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The ERISA Litigation Newsletter

July 2014

Editor's Overview

The end of the U.S. Supreme Court's term brought two significant ERISA decisions. The first concerns the standard of review that courts apply when evaluating ERISA stock-drop claims. As discussed below, the Supreme Court concluded that the "presumption of prudence," which had been adopted by every circuit court to consider it over the past twenty years, could not be supported by the text of ERISA. The second opinion held that the federal government overstepped its bounds by requiring faith-based private, for profit employers to pay for certain forms of birth control when that coverage contradicted the employers' professed religious beliefs. The decision's implications are explained below.

Also on the topic of health care, we provide an article that discusses developing issues and litigation arising under the Federal Mental Health Parity Act and Affordable Care Act. Last, we round out the month with an article on structuring equity compensation arrangements for publicly traded companies.

As usual, we provide an overview of a number of interesting decisions and regulatory items over the past month, including items concerning claims for fiduciary breach and equitable relief, an IRS Revenue Ruling on the applicability of Section 457A to stock options and stock appreciation rights, final ACA regulations on orientation periods, and the U.S. Department of Labor's proposal to change the FMLA definition of spouse to accommodate same-sex marriages.

Fifth Third Bancorp v. Dudenhoeffer – An Analysis of the U.S. Supreme Court's Decision

By Myron Rumeld and Russell Hirschhorn

For over two decades, federal courts have embraced the so-called Moench presumption of prudence in ERISA stock-drop cases. Pursuant to that presumption, courts have routinely dismissed such claims absent allegations in a complaint that a company's situation was dire, or that the company was on the brink of collapse. On June 25,2014, the U.S. Supreme Court issued its decision in the highly anticipated case, Fifth Third Bancorp v. Dudenhoeffer, wherein it concluded by unanimous decision that the presumption of prudence could not be supported by the text of ERISA. As discussed below, that may be at most only mixed victory for the plaintiffs' bar.

Factual Background

Participants in Fifth Third Bancorp's (Fifth Third's) defined contribution retirement plan (Plan) brought a putative class action against the Plan's fiduciary committee, among others, alleging that defendants breached their fiduciary duties in violation of ERISA.

Under the Plan, participants made contributions into an individual account and directed the Plan to invest those contributions in a menu of options pre-selected by Fifth Third. Of the twenty options available to participants during the relevant period, one was the Fifth Third stock fund, which had been designated an employee stock ownership plan (ESOP). Fifth Third matched the first 4% of a participant's contributions with company stock, after which participants could move such contributions to any other investment option.

Plaintiffs' complaint alleged that Fifth Third shifted from a conservative to a subprime lender and, consequently, Fifth Third's loan portfolio became increasingly exposed to defaults. It further alleged that Fifth Third either failed to disclose the resulting damage to the company and its stock or provided misleading disclosures. During the relevant period, Fifth Third's stock price declined 74%, resulting in the ESOP losing tens of millions of dollars.

Plaintiffs commenced a putative class action lawsuit, alleging, among other things, that defendants breached their fiduciary duties under ERISA by: (i) imprudently maintaining significant investment in Fifth Third stock and continuing to offer it as an authorized investment option; and (ii) by failing to provide Plan participants with accurate and complete information about Fifth Third and the risks of investment in Fifth Third stock.

The District Court's Decision

The district court granted defendants' motion to dismiss. *Dudenhoeffer v. Fifth Third Bancorp*, 757 F. Supp. 2d 753 (S.D. Ohio 2010). In so ruling, the district court first held that the determination as to whether the Fifth Third stock fund was an ESOP is a question of law appropriate for consideration on a motion to dismiss and concluded that it was, in fact, an ESOP. Second, the district court held that applying the *Moench* presumption is appropriate on a motion to dismiss, reasoning that a fiduciary breach claim involving an ESOP is plausible only if plaintiffs pled facts sufficient to overcome the presumption. Third, the district court found that plaintiffs' complaint failed to allege sufficient facts to overcome the presumption of prudence. As to the last point, the district court observed that Fifth Third's viability was never in serious doubt, and other large institutional investors actually increased their holdings in Fifth Third stock during the relevant period.

The district court also rejected plaintiffs' disclosure claims, finding that defendants' incorporation of securities filings (which allegedly contained misstatements and/or omissions regarding Fifth Third's financial condition) into the Plan's summary plan description were not made in a fiduciary capacity.

The Sixth Circuit's Opinion

The Sixth Circuit reversed. *Dudenhoefer v. Fifth Third Bancorp*, 692 F.3d 410 (6th Cir. 2012). It concluded that a fiduciary's decision to invest in employer securities enjoys a presumption of prudence, but a plaintiff can rebut that presumption by showing that a prudent fiduciary acting under similar circumstances would have made a different investment decision. It further concluded that the presumption is not an additional pleading requirement and consequently does not apply at the motion to dismiss stage. In so ruling, the Sixth Circuit stated that its precedent (unlike in other circuits) had not established a specific rebuttal standard. Rather, the Sixth Circuit's standard imposes upon a plaintiff the burden to prove, through a fully developed evidentiary record, that a prudent fiduciary facing similar circumstances would have acted differently. Accordingly, to survive a motion to dismiss, plaintiffs' complaint only need allege facts sufficient to show that a fiduciary committed a breach that caused the loss. The Sixth Circuit found that plaintiffs had adequately pled: (a) a breach—Fifth Third engaged in subprime lending, Defendants were aware of the risks caused by such lending, and that such risks made investment in Fifth Third stock imprudent; (b) harm—the stock's value dropped 74%; and (c) causation—an investigation would have led a reasonable fiduciary to make different investment decisions.

The Sixth Circuit also concluded that Fifth Third's incorporation of the securities filings into the SPD constituted a fiduciary act. The court reasoned that the SPD is a fiduciary communication required by ERISA and selecting the information to convey through the SPD is a fiduciary activity, regardless of whether the information is explicit or incorporated by reference.

Fifth Third's Petition for Certiorari

The Supreme Court granted Fifth Third's petition for certiorari to consider whether the Sixth Circuit erred by holding that plaintiffs were not required to plausibly allege in their complaint that ESOP fiduciaries abused their discretion by remaining invested in employer stock in order to rebut the presumption of prudence.

The Supreme Court, however, declined to address the disclosure claim, *i.e.*, whether the Sixth Circuit erred by holding that securities filings become actionable ERISA fiduciary communications when they are incorporated by reference into plan documents.

The Supreme Court's Decision

The Supreme Court held that there was nothing in ERISA that supported the imposition of a presumption of prudence for ESOPs, and that, with the exception of ERISA's diversification requirement, the same standard of prudence applies to ESOPs as to all other ERISA plans. In so ruling, the Court focused on ERISA's provision that an ESOP fiduciary is exempt from the diversification requirement and also from the duty of prudence, but "*only to the extent that it requires diversification.*" 29 U.S.C. § 1104(a)(2) (emphasis added).

The Court rejected several arguments advanced by Fifth Third in favor of adopting the presumption of prudence. Among them were the arguments that: (i) ERISA's duty to act prudently is in relation to "an enterprise of like character and like aims," and thus should be adjusted here to take into account the aims of ESOPs; and (ii) Congress had stated it was "deeply concerned" that its goals of encouraging employee stock ownership could be rendered unattainable by rulings treating ESOPs as conventional retirement plans. The Court concluded that the responsibilities of an ESOP fiduciary must be directed toward the duty to provide benefits and defray expenses, and thus any non-pecuniary interests, such as Congress' strong encouragement of employee stock ownership, did not warrant an alteration of the fiduciary standard.

The Court also concluded that: (i) plan sponsors cannot reduce or waive the prudent man standard of care by requiring investment in the company stock fund; (ii) the presumption "is an ill-fitting means" to protect ESOP fiduciaries from conflicts with the legal prohibition on insider trading; and (iii) the presumption was not an appropriate way to weed out meritless lawsuits.

The Court ultimately determined that the weeding out of meritless claims can be better accomplished through careful scrutiny of a complaint's allegations, and instructed the Sixth Circuit on remand to apply the pleading standard set forth in *Twombly* and *Iqbal*. In conducting that evaluation, the Court stated that allegations that a fiduciary should have recognized from *publicly available information* that the market improperly valued the stock are "implausible as a general rule, at least in the absence of special circumstances" that would make reliance on the market's valuation imprudent.

To state a claim for breach of the duty of prudence on the basis of *inside information*, the Court stated that "a plaintiff must plausibly allege an alternative action that the defendant could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it." The Court noted three points for the lower courts consider in this regard. First, the duty of prudence does not require a fiduciary to break the law. Second, courts should consider whether a plan fiduciary's decision to purchase (or refrain from purchasing) additional stock or for failing to disclose information to the public could conflict with the federal securities laws or with the objectives of those laws. Third, courts should consider whether a prudent fiduciary could not have concluded that stopping purchases or publicly disclosing negative information would do more harm than good to the stock fund.

View from Proskauer

Although the presumption of prudence in ERISA stock drop cases is no more, the Court has nevertheless imposed considerable burdens on plaintiffs. In the absence of insider information, it would appear that the opportunity to assert a viable claim will be limited, given the Court's requirement that the plaintiffs plead "special circumstances" that would support the conclusion that the price does not reflect the value of the stock.

The Court has also set forth substantial pleading requirements even in the case of claims based on nonpublic information, including that there was an alternative course of conduct (such as refraining from purchasing or providing information) that would have left the plan better off, and that was not inconsistent with the securities laws. It remains to be seen whether district courts will be prepared to evaluate allegations and theories proffered to sustain this burden at the motion to dismiss stage, but the Supreme Court has certainly suggested that they endeavor to do so.

Hobby Lobby: The Supreme Court's View and Its Impact

By Peter Marathas, Robert Rachal and Stacy Barrow

For the second time in two years the United States Supreme Court (the "Court") has ruled against the Obama Administration with respect to elements of the Affordable Care Act (the "ACA"). In a 5-4 decision announced today in *Burwell v. Hobby Lobby Stores, Inc.* ("*Hobby Lobby*") (f/k/a *Sebelius v. Hobby Lobby Stores, Inc.),* the Court ruled that the federal government, acting through Health and Human Services ("HHS"), overstepped its bounds by requiring faith-based private, for-profit employers to pay for certain forms of birth control that those employers argued contradicted their religious beliefs, in violation of the Religious Freedom Restoration Act of 1993 ("RFRA").

In *Hobby Lobby*, the Court found that for-profit employers are "persons" for purposes of the RFRA. The Court, assuming that the government could show a compelling interest in its desire to provide women with access to birth control, ultimately held that the government could have met this interest in a less burdensome way.

Background

Among its many insurance mandates, the ACA requires non-grandfathered health insurance plans to cover "preventive services" at no cost to participants.

As part of its implementation of the ACA, HHS added 20 contraceptives that were required to be included as preventive services, including four that may have the effect of preventing a fertilized egg from developing.

Hobby Lobby argued that requiring the company to pay for or provide pills and procedures that they believe terminate life—so-called abortifacients—intrudes on their religious beliefs. Hobby Lobby sued HHS, asserting that requiring them to pay for or provide abortifacients violated their First Amendment rights to freedom of religion and also violated the RFRA.

The RFRA provides that the federal government "shall not substantially burden a person's exercise of religion" unless that burden is the least restrictive means to further a compelling governmental interest. The Administration argued, however, that neither Hobby Lobby nor Conestoga or any other for-profit, faith-based employer was a *person* for purposes of the RFRA or the First Amendment.

The Decision

Writing for the majority, Justice Samuel Alito held that private—as opposed to publicly traded—employers could be considered "persons" for the RFRA. The Court noted that the law imposed a substantial burden on religious beliefs, requiring the owners of Hobby Lobby to engage in conduct that "seriously violates their sincere religious beliefs."

The Court noted that for the government to prevail it needed to demonstrate a compelling state interest and that its application was the least restrictive means to achieve its goals. The Court assumed (with Justice Kennedy providing the swing vote in his concurrence) that the government does, in fact, have a compelling interest to, among other things, promote "public health" and "gender equality" by providing contraceptive coverage for women. However, the Court found that even assuming a compelling interest there were less restrictive alternatives for the government. The government could, the four-person majority noted, simply provide these benefits to all, without charge to the individuals; in his concurrence, Justice Kennedy questioned this, and noted the Court's opinion does not decide this issue. But Kennedy and the four-person majority agreed the government could extend the accommodation it made religiously affiliated employers: they do not have to provide the benefit but their insurers or third-party administrators would without charge to either the employers or the employees.

Because there are less restrictive alternatives, the Court found that HHS had violated the RFRA as applied to these faith-based, for profit, private employers.

The Impact

The *Hobby Lobby* ruling has a direct impact on a relatively small number of employers—as a percentage of total employers across the country there are very few that can be considered faith-based employers.

However, the ruling is significant in that it signals an ongoing willingness by the Court to exercise its checks-and-balances power. The Court indicated it may not provide the Administration much leeway in its implementation of the ACA, when implementation impacts and is limited by other federal rights.

The ruling may also be significant for certain religious-affiliated non-profit employers who are operating under the accommodation discussed above. By identifying the accommodation as a less restrictive alternative, the Court may be signaling it believes that the exception HHS provided them suffices to meet any concerns they may have. The Court, however, noted it was not deciding this issue, and the "government-pay" approach tendered by four justices may provide a possible opening for relief for the religious-affiliated non-profit employers.

Finally, the *Hobby Lobby* decision should stand as a reminder that while there may be differences of opinion about specific rules and requirements under the ACA, and some of those differences may be decided against the government, the law itself is not going away. Employers need to continue to monitor new developments and implement strategies for complying with the ACA.

Developing Issues and Litigation Arising Under the Federal Mental Health Parity Act and the Affordable Care Act*

By Robert Rachal and M. Todd Mobley

The Employee Retirement Income Security Act of 1974 ("ERISA") historically distinguished between pension plans (*see* 29 U.S.C. § 1002(2)(A)(i)-(ii)) and welfare plans (*see* 29 U.S.C. § 1002(1)). Pension plans have long been subject to substantive statutory and regulatory requirements, which has resulted in substantial litigation on many of those technical requirements; for example, whether changes in benefits "cut back" "accrued benefits" in violation of ERISA § 204(g), 29 U.S.C. § 1054(g). Welfare plans, however, generally have not been subject to much substantive regulation. Historically, welfare plan litigation has been driven by the terms of the plans, procedural issues related to administrative exhaustion of claims for benefits, and court review of those benefit decisions, as opposed to the interaction between those plans and statutory requirements.[1]

Health care reform, however—and, particularly, the Patient Protection and Affordable Care Act ("ACA")—may be shifting the paradigm. As more of the ACA's statutory requirements are rolled out and imposed on welfare plans, we expect the nature of litigation concerning welfare plans to expand. In fact, this is already starting to happen regarding substantive requirements imposed on welfare benefits by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Federal Parity Act").

The Federal Parity Act

The Federal Parity Act, which amended ERISA, the Public Health Service Act, and the Internal Revenue Code, was enacted to provide greater parity between mental health and substance-use-disorder benefits (collectively, "Mental Health Benefits") on the one hand, and medical and surgical benefits (collectively, "Medical Benefits"), on the other hand. *See*, *e.g.*, *Coalition for Parity v. Sebelius*, 709 F. Supp. 2d 10, 12-13 (D.D.C. 2010). The Federal Parity Act applies to group health plans sponsored by private- and public-sector employers and the health-insurance issuers selling coverage in connection with group health plans. The Federal Parity Act does not by its terms require plans or issuers to cover Mental Health Benefits; instead, compliance is required only when a plan or issuer chooses to provide such benefits. However, state insurance law may require such coverage, and the vast majority of employer-provided plans cover Mental Health Benefits.[2]

To achieve its goal, the Federal Parity Act mandates that financial requirements (*e.g.*, copayments, coinsurance, or deductibles) and treatment limitations (*e.g.*, limitations on the frequency of treatment, number of out-patient visits, or amount of days covered for in-patient stays) applicable to Mental Health Benefits generally can be no more restrictive than the requirements and limitations applied to substantially all of the Medical Benefits within a given classification.[3] The Federal Parity Act also prohibits financial requirements or treatment limitations that are applicable only to Mental Health Benefits.

The Federal Parity Act also requires parity with regard to non-quantitative treatment limitations ("NQTLs"), which are non-numerically-expressed restrictions that affect the scope or duration of benefits under a group health plan.[4] Importantly, NQTLs are not limited to the terms of a plan; rather, NQTLs also involve the ways in which a plan operates. Under the Federal Parity Act, any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to Mental Health Benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Medical Benefits (the "NQTL Requirements").

Regulatory Guidance

The Departments of Labor, Treasury, and Health and Human Services (collectively, the "Departments") jointly issued on February 2, 2010 interim final regulations that control the rules applicable to health plans until July 1, 2014. The Departments have now issued final regulations (effective after July 1st for calendar year plans after January 1, 2015), which have expanded the scope of the parity obligation, and is leading to litigation.

The interim final regulations contained an exception to the NQTL Requirements, which provided that "recognized clinically appropriate standards of care" may permit differences between NQTLs applied to Mental Health Benefits and NQTLs applied to Medical Benefits. *See* 75 FR 5410, 5416 (Feb. 2, 2010). After determining that this exception was "confusing, unnecessary, and subject to potential abuse," the Departments removed it from the final regulations (*see* 78 FR 68240, 68245 (Nov. 13, 2013)). *Id.* at 68240. The final regulations recognize, however, that using clinically appropriate standards of care can result in disparate results, as long as the evidentiary standards applied to the Mental Health Benefits are comparable to, and not applied more stringently than, those used for Medical Benefits. *Id.* at 68245.

The final regulations also changed the rules on the "scope of services"/"continuum of care" issue, which relates to whether and how the parity rules apply to coverage for intermediate services, such as residential treatment, partial hospitalization, and intensive-outpatient treatment. *Cf. Brazil v OPM*, 2014 U.S. Dist. LEXIS 44856, at *34 (N.D. Cal.. Mar. 28, 2014) (noting residential-treatment requirement in the final regulations did not apply to treatment in 2011). Despite the Departments' recognition that not all treatment or treatment settings for Mental Health Benefits correspond to those for Medical Benefits, they did not resolve this "scope of services" issue in the interim final regulations. *See* 75 FR 5410, 5416 (Feb. 2, 2010). Instead, the Departments asked for comments on whether the NQTL Requirements needed to address specifically this or other NQTL-related issues, such as prior authorizations and concurrent review, service coding, and provider-network criteria.[5] Ultimately, the Departments did address these issues in the final regulations, which require that plans and issuers provide intermediate services, such as residential treatment, under the same conditions applied to Medical Benefits. *See* 78 FR 68240, 68246-47 (Nov. 13, 2013) & 2590.712(c)(4)(ii)(H) & Ex. 9.

Litigation Involving State and Federal Parity Acts

The final Federal Parity Act regulations appear to be leading to a rise in litigation. Several lawsuits also have been brought under state parity laws (ERISA does *not* preempt state insurance laws that provide the same or more benefits than federal law),[6] and these cases offer a preview of issues that may arise in Federal Parity Act litigation.

State Parity Act Litigation

While most state litigation has related to parity issues revolving around whether plans provided comparable Mental Health Benefits, at least one case enforced state requirements that, per the court, go beyond parity to enforce minimum benefit mandates. In *Harlick v. Blue Shield of California*, plaintiff had a covered condition (anorexia nervosa) under California's parity act, which required insurers to provide coverage for "medically necessary treatment of [certain specified] severe mental illnesses." 686 F.3d 699, 710-11 (9th Cir. 2012). The Ninth Circuit held that this means a plan must cover *all* forms of health-care treatment found medically necessary for the mental illness regardless of whether the benefit is provided for Medical Benefits. Thus, the plan had to pay for nine months of residential care for the plaintiff, despite the plan language specifically excluding coverage for residential treatment.

Several cases address Washington's mental health parity act, which has been implemented in phases, with the final phase including a parity requirement. For example, in *Z.D. v. Group Health Coop.*, the court found that an insurer's policy of denying coverage for medically necessary neurodevelopmental therapy for those over the age of six was a violation of Washington's parity act, since the insurer did not impose those age-based limits on its coverage of physical therapy. 2012 U.S. Dist. LEXIS 76503 (June 1, 2012). In a subsequent decision, the court held that the insurer could enforce a sixty-visit yearly cap on outpatient visits for neurodevelopmental therapy for treatment of a mental illness, since the same limitations are imposed on therapies provided for physical injury or illness. 2013 U.S. Dist. LEXIS 50402 (W.D. Wash. Apr. 8, 2013).

In *K.M. v. Regence BlueShield*,the insurer excluded neurodevelopmental services for anyone over six years of age. 2014 U.S. Dist. LEXIS 27685 (W.D. Wash. Feb. 27, 2014). Although the insurer argued it applied this age-based exclusion to both physical and mental conditions, the court found this blanket exclusion to be a coverage exclusion (not just a treatment limitation) that likely violated the act. The court seemed to be implicitly accepting plaintiff's argument that the Washington state act went beyond parity to impose coverage mandates. In any event, because the loss of this coverage could cause irreparable harm, the court granted a preliminary injunction and certified a class of plans seeking to bar enforcement of the age limit by the insurer.

Federal Parity Act Litigation

Plaintiffs have brought two class action system-wide lawsuits against UnitedHealth. In *New York State Psychiatric Ass'n v. UnitedHealth Group*, a group of participants, providers with assignments, and the New York State Psychiatric Association sued UnitedHealth in its capacity as claims administrator for a class of plans. 2013 U.S. Dist. LEXIS 158438 (S.D.N.Y. Oct. 31, 2013). The lawsuit alleged that various claims-practices by UnitedHealth violated the Federal Parity Act and the ACA, including by allegedly: (i) implementing more restrictive prospective and concurrent review of claims for mental health benefits in violation of the Federal Parity Act; and (ii) failing to provide continuing coverage during claims appeal and external review of the claims in violation of the ACA. The court stated that, if proven, the claims demonstrated violations of the acts, but held UnitedHealth was not a proper defendant. The court noted that the Federal Parity Act and the ACA apply to "group health plans" and "health insurance issuers." Because UnitedHealth was neither the insurer nor the plan administrator (it was the claims administrator), the court held it was not a party to which the acts applied. The decision is currently on appeal to the Second Circuit.

More recently, in *Wit v. UnitedHealthcare Ins. Co.*, No. 14-cv-2346 (N.D. Cal.), *complaint filed* May 21, 2014, plaintiffs commenced a putative class action against UnitedHealth for allegedly violating the Federal Parity Act by, for example, denying coverage for residential treatment by using more restrictive standards that fail to take into account the effectiveness of the treatment. UnitedHealth was sued both as claims administrator for self-insured plans, and as insurers for fully-insured plans.

Federal Parity Act claims are also being brought against employers and their plans. In *C.M. v. Fletcher Allen Health Care, Inc.*, the medical plan was administered by the employer, Fletcher Allen. 2013 U.S. Dist. LEXIS 120469 (D. Vt. Apr. 30, 2013). Plaintiff alleged that Fletcher Allen violated the Federal Parity Act by conducting both prospective and concurrent medical-necessity reviews for certain mental-health office visits, and by limiting the number of outpatient visits a participant may schedule without the need to first obtain pre-approval—both of which were limitations allegedly not applied to Medical Benefits.

Fletcher Allen argued that, to survive a motion to dismiss, plaintiff had to show that the plan's terms create disparities between Mental Health Benefits and Medical Benefits. The court disagreed. First, the court noted that engaging in an analysis of the plan's terms to determine whether they do or do not create disparities is more appropriate for summary judgment. Second, the court explained that plaintiff's claims were not necessarily tied to the plan's terms—plaintiffs also alleged that Fletcher Allen violated the NQTL Requirements, which include the ways in which a plan operates. With regard to NQTLs, the court found that it was defendant's burden to prove that clinical or other appropriate standards justify any alleged differences between the ways in which Mental Health Benefits and Medical Benefits are covered.

Boeing and Microsoft have also recently been sued under the Federal Parity Act. On March 11, 2014, a complaint was filed in *S.S. v. Microsoft Corp. Welfare Plan*, No. 14-cv-351 (W.D. Wash.), alleging that Microsoft violated the Federal Parity Act by excluding coverage for psychiatric treatment in residential centers, even when such treatment is medically necessary. According to plaintiffs, this exclusion is not "at parity" with Microsoft's coverage of Medical Benefits. Microsoft has moved to dismiss, arguing, *inter alia*, that plaintiff's allegations rest on guidance and obligations imposed in the final regulations, which do not become applicable until July 1, 2014.

In *C.S. v. Boeing Company Master Welfare Plan*, No. 14-cv-574 (W.D. Wash.), *complaint filed* April 17, 2014, plaintiffs commenced a putative class action against Boeing for allegedly applying an NQTL to Applied Behavior Analysis ("ABA") therapy for certain participants and beneficiaries diagnosed with Autism Spectrum Disorders ("ASD"). According to plaintiffs, the alleged limitation is effectuated by Boeing's failure to provide access to licensed entities offering ABA therapy in the State of Washington, which results in a "*de facto* exclusion of services that are otherwise covered under the terms of the Boeing Plan." The parties have stipulated to an extension of time for Boeing to respond to the complaint until July 17, 2014.

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View From Proskauer

There is an advocacy infrastructure aggressively pursuing claims under the state and federal mental health parity acts, with several of the plaintiffs' counsel appearing in multiple lawsuits. Medical providers also may use these acts to seek to enforce expansion of coverages. These parity act lawsuits will bear close watching, both for their effect on obligations imposed by the various parity acts, and as possible roadmaps for future litigation seeking to enforce the broader range of benefit obligations imposed by the ACA. Indeed, as the *New York State Psychiatric Association* lawsuit illustrates, some linkage between the acts and claims is already occurring.

Structuring Equity Compensation for Publicly Traded Partnerships*

By Colleen M. Hart

Overview

There are many reasons why a publicly traded partnership may want to change its equity compensation structure in connection with an initial public offering. Most private partnerships provide equity compensation to their top executives in a manner that is significantly different than private corporations. In particular, partnerships often award key service providers with profits interests that have the potential to result in capital gains treatment. After an IPO, the favorable tax treatment afforded to profits interests is not applicable to a publicly traded partnership.[7] Many private partnerships may also limit grants of equity to high level executives. Following an offering, a publicly traded partnership may desire a more flexible omnibus equity compensation program that allows the partnership achieve a variety of business goals, including granting awards to a broader class of employees.

A publicly traded partnership's incentive plan goals may include attracting and retaining employees and other service providers in competitive markets, incentivizing these individuals to contribute to the growth of the publicly traded partnership and aligning the interests of these individuals with the publicly traded partnership's partners. An omnibus equity compensation program that provides for the grant of a variety of equity awards based on the publicly traded partnership's units can achieve these goals and allow participants to benefit from the marketability of any units received.

While one's initial instinct may be to replace "corporation" with "partnership" in a standard omnibus equity plan, there are a number of issues specific to publicly traded partnerships. If a publicly traded partnership intends to implement an omnibus equity compensation program, the partnership should consider the special issues that may arise due to the entity's status as a partnership, including unique tax, securities, corporate governance and other issues.

Types of awards

Many equity compensation plans are structured to permit the grant of a variety of equity compensation awards. Publicly traded partnerships may grant equity awards that are similar to the types of awards granted by public corporations, though the awards may be based on partnership units and not stock. Publicly traded partnerships may consider granting the following types of equity-based awards:

- Options to purchase units with a fixed exercise price, typically based on the fair market value of a unit on the date of grant;
- Restricted units – awards of actual units, subject to forfeiture and/or restrictions on transfer;
- Deferred units – phantom awards that are settled in units, typically upon vesting of the award;
- Cash-settled phantom units – phantom awards that are settled in cash, typically in an amount based on the value of the reference unit or the appreciation in the value of the reference unit above a certain value (typically the value on the grant date); and
- Other unit-based awards as would suit the needs of the partnership, such as units that pay distribution equivalents or phantom units that only settle upon retirement.

Tax Considerations

The tax implications of the equity plan should be considered at both the individual and entity level. Items that otherwise could be taken for granted in stock-based equity plans, such as Section 162(m) and Section 409A of the Internal Revenue Code (the "Code"), require a different perspective in the analysis. In addition, in determining which type of awards to grant, the partnership should consider that employees who receive partnership units will become limited partners and receive K-1s at the end of each year.

- Section 162(m). Section 162(m) provides for a $1 million annual limitation on the deductibility of certain remuneration paid to covered employees of any publiclyheld corporation. The applicable Code section and regulations refers to a "publicly held corporation." The plain language of Section 162(m) does not appear to apply to partnerships, even when the partnership is publicly held, and there is no guidance that explicitly extends the application of Section 162(m) to partnerships. Accordingly, the better position appears to be that the Section 162(m) does not apply to publicly traded partnerships.

- Section 409A

  - Application to partnerships. The Section 409A statute and regulations do not specifically address the application of Section 409A to arrangements between partnerships and partners. The IRS and Treasury continue to analyze the issue and IRS Notice 2005-1, Q&A-7 and Sections II.E and VI.E of the preamble to the proposed Section 409A regulations provide interim guidance until further guidance is issued. Notice 2005-1 states that taxpayers may treat the issuance of a partnership interest (including a profits interest) or an option to purchase a partnership interest granted in connection with the performance of services under the same principles that govern the issuance of stock. Accordingly, the rules applying to grants of options to purchase stock or promises to deliver stock, including the requirements of service recipient stock, may be applied by analogy to options to purchase partnership interests or promises to deliver partnership interests.

  - Specified employee rules. Section 409A requires a six month delay in the payment of deferred compensation payable upon separation from service to a specified employee. A specified employee generally means a key employee (determined by reference to Code Section 416(i)) of a *corporation* any stock of which is publicly traded on an established securities market or otherwise. The applicable guidance does not make reference to partnerships in the context of specified employees or state that the specified employee rules should apply by analogy (as is explicitly stated with respect to other Section 409A areas). Therefore, it is not clear whether the specified employee rules apply by analogy to a publicly traded partnership. Partnerships should analyze their structure and discuss the application of the Section 409A specified employee rules with their counsel.

- Reporting. Employees who receive units in a partnership become limited partners in the publicly traded partnership for tax purposes. Fully vested units held by employees will generally be subject to the same tax rules as other units, including the use of Schedule K-1 to report the applicable share of the partnership's income, deductions, and credits.

Securities Law Considerations

- Section 16. Section 16 of the United States Securities Exchange Act of 1934, as amended (the "Exchange Act") contains provisions to the effect that, among other things, any person who is an "officer" (as defined in regulations adopted under Section 16 of the Exchange Act) or director of the registrant or a beneficial owner (as defined in regulations adopted under Section 13 of the Exchange Act) of more than 10% of a class of the registrant's equity securities registered under the Exchange Act may be liable to the registrant for profits realized from any purchase and sale (or any sale and purchase) of the registrant's equity securities within a period of less than six months, regardless of the intention on the part of such person in entering the transaction. Section 16 applies to publicly traded partnerships as well as corporations. Publicly traded partnerships often have structures that differ from corporations, in that the public partnership is a limited partnership managed by a general partner. Because of this structure, it is likely that the officers and directors of the general partner of the publicly traded partnership will be considered the officers and directors of the publicly traded partnership for Section 16 purposes. Any rules relating to Section 16 approvals by a compensation committee must be evaluated in light of the publicly traded company's governance structure (see below).

- Form S-8. A publicly traded partnership may use a Registration Statement on Form S-8 to register the offer and sale of the publicly traded partnership units to employees or other service provides of the partnership pursuant to "an employee benefit plan," including units offered pursuant to an equity plan. The requirements relating to Form S-8 generally do not differ between a publicly traded partnership and a corporation.

Corporate governance

The New York Stock Exchange corporate governance rules require that many of the decisions relating to equity plans, including the grants of awards, must be made by an independent compensation committee, or the full board of directors. However, the New York Stock Exchange corporate governance rules do not require a publicly traded partnership to have an independent compensation committee. Accordingly, unless the publicly traded partnership voluntarily creates a compensation committee, many decisions relating to the equity plan will be made by the board of directors of the publicly traded partnership's general partner. Pursuant to NYSE Listed Company Manual, Section 303A, a publicly traded partnership is required to comply (at the general partner level) with certain other NYSE corporate governance requirements, including the requirements regarding security holder approval of equity compensation plans. Similar rules apply with respect to the NASDAQ corporate governance requirements.

International Considerations

If the publicly traded partnership is granting equity awards in jurisdictions other than the United States, the publicly traded partnership should consider any special potential tax, securities law and labor considerations that may be raised by equity grants in the jurisdiction. For example, the taxation of equity grants made with respect to partnership units may not track identically the taxation of equity grants made with respect to corporate stock, so certain exemptions or requirements upon which a corporation could generally rely for equity plans may be uncertain, or not applicable at all.

View From Proskauer

Ultimately, it is possible to establish an equity plan for a publicly traded partnership that is a reasonable facsimile of equity plans established by corporations. From the perspective of the employee or other service provider, the grants and mechanics are likely to appear very similar, while there are a number of tax, securities, corporate governance and other issues that can result in an interesting challenge for practitioners, and some provisions in the documentation that are unique to publicly traded partnerships.

Rulings, Filings, and Settlements of Interest

Plan Sponsors' Decision to Change Form of Employer Contributions Not A Fiduciary Function

By Tulio Chirinos

- The Second Circuit recently held that Morgan Stanley and others were not *de facto* ERISA fiduciaries by virtue of having authority and means to fund company contributions with stock rather than cash. In so ruling, the Court explained that at the time of the decision to fund contributions with company stock, the stock was not a plan asset and thus the decision to fund company contributions with stock was not a fiduciary act. The Court also dismissed conflict of interest claims against the Chairman of the Board of Directors because such claims are not viable when based solely on the fact that compensation was linked to the company's stock. The case is *Coulter v. Morgan Stanley & Co. Inc.*, 2014 U.S. App. LEXIS 10027 (2nd Cir. May 29, 2014).

Plaintiff's Claim for Estoppel, Reformation and Surcharge Strikes Out

By Russell Hirschhorn

- A divided panel of the Ninth Circuit recently held that plaintiff Gregory Gabriel could not recover, as "appropriate equitable relief," pension benefits he thought he was owed from the Alaska Electrical Pension Fund, after the Fund stopped paying him pension benefits that it had mistakenly advised him that he was entitled to. In so doing, the Ninth Circuit may be creating a circuit-split on the scope of monetary surcharge remedies, with the Ninth Circuit holding surcharge is limited to disgorgement of any profits a fiduciary made from his breach (unjust enrichment), or compensation for any loss the breach caused the trust estate. The Ninth Circuit rejected extending surcharge to include "make whole" monetary relief to compensate the participant for his claimed loss.

  The Fund initially credited Gabriel with eleven years of credited service, which was enough to provide him with a vested benefit under the Fund's ten year vesting schedule. Before he retired, a Fund representative advised Gabriel that he was entitled to a monthly pension, in excess of $1,200. After commencing payments to Gabriel, the Fund discovered that Gabriel owned the company for which he was working for a certain period and thus was not entitled to credited service for those years. Once those years were removed, Gabriel no longer satisfied the Fund's vesting requirements.

  After the Fund discontinued payments to him, Gabriel commenced a lawsuit seeking to recover the payments that he was originally advised he would be receiving. He advanced various arguments why he was entitled to benefits as "appropriate equitable relief." Each argument was rejected by the Ninth Circuit. First, the Court rejected Gabriel's claim that the Fund should be equitably estopped

from relying on its corrected records that showed he never vested in his pension benefit. In so ruling, the Court determined that: (a) Gabriel had failed to show, as he was required to, that the Fund representative's statement about his eligibility for a pension benefit was the result of ambiguous plan language, as opposed to a mistake in assessing his entitlement to benefits; and (b) even if the Plan's terms were ambiguous, Gabriel could not show he was ignorant of the true facts, *i.e.*, he admitted to having received a letter decades earlier informing him that he was not eligible for credited service while the owner of the company. Second, the Court rejected Gabriel's request for reformation because the Plan contained no error and there was no evidence of fraud. Third, the Court rejected Gabriel's request for surcharge because he could not establish that: (a) the defendants were unjustly enriched by the alleged fiduciary breaches, or (b) he was seeking a monetary award to recoup losses that the Fund suffered from alleged fiduciary breaches, since the money he was seeking was not due to him. The Dissent would have remanded the case for further consideration on the ground that the Supreme Court's ruling in *Amara v. Cigna* did not limit equitable surcharge to instances of unjust enrichment or a losses to the plan.

The case is *Gabriel v. Alaska Electrical Pension Fund*, No. 12-35458, 2014 WL 2535469 (9th Cir. June 6, 2014).

Equitable Surcharge Awarded to Life Insurance Plan Beneficiary

By Joseph Clark

- A federal district court in California awarded relief in the form of surcharge to a life insurance plan beneficiary who claimed that a plan administrator failed to provide complete and accurate information in response to inquiries about how to prevent coverage from lapsing. In so ruling, the court stated that the plan administrator's response to the decedent did not answer her questions or direct her to where she could find the requested information. As a result, the court determined that equitable surcharge was the most suitable remedy and awarded the beneficiary an amount equal to the face value of the life insurance policies. The case is *Echague v. Metro. Life Ins. Co.*, 2014 WL 2089331 (N.D. Cal. May 19, 2014).

Yet Another Decision On The Availability of Equitable Surcharge

By Russell Hirschhorn

- A district court in Pennsylvania concluded that a decedent's life insurance plan beneficiaries were entitled to equitable surcharge where the plan administrator failed to, among other things, inform the decedent about the need to convert her

group policy to an individual policy. *Weaver Brothers Insurance Associates, Inc. v. Braunstein*, 2014 WL 2599929 (E.D. Pa. June 9, 2014). This ruling and others like it (as reported on here) stand in contrast to a ruling in the Ninth Circuit (as reported on here) that surcharge was not an appropriate remedy where a plan stopped paying a participant pension benefits that it had mistakenly advised him that he was entitled to, based on a narrower construction of the scope of surcharge relief following the Supreme Court's decision in *Amara v. Cigna*. As the number of post *Amara* claims for equitable surcharge make their way through the courts, we are likely to see an uptick in the number of decisions on this issue.

IRS Issues Revenue Ruling on Applicability of Section 457A to Options and Stock Appreciation Rights

By William Fogelman and Joshua Miller

- On June 10, 2014, the IRS issued Revenue Ruling 2014-18, which holds that nonqualified stock options, as well as stock-settled stock appreciation rights (SARs), do not constitute nonqualified deferred compensation subject to taxation under Code Section 457A as long as they are exempt from the requirements of Code Section 409A. This ruling reaffirms interim guidance issued by the IRS in January 2009 in Notice 2009-8. (For more information on Section 457A and Notice 2009-8, please refer to our Client Alert, available here.)

  Under Section 457A, compensation that is payable under nonqualified deferred compensation plans of certain foreign corporations and partnerships that are "nonqualified entities" is includible in gross income when the compensation is not subject to a substantial risk of forfeiture. For this purpose, a substantial risk of forfeiture exists only to the extent that a person's right to the compensation is conditioned on the performance of substantial services by any individual. Where an amount of deferred compensation is not determinable at the time it ceases to be subject to a substantial risk of forfeiture (such as amounts which vest prior to the end of a performance period when the underlying performance measurements are still variable), the amount must be included in gross income when it becomes determinable and at such time, will be subject to an additional penalty tax of 20% plus interest at the underpayment rate plus 1% from the later of the time of deferral and the date when the substantial risk of forfeiture lapses.

  Section 457A generally uses the same definition of "nonqualified deferred compensation plan" as is used for Section 409A purposes. Under Section 409A, nonqualified stock options and SARs are generally not considered deferrals of compensation, as long they meet certain specific requirements, including, most notably: (1) having an exercise price not less than fair market value on the date of

grant; (2) being in respect of service recipient stock; and (3) not having any feature providing for the deferral of compensation.

Unlike Section 409A, however, Section 457A specifically includes in its definition of deferred compensation plans any plan that "provides a right to compensation based on the appreciation in value of a specified number of equity units of the service recipient." In Notice 2009-8, the IRS indicated that nonqualified and incentive stock options exempt from Section 409A are also exempt from Section 457A. Further, Notice 2009-8 noted that stock-settled SARs exempt from Section 409A are generally excluded from Section 457A. However, since the release of Notice 2009-8, the IRS has not issued further guidance under Section 457A.

In Revenue Ruling 2014-18, the IRS reaffirmed the interim guidance under Notice 2008-8 as to stock-settled SARs. By specifically noting that stock-settled SARs exempt from Section 409A are functionally identical to nonqualified stock options with a "net exercise" feature (*i.e.*, a right to exercise the option by withholding shares subject to the option having a fair market value equal to the applicable exercise price on the date of exercise), the IRS concluded that these SARs are also exempt from Section 457A. The Revenue Ruling confirms that SARs that could be settled other than in stock – such as in cash – are not exempt from Section 457A, even if exempt from Section 409A.

Revenue Ruling 2014-18 puts to rest any uncertainty regarding the application of Section 457A to SARs generally and serves as a useful reminder of the Code's nuanced treatment of equity-based compensation. However, Revenue Ruling 2014-18 does not address other areas of the Code that may impact tax treatment of stock options and SARs granted by nonqualified entities, such as the applicability of the "passive foreign investment company" rules.

Final Regulations on Orientation Periods Released

By Paul M. Hamburger, Peter Marathas and Stacy Barrow

- On June 20, the Federal regulatory agencies in charge of health care reform guidance (the Departments of Labor, Treasury, and Health and Human Services) released final regulations ("Final Regulations") clarifying the relationship between a group health plan's eligibility criteria and the Affordable Care Act's (ACA) 90-day limit on waiting periods. Specifically, the Final Regulations (published in the June 25 Federal Register) address an employer's ability to require new employees to satisfy a "reasonable and bona fide employment-based orientation period" before starting a group health plan's waiting period.

The Final Regulations on orientation periods are effective for plan years beginning in 2015. (For the remainder of 2014, employers may rely on the proposed regulations on orientation periods that were released in February 2014 and which are substantively identical to the Final Regulations.)

90-Day Limit on Waiting Periods

Starting with plan years beginning in 2014, the ACA prohibits group health plans from requiring otherwise eligible employees to wait longer than 90 days for coverage to be effective once an employee is eligible to enroll under the terms of the plan. Being "otherwise eligible" to enroll means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms). Thus, under the waiting period rules, once an individual is determined to be otherwise eligible for coverage under a group health plan's terms, any waiting period for coverage may not extend beyond 90 days. All calendar days are counted, including weekends and holidays. In other words, coverage must be effective no later than the start of the 91st day after the employee becomes eligible.

Final regulations on the 90-day waiting period limit were issued February 24, 2014. At the same time, the Federal agencies issued proposed regulations that allowed plans to use "orientation periods" of up to one month in addition to a 90-day waiting period as long as the period was a reasonable and bona fide employment-based orientation period.

Final Regulations Orientation Periods

The most recent Final Regulations clarify that orientation periods are "reasonable" and "bona fide" based on all relevant facts and circumstances. The Final Regulations provide little explanation or guidance as to the circumstances under which an orientation period might satisfy these requirements; however, they clarify that the one month limit on orientation periods is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage.

For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the

employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

Compliance with the Employer Mandate

The Final Regulations note that compliance with the orientation period and waiting period rules is not determinative of whether an employer has complied with the ACA's "pay-or-play" employer mandate. An employer subject to the mandate may be exposed to tax penalties if it fails to offer affordable minimum value coverage to certain newly-hired full-time employees by the first day of the fourth full calendar month of employment.

For example, an employer that has a one-month orientation period may comply with both the waiting period rules and the employer mandate by offering coverage no later than the first day of the fourth full calendar month of employment. However, the employer would not be able to impose the full one-month orientation period and the full 90-day waiting period without potential exposure to a penalty under the employer mandate. For example, if an employee is hired as a full-time employee on January 6, a plan may offer coverage May 1 (first day of the fourth full month of employment) and comply with both the orientation period and waiting period provisions. However, if the employer starts coverage May 6, which is one month plus 90 days after date of hire, the employer may be exposed to a penalty under the employer mandate.

Employer Action Steps

Now that the 90-day waiting period regulations are finalized in full, employers should review the terms of their group health plans and work with qualified ERISA counsel to ensure that any orientation period is reasonable, bona fide and employment-based, and not merely a subterfuge for the passage of time. In addition, employers should consider application of the pay-or-play mandate when structuring eligibility and waiting periods to ensure that coverage is offered to new full-time employees no later than the first day of the fourth full calendar month of employment.

DOL Proposes Change to FMLA Definition of Spouse to Accommodate Same-Sex Marriage

By Roberta Chevlowe

- As was expected, the U.S. Department of Labor has issued a proposed regulation changing the definition of "spouse" for FMLA purposes in order to protect the FMLA rights of employees with same-sex spouses.

  The proposed regulation adopts a "place of celebration" rule, consistent with the current DOL interpretation in the context of other federal laws. Under this "celebration" rule, an employee may take FMLA leave to care for an ill same-sex spouse even if they couple resides in a state that does not permit or recognize their marriage, as long as they were married in a jurisdiction that allowed their marriage.

  This change was necessary to accommodate employees with same-sex spouses because the current FMLA definition refers to the state of an employee's *residence* when determining whether the employee is married. Under that definition, an employee technically is entitled to take FMLA leave to care for an ill same-sex spouse only if they actually reside in a state that recognizes same sex marriage.

  The DOL issued Frequently Asked Questions and a Fact Sheet along with the proposed regulation.

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[1] There have been, of course, exceptions. For example, enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") gave rise to a considerable amount of litigation. *See* Golub, Ira M.; Chevlowe, Roberta K: COBRA Handbook, 2014 Edition.

[2] Further, the ACA requires that non-grandfathered health plans in the individual and small group markets offer Mental Health Benefits as one of the ten essential health benefits ("EHB"). In its regulations implementing EHB, the Department of Health and Human Services determined that EHB must meet the parity standards of the Federal Parity Act. *See* 78 FR 12834, 12844 (Feb. 25, 2013). The Federal Parity Act, however, exempts plans of employers with 50 or fewer employees from its requirements. *See* 29 U.S.C. § 1185a(c)(1). It is not clear how the EHB mandates fit with this small-employer exemption.

[3] There are six classifications: (1) inpatient in-network; (2) inpatient out-of-network; (3) outpatient in-network; (4) outpatient out-of-network; (5) emergency care; and (6) prescription drugs. *See* 29 C.F.R. § 2590.712(c)(2). Thus, by way of example, if a $10 copay applies to substantially all (*i.e.*, at least two-thirds) inpatient in-network Medical Benefits, a $10 copay is the most restrictive copay that can apply to inpatient in-network Mental Health Benefits. *See* FAQs for Employees about the Mental Health Parity and Addiction Equity Act, issued by U.S. Department of Labor, May 18, 2012.

[4] For example, NQTLs include: Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether treatment is experimental or investigative; formulary design for prescription drugs; standards for admission to plan provider networks, including reimbursement rates; plan methods used to determine usual, customary, and reasonable fee charges; "fail first" policies such as refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective; and exclusions based on failure to complete a course of treatment. *See* 29 C.F.R. § 2590.712(c)(4).

[5] Of note, the report prepared for the Departments found that only 18% of the employer-based plans had claims for residential treatment. *See* http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml

[6] In this area, ERISA only preempts state insurance law if it "prevents the application of a requirement of [the Federal Parity Act]." 29 U.S.C. § 1191(a)(1).

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[7] Rev. Rul. 93-27. As a general matter, the favorable tax treatment afforded to profits interests is not extended to limited partnership interests in publicly traded partnerships.

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