EMPLOYEE BENEFITS DEVELOPMENTS JANUARY 2014

Hodgson Russ Newsletter
January 31, 2014

CASES

Attorneys

Peter Bradley

Michael Flanagan

Richard Kaiser

Ryan Murphy

Practices & Industries

Employee Benefits

Court Finds Former NFL Player's First Wife Is Surviving Spouse

A recent decision by the U.S. Court of Appeals for the Third Circuit demonstrates once again the importance of divorcing your first spouse before you marry your second. Upholding a lower court decision, the appeals court rejected a purported widow's claim for surviving spouse benefits under the NFL Player Retirement Plan because her husband was still legally married to his first wife at the time of his death.

Thomas Sullivan played in the National Football League from 1972 to 1978. In 1979, he married Lavona Hill. Although the couple separated sometime in the 1980s, they were never divorced. Nevertheless, Sullivan married again in 1986, and he and his second wife, Barbara, lived together as husband and wife until Sullivan died in 2002. Barbara filed for benefits under the NFL's retirement plan as Sullivan's surviving spouse, and the plan began to pay benefits to her in 2002. Four years later, Sullivan's first wife also requested surviving spouse benefits, eventually filing suit against the plan.

Finding Sullivan's second marriage void under South Carolina law, the district court held that his first wife was entitled to the benefits. Barbara appealed the decision, arguing that her marriage to Sullivan was valid under an exception to South Carolina bigamy law. South Carolina law provides that a second marriage is void if one of the spouses has a living prior husband or wife, unless the prior husband or wife is absent for at least five years and the spouse did not know whether he or she was still living during that time. Despite Barbara's argument that Sullivan and his wife separated more than five years before she met Sullivan, the appeals court agreed with the lower court that the second marriage did not meet the exception to South Carolina's prohibition on bigamy. Under the bigamy law, a presumption of death may arise after five years, but only if evidence is introduced that "diligent search and inquiry have been made." In addition to questions about the last date of contact

between the two, no evidence was introduced that Sullivan searched or inquired as to his first wife's whereabouts. As a result, Barbara's marriage was found to be void under South Carolina law. Finally, Barbara's alternative argument that her rights were protected under the "putative spouse doctrine" was precluded by the South Carolina Supreme Court's rejection of the doctrine. Acknowledging "the obvious equities in favor of Barbara as the apparent wife" for the last 16 years of Sullivan's life, the court nevertheless upheld the first wife's entitlement to surviving spouse benefits as the legal surviving spouse under South Carolina law. *Hill v. Bert Bell/Pete Rozelle NFL Player Ret. Plan* (3d. Cir. 2013)

Failure to Notify Participant That Coverage Is Out of Network May Be a Fiduciary Breach

The U.S. Court of Appeals for the Seventh Circuit, in an en banc decision, held that the husband of a deceased plan participant may continue with his fiduciary breach claim against his spouse's former employer and health plan. In this case, the participant had lung cancer that had spread to her brain. After physicians at her in-network hospital determined that they could not operate, she sought a second opinion from an out-of-network hospital that soon after admitted her for surgery. Although the surgery successfully removed the tumor, her cancer treatment was ultimately unsuccessful, and she died a few months later. Because the treating hospital was considered out of network, the plan denied many of the medical expenses later submitted by her husband. The widower sued the employer and the plan, arguing, in part, that the plan breached its fiduciary duty by not informing him that the treating hospital was considered out-of-network. The plan document did not list network coverage, rather directed participants to call a dedicated telephone number. The plaintiff twice called the numbers on the insurance card prior to his wife's surgery, and although he did not explicitly ask, no one notified him that the treating hospital was out of network and that he would be responsible for the additional expenses. The court, quoting a prior case, noted "regardless of the precision of his questions, once a beneficiary makes known his predicament, the fiduciary 'is under a duty to communicate … all material facts in connection with the transaction which the trustee knows or should know.'" On the fiduciary breach claim, the court reversed the grant of summary judgment and remanded the case to the trier of fact to determine 1) if the calls put the plan on notice, giving rise to a duty to disclose the out-of-network status, 2) whether the plan breached its duty, and 3) whether the breach harmed the plaintiff. *Killian v. Concert Health Plan* (7th Cir. 2013)

Severance Plan Denial of Benefits Held to Be Reasonable

Constellation Energy Group sold several of its power plants to Raven Power Holdings LLC. Raven, through its subsidiary, Topaz Power Management, made offers of employment to two Constellation employees, contingent on the closing of the transaction. Constellation had a severance plan that was applicable in the event of a change in control. The benefit was not available to individuals who were offered a position with a "successor." The employees applied for benefits under the severance plan and were denied benefits by the plan administrator of the Constellation plan. The administrator noted that both employees were hired by Topaz, which, because it was a subsidiary of Raven, the plan administrator deemed to be a successor under the plan terms. The employees filed suit, claiming the successor definition did not include a subsidiary of the actual purchaser. The District Court for the District of Maryland granted Constellation's motion to dismiss finding that the interpretation employed by the plan administrator to define successor not only to mean Raven but its subsidiary Topaz

was reasonable and consistent with other defined terms within the plan.

While the plan administrator's decision in this case was upheld, severance plans should be reviewed to make certain that the common provision denying benefits where employment is continued with a purchaser clearly includes subsidiaries or other affiliates of the actual party involved in the transaction so that litigation may be avoided. *Strauch v. Exelon Corp.* (D. Md., 2013)

Incorporating SEC Filings Into an SPD Can Have ERISA Liability Implications

In our August issue, we reported on a stock drop case decided in June 2013 by the U.S. Court of Appeals for the Ninth Circuit (*Harris v. Amgen, Inc.* (9th Cir. 2013)). In that case, the Ninth Circuit reversed a district court decision and remanded the case for further proceedings. In reaching its decision, the Ninth Circuit ruled that because the plan terms did not require or encourage the defendant fiduciaries to invest in employer stock, a presumption of prudence did not apply – plan language merely permitting investments in employer stock is not sufficient to protect the presumption of prudence. In the absence of the presumption, the Ninth Circuit held that the plaintiffs sufficiently alleged violation of defendants' fiduciary duties regarding two employer-sponsored retirement plans. Following the Ninth Circuit's decision, the defendants in the case filed a petition for rehearing.

The Ninth Circuit has since denied the petition. In doing so, the Ninth Circuit also amended its June 2013 opinion. The reversal of the district court's decision to dismiss as well as other holdings remain unchanged. But the amended opinion is significant because it expressly holds that the defendants' preparation and distribution of summary plan descriptions (SPDs), which incorporated certain filings with the Securities Exchange Commission (SEC) by reference, were acts performed in a fiduciary capacity. The plaintiffs allege the SEC filings that were incorporated into the SPDs include false and materially misleading statements concerning the company's financial health and the value of its stock. The Ninth Circuit reasoned that the SPDs are fiduciary communications to plan participants, and the defendants exercised discretion in choosing to incorporate the SEC filings into the SPDs as a means for providing information on the company's financial health. Accordingly, statements, including the allegedly misleading statements made in the incorporated SEC filings, may be used under ERISA to show that the defendants knew or should have known that the price of the company's stock was artificially inflated and to show that the plaintiffs presumptively relied on those statements to their detriment.

A decision to incorporate SEC filings into an SPD should be carefully considered in light of the potential ERISA liability implications suggested by this case. *Harris v. Amgen, Inc.* (9th Cir. 2013)

Reduction in "Banked Hours" Violates the ERISA Anti-Cutback Rules

A union was formed through the merger of four former local unions. After the merger, the local unions' employee benefits plans and related pension plans and funds also merged. The post-merger pension plan retained certain provisions from the pre-merger plans regarding banked hours. "Banked hours" are hours of service worked in covered employment or otherwise accrued by plan participants within a given year in excess of the minimum number of hours required to earn a full year of

service for pension credit under the applicable plan. Those hours can be banked for a variety of uses, including filling in of hours of service for years in which the participant falls short of the minimum required for a full year of credit. The provisions contained in the various pre-merger plan documents had different accrual, use, and value of banked hours. The post-merger plan document eliminated those variations and chose to use each banked hour provision from among the most generous benefit terms from the earlier provisions. As a result, a number of plan participants, the plaintiffs among them, retrospectively received increased levels of banked hour pension credits and increased pension benefit levels immediately after the merger.

The post-merger plan subsequently experienced funding deficiencies, which led to the enactment of an amendment that reduced plan participants' retrospective banked hour pension benefits for hours accumulated prior to the merger back to the lower levels promised under plan participants' respective pre-merger plan document. The plaintiffs sued, alleging that the implementation of the amendment conflicts with ERISA's "anti-cutback" rule. The district court granted the plaintiffs' motion for summary judgment and held that the plaintiffs' pre-merger banked hour benefits constituted "accrued benefits" under ERISA that could not be decreased by plan amendment. The plan trustees appealed.

On appeal, the U.S. Court of Appeals for the First Circuit affirmed the decision of the district court. The Trustees' core argument was that the plaintiffs did not "earn" these retrospective benefits by working; the retrospective benefits were a gratuity resulting from a prior merger of benefit plans. The First Circuit disagreed, concluding that the focus of the anti-cutback rule is not on whether benefits are earned, but on whether benefits have accrued. And once an individual continues employment in exchange for promised benefits, those promised benefits are protected from cutback even if the benefits were conferred retroactively. *Bonneau v. Plumbers & Pipefitters Local 51 Pension Trust Fund* (1st Cir. 2013)

Compensation Paid to IRA Owner by Corporation Results in Account Ceasing to Be IRA

In our July 2013 newsletter, we discussed the consequences of an individual retirement account (IRA) engaging in a prohibited transaction, with the end result being the account ceases to be treated as an IRA on the first day of the taxable year in which the prohibited transaction occurs and the IRA's assets are considered to be distributed to the IRA owner on that date. The prohibited transaction discussed in our July 2013 newsletter involved an indirect extension of credit by two IRA owners to their IRAs through the IRA owners' guaranty of a promissory note from a corporation wholly owned by the IRAs. Two additional variations of a prohibited transaction involve (i) the direct or indirect transfer to an IRA owner of the income or assets of an IRA, and (ii) an act by an IRA owner whereby he directly or indirectly deals with the income or assets of the IRA in his own interest or for his own account.

In 2005, Terry Ellis formed CST, a Missouri limited liability company that elected to be taxed as a corporation. CST's operating agreement listed a not-yet formed IRA owned by Ellis as owning 98 percent of the membership units in CST; the remaining 2 percent was owned by a person not involved in the case. Ellis subsequently established the IRA and rolled over $321,345.25 from his former employer's 401(k) plan to the IRA, of which $319,500 was then contributed to CST in exchange for the IRA's 98 percent membership interest. During 2005, Ellis served as manager for CST and received compensation of $9,754 from CST.

The IRS issued a notice of deficiency for Terry and Sheila Ellis' 2005 income tax return (they filed a joint income tax return for 2005), raising alternative theories as to why a prohibited transaction had occurred with respect to the IRA, including that a prohibited transaction occurred when Mr. Ellis caused CST to pay him compensation. The tax court sided with the IRS. The tax court agreed that, by causing CST to pay him $9,754 in compensation, Mr. Ellis had (i) engaged in a transfer of the IRA's income or assets to himself, and (ii) dealt with the IRA's income or assets for his own interest. As a result, the account ceased to be treated as an IRA, and its assets were deemed to be distributed.

The Ellis case is only the most recent example of courts' willingness to construe the term "indirect" broadly under the prohibited transaction rules. Under this view, any transactions between a company that is substantially owned by an IRA and the IRA owner are likely to be closely scrutinized. Those capitalizing a new business by utilizing IRA funds as part of a so-called rollover business start-up (or ROBS) do so at their own peril. *Ellis v. Commissioner*, TC Memo 2013-245

RULINGS, OPINIONS, ETC.

IRS Issues Final Rules on Mid-Year Modification of Safe Harbor Contributions

Safe harbor 401(k) and 403(b) plans require that an employer make either matching or non-elective contributions for an entire plan year. Previous Internal Revenue Service (IRS) regulations permitted employers to suspend matching contributions upon giving 30 days advance notice to participants. The previous guidance did not address mid-year changes to non-elective contributions. In 2009, the IRS issued proposed regulations that would permit suspension of non-elective contributions if the employer satisfied certain financial hardship conditions. Under the proposed regulations, in order to show financial hardship, an employer would have to have met the stringent rules for requesting a waiver of the minimum funding standard. The IRS final regulations provide uniformity in the rules for both suspension and reduction of safe harbor matching or non-elective contributions. Under the final regulations, there are two methods by which a mid-year change could be made. Under the first method, the employer must be operating at an economic loss. This requirement is only one of several standards that would have to have been satisfied for requesting a minimum funding waiver. This change will allow employers more certainty in determining whether they satisfy the requirement. The second way in which a safe harbor contribution can be suspended is if the annual safe harbor notice provides that the plan may be amended during the plan year to eliminate or reduce the safe harbor contribution with 30-days advance notice to participants. The 30-day advance notice must explain the consequences of the amendment, procedures for making changes in cash or deferred elections, and the effective date of the amendment, and participants must be provided a reasonable opportunity to change their salary deferral elections. Note that, because the safe harbor requirements are no longer being met, the final regulations require that the ADP and ACP tests must be satisfied using the current year testing methodology. The final regulations also provide for a mid-year plan termination without advance notice if the termination is in connection with a corporate merger or reorganization or the plan sponsor incurs a substantial business hardship.

It is recommended that plan sponsors modify the next safe harbor notice to provide for the 30-day notice of suspension language in order to provide the greatest degree of flexibility in operation of their plans. (T.D. 9641)

Agencies Issue Final Regulation on Mental Health Parity

On November 8, 2013, the Departments of Labor, Health and Human Services, and the Treasury issued a final regulation implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). For calendar year plans, the effective date of the regulation is January 1, 2015. For non-calendar year plans, the effective date is the first day of the plan year beginning on or after July 1, 2014. Until the final regulation becomes effective, group health plans must continue to comply with the interim final regulation, which became effective for plan years beginning on or after July 1, 2010.

Background

MHPAEA applies to insured and self-insured group health plans sponsored by private and public sector employers. It applies to both fully insured and self-funded group plans, as well as individual plans sold on and off the health insurance exchanges. Plans for state and local government employees that are self-insured may opt-out of MHPAEA if certain administrative steps are taken. Retiree-only plans are not subject to MHPAEA. Finally, MHPAEA contains an increased cost exemption for group health plans that meet certain requirements.

Self-funded group health plans and fully insured group health plans maintained by large employers are not required to offer mental health and substance use disorder benefits under federal law, but plans that do must comply with MHPAEA. Thus, for example, if a self-insured group health plan does not provide any mental health and substance use disorder benefits, the plan is not required to comply with MHPAEA. [1]MHPAEA does not preempt state health insurance coverage mandates that are more stringent than federal parity requirements.

Group health plans that provide mental health and substance use disorder benefits must ensure that the financial requirements (e.g., co-pays, deductibles, coinsurance requirements, and out-of-pocket limits) and treatment limitations (e. g., number of treatments, visits, or days of coverage limits) that apply to those benefits are no less generous than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. To determine if a financial requirement or treatment limitation is permissible, the parity analysis must be applied for that type of financial requirement or treatment limitation within a coverage unit for each of six classifications of benefits separately. The six classifications of benefits are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs.

If a group health plan that provides medical and surgical benefits is on an out-of-network basis, it must also provide mental health and substance use disorder benefits on an out-of-network basis.

If a plan imposes non-quantitative treatment limits on mental health or substance use disorder benefits, these processes must not be more stringent or restrictive than the processes that apply to medical benefits. Non-quantitative treatment limits include: medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness; whether a treatment is experimental or investigative; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; plan methods for determining usual, customary, and reasonable charges for out-of-network providers; refusal to pay for higher-cost therapies until it can be shown that lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and exclusions based on failure to complete a course of treatment.

In addition to the benefit mandates, MHPAEA contains specific disclosure rules. First, the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. In addition, the reason for any denial of reimbursement or payment for services with respect to mental health benefits must be made available, upon request or as otherwise required, to the participant or beneficiary.

Detailed information regarding MHPAEA can be found here.

New Guidance

The final regulation offers a number of clarifications about the parity law. Here are some of the more important clarifications:

New Sub-Classification for Office Visits. As noted above, parity analysis must be conducted on a classification-by-classification basis in six specific classifications of benefits, including outpatient benefits. Under the final regulation, group health plans may further subdivide the outpatient classification into two sub-classifications: (1) office visits and (2) all other outpatient items and services. This means that with respect to outpatient benefits, plans and issuers may require a copayment for office visits (such as physician or psychologist visits) and coinsurance for all other outpatient services (such as outpatient surgery).

New Sub-Classification for Tiered Provider Networks. Using tiered provider networks can help group health plans manage the costs and quality of care. The final regulations permit plans and issuers that maintain tiered provider networks to treat an in-network provider tier as a separate sub-classification for purposes of applying the financial requirement and treatment limitation rules under MHPAEA. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification. This means, for example, that within any one of the six categories (e.g., outpatient care), a plan will not violate MHPAEA simply because it provides more favorable cost-sharing treatment (e.g., more favorable co-pays) for services rendered by preferred providers than it provides for services rendered by non-preferred providers. The in-network provider tiers must be based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/ surgical provider.

Scope of Services — Continuum of Care. Scope of services generally refers to the types of treatment and treatment settings that are covered by a group health plan or health insurance coverage. The interim final regulation did not address this issue. To address this open question, the final regulation requires plans and issuers to assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. So, for example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

As noted, the final regulation applies to calendar year plans effective January 1, 2015. Employers, and in particular those that maintain self-insured plans, should begin a compliance review of their plans in the next several months to ensure that there will be sufficient time in advance of the 2015 open enrollment period to analyze plan design choices.

[1]While such a plan would not be required to comply with MHPAEA, exclusion of all mental health and substance use disorder benefits might cause a plan to fail the "minimum value" requirement (i.e., have an actuarial value of less than 60 percent) thereby exposing the employer to the unaff ordable plan play-or-pay penalty.

Employee Benefits Practice Group

Peter K. Bradley pbradley@hodgsonruss.com
Anita Costello Greer agreer@hodgsonruss.com
Michael J. Flanagan mflanagan@hodgsonruss.com
Richard W. Kaiser rkaiser@hodgsonruss.com
Arthur A. Marrapese, III art_marrapese@hodgsonruss.com
Ryan M. Murphy rmurphy@hodgsonruss.com