Proskauer

The ERISA Litigation Newsletter

June 2013

Editor's Overview

Our articles this month focus on health care reform. First, Jim Napoli and Brian Neulander comment on the potential for litigation under the Affordable Care Act's (ACA's) whistleblower protections and ERISA Section 510 as a result of workforce realignments or other attempts by employers to avoid ACA's coverage requirements and corresponding tax penalties. Next, Eugene Holmes reminds us that, in making certain health care plans are compliant with ACA, we should not forget about HIPPA/HITECH. The new regulatory guidance addresses multiple issues, but, as Eugene explains below, the most prominent impact is in the security breach notification rules, business associate agreements, limitations on protected health information, and HIPAA Notice of Privacy Practices.

As always, the Newsletter also addresses a multitude of topics under Rulings, Filings and Settlements of Interest, including wellness programs, DOMA, COBRA, ERISA's anti-alienation rule, benefit claims, PBGC Guidance, and NYSE and NASDAQ Compensation Committee Adviser Independence Rules.

The View From Proskauer: Health Care Reform Litigation Risks — The Intersection of ERISA Section 510 and the Affordable Care Act's Whistleblower Provisions*

By James R. Napoli and Brian S. Neulander

The Affordable Care Act (ACA) is significantly changing employer health care obligations under the Employee Retirement Income Security Act (ERISA). Prior to ACA, the Supreme Court held that ERISA did not require employers to offer any level or type of welfare benefits, such as health care benefits.[1] Now that ACA has passed constitutional muster, effective 2014, employers with more than 50 full-time employees will be required to provide "affordable" health care coverage to their full-time employees or face financial penalties. Because the penalties are calculated based on the number of full-time employees, employers should carefully examine the legal risks of realigning their workforces to minimize the use of full-time employees in favor of employees whose status would not trigger ACA's coverage mandate. This article discusses the ACA whistleblower and ERISA Section 510 claims that might arise from such workforce restructurings or other attempts by employers to avoid ACA's coverage requirements and corresponding tax penalties.

The "Play or Pay" Mandate. ACA Section 1513, codified at 26 IRC § 4980H, is known as the shared responsibility or "play or pay" mandate. This provision applies to "large" employers, defined as 50 or more full-time employees (including full-time equivalents). For this purpose, "full-time" means employees that work 30 or more hours per week or 130 hours per month; part-time employees are counted based on their fraction of full-time status and then summed towards the total number of "full-time" employees.

Employers subject to the "play or pay" mandate face financial penalties if they fail to provide *any* health coverage or fail to provide "affordable" coverage that meets "minimum value." A failure to provide any coverage results in a $2,000 penalty multiplied by *all* full-time employees (excluding the first 30 employees), when at least one employee receives a federal subsidy[2] for purchasing coverage through a public health insurance exchange.[3] For example, Large Employer has 130 employees and does not offer health coverage. If one employee is eligible for a federal subsidy to obtain coverage on a public health insurance exchange and actually purchases such coverage via a public exchange, Large Employer's annual penalty would be $200,000 ((130 – 30) x $2,000). The second penalty applies to employers that offer "unaffordable" coverage. Health coverage is generally deemed unaffordable if its cost exceeds 9.5% of a full-time employee's household income (W-2 wages can be used) or it fails to provide minimum value to the employee (*i.e.*, provides less than 60% actuarial value).[4] The penalty for offering "unaffordable" coverage is $3,000 multiplied by the number of full-time employees receiving federal subsidies to purchase coverage from a public health insurance exchange. Again using Large Employer as an example, the "unaffordable" penalty could be any amount between $0 and $390,000, depending on the number of employees that qualify for a subsidy and purchase coverage from an exchange.

Avoiding ACA's "Play or Pay" Mandate. Employers are currently weighing the costs of ACA compliance against the risks and costs of realigning their workforces to avoid the mandate. Any workforce realignment to reduce the number of employees working more than 30 hours per week (or the number of employees below 50) may give rise to arguments that the employer specifically interfered with the right to benefits under ACA's whistleblower provisions, or ERISA § 510, or both.

ACA's Whistleblower Provision. ACA's whistleblower provision states that no employer shall discharge or discriminate against "any employee with respect to his or her compensation, terms, conditions, or other privileges of employment" because, among other things, the employee "has received" a credit or subsidy provided by ACA.[5] The U.S. Department of Labor recently issued regulations and guidance on the statute's whisteblower provisions. This guidance specifically states that an employee's hours or pay may not be reduced for having received a subsidy to purchase insurance via a public health insurance exchange.[6] The guidance leaves open whether courts will view ACA's whistleblower provisions as applicable to the reduction of an employee's hours so that the employee would not have coverage and also not be full-time. In that case, the employee might go to a health insurance exchange to purchase coverage and obtain a premium subsidy. As explained above, had the employee been full-time, the employee's action might have resulted in a tax penalty to the employer. The ACA whistleblower issue is whether this type of employer activity would be prohibited by being viewed as reducing hours of work in anticipation of the employee receiving a subsidy to purchase insurance via an exchange and in an effort to avoid a penalty with respect to the employee. This open issue is at the heart of workforce realignment strategy.

ACA did not create its own whistleblower claims procedures, but adopted the notice requirements, limitations periods, and remedies of the Consumer Products Safety Improvement Act (CPSIA).[7] Under CPSIA, and now ACA, employees have 180 days following an adverse employment action to submit a complaint to the Occupational Safety & Health Administration (OSHA).[8] OSHA is charged with investigating the claim and can order preliminary reinstatement of the employee upon finding "reasonable cause."[9] Following a preliminary investigation, OSHA must provide the parties with its findings; either party may object and request a hearing. Within 120 days of the hearing, OSHA must issue its final order. Final orders are reviewable in the United States Court of Appeals. If OSHA fails to issue a decision within 210 days of the filing of the complaint, the complainant may bring an action for *de novo* review in United States District Court, without regard to the amount in controversy, and either party can ask for a trial by jury.

During this process, complainants must show only that a protected activity was a "contributing factor" leading to the adverse employment action. Upon making this prima facie case, the burden shifts to the employer to demonstrate by clear and convincing evidence that the same employment action would have resulted absent the protected activity. A "contributing factor" is "any factor which, alone or in connection with other factors, tends to affect in any way the outcome of the decision."[10] OSHA's interim final rule notes the nature of the "contributing factor" test:

In proving that protected activity was a contributing factor in the adverse action, a complainant need not necessarily prove that the respondent's articulated reason was a pretext in order to prevail, because a complainant alternatively can prevail by showing that the respondent's reason, while true, is only one of the reasons for its conduct, and that another reason was the complainant's protected activity.[11]

As for remedies, ACA authorizes "all relief necessary to make the employee whole, including injunctive and compensatory damages," such as reinstatement, back pay with interest, and "special damages," including but not limited to: litigation costs, attorneys' fees, and expert fees.[12]

It remains unclear whether ACA's whisteblower protections will apply to workforce realignment decisions. As discussed above, ACA's "pay or play" penalties are only assessed on the number of full time employees, thus realignments to reduce hours, especially for low wage workers eligible for subsidies and credits, could be viewed as unlawful interference with the terms of employment. From the employees' perspective, such workforce changes directly impact access to medical care for all similarly-situated individuals, and would stem solely from to an employer's desire to avoid ACA's penalties – penalties that are triggered when one or more full-time employees receive a subsidy through a public health insurance exchange. From the employer's perspective, realignment is a business decision to avoid taxes, and such changes could help workers qualify for subsidies and credits, thereby providing more affordable access to care. Given the burden shifting approach for ACA's whistleblower protections, and the enhanced remedies provided by ACA, including back pay with interest and special damages, plaintiffs may well pursue claims that workforce realignments interfere with protected rights to coverage. Because ACA's protections mirror Title VII, it is possible that courts will apply the forward-looking Title VII protections announced in *Burlington N. & Santa Fe Ry. Co. v. White*, 548 U.S.C. 53, 57 (2006), to expand ACA's protections from tangible adverse employment actions to any action that "could well dissuade a reasonable worker" from obtaining coverage.

ERISA Section 510. Section 510 of ERISA makes it unlawful to interfere with employee benefits and protects the right to both present *and* future benefit entitlements. First, the provision protects plan participants from adverse employment action, such as termination, discipline, or discrimination, for exercising the right to benefits available under the terms of the governing plan. Second, employers may not use adverse employment action to interfere "with the *attainment* of any right to which such participant *may become* entitled under the plan."[13] Third, participants are protected from retaliation when they give information, have testified, or are about to testify "in any inquiry or proceeding relating to [ERISA]."[14] Because any employment decision may impact the right to present or future benefits, courts require plaintiffs to show specific intent to interfere with benefits to prevail under Section 510.[15] Plaintiffs enforce these anti-retaliation and anti-discrimination protections under ERISA's remedial provisions, Section 502(a)(3). Remedies are thus generally limited to "appropriate equitable relief," which can include reinstatement, restitution, and back pay.[16] There are substantial disputes, however, regarding the scope of any monetary remedies, including backpay, for Section 510 violations.[17] Thus, plaintiffs may try to argue their claims also arise under ACA's whistleblower protections to qualify for the enhanced remedies available to such claims.

Because ERISA applies to health plans established or maintained by employers, the statute's anti-discrimination and anti-retaliation provision may apply to workforce realignment decisions when such action interferes with employee access to employer-provided health coverage.

Proskauer's Perspective. Employers seeking to avoid ACA's coverage mandates by realigning their workforces may risk suit under the statute's whistleblower protections and ERISA § 510. Because such suits may straddle both ACA and ERISA, parts of these cases could proceed before a jury. In the event that such cases arise, plaintiffs may try to first establish that the employer was acting with specific intent to avoid the newly codified health care coverage responsibilities. If "specific intent" is demonstrated under ERISA § 510, then violation of the ACA's "contributing factor" standard may be a foregone conclusion. There are, however, substantial defenses against such claims, including that such changes are the natural result of legitimate business decisions and completely insulated from attack. More plainly, efforts to avoid ACA's penalties flow from the desire to limit a company's tax bill, not a specific intent to interfere with the provision of benefits. Individualized facts also may be important to this analysis, *e.g.*, an employer's decision to limit a newly hired employee's hours may be viewed differently than an employer's decision to reduce the hours of a full-time employee. Because of the various facts and circumstances that may arise from any workforce restructuring, employers may be able to successfully defend these claims during administrative exhaustion, and as to class certification, remedies, and merits issues.

More To Do's to Add to Your 2013 Health Plan Compliance Calendar – Don't Forget About HIPAA/HITECH*

By Eugene M. Holmes

For much of 2013, group health plan sponsors have been gearing up for the compliance challenges associated with the Affordable Care Act. There is no doubt that much of the planning, focus and energy trained on the next round of effective dates under the Affordable Care Act is warranted. Nevertheless, plan sponsors must be certain not to overlook the *other* compliance challenge for 2013 – HIPAA/HITECH. On January 25, 2013, the Department of Health and Human Services ("HHS") issued fairly significant regulations modifying the HIPAA Privacy, Security and Enforcement rules (the "Final Rule"). The Final Rule is generally effective March 26, 2013. However, covered entities (including group health plans) and business associates (i.e., service providers that conduct business with a covered entity that involves the use or disclosure of individually identifiable health information) must comply with the new provisions by September 23, 2013. Although the Final Rule includes a multitude of significant changes, some of the most pressing compliance obligations facing plan sponsors of group health plans and their business associates impact the security breach notification rules, business associate agreements, limitations on protected health information ("PHI"), and HIPAA Notice of Privacy Practices ("NPPs").

Security Breach Notification Standards

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") requires covered entities to provide notification to both affected individuals and HHS following the discovery of a breach of unsecured PHI. The HITECH Act requires HHS to post on its website a list of covered entities that experience breaches of unsecured PHI involving more than 500 individuals. Prior to the Final Rule, a "breach" was defined as an unauthorized use or disclosure that posed a "significant risk of financial, reputational, or other harm to the individual." The Final Rule substantially alters the definition of breach by eliminating the "risk-of-significant harm" standard and replaces it with a provision that requires covered entities and business associates to notify individuals of a breach unless a risk assessment determines that there is a low probability that the PHI has been compromised. This change ostensibly ensures that covered entities will not be able to use the absence of clear information about a breach as justification for a "no notice" decision.

To demonstrate that there is low probability that PHI has been compromised, a covered entity or business associate must perform a risk assessment that addresses, at a minimum, the following factors: (1) the nature and extent of the PHI involved; (2) the unauthorized person who used the PHI or to whom the disclosure was made; (3) whether the PHI was actually acquired or viewed; and (4) the extent to which risk has been mitigated. HHS has indicated that it will issue guidance regarding performing assessments with respect to frequently occurring scenarios. It is likely that the new standard will result in more impermissible uses and disclosures being considered as breaches that require notification to affected individuals. As a result, plan sponsors and business associates should begin conducting compliance assessments and providing training to employees who have access to PHI, particularly since HHS often uses breach notifications as a means to conduct audits and investigations.

Business Associates and Business Associate Agreements

As mentioned earlier, the Final Rule has a direct impact on business associates and business associate agreements. For example, the Final Rule makes certain HIPAA Privacy and Security rules directly applicable to business associates, including rules pertaining to security standards, administrative safeguards, physical safeguards and disclosures of PHI. The Final Rule also requires business associates to agree in business associate agreements to comply with the required provisions imposed on them under HIPAA. Generally, for business associates, this new rule should not affect their behavior or performance of services because they are typically contractually obligated under their business associate agreements to comply with HIPAA. The Final Rule now creates legal exposure beyond any already existing contractual obligations for violations. In addition, the Final Rule clarifies that covered entities may be liable under the "federal common law of agency" for the acts and omissions of their business associates.

The Final Rule also requires that business associates not only have a business associate agreement in place with the covered entity to whom they are providing services, but also with subcontractors who will receive, create, or transmit PHI on their behalf. Likewise, subcontractors will also need business associate agreements with their subcontractors as long as PHI is being used. The subcontractor business associate agreement must be at least as stringent as the business associate agreement for the entity retaining the subcontractor. Any new business associate agreements entered into on or after September 23, 2013 must meet the new requirements set forth in the Final Rule. With respect to business associate agreements that were in place as of the effective date of the Final Rule, there is a transition period for updating such business associate agreements. Current business associate agreements must be updated for the new requirements under the Final Rule by the earlier of: (1) the next renewal after September 23, 2013, or (2) September 23, 2014.

Due to the Final Rule, covered entities as well as business associates will need to determine both whether they have requisite business associate agreements in place for service providers and whether amendments to current business associate agreements are necessary to account for the risk of liability as a result of having their business associate be considered an agent.

Limitations on PHI

The Final Rule implements important limitations with respect to the marketing of PHI and the sale of PHI. HHS restricts marketing without authorization where the covered entity receives "remuneration" for such marketing. Marketing is defined as a "communication about a product or service that encourages recipients…to purchase or use the product or service." This applies to both "direct" and "indirect" remuneration, but does not apply to non-financial benefits, such as in-kind benefits, and payments for purposes other than making a communication, such as payments to implement a disease management program. Plan sponsors should keep in mind that the authorization requirement applies even when a business associate receives remuneration for making a communication, but the plan sponsor will not receive remuneration directly. Despite the general rule, authorization is not necessary for face-to-face communications (e.g., where an individual is handed a pamphlet) and "refill reminders" so long as the remuneration for making such a communication is reasonably related to the cost for making the communication.

HHS also restricts the sale of PHI without authorization. The "sale of PHI," is defined to include where the plan directly or indirectly receives remuneration for PHI, however, unlike with marketing, remuneration in this instance includes both financial and non-financial benefits. Plan sponsors should note that authorization is not needed for disclosures: (1) for public health purposes; (2) for treatment and payment for health care; (3) for certain corporate transactions (i.e., the sale, transfer, merger, or consolidation of all or part of a covered entity and for related due diligence); (4) to a business associate in connection with the business associate's performance of activities; (5) to a patient or beneficiary upon request; and (5) as otherwise required by law. Plan sponsors will need to identify any situations where marketing and/or the sale of PHI may be implicated and evaluate whether changes in operations or any agreements with service providers are necessary in light of the new standards.

Changes for HIPAA Notice of Privacy Practices (NPPs)

In addition, Plan sponsors will want to view their existing NPPs, and make changes as necessitated by the Final Rule. More specifically, the Final Rule requires that the NPP must now include the following information: (1) that the sale of PHI and the use of such information for paid marketing requires authorization; (2) that other uses and disclosures of PHI not specifically described in the NPP will be made only with authorization; (3) that affected individuals must be notified of breaches of their PHI; and (4) that individuals can restrict disclosures to their health plan for services for which they pay "out of pocket."

Aside from the substance of the NPP changes, the Final Rule also includes important provisions concerning requirements for distributing revised NPPs. The Final Rule provides that health plans that post their NPPs on their websites must post material changes on their websites by the effective date of the change, and provide information about the change in their next mailing to covered individuals. Plans that do not post their NPPs on their websites must provide information about any material change to their NPP to covered individuals within 60 days of the material revision to the NPP. With the new distribution provisions, health plans can now avoid the cost of having to distribute a separate mailing with each revised NPP.

View from Proskauer

Given the many significant changes brought about by the Final Rule and the impending compliance date of September 23, 2013, plan sponsors of group health plans and their business associates will have to take prompt action to meet the deadline. This includes revising NPPs, reviewing and revising policies and procedures, as necessary, concerning breach notification, the sale of PHI and the use of PHI for paid marketing activities and developing new forms of business associate agreements. In addition, plan sponsors and business associates should begin conducting compliance assessments and providing training to all employees, both veterans and newly hired, who will have access to PHI. After all, the Affordable Care Act is not the only compliance challenge for 2013.

Rulings, Filings, and Settlements of Interest

Final Wellness Program Regulations Issued

By Austen Townsend

On May 29, 2013, the Departments of Health and Human Services, Labor and Treasury (the "Departments") issued final regulations on implementing and expanding employment-based wellness programs. The rules set forth in the final regulations remain largely unchanged from the proposed rules issued on November 20, 2012. For example, as provided for in the proposed rules, the final regulations increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan from 20 percent to 30 percent of the cost of coverage. The final regulations also increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. http://www.proskauer.com/publications/client-alert/new-guidance-on-wellness-programs-issued/. However, a few points and clarifications are particularly noteworthy:

1. The Departments reiterated that compliance with the final rules is not determinative of compliance with any other applicable Federal or State law, including the Americans with Disabilities Act. Therefore, uncertainty remains for employers designing wellness programs given that the Equal Employment Opportunity Commission still has not provided more definitive guidance on permissible incentives in the wellness program context. http://www.erisapracticecenter.com/2013/03/22/still-no-eeoc-guidance-on-permissible-wellness-program-incentives/

2. The intention of the Departments is that every individual participating in a wellness program should be able to receive the full amount of any reward or incentive, regardless of any health factor.

3. The Departments clarified that the final regulations do not establish requirements for all types of programs or platforms that could be labeled a wellness program. Rather, the final rules establish criteria for an affirmative defense that can be used by a plan in response to a claim that the plan impermissible discriminated against an individual based on health status in violation of HIPAA.

4. The final rules give employers a fair amount of flexibility. For example, the final rules permit plans to determine apportionment of the reward under a health-contingent wellness program among family members, as long as the method is reasonable.

5. The final rules indicate that the permissibility of rescinding an individual's health coverage in connection with his or her statement regarding tobacco may be addressed by the Departments in future regulations or subregulatory guidance under Public Health Service Act section 2712.

6. The Departments anticipate issuing future subregulatory guidance to provide additional clarity on wellness programs and potentially proposing modifications to this final rule as necessary.

In designing and administering wellness programs, employers typically try to fit within the HIPAA standards. Now that the regulations are finalized, it will be easier to implement these programs. At the same time, employers need to be mindful of any future guidance from the EEOC on wellness programs as well as any additional guidance from the Departments as they establish wellness incentives.

IRS Releases Guidance on Wellness Programs and "Affordability" under the Employer Mandate

By Austen Townsend, Lynda Noggle and Stacy Barrow

On May 3, 2013, the IRS released proposed regulations on certain provisions relating to the federal premium tax credits that eligible individuals will use to purchase subsidized health insurance coverage from public exchanges starting in 2014.

The regulations are important for employers that are subject to the Affordable Care Act's (ACA's) employer shared responsibility provisions because they affect the determination of whether coverage offered by employers is "affordable." Coverage is "affordable" if the employee's annual contribution for self-only coverage under the plan does not exceed 9.5% of the individual's household income. Employers will owe a tax if they fail to provide affordable coverage and full time employees purchase subsidized coverage from a public exchange.

The proposed regulations address the impact of employer-provided wellness programs. If adopted, they would require employers offering such programs to include any penalties that would be applied, and not to include any premium contribution reductions that would be available under the wellness program when determining whether coverage is "affordable", except in two situations:

1. **Wellness Programs in Existence on May 3, 2013.** For plan years beginning before January 1, 2015, and only to the extent of the wellness program terms in effect on May 3, 2013, an employer may treat employees as "participating" in a wellness program and therefore being eligible to make the reduced premium contribution applicable to employees who have satisfied the wellness program's criteria. This relief does not appear to apply to any increase in the reward or penalty under the wellness program after May 3, 2013. In addition, the relief applies to any employee who is in a class of employees eligible for the wellness program on May 3, 2013, even if the employee was hired after that date.

2. **Wellness Programs Related to Tobacco Use.** An employer may assume that all employees will pay the contribution rate for non-tobacco users (i.e., the "participating", or lower rate) or for employees who complete a tobacco-related wellness program. Unlike the proposed safe harbor for wellness programs in existence on May 3, 2013, this rule is ongoing and is not limited to plan years beginning before January 1, 2015.

Proskauer's DOMA Task Force

By Roberta Chevlowe

Proskauer's Employee Benefits Practice Center's DOMA Task Force, which is comprised of lawyers from our offices nationwide, regularly advises employers and other plan sponsors on the myriad benefits issues that arise in the context of domestic partner benefits. As more states legalize same-sex marriage and the U.S. Supreme Court is poised to issue a decision on whether or not the Defense of Marriage Act is Constitutional, the Task Force is analyzing the implications for employers and benefit plans, and is prepared to provide assistance in all aspects of benefit plan compliance when the Supreme Court issues its decision, which is expected in June. Keep an eye on our blog in the coming weeks as we comment on the various potential effects of the impending Supreme Court decision.

U.S. Supreme Court Decision on DOMA May Impact Status of Children of Same-Sex Spouses for Employee Benefits Purposes

By Emily Erstling and Tzvia Feiertag

The Defense of Marriage Act (DOMA) defines marriage at the federal level as a legal union between one man and one woman and excuses states from any obligation to recognize same-sex marriages recognized in any other state. As a result, many states have enacted so-called "mini-DOMA" laws providing that those states will not recognize for any purpose same-sex marriages recognized in other states.

As has been widely reported, DOMA's constitutionality is currently under consideration by the U.S. Supreme Court in *United States v. Windsor* and a decision is expected in June. If DOMA is struck down, employers and other benefit plan sponsors should consider the potential effects not only on the definition of "spouse" for benefits purposes, but also the definition of "child."

Currently, if employer-sponsored health coverage is made available to a child of an employee's same-sex spouse or partner (who is not the child of the employee), it may result in imputed income to the employee for federal tax purposes based on the value of that coverage if the child does not meet certain requirements under the Internal Revenue Code (Code). But, depending on whether DOMA is repealed (and the effect of that repeal on state mini-DOMA laws), a child's status may change for this purpose.

Code Section 152(f)(1) defines "child" as including "stepson" and "stepdaughter." This definition is used for various federal income tax purposes, including certain fringe benefit rules, certain retiree health benefit rules and the new shared responsibility rules relating to the age 26 mandate of the Affordable Care Act. But what is a stepchild? Although the term has varying definitions (or no definition at all) for various state and federal laws, a stepchild may generally be viewed as any child of an individual's spouse who is not also that individual's adopted or natural child.

The IRS has issued FAQs stating that an individual is the stepparent of the child of his or her *same-sex* spouse for federal income tax purposes if he or she is the stepparent under the laws of the state in which the couple resides. Therefore, because a child of a same-sex spouse is already considered to be an employee's stepchild for federal income tax purposes if the couple resides in a state that recognizes the employee as the stepparent, the employee can avoid having imputed income for federal tax purposes on the value of employer-sponsored health coverage provided to the child. If DOMA is struck down (and depending on the impact of the decision on state mini-DOMA laws), additional children of same-sex spouses may attain similar favorable tax status. This status may even extend to situations where a couple resides in a state that does not recognize the child as a stepchild or permit same-sex marriage depending on the specific definition of "child" in the benefit plan.

Employers and health plan administrators should start reviewing their employee benefit plans to understand the potential impact of a decision striking down DOMA (and the effect of that repeal on state mini-DOMA laws) on their plans' definitions of "children" and "stepchildren" and the changes this may impose on plan coverage and administration.

Seventh Circuit: Terminated Employee's Release Agreement Bars Pension Claim, ERISA's Anti-Alienation Provision Does Not Apply

By Jacklina Len

The Seventh Circuit dismissed a former employee's claim for additional pension benefits after concluding that a release agreement he signed had waived any claims that arose prior to the signing of the release and his claim was not protected by ERISA's anti-alienation provision. *Hakim v. Accenture United States Pension Plan*, No. 11-3438, 2013 WL 2249454 (7th Cir. May 23, 2013) (unpublished). The plaintiff, Omar Hakim, sought additional pension benefits based on alleged inadequate notice of a pension plan amendment affecting his benefit eligibility. The Seventh Circuit held that pension claims, unlike pension entitlements, are outside the realm of ERISA's anti-alienation provision and therefore can be released. The Court reasoned that pension entitlements are vested benefits to which a participant is entitled, while contested pension claims seek "additional benefits above and beyond the benefits to which he was entitled under the terms of the plan." The Court also held that Hakim's claim was time barred because he had actual or constructive notice of his claim when he signed the release and the latest he could have claimed to be unaware of his changed status was when he received his Statement of Individual Benefits in 2000.

Sixth Circuit: Plan Fiduciary Reasonably Relied On Benefit Calculations In Communicating To Participant

By Jacklina Len

The Sixth Circuit recently rejected a participant's claim that a benefit estimate should override the specific benefit promised under the terms of the plan. In *Stark v. Mars Inc.*, No. 12-3956, 2013 WL 1908889 (6th Cir. May 9, 2013) (unpublished), the Sixth Circuit affirmed summary judgment in favor of the plan's fiduciary committee. The plaintiff, Virginia Stark, filed her lawsuit seeking to continue receiving higher pension benefits that she had been erroneously receiving from the plan. When Stark first sought her benefit, she received a letter stating that she was entitled to commence her benefit and she obtained estimates of different benefit options she had under the plan. In each case, the benefit estimate she received included a disclaimer that the plan reserved the right to correct any errors. After Stark received several monthly payments, the plan's service provider responsible for calculating her benefit determined that a system error caused a calculation error in several participants' benefits, including Stark's. After unsuccessfully pursuing her claim through the plan's administrative claims process, Stark sued the company and fiduciary committee asserting a claim for equitable estoppel and breach of fiduciary duty. The district court granted summary judgment to the company and committee on the basis that, as a matter of law, Stark could not establish the elements of a successful equitable estoppel claim. The Sixth Circuit upheld that ruling and determined that her equitable estoppel claim could not proceed because she failed to provide any evidence of fraud, i.e., either intended deception or such gross negligence as to amount to constructive fraud, or that she had detrimentally relied on the committee's misrepresentations. The Sixth Circuit also agreed with the district court that the fiduciary breach claim should be dismissed because any misrepresentation made by the committee was not made negligently. In this case, the service provider performed a ministerial function for the plan by managing software to calculate benefits according to unambiguous plan terms, the committee relied on the service provider's program to provide the estimates, and the committee had no reason to doubt the service provider's competence. Plan administrators often rely on the services and systems of third party service providers to communicate plan benefits. This case is a reminder that administrators need to monitor their systems closely and address any errors as quickly and reasonably as possible.

PBGC Releases 4062(e) Enforcement Guidelines

By Justin Alex

ERISA section 4062(e) addresses situations in which an employer ceases operations at a facility in any location and, as a result, separates more than 20% of its employees who participate in the employer's defined benefit plan. If a 4062(e) event occurs, the employer is subject to a liability that equals the plan's unfunded benefit liabilities (measured on a termination basis) at the time of the event times the percentage reduction in active plan participants. The liability is meant to provide financial protection for the plan if it terminates in a distress or involuntary termination within five years after the 4062(e) event. Employers and practitioners have been particularly concerned about these provisions over the last several years because the Pension Benefit Guaranty Corporation (or PBGC), which enforces this requirement, has taken an extremely expansive view of what constitutes a section 4062(e) event.

Last fall, the PBGC introduced a 4062(e) Enforcement Pilot Program under which the PBGC would not enforce 4062(e) liability against "creditworthy companies" or "small plans with 100 participants or less." Although this was welcome news, reaction was tempered in part because it was unclear how the PBGC determined whether a company was "creditworthy."

Recently, the PBGC posted on its web site(http://www.pbgc.gov/Documents/4062(e)-enforcement-of-guidelines.pdf) the guidelines it uses to determine whether a company is "creditworthy." The posting states that the PBGC generally considers a company creditworthy if:

(I) The company has unsecured debt-equivalent ratings from both Moody's and S&P, and the ratings are at least Baa3 by Moody's and BBB- by S&P;

(II) The company is rated by only one of those agencies, and the rating is at least Baa3 or BBB-; or

(III) The company is rated by neither of those agencies, and:

(i) The company has a D&B Financial Stress Score of 1477 or higher; and

(ii) The company's secured debt (disregarding debt incurred to purchase real estate or equipment) does not exceed 10 percent of its asset value.

Creditworthy companies under existing section 4062(e) settlement agreements should consider contacting the PBGC and seeking a suspension of their obligations under the agreements. Companies involved in active section 4062(e) negotiations with the PBGC or contemplating transactions or other actions that may give rise to section 4062(e) liability should also carefully review the creditworthiness guidelines.

NYSE and NASDAQ Compensation Committee Adviser Independence Rules Effective July 1, 2013

By Joshua Miller and Ali Fawaz

Publicly traded companies are reminded of the approaching deadline for compliance with certain of the SEC-approved final amendments of the NYSE and Nasdaq stock exchange listing rules governing compensation committee independence: By July 1, 2013, compensation committees must have the authority to retain and pay outside consultants, legal counsel and other advisers and the responsibility to consider certain independence factors before selecting such advisers.

NYSE companies will be required to include these authorities and responsibilities in their compensation committee charter by the July 1 deadline; however, Nasdaq companies may grant this authority by charter, resolution or other board action (subject to state corporate law) until the earlier of their first annual meeting after January 15, 2014 and October 31, 2014, when a formal compensation committee charter setting forth such authorities and responsibilities will first be required.

For a summary of and guidance on the Final Listed Company Rules as approved by the SEC, please refer to our Special Report, *SEC Approves NYSE and NASDAQ Revised Listing Rules Regarding the Independence of Compensation Committees and Their Advisers dated March 2013* (http://www.proskauer.com/en-US/publications/newsletters/special-report-sec-approves-nyse-and-nasdaq-revised-listing-rules/).

Under the amended stock exchange listing rules, a compensation committee may retain or obtain the advice of a compensation consultant, outside legal counsel or other adviser; is directly responsible for the appointment, compensation and oversight of the work of any such adviser retained by the compensation committee; and must be provided appropriate funding, as determined by the compensation committee, for payment of reasonable compensation to such advisers. However, before a listed company's compensation committee may retain such advisers or obtain their advice, it must consider the following six independence factors:

- whether the adviser's employer provides other services to the listed company;
- the amount of fees the adviser's employer receives from the listed company (as a percentage of such employer's total revenue);
- the conflict of interest policies and procedures of the adviser's employer;
- any business or personal relationship between the adviser and a member of the compensation committee;
- any stock of the listed company owned by the adviser; and
- any business or personal relationship between the adviser or the adviser's employer with an executive officer of the listed company.

Nasdaq's final rules require compensation committees to consider only these six factors prior to selecting advisers. By contrast, NYSE's rules require that compensation committees take into consideration these six factors as well as "all factors relevant to that person's independence from management."

In any case, compensation consultants, outside legal counsel and other advisers are not required to satisfy the "independence" criteria; the adviser independence rules only require that the compensation committee consider independence of their advisers before retaining or receiving advice from them.

Notably, the Compensation committee adviser independence assessment does not have to be conducted with respect to:

- advice from in-house legal counsel;

- advice from advisers whose role is limited to consulting on broad-based plans generally available to all salaried employees on an non-discriminatory basis; or

- information that is not customized for the company or that is customized based on parameters not developed by the consultant and as to which the consultant does not provide advice.

SEC staffers have indicated that with respect to the determination of what it means to "provide advice" to the compensation committee, a facts and circumstances test applies. Nevertheless, particularly because of the potential broad scope of what "providing advice" means, at the outset of retaining and seeking advice from outside counsel, consultants and other advisers whose advice might be provided directly to, or otherwise influence the advice given to, the compensation committee, we recommend that in-house legal counsel solicit the requisite information necessary to enable the compensation committee to assess the independence of any outside counsel or other advisers before any such advice is provided to the compensation committee.

DOL Updates Model COBRA Notice in Light of Health Care Reform

By Roberta Chevlowe

Come 2014, the Health Insurance Exchanges will provide another option to COBRA "qualified beneficiaries" who are considering whether to elect to continue health coverage under an employer's group plan. In an effort to ensure that qualified beneficiaries understand this option, the U.S. Department of Labor has revised its model COBRA Election Notice to refer specifically to the availability of the Exchanges. The updated Notice also includes other revisions related to health care reform. For example, the updated notice reflects the ACA's prohibition on preexisting condition exclusions and eliminates the prior model language relating to the Health Coverage Tax Credit, which will expire as of January 1, 2014. The updated notice (including a redlined version showing the updates) can be found here: http://www.dol.gov/ebsa/modelelectionnotice.doc (model notice not redlined); http://www.dol.gov/ebsa/newsroom/tr13-02.html (guidance on updated COBRA notice).

* Originally published by Law 360. Reprinted with permission.

[1] *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996).

[2] Subsidized coverage may be available to those making less than 400% of the federal poverty level ($45,960 for an individual or $94,200 for a family of four), depending on whether "affordable" coverage is available from an employer. It has been estimated that at least 26 million Americans will quality for such subsidies.

[3] A health care exchange "is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality." http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html. For individual consumers, open enrollment in the health care exchanges is set to begin October 1, 2013.

[4] ACA § 1401, 26 U.S.C. § 36B(c)(2)(C). "60% actuarial value" means that the health plan will pay at least 60% of the expected costs for essential health benefits, leaving the individual members to pay 40% of the costs for these benefits.

[5] Specifically, ACA's whistleblower provision prohibits adverse employment action when an employee: (i) reported a violation of Title I of ACA to the employer, the federal government, or a state Attorney General; (ii) testified or will testify in a proceeding concerning such a violation; (iii) objected to any act that the employee reasonably believed to be such a violation; or (iv) received a credit or subsidy under the ACA. ACA § 1558, 29 U.S.C. § 218c(a)(1).

[6] www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf. The California State Assembly is also considering a bill that would penalize large employers, defined as having more than 500 employees, for realigning their workforces to shift the costs of health coverage for low income workers onto the state. The stated purpose of the bill "is to extend the employer responsibility requirement in the ACA to employers with employees who enroll in Medi-Cal to discourage these employers from shifting the cost of providing health coverage for their employees onto the state." AB 880, 2013 Gen. Assem. Cmte. on Health, *available at* http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0851-0900/ab_880_cfa_20130426_181728_asm_comm.html, p. 9.

[7] ACA § 1558(b), FLSA § 18C(b).

[8] 15 U.S.C. § 2087(b)(1); *see also* OSHA's Whistleblower Protection Program, *available at*, http://www.whistleblowers.gov/statutes_page.html (listing all of the whistleblower statutes enforced by OSHA).

[9] 15 U.S.C. § 2087(b)(2).

[10] *Marano v. Dep't of Justice*, 2 F.3d 1137, 1140 (Fed. Cir. 1993) (interpreting Whistleblower Protection Act, 5 U.S.C. 1221(e)(1)).

[11] Procedures for the Handling of Retaliation Complaints Under Section 219 of the Consumer Product Safety Improvement Act of 2008, 75 Fed. Reg. 53533-01, at 53536 (Aug. 31, 2010) (citing *Klopfenstein v. PCC Flow Techs. Holdings, Inc.*, No. 04-149, 2006 WL 3246904, *13 (ARB May 31, 2006) (internal quotation omitted)).

[12] 15 U.S.C. § 2087(b)(4).

[13] ERISA § 510, 29 U.S.C. § 1140 (emphasis added).

[14] *Id.*; *see also George v. Junior Achievement of Central Indiana Inc.*, 694 F.3d 812 (7th Cir. 2012) (reading the term "inquiry" broadly to include unsolicited employee complaints about benefits owed as protected activity).

[15] *E.g., Salus v. GET Directories Serv. Corp.*, 104 F.3d 131 (7th Cir. 1997) (holding plaintiff must prove employer's specific intent to interfere with employee benefits); *Abbott v. Pipefitters Local Union No. 522 Hosp., Medical, and Life Ben. Plan*, 94 F.3d 236 (6th Cir. 1996) (same).

[16] *E.g.*, *Sandberg v. KPMG Peat Marwick*, 111 F.3d 331, 336 (2d Cir. 1997) (discussing restitution and back pay as typical remedies for ERISA § 510 violations).

[17] *See BNA Employee Benefits Law, Ch. 15.IX.H (2010 Supp); Millsap v. McDonnell Douglas Corp.*, 368 F.3d 1246 (10th Cir. 2004).

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

Related Professionals

- **Russell L. Hirschhorn**
  Partner

- **Myron D. Rumeld**
  Partner