish a "guide" to assist ERISA plan fiduciaries in reviewing the initial disclosures required by the final regulations, but only if the required initial disclosures are contained in multiple or "lengthy" documents.

The final regulations were part of a three-pronged approach to new disclosure rules issued by the DOL within the past decade that was aimed at improving the transparency of plan fees and conflicts of interest to plan fiduciaries, the DOL and plan participants and beneficiaries:

- First came the changes to the Form 5500 Schedule C reporting requirements — these relate to a plan's reporting requirements to the DOL on the plan's annual Form 5500 Return/Report;
- Next came new ERISA Section 404(a)(5) participant-level disclosure rules — these relate to a 401(k)-type plan's reporting requirements to its participants and beneficiaries; and
- Finally, new ERISA Section 408(b)(2) service provider compensation disclosure regulations (i.e., the final regulations) — these relate to an ERISA pension plan service provider's reporting requirements to its ERISA pension plan clients.

Together, these rules were intended to provide (i) plan fiduciaries with the information they need to assess the reasonableness of the compensation that is paid for the services being rendered to the plan, and hopefully flesh out any potential service provider conflicts of interest and (ii) plan participants and beneficiaries with the information they need to effectively manage and invest the money they contribute to their 401(k)-type pension plans.

Given the process for ultimately issuing all of these rules — first, proposed regulations, then public comments, then possibly interim final regulations, followed finally by final regulations which are supplemented by additional guidance, etc. — it has seemed like new ERISA disclosure regulations have been the new constant in life.

A review of all of the aforementioned disclosure rules is beyond the scope of this article, and since we've been living with them for a while now, we assume you are already (at least to an extent) aware of and familiar with the rules. Accordingly, the remainder of this article is intended to be a general summary of only certain aspects of the proposed amendment and the final regulations — in particular, those aspects that are most likely to

---

* Originally published in *Law360*. Reprinted with permission.

apply to investment advisers providing services to ERISA plans and plan asset funds — and is not intended to be an exhaustive review of the requirements thereunder.

Background

Under the final regulations (which became effective July 1, 2012), "covered service providers" (e.g., investment advisers to ERISA-covered pension plans and private investment funds deemed to hold the "plan assets" of ERISA-covered pension plans) must disclose to "covered plans" (e.g., ERISA-covered pension plans) certain information regarding the services they provide and the compensation they receive.

Investment advisers to ERISA-covered pension plans (either directly or as investors in private investment funds deemed to hold "plan assets" under ERISA) rely on the "necessary services exemption" under Section 408(b)(2) of ERISA to provide investment-related services to ERISA-covered pension plans for compensation without engaging in a non-exempt "prohibited transaction" under ERISA or the Internal Revenue Code. Unless another exemption is available, failure to comply with the final regulations could lead to a non-exempt prohibited transaction, the penalties for which can include the imposition of excise taxes and potentially a refund of compensation.

Investment advisers to private investment funds that are not deemed to hold "plan assets" under ERISA (e.g., funds that (i) restrict "benefit plan investor" participation to less than 25 percent of the value of each class of equity interest in the fund (generally excluding for these purposes commitments held by the fund's sponsor and investment adviser and their affiliates), and/or (ii) qualify either for the venture capital operating company ("VCOC") or real estate operating company ("REOC") exception) generally are not subject to the disclosure requirements under the final regulations (and, therefore, would also not be subject to any new guide requirement under the proposed amendment) with respect to such funds or investors in such funds.

The Final Regulations

The initial disclosures required by the final regulations include, among other items:

- a description of the services to be provided by the covered service provider;
- a description of the direct and indirect compensation to be received by the covered service provider and the manner in which it will be received;
- a statement as to whether the covered service provider reasonably expects to provide services as an ERISA fiduciary or a registered investment adviser; and
- for an adviser to a private investment fund deemed to hold "plan assets" under ERISA, certain additional investment-related information (e.g., the annual operating expenses).

The final regulations require that the initial disclosures be made reasonably in advance of the date on which the applicable investment management or advisory contract or limited partnership agreement is entered into, extended or renewed. In addition, there are special disclosure timing rules in certain situations, including when non-plan asset funds become plan asset funds.

The final regulations do not require the disclosures to be made in any particular manner or format. In fact, the preamble to the final regulations specifically noted that covered service providers could use different documents from separate sources, provided that all of the documents collectively contain the required disclosures. The DOL did include a

"sample guide" as an appendix to the final regulations, which the DOL encouraged, but did not require, covered service providers to use. The DOL noted its intent to publish, in a separate proposal, a guide or similar requirement to assist plan fiduciaries' review of the required disclosures.

The Proposed Amendment

Based on its review of service providers' disclosures and plan fiduciaries' experiences in reviewing those disclosures, the DOL determined that a "guide" requirement would assist plan fiduciaries (especially fiduciaries to small and mid-sized plans) in their review of the required disclosures (which the DOL views as an important part of satisfying their fiduciary duties). Given that the ultimate goal of the final regulations was to put plan fiduciaries in a better position to be able to assess the reasonableness of the fees/compensation being paid to the plan's service providers by having more information regarding such fees/compensation, it seems reasonable to require the relevant information to be provided in a manner that will not be extremely difficult to review.

Accordingly, the DOL has proposed that covered service providers who make their disclosures through multiple or "lengthy" documents must furnish a separate written "guide" to those documents. The DOL has requested comments on what number of pages would be considered "lengthy" for these purposes. A separate written guide would not be required under the proposed amendment to the extent the initial disclosures are provided in a single document that is not considered "lengthy."

If the guide is required, the proposed amendment requires that it must specifically identify the document and page number, or use some other "sufficiently specific locator" (e.g., a section reference), that enables the responsible plan fiduciary to quickly and easily find the required initial disclosures applicable to the contract or arrangement. The guide must also identify a person or office (including contact information) that the responsible plan fiduciary may contact regarding the disclosures. The guide must be furnished along with the required initial disclosures but must be set forth in a separate document. Changes to the information contained in the guide must be disclosed at least annually.

The DOL did not provide a "model guide" in the proposed amendment but did once again refer covered service providers to the "sample guide" (which was included as an appendix to the final regulations) as a helpful example.

The proposed amendment would become effective 12 months after publication of a final rule in the Federal Register, so it is intended that there will be some time to adjust to the new guide requirement if finalized.

The DOL has requested comments on all aspects of its proposal (e.g., the specific elements of the guide, as well as whether to even require a guide at all or some alternative tool, such as a summary of key disclosures), which are due June 10, 2014.

The DOL also announced its intention to conduct focus group sessions with fiduciaries to small pension plans (those with fewer than 100 participants) to explore current practices and effects of the final regulations and the need for a guide, summary or other similar tool to assist plan fiduciaries in navigating and understanding the required disclosures. The DOL noted that it would release the results to the public after the testing has been completed (which is expected to occur after the expiration of the comment period).

Items to Note

First, the proposed amendment expressly requires that the guide be provided as a "separate" document. Accordingly, unless revised or clarified, the proposed amendment would presumably prohibit a covered service provider from including the guide as an exhibit or attachment to another document (e.g., as an exhibit or attachment to a subscription agreement or an investment management agreement).

Second, it is not clear whether the guide requirement will only apply on a prospective basis (i.e., to contracts or arrangements entered into, renewed or extended after the effective date of the finalized amendment) or to existing arrangements as well. Accordingly, it is possible that a covered service provider would need to deliver a guide even in situations where it had already sent out 408(b)(2) disclosures in compliance with the final regulations. Further, even those covered service providers that have already delivered a form of guide might need to deliver a new one if the original delivery did not comply with the requirements of the proposed amendment (e.g., if the original guide was included as an exhibit or attachment to another document and was not provided as a separate document).

Practice Tip — Although it is not yet certain that a guide will be required (or what will be required to be set forth in any such guide), to the extent you are a service provider that is subject to the final regulations (or a plan hiring such a service provider), it might make sense to prepare and deliver a guide to the required initial disclosures similar to the "sample guide" included within the final regulations (or request that such a guide be prepared and delivered) with respect to any covered arrangements on a going forward basis or even with respect to existing covered arrangements. This might decrease the burden of compliance if and when these rules are finalized, and give service providers and plans some potentially helpful advance experiences in dealing with such guides.

Third, assuming the proposed amendment is finalized in its current form, a failure to deliver the guide in accordance with the requirements of the proposed amendment would be treated as a failure to comply with the requirements of the ERISA Section 408(b)(2) "necessary services exemption," potentially resulting in a non-exempt prohibited transaction if no other exemption is available.

Fourth, the proposed amendment does not change who is covered by the final regulations (i.e., to the extent a service provider is not a "covered service provider" under the final regulations, it would not be required to deliver a guide under the proposed amendment) — it merely provides for a potential new disclosure requirement for certain already covered service providers.

Apparently next up on the ERISA disclosure rules list: the potential requirement for 401(k)-type retirement plans to provide retirement income projections to plan participants on a periodic basis. Like we said, death, taxes and….

Rulings, Filings, and Settlements of Interest

District Court Concludes Statute of Limitations Defense Must Be Asserted During Administrative Claims Process

By Joseph Clark

> Plan administrators sometimes are confronted with claims that appear untimely, but nevertheless focus solely on the substantive issue raised by the claim. A recent ruling from a federal district court in New Jersey suggests that the failure to address procedural issues may result in a finding that such defenses have been waived. In *Becknell v. Severance Pay Plan of Johnson & Johnson*, 2014 U.S. Dist. LEXIS 54684 (D.N.J. Apr. 21, 2014), plaintiff Alan Becknell submitted a claim for severance benefits in 2012. The plan denied his claim on substantive grounds. The denial letter stated nothing about the timeliness of the claim notwithstanding the fact that it had been filed more than four years after Becknell's last date of employment and the plan provided that all claims for severance benefits must be filed within 180 days after a qualifying event (e.g., last date of employment). After Becknell filed suit, the plan moved to dismiss, arguing for the first time that the claim was untimely under the terms of the plan. Observing that "district courts should not rely on a plan administrator's *post hoc* rationales for denying claims when it failed to provide those reasons during the administrative hearing," the court determined that plan had waived its untimeliness defense and thus denied the plan's motion to dismiss.
>
> *Proskauer's Perspective: Plan fiduciaries charged with adjudicating administrative claims and appeals should consider whether it is appropriate to raise not only all substantive reasons for denying a claim and appeal, but also all procedural defenses.*

Eighth Circuit: ERISA Plan Beneficiary Designation Trumps Will

By Tulio Chirinos

> The Eighth Circuit held that the named beneficiary of an ERISA governed life insurance policy was entitled to the proceeds even though the decedent's will named a different beneficiary. *Hall v. Metro. Life Ins. Co.*, 2014 U.S. App. LEXIS 8652 (8th Cir. May 8, 2014). Dennis Hall, the decedent, obtained a life insurance policy issued by MetLife and named his son, Dennis Hall II, as the sole beneficiary. Hall subsequently married Jane Hall but never added her as a beneficiary of the life insurance plan. Although he completed and signed a beneficiary-designation form naming Jane as the sole beneficiary, he never submitted the form to MetLife. After being informed that he had little time to live, Hall executed a will stating that all life insurance and benefits should be distributed to Jane Marie Hall. Hall died shortly thereafter.
>
> Jane Hall filed a claim with MetLife for the life insurance benefits based on the terms of Dennis Hall's will. MetLife denied her claim and distributed the life insurance proceeds to Dennis Hall II as the sole beneficiary. The court determined that MetLife reasonably concluded that the will was inadequate to effect a change in beneficiary because the will only addressed life insurance proceeds that were the property of the estate and the estate was not a beneficiary of the life insurance policy. The court also found that the beneficiary-designation form that Hall signed but never submitted did not satisfy the plan's requirement because it was not submitted within 30 days of

being signed. In so ruling, the court rejected Jane Hall's argument that the 30-day requirement was not valid because it did not appear in the summary plan description. The court reasoned that an unambiguous provision in the plan document prevails over a silent SPD. The court also rejected Jane Hall's argument that the federal common law doctrine of substantial compliance effected a change of beneficiary.

Proskauer's Perspective: The Eighth Circuit's ruling is consistent with well-established principles including that valid ERISA plan beneficiary designation forms control the distribution of plan benefits; and the terms of the plan document are controlling.

Sixth Circuit: ERISA's Whistleblower Provision Doesn't Protect Giving Information

By Todd Mobley

> The Sixth Circuit (in a 2-1 decision) recently held that ERISA Section 510 does not protect unsolicited employee complaints. See *Sexton v. Panel Processing, Inc.*, 2014 U.S. App. LEXIS 8752 (6th Cir. May 9, 2014). Plaintiff Brian Sexton worked as a general manager for defendant Panel Processing and also served as a trustee for the company's employee retirement plan. In 2011, Sexton and others campaigned on behalf of two employees running for the company's board of directors. Although the two employees won the election, the board refused to seat them on the ground that the company's bylaws limit the number of inside directors. The board also removed Sexton as a trustee of the retirement plan. Sexton subsequently emailed the chairman of the board and complained that he believed that the refusal to seat the employees as directors of the company and removing him as a Trustee of the retirement plan violated ERISA and other laws. Sexton was fired about six months later and commenced this suit, alleging, among other things, violations of ERISA Section 510.

In relevant part, ERISA Section 510 provides that: "It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has *given information* or has testified or is about to testify *in any inquiry* or proceeding relating to [the Act]." 29 U.S.C. § 1140 (emphasis added).

The Court first observed that neither party claimed that Sexton sent the email in the context of a "proceeding" or that it constituted "testimony." As such, the only possibility was that Sexton had "given information . . . in any inquiry." While the Court agreed that Sexton had given information, it concluded that he had not done so in connection with an "inquiry"—regardless of whether inquiry meant something formal or merely an inquiry in the colloquial sense. In so ruling, the Court observed that Congress had enacted approximately four dozen anti-retaliation laws and that most of them include two distinct types of prohibitions: (i) the type that protects employees who report unlawful practices; and (ii) the type that protects employees who participate in inquiries, proceedings, or hearings. With respect to ERISA Section 510, Congress only included the latter and that must be given effect.

The majority decision also criticized the dissent's reliance on decisions from the Fifth, Seventh, and Ninth Circuits to argue that the circuits are split over whether the text of ERISA Section 510 is ambiguous as to protection of unsolicited internal complaints. After reviewing the language of those decisions, the majority found that none of them actually *held* that ERISA Section 510 contained such protections. To the extent there

was any dicta to that effect in the decisions, the majority found it unpersuasive because the decisions failed to evaluate ERISA Section 510 against the backdrop of other federal whistleblower laws.

Eighth Circuit: "Satisfactory to Us" Plan Language Sufficient to Entitle Plan Fiduciary to Deferential Review

By Jacklina Len

> The Eighth Circuit recently held that language in Prudential's disability policy requiring proof of disability that is "satisfactory to Prudential" was sufficient to grant the plan discretionary authority and entitled the plan to a deferential judicial review. *Prezioso v. Prudential Ins. Co. of Am.*, No. 13-1641, 2014 WL 1356862 (8th Cir. April 4, 2014) (unpublished). The day after plaintiff Michael Prezioso injured his back he was fired for failing to meet target sales. Prezioso sued Prudential for denying his claim for short and long term disability benefits. Prezioso argued that the district court erred in applying the abuse of discretion standard of review because Prudential's plan document did not include language conferring such discretion. The Eighth Circuit held that the language in the plan providing that Prudential had the right to request "proof of continuing disability, satisfactory to Prudential" was sufficient to review the plan's decision under an abuse of discretion standard. In so holding, the Court recognized that the circuits were divided on the issue concerning the language required to defer to the plan administrator's decision. Prezioso urged the Court to follow contrary decisions of other circuits, which have held that "satisfactory to us" language is insufficient to confer discretion. Those courts reasoned that such language was ambiguous and that ambiguities in an ERISA plan should be construed against the plan. The Eighth Circuit found the other circuits' reasoning "unpersuasive" and also determined that an earlier case from Eighth Circuit, which concluded that a plan requiring an employee to submit "written proof of continued total disability… satisfactory to [the plan administrator]" was sufficient to trigger abuse of discretion review, was controlling.
>
> Applying a deferential standard of review, the Court found that Prudential did not abuse its discretion in denying the Prezioso's claim. Prudential afforded Prezioso a "full and fair review": it considered "all comments, medical records, and other information submitted by Prezioso, did not afford deference to the initial claim denial, referred the appeal to a different decision-maker, consulted a neutral health care professional with appropriate training and experience in lower back disabilities, and obtained advice from a qualified vocational expert regarding the demands of Prezioso's 'regular occupation.'"
>
> *Proskauer's Perspective:* While "satisfactory to us" remains sufficient in some circuits to entitle plan fiduciaries to a more deferential standard of review by courts reviewing benefit denials, plan sponsors should consider reviewing their plan documents to determine whether their plan language can be bolstered to support deferential review in all circuits. Given ERISA's broad venue and nationwide service of process rules, plan fiduciaries could find themselves sued in jurisdictions other than where the plan is administered.

Court Approves USERRA Class Action Settlement Over Pension Contributions

By Joseph Clark

> A federal district court in Colorado recently approved a settlement agreement resolving class action claims brought under the Uniformed Services Employment and Reemployment Rights Act (USERRA). The documents filed in support of approval of the settlement stated that United Airlines agreed to pay $6.15 million to a class of pilots who alleged that United's method of calculating and making pension contributions for pilots on military leave violated USERRA. The complaint alleged that United violated USERRA by calculating pension contributions for pilots on military leave based on the minimum flight hours guaranteed pursuant to the pilots' collective bargaining agreement instead of on "the average rate of compensation or flight hours during the 12-month period immediately preceding the military leave." *Tuten v. United Airlines Inc.*, D. Colo. Case No. 1:12-cv-01561 (settlement approved May 19, 2014).

The Debate Continues Over The Fiduciary Status of 401(k) Plan Service Providers

By Robert Rachal

> In *Golden Star Inc. v. MassMutual Life Ins. Co.*, 2014 WL 2117511 (D. Mass. May 20, 2014), a district court addressed two issues that have become hotly contested in 401(k) plan fee litigation: (1) whether and when a plan provider's possession or exercise of discretion over fees confers fiduciary status; and (2) whether, to be a fiduciary with respect to plan investments, a plan provider must not only possess, but actually exercise discretion over the investment options offered by the plan.
>
> MassMutual offered plaintiff Golden Star (the plan sponsor and named fiduciary) recordkeeping and other services for its 401(K) plan. MassMutual defined the menu of investment options offered, and Golden Star selected the options to be offered in its plan from that menu. The mechanism for these investments was separate accounts owned by MassMutual as an insurer; MassMutual would pool the investments of several 401(K) plans investments into these separate accounts and then invest the accounts into mutual funds, or other selected investment options. The group annuity contract between Golden Star and MassMutual allowed MassMutual to assess management fees on the separate accounts of up to 1% of the market value.
>
> MassMutual also collected revenue sharing payments made by the mutual funds for the investments from the separate accounts placed in their funds. Mutual funds that made these payments generally charged higher fees to cover the payments. MassMutual claimed that the revenue sharing payments offset fees and payments it would have otherwise collected from Golden Star's plan for the management of the separate accounts, but Golden Star claimed there was no dollar-for-dollar offset.
>
> Regarding fiduciary status over setting fees, the district court found the record "impenetrable" on whether and how MassMutual charged fees on its separate accounts, and thus held there was a triable issue regarding whether MassMutual acted as a fiduciary in setting its own fees. The court distinguished between providers who negotiate compensation when the contract is first agreed to, versus a service provider who retains discretion in that contract to unilaterally adjust their compensation. The court stated that in the latter case, the control over compensation would make the service provider a fiduciary with respect to its compensation.

The court also determined that MassMutual was not a fiduciary with respect to fund selection because MassMutual never *exercised* its discretion to change the investment options offered by the plan. In support of that conclusion the court noted that the first prong used to determine fiduciary status provides that a party is a fiduciary "to the extent" it exercises discretionary authority or control over plan management, or exercises any authority or control over plan management. ERISA § 3(21)(A)(i).

The court noted that there was a substantial dispute over whether the reserved power to change plan investments makes a service provider a fiduciary under the "administration" prong of fiduciary status, which does not include "exercise," but simply states that a party is a fiduciary "to the extent" he or she "has" any discretionary authority or responsibility regarding plan administration. ERISA § 3(21)(A)(iii). The court thought it significant that subsection (iii) does not include management of plan assets, but noted there are cases that read the term "plan administration" broadly to include reserved powers over plan investments. The court concluded it did not need to decide this issue: since there was no evidence that MassMutual unilaterally substituted higher cost funds, the court held plaintiffs' claim failed the "to the extent" requirement, even if plan administration were construed broadly.

Proskauer's Perspective: *MassMutual* illustrates the current unsettled state of the law in this area, including how that law applies to various practices commonly followed by insurance providers to 401(k) plans. The U.S. Department of Labor ("DOL") is taking very aggressive positions in this area, including arguing in several cases that the ability to change plan investment options can make a provider a fiduciary, even if that power was never exercised. In negotiating and monitoring provider contracts, both providers and plan fiduciaries will thus want to carefully evaluate how provider compensation and fund selection is structured.

District Court Finds Fiduciaries Have No Duty to Investigate False Sale Allegations for ESOP Investment

By Jacklina Len

In *Malcolm v. Trilithic, Inc.*, 2014 WL 1324082, No. 1:13-cv-00073 (S.D. Ind. Mar. 31, 2014), the Southern District of Indiana held that plan fiduciaries were under no duty to investigate allegations that a false sale had been included in the company's records as a way of "puff[ing] up [its] receivables account and profitability" to present a better record to the company's lender bank. Plaintiff, the former CEO and board chairman of the company brought the suit, alleging several ERISA-based causes of action, including a claim for breach of fiduciary duty based on a theory that recording the false sale would put the Company in default of its lending agreement, such default would impact the continued viability of the company, which would put the company's stock price at risk, and also put the plan participants at risk of losing their benefits. With respect to plaintiff's fiduciary breach claims, the court cited the Seventh Circuit in finding that a "fiduciary's duty to investigate 'only arises when there is some reason to suspect that investing in company stock may be imprudent—that is, there must be something akin to a 'red flag' of misconduct.'" The court, however, allowed the action to proceed against two members of the board of directors who knew of but

failed to disclose potentially material information regarding the company's stock value.

Despite Windsor, Federal Court Rejects Challenge to a Self-Insured ERISA Health Plan's Denial of Coverage for Same-Sex Spouses

By Roberta Chevlowe and Joseph Clark

> Following the U.S. Supreme Court's decision in *US v. Windsor*, the requirement that an ERISA health plan provide health coverage for same-sex spouses has often hinged on whether an employee benefit plan was insured or self-insured and, in the case of insured plans, the requirements of state insurance law. In states where same-sex marriage is recognized, the state insurance and other laws generally require ERISA plans to provide coverage for same-sex spouses (if spousal coverage is offered under the plan). In the case of self-insured plans that aren't subject to state insurance law (because ERISA preempts the state insurance law), some have started to question whether federal law now requires self-insured health plans to provide coverage for same-sex spouses.
>
> A federal district court in the Southern District of New York found that a self-insured health plan that specifically excludes same sex couples does not run afoul of ERISA. *Roe v. Empire Blue Cross Blue Shield*, 2014 WL 1760343 (S.D.N.Y. May 1, 2014). The case involved an employee of St. Joseph's Medical Center in New York, who married a person of the same sex in 2011. Later that year, the employee sought to add her spouse as a dependent under St. Joseph's self-insured health plan. Inasmuch as the plan specifically excluded same-sex spouses and domestic partners from coverage, the employee's request to have her spouse covered under the plan was denied. The employee and spouse thereafter filed a putative class action against the employer and its third party administrator claiming that, after *Windsor*, ERISA requires a self-insured plan to provide coverage for same-sex couples. More specifically, plaintiffs claimed that the employer and third party administrator violated ERISA section 510, which generally prohibits interference with the attainment of employee benefits, and ERISA's fiduciary duty rules by enforcing an unlawful exclusion from coverage.
>
> The court first observed that ERISA gives employers broad discretion in writing the terms of welfare benefit plans and does not include an outright anti-discrimination provision. The court then determined that there could not be any violation of ERISA section 510 because there was no adverse employment action. It also rejected plaintiffs' argument that *Windsor* changed the legal landscape concerning the requirement to provide benefits to same sex spouse. In so ruling, the court considered the only other decision to have addressed the application of *Windsor* to ERISA-covered plans, *Cozen O'Connor P.C. v. Tobits*, 2013 WL 3878688 (E.D. Pa. Jul. 29, 2013) (holding that the provision of spousal benefits to a deceased's same-sex spouse in a plan that did not define "spouse" was required following *Windsor*) and found that it was distinguishable on the ground that the St. Joseph's plan specifically excluded same-sex spouses from coverage whereas *Cozen* dealt with a plan that did not define the term "spouse." In light of the foregoing, the court determined that there had been no fiduciary breach.
>
> *Proskauer's Perspective: Perhaps the St Joseph's and Cozen decisions will pave the way for future courts to provide clarity on this issue for self-insured health plans. New*

federal anti-discrimination legislation may also have an impact on this issue. Employers and other sponsors of self-insured health plans will want to keep their eyes on developments in this area.

Transgender Woman Seeks Coverage Under ACA

By Robert Rachal and Todd Mobley

> A transgender woman recently filed a complaint in the U.S. District Court for the Central District of Illinois against her primary care physician, as well as the not-for-profit health-care clinic with which her physician is affiliated, for alleged violation of the anti-discrimination provision of the Affordable Care Act (ACA). *Taylor v. Lystila*, No. 14-cv-2072 (C.D. Ill.). According to the complaint, plaintiff began self-administering hormones that she had purchased on the internet in early 2013. Thereafter, plaintiff's physician allegedly refused to monitor her hormone levels or provide any sort of long-term transition-related treatment. Plaintiff claims to have been told by the clinic that it was not obligated "to treat people like you."
>
> Plaintiff contends that the clinic and her physician fall under the purview of ACA § 1557(a), 42 U.S.C. § 18116(a), and the prohibitions against discrimination contained therein, because the clinic receives federal funds in the form of Medicare and Medicaid. Section 1557(a) mandates that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . ." Unlike other provisions of the ACA, section 1557(a) is not enforced through ERISA. Rather, violations are made enforceable through Title VI of the Civil Rights Act (prohibiting discrimination based on race or national origin in any program or activity receiving federal financial assistance), Title IX of the Education Amendments of 1972 (prohibiting discrimination based on sex in any federally-funded education program or activity), and the Age Discrimination Act (prohibiting discrimination based on age in any program or activity receiving federal financial assistance). Curiously, rather than citing any of the enforcement mechanisms set forth in section 1557(a), plaintiff stated that she brought the action under the Declaratory Judgment Act (which does not create an independent basis for jurisdiction).
>
> It remains to be seen how the defendants will frame their response and how the litigation will pan out. It will be interesting to see how plaintiff supports her basis for jurisdiction (should any challenges arise to this aspect of her case). Although this is not an ERISA case, it is one example of the ways in which plaintiffs are beginning to explore various aspects of the ACA.

New Guidance on COBRA and ACA Marketplace Coverage: The Gap in Coverage is (Not Quite) Filled

By Paul M. Hamburger and Damian A. Myers

> There has been much confusion and concern about the interplay between the COBRA continuation coverage rules and the new Health Insurance Marketplace established under the Affordable Care Act (the "Marketplace"). One important question has been how individuals could transition from COBRA continuation coverage to (often cheaper) Marketplace coverage. Also, many individuals are

confused about whether they should continue their available COBRA continuation coverage or separately opt for coverage through the Marketplace. To help clarify the rules, the government agencies have issued some important new guidance.

Background. COBRA continuation coverage is available to eligible individuals (qualified beneficiaries) who lose group health plan coverage due to certain qualifying events (such as job loss, divorce, employee death, and cessation of dependent child status). COBRA coverage is typically expensive (up to 102% of the full cost of group health plan coverage) and lasts for limited periods (*e.g.*, 18 months after a termination of employment and 36 months for other qualifying events). By contrast, qualified health plans available in the Marketplace are generally cheaper and continue for as long as an individual wishes to pay for coverage. A problem arises where someone elects COBRA coverage and continues that coverage outside of an annual open annual enrollment period for Marketplace coverage (the first of which ended on March 31, 2014).

The Problem. As explained in a Frequently Asked Question issued by the Centers for Medicare and Medicaid Services (CMS) dated April 21, 2014, once someone elects COBRA coverage, he or she cannot simply drop COBRA coverage and enroll in a qualified health plan through the Marketplace outside of an annual enrollment period. The person may voluntarily drop COBRA coverage, but will have to wait until the next annual open enrollment period (or an otherwise available special enrollment period) to take cheaper Marketplace coverage. Or, if the person wants continuous coverage, he or she must continue to pay for COBRA coverage until that next available enrollment period for the Marketplace.

The government agencies were concerned that this understanding of the interplay between COBRA coverage and Marketplace coverage was not widely understood and may have left people forced to pay for COBRA coverage when they might prefer to pay less for the Marketplace coverage.

The Solution. To solve that problem, two pieces of new guidance were issued.

First, on May 2, 2014, CMS issued a bulletin describing, among other things, Marketplace special enrollment periods for COBRA qualified beneficiaries. Citing concerns that individuals may not have understood these rules and may have inadvertently locked themselves into COBRA coverage, CMS established a limited special enrollment period, beginning on May 2, 2014 and ending on July 1, 2014, during which any individual currently receiving COBRA coverage benefits may voluntarily drop COBRA coverage and enroll in a qualified health plan through the Federal Marketplace (if the individual is otherwise eligible for coverage through the Federally-facilitated Marketplace).

Second, also on May 2, 2014, the U.S. Department of Labor ("DOL") released proposed regulations related to its model COBRA general notice and its model COBRA election notice. The proposed regulations explain that the model notices have been revised to reflect that the Marketplace is now open and to explain the Marketplace special enrollment rules in more detail. The revised notices are available at http://www.dol.gov/ebsa/cobra.html. Until final regulations are issued, use of the new model notices will be considered good faith compliance with the COBRA notice requirements.

Problem Solved? Not Exactly. The new guidance responds to the immediate confusion by providing affected individuals with a limited window, until July 1, 2014, to opt out of COBRA coverage and opt in to a qualified health plan through the Marketplace. One drawback to this relief is that the new special enrollment period is only directly applicable for the Federally-facilitated Marketplaces. CMS encouraged state-based exchanges to adopt similar opportunities; however, that decision is up to each state-based exchange.

Another limitation on this guidance is that it does not really solve the problem that these issues are still quite confusing for many COBRA qualified beneficiaries and could raise a serious problem for many people trying to choose between COBRA and Marketplace coverage. Here's why. When a COBRA qualifying event occurs, coverage could be lost either immediately or, in many cases, at the end of the month in which the event occurs. Notice of COBRA rights (which will now explain Marketplace rules) is not provided for weeks and, sometimes, a couple months after the qualifying event. At that point, there is a gap between the loss of coverage and someone's actual choice of COBRA or Marketplace coverage.

During that gap, individuals could incur significant claims. The hallmark of COBRA coverage is that it is retroactive to the date of the loss of coverage – it is designed to fill that gap. Marketplace coverage, by contrast, applies prospectively only. Therefore, individuals will be faced with a choice: (a) elect the more expensive COBRA coverage retroactively to make sure claims are paid but then be forced to continue that coverage until the next annual enrollment period (or a special enrollment period if earlier); or (b) take the cheaper Marketplace coverage but suffer the gap in coverage and be forced to pay for the claims incurred without coverage. That conundrum is not explained in the new model COBRA notices. Perhaps future guidance will solve this problem by simply allowing individuals the choice to opt out of COBRA coverage and into Marketplace coverage on more frequent intervals.

Plan sponsors and administrators should review this new guidance closely and consider how to modify the model notices to address their specific factual situations.

Reminder: ACA's Out-of-Pocket Limits Differ from HSA-Qualified HDHPs Starting in 2015

By Paul M. Hamburger and Stacy Barrow

> In April, the IRS released the 2015 inflation adjustments for Health Savings Accounts (HSA) and HSA-qualified high deductible health plans (HDHPs). A month earlier, HHS released details on the "premium adjustment percentage," which is used to calculate annual increases in cost sharing under the Affordable Care Act's (ACA) maximum out-of-pocket rules. These ACA rules limit participant cost-sharing under non-grandfathered group health plans for covered, in-network essential health benefits.

For plan years beginning in 2014, the ACA's maximum out-of-pocket limits were tied to the out-of-pocket limits established for HDHPs. That caused some to assume that the ACA maximum out-of-pocket limits and the HDHP limit would always be the same. But they aren't. Under the ACA, HHS is required to use a different methodology for calculating any annual adjustments than the IRS uses for HDHPs. Therefore, starting in 2015, the two limits will begin to differ as shown in the first table

below. The second table contains other inflation adjustments for HSAs and HDHPs. In both tables, figures are shown single/family.

	2015	2014
ACA Out-of-Pocket Limits	$6,600 / $13,200	$6,350 / $12,700
IRS Out-of-Pocket Limits for HDHPs	$6,450 / $12,900	$6,350 / $12,700
Other HSA-Related Provisions	**2015**	**2014**
Annual HSA Contribution Limit	$3,350 / $6,650	$3,300 / $6,550
Minimum Annual HDHP Deductible	$1,300 / $2,600	$1,250 / $2,500

This means that in addition to the HDHP limits being lower than the ACA limits in 2015, expenses will accumulate toward the HDHP limit more quickly because the HDHP limits apply to all covered in-network benefits, not just essential health benefits. Note that under both the ACA and IRS rules, cost-sharing includes deductibles, coinsurance and copayments, and excludes premiums.

One final point – the "premium adjustment percentage" also applies to the employer "pay-or-play" mandate penalties. That could increase the $2,000 "no coverage" penalty to $2,080 and the $3,000 "unaffordable coverage" penalty to $3,120 starting in 2015; however, the IRS has not officially confirmed these numbers at this time.

Employers should keep an eye out for future adjustments and be sure to review their plan documents and communications materials to make sure the appropriate limits are reflected.

What Does PPACA Stand For? Punitive Penalties Are Clearly Authorized

By Paul M. Hamburger

> A recently posted IRS Q&A raises the specter of serious penalties for non-compliance with the Affordable Care Act. The context of the question relates to the consequences to employers that do not establish a health insurance plan for their own employees, but instead reimburse them for premiums they pay for other health insurance. The IRS relied on its earlier guidance, Notice 2013-54 (See our prior blog entry), and pointed out that these premium reimbursement arrangements (known as "employer payment plans") raise significant compliance issues under the ACA.
>
> The IRS indicated that after-tax reimbursement arrangements, whereby an employer pays taxable money to employees that they can use for health coverage or any other purpose, are not a problem. However, tax-free reimbursement arrangements could

be a problem for the IRS. As if to emphasize the seriousness of this issue, the IRS warned that any arrangement that does not comply with its rules (which are only articulated in Notice 2013-54) could subject an employer to a non-deductible excise tax of $100 per day per employee; or $36,500 per employee per year. The penalties are reportable on IRS Form 8928, which has been updated for ACA penalties.

Interestingly, in other compliance areas, the federal agencies have repeatedly indicated that they are not seeking to penalize employers as they try to come into compliance with the new rules; rather they are trying to encourage compliance. The statement in this new Q&A might signal a shift in attitude, at least on this one issue.

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

This publication is a service to our clients and friends. It is designed only to give general information on the developments actually covered. It is not intended to be a comprehensive summary of recent developments in the law, treat exhaustively the subjects covered, provide legal advice, or render a legal opinion.

Beijing | Boca Raton | Boston | Chicago | Hong Kong | London | Los Angeles | New Orleans | New York | Newark | Paris São Paulo | Washington, DC

www.proskauer.com

© 2014 PROSKAUER ROSE LLP. All Rights Reserved. Attorney Advertising.