EMPLOYEE BENEFITS DEVELOPMENTS AUGUST 2015

Hodgson Russ Newsletter
August 31, 2015

Certain Closely Held For-Profit Employers Need Not Provide Women's Contraceptive Services. Under the ACA, non-grandfathered group health plans must cover specified preventive services, including certain women's preventive health services, without cost-sharing (co-pays, deductibles, and coinsurance) when delivered by in-network providers. Women's services include all FDA-approved contraceptive services for women with child-bearing capacity, as prescribed by a provider. In July 2015, the Departments of Labor, Health and Human Services, and Treasury (the Departments) published a rule that, among other things, finalizes a proposal, issued last year, to provide an accommodation for closely held for-profit entities with religious objections to some or all of the mandated contraceptive services.

Religious Employers. Under regulations issued in July 2013, group health plans of "religious employers" are exempt from having to provide coverage for contraceptive services.

Nonprofit Religious Organizations. The final rules issued in July 2013 provide an accommodation for nonprofit religious organizations that have a religious objection to the services; that hold themselves out as a religious organization; that certify to these facts; and that provide the certification to their insurer provider (insured plans) or third-party administrator (self-insured plans). Upon receipt of the self-certification, the health insurer (or third-party administrator) must arrange for the services for the women in the plan maintained by the nonprofit at no cost to the women or to the organization. As an alternative, an eligible nonprofit can notify the Department of Health and Human Services (HHS) in writing of its religious objection to providing coverage for contraceptive services, which, in turn, will then notify the insurer (or third-party administrator) that the nonprofit employer objects to providing coverage for contraceptive services, and that the insurer (or third-party administrator) will be responsible for providing the mandated benefits.

Certain Closely Held For-Profit Entities. In August 2014, in response to the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.*, the Departments issued a proposed regulation that would extend the nonprofit accommodation to closely held for-profit entities that have a religious objection to providing coverage for some or all contraceptive services. This proposed rule has been finalized. Under the final

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rule, a closely held for-profit entity will qualify for an accommodation if:

- It is not a nonprofit entity;
- Has no publicly traded ownership interests; and
- Has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals.

Ownership interests held by members of a family are treated as being owned by a single individual. Entities whose ownership structure is substantially similar to this definition can also qualify for the accommodation. An organization that is unsure about whether its ownership structure qualifies as "substantially similar" can seek guidance from HHS.

To be eligible for the accommodation, the for-profit entity's highest governing body (e.g., board of directors or LLC members) must adopt a resolution that conforms to the entity's governing documents and state law, stating that its owners have a sincerely held objection to some or all of the mandated contraceptive services. An eligible closely held for-profit entity may use either of the two notification options that are available under the accommodation that applies to nonprofit employers (discussed above).

SEC Proposes New Clawback Rule for Executive Compensation. In a divided vote, the Securities and Exchange Commission recently voted to propose a new rule requiring public companies to "claw back" any incentive-based compensation awarded to executives based on incorrect financial statements. Under the proposed rule, any listed company required to restate its financial statements because of material errors would be required to recover the amount of incentive-based compensation received by an executive officer exceeding the amount the officer would have received had the compensation been determined based on the accounting restatement. The mandatory recovery would apply to all current and former executive officers who received incentive-based compensation during the three fiscal years preceding the date of the restatement and would be enforced on a "no-fault" basis, without regard to whether an officer engaged in misconduct or had any responsibility for the erroneous financial statements. The definition of "executive officer" is based on the definition of "officer" under Section 16 of the Securities Exchange Act and includes a company's chief executive officer; chief financial officer; chief accounting officer; any vice president in charge of a principal business unit, division, or function; and any other person who performs policy-making functions for the company. Companies would not be permitted to indemnify or repay executive officers for any amount subject to recovery. Each listed company would be required to file its clawback policy as an exhibit to its annual report under the Securities Exchange Act, and would be subject to delisting if it fails to adopt a compliant compensation recovery policy, properly disclose the policy, or comply with the policy's clawback provisions. The comment period for the proposed rules is 60 days after publication in the Federal Register.

IRS Announces Major Revisions to Determination Letter Program. Under the IRS's existing determination letter program for qualified retirement plans, sponsors of individually designed plans are generally permitted to apply for an IRS determination letter every five years. The IRS recently announced that, due to limited resources, the determination letter program is being revised to eliminate a sponsor of an individual designed plan's ability to apply for a determination letter every fifth year. The change will be effective January 1, 2017, except sponsors of Cycle A plans (i.e., generally employers whose employer identification number ends in 1 or 6) may continue to submit a determination letter application during the 12-month period ending January 31, 2017.

Sponsors of individually designed plans may continue to apply for an IRS determination letter on initial plan qualification and for qualification upon plan termination. In addition, the IRS indicated that sponsors of individually designed plans will also be permitted to submit a determination letter application in certain other limited circumstances that will be determined by the IRS.

Effective immediately, the IRS announced that it will no longer consider determination letter applications for individually designed plans that are filed "off-cycle" (i.e., in a submission year for which the plan is not scheduled to be submitted under IRS procedures), except for determination letter applications on initial plan qualification and qualification upon plan termination.

Sponsors of qualified retirement plans that are maintained on an IRS pre-approved plan document are unaffected by the announcement.

Second Circuit Holds Normal Retirement Age Can Not Be Defined by Years of Service. A case with a long history of litigation (see *Employee Benefits Developments October 2013*) recently reached another milestone when the U.S. Court of Appeals for the Second Circuit upheld a lower court ruling regarding a plan's definition of normal retirement age. The retirement benefit accumulation plan for employees of PricewaterhouseCoopers LLP defined normal retirement age as completion of five years of service. Certain participants objected to that definition and claimed that normal retirement age should be age 65 and, as a result, they are entitled to additional amounts payable to them as a lump sum because of what is known as a "whipsaw calculation" in a cash balance plan. The U.S. District Court for the Southern District of New York indicated that when a person commences participation at a certain age, and that person's age is increased by five years, the normal retirement age definition still results in an ascertainable age (i.e., the age at the time participation commences plus five years). But years of service is a different calculation than years of participation (i.e., because it may be longer than five years for a participant to accumulate five years of service). Accordingly, the district court held that the plan's normal retirement age definition did not define an "age."

The focus of the Second Circuit opinion was slightly different. While there is no definition of normal retirement age under the Employee Retirement Income Security Act of 1974 (ERISA), the Second Circuit ruled the plan language referencing a five-year period of service to be inconsistent with the normal, usual, or typical meaning of "retirement," which more commonly means withdrawing from business or public life and living on one's income, savings, or pension. The Second Circuit found the plan's definition of five years of services would allow employers to pick an unreasonably low age as normal retirement age. The Second Circuit found that a contrary ruling in the Fourth Circuit was unpersuasive as dicta, and disagreed with a Seventh Circuit ruling that normal retirement age could be based on years of service. Given the long history of litigation, we may expect to see further developments and perhaps a Supreme Court decision settling the apparent conflict between these three circuit courts. *Laurent v. PricewaterhouseCoopers LLP*, 2nd Cir. 2015

Second Circuit Rules Severance Plan Is Subject to ERISA. Reversing a lower court decision dismissing a physician's complaint against his employer, the U.S. Court of Appeals for the Second Circuit ruled that a medical center's severance plan for physicians is an employee welfare benefit plan subject to ERISA. The medical center's severance policy covers full-time physicians employed before August 1, 1996, who are terminated without cause. Eligible employees are entitled to either 12 months' notice or six months' severance pay, and eligible employees with more than 15 years of service are also entitled to automatic review of their severance pay by the president of the medical center. The plaintiff physician in this

case notified his supervisor on May 1, 2011, that he was leaving the following September to take a new job. On May 13, the physician was fired "for cause," ostensibly because of comments made in front of a guest speaker just prior to his dismissal.

The physician brought suit in federal court, alleging that his termination was a pretext designed to interfere with his right to severance under the policy and ERISA. The medical center moved to dismiss the claims for lack of subject matter jurisdiction, claiming the plan was exempt from ERISA. The lower court agreed, finding that the plan did not require the kind of ongoing administrative program required of an ERISA plan, and dismissed the claim. On appeal, the Second Circuit identified three factors to help determine whether an employer's plan or arrangement involves an ongoing administrative scheme under ERISA:

1. Whether the employer's undertaking or obligation requires managerial discretion in its administration;
2. Whether a reasonable employee would perceive an ongoing commitment by the employer to provide employee benefits; and
3. Whether the employer was required to analyze the circumstances of each employee's termination separately in light of certain criteria.

Looking at each factor, the Second Circuit concluded that the severance policy was an ERISA plan. First, the court found that the policy requires discretion and individualized evaluation to administer. In this case, the employer must determine whether an employee left voluntarily or was terminated, and whether the termination was "for cause." Also, any employee with 15 or more years of service may require a discretionary review by the president of the amount of his or her severance benefits. Second, the court found it plausible that such a longstanding policy, existing in its current form since 1996, would give employees the reasonable impression that the employer has undertaken an "ongoing commitment" to provide severance benefits, despite language in the policy that gives the medical center the unilateral right to amend the policy without notice. And finally, the court found there was at least some managerial discretion in the president's review of severance and in the classification of the termination of each employee as being for or without cause. Accordingly, the court vacated the judgment and remanded the case to the district court for consideration of the interference claims. *Okun v. Montefiore Med. Ctr.*, 2nd Cir. 2015

Court Rules Health Care Providers Are Not Plan Beneficiaries. The U.S. Court of Appeals for the Second Circuit recently ruled that doctors are not beneficiaries of their patients' health plans and therefore lack standing to seek relief under Section 502 of ERISA. In the case, a health care provider sued an insurance carrier in an effort to be reinstated in the insurance company's provider network. Only plan participants and beneficiaries have standing to sue under ERISA Section 502. The health care provider argued that it had standing to bring the action because the health care provider's patients assigned the health care provider the right to collect payment for medical services directly from the insurance company. It follows, argued the health care provider, that the right to receive payment from the plan made the health care provider a beneficiary; both through the assignment of the right to receive payment and actually receiving payment (a "benefit") from the plan. Channeling its inner Yoda, the court rejected these arguments stating that "the right to payment does not a beneficiary make." The court explained that a beneficiary is best understood as an individual who enjoys rights equal to the participant's to receive coverage from a health plan (such as a participant's spouse or child). The assignment of rights theory failed to persuade the court because the assignment was limited to collection of payment and did not extend to ERISA's anti-retaliation protections. *Rojas v. Cigna Health & Life Ins. Co.*, 2nd Cir. 2015

Despite "Abuse of Discretion," Plan Fiduciaries Not Liable in Investment Mapping Case. In the May 2014 edition of *Employee Benefits Developments*, we reported on a case decided by the U.S. Court of Appeals for the Eighth Circuit (*Tussey v. ABB, Inc.*, 8th Cir. 2014) involving a variety of fiduciary breaches alleged by employees participating in an employer's 401(k) plans. The federal district court that first decided the case in 2012 found the plan fiduciaries guilty of a number of fiduciary breaches, including breaches associated with removing the Vanguard Wellington Fund from the investment fund line-up and replacing it with Fidelity's Freedom Funds. With regard to that fund removal issue, the Eighth Circuit found that the district court erroneously substituted its own de novo plan interpretation and view of the ideal plan investments for the reasoned judgment of the plan fiduciaries. The Eighth Circuit concluded that the district court did not show appropriate deference to the plan fiduciaries in evaluating whether they, based on what they knew at the time they made their investment decisions, breached their fiduciary duties in evaluating, selecting, and implementing the new plan investment fund option. The Eighth Circuit also concluded that the district court's opinion improperly relied on hindsight to evaluate the prudence of the investment selection. As a result, the Eighth Circuit vacated the district court's $21.8 million judgment and award on the fund removal claim and remanded it for further consideration.

Following an unsuccessful attempt to appeal the case to the U.S. Supreme Court, a federal district court in Missouri, on remand, decided the plan fiduciaries did abuse their discretion by removing the Vanguard Wellington Fund from the investment fund line-up and replacing it with Fidelity's Freedom Funds. Based on the totality of the evidence in the record, the district court found it "more likely than not" that the Vanguard Wellington Fund was removed and replaced by the Fidelity Freedom Funds to produce increased revenue sharing that ultimately benefitted the plan sponsor.

Despite finding abuse of discretion by the plan fiduciaries, the district court, on the matter of damages, ruled the plaintiffs in the case "failed to prove damages consistent with the method of damage calculation suggested by the Eighth Circuit," and entered a judgment in favor of the plan fiduciaries. Because the plan's investment policy statement required the addition of a managed allocation fund, the Eighth Circuit ruled in 2014 that the plaintiffs' damages, if any, "would be more accurately measured by comparing the difference between the performance of the Freedom Funds and the minimum return of the subset of managed allocation funds the ABB fiduciaries could have chosen without breaching their fiduciary obligations." Because the district court, on remand, found the Eighth Circuit's measure "persuasive" and because the plaintiffs failed to present evidence of the only measure of damages that the Eighth Circuit has tacitly approved," the court ruled the plaintiffs failed to satisfy their burden of proof on the issue of damages."

While the plan fiduciaries walk away the winner in this round of litigation, there are important lessons for plan fiduciaries to take away from this case. Among those lessons is a reminder for plan fiduciaries that the best interests of the plan participants are paramount and, while there is an obligation to ensure fees for plan services are reasonable, efforts to reduce service fees borne by the plan sponsor may not overshadow the interests of the participants. *Tussey v. ABB, Inc.*, W.D. Mo. 2015