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EMPLOYEE BENEFITS DEVELOPMENTS
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Employee Benefits

RULINGS, OPINIONS, ETC.

Following *Windsor*, IRS and DOL Adopt "State of Celebration" Rule

The Internal Revenue Service (IRS) and Department of Labor (DOL) recently released guidance clarifying the employee benefits implications associated with the Supreme Court's decision in *United States v. Windsor* that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. Section 3 of DOMA provided that, for purposes of federal law, the term "marriage" means a legal union between one man and one woman as husband and wife, and the term "spouse" refers only to a person of the opposite sex who is a husband or a wife.

The IRS and DOL guidance provides that, for purposes of federal taxation and the Employee Retirement Income Security Act of 1974 (ERISA), individuals of the same sex will be considered lawfully married as long as they were married in a state whose laws authorize the marriage of two individuals of the same sex, even if they are domiciled in a state that does not recognize the validity of same-sex marriages. The guidance defines "state" to mean any domestic or foreign jurisdiction having the legal authority to sanction marriages.

Adoption of this so-called "state of celebration" rule avoids the administrative burdens associated with a rule of recognition based on domicile, which would require employers to continually track the domicile of same-sex married employees and former employees. The state of celebration rule also eliminates the likelihood of plan errors that could arise under a state of domicile rule, such as a failure to comply with the spousal consent or required minimum distribution rules applicable to qualified retirement plans.

Employers should take note that the DOL curiously adopted a "state of residence" rule for purposes of the Family Medical Leave Act (FMLA). Whether the DOL will revisit its FMLA stance following its more recent guidance for purposes of ERISA remains to be seen.

In general, the IRS's guidance is effective prospectively as of September 16, 2013. However, the guidance may be applied retroactively with respect to certain employer-provided health coverage benefits or fringe benefits under which amounts are excludable from income based on an employee's marital status. Thus, for example, in the situation where an employee was treated as having received additional wages with respect to employer-provided health coverage for a same-sex spouse, an employer may file a claim for refund of employment taxes paid by the employer on those additional wages, provided the statute of limitations for filing a claim for refund has not expired.

The IRS has issued streamlined special administrative procedures that employers may elect to use to correct the overpayment of employment taxes as a result of the *Windsor* case. With respect to employment taxes overpaid for the first three quarters of 2013, an employer may use the fourth quarter 2013 Form 941 to correct the overpayment, provided the employer repays or reimburses employees for the overpaid employment taxes on or before December 31, 2013. Alternatively, an employer may file one Form 941-X for the fourth quarter of 2013 to correct overpayments of FICA taxes for all quarters in 2013. For years prior to 2013, an employer may similarly file one Form 941-X for the fourth quarter of the applicable year, provided the statute of limitations on refunds has not expired and, in the case of adjustments, the period of limitations will not expire within 90 days of filing the adjusted return (the statute of limitations on refunds generally expires on the later of three years from the date the return was filed or two years from the date the tax was paid). In all cases where an employer elects to file a Form 941-X to correct an overpayment of employment taxes, the employer must repay or reimburse employees for overwithheld FICA taxes (or secure affected employees' consent for refund claims), obtain written statements from affected employees that the employee has not made, and will not make, any claims for refund or credit of the amount of overcollected FICA tax, and the employer files a Form W-2c (if necessary). An employer generally may not make an adjustment for overwithheld income tax for a prior calendar year.

The IRS intends to issue further guidance on the retroactive application of the *Windsor* decision to other employee benefits arrangements. The IRS has indicated that any future guidance will provide sufficient time for plan amendments and any necessary corrections.

Although the IRS and DOL guidance create a degree of certainty with respect to federal taxation and ERISA following Windsor, many employers may still be required to negotiate state tax issues associated with having same-sex married employees. It should be noted on this point that at least one federal district court, following the Windsor decision, held that Ohio was required to recognize a same-sex couple as being married when that couple was legally married in another state.

In terms of immediate action steps, employers should review their employee benefit plan documents and payroll practices to ensure they are in compliance with federal law, and they may wish to examine whether to seek an adjustment or refund of employment taxes for open tax years.

CASES

Court Affirms HSA Balance Is Not Excluded From Bankruptcy Estate

The U.S. Bankruptcy Appellate Panel for the Eighth Circuit affirmed a lower court ruling that the funds in a debtor's Health Savings Account (HSA) are not excluded from the bankruptcy estate and are not exempt. On the date of his bankruptcy filing, the debtor listed the funds in his HSA as an asset that should be excluded from the bankruptcy estate. He specifically asserted that under 11 U.S.C. § 541(b)(7)(A)(ii), "property of the estate does not include … any amount withheld by an employer from the wages of employees for payment as contributions … to a health insurance plan regulated by state law …" The court rejected this argument, noting that an HSA is not a health insurance plan. It is simply a trust account. The court further noted that an HSA account beneficiary has unrestricted access to the funds. Although the account beneficiary may receive certain tax benefits if the funds are used for medical expenses, that beneficial tax treatment does not make the account a health insurance plan regulated by state law. Although most clients will not be faced with this specific set of facts, this case is a helpful reminder that although HSAs are paired with high deductible health plans, in most cases the HSA itself is not a health plan.

District Court Holds That Normal Retirement Age Can Not Be Defined by Years of Service

In the case of a cash balance plan with a long history of litigation, the participant's lawsuit has survived a motion to dismiss. 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. In a case involving a different plan, the Seventh Circuit Court of Appeals held that a plan that defined normal retirement age as the fifth anniversary of commencing participation in the plan was an acceptable definition of normal retirement age. In this case, the District Court for the Southern District of New York, after questioning the decision by the Seventh Circuit, distinguished the definition upheld by the Seventh Circuit. The district court indicated that when a person commences participation at a certain age, and you then increase the age by five years, the normal retirement age definition still results in an age (age at time of participation plus five years). Because years of service is a different calculation than years of participation (it may be longer than five years), the district court held that this definition did not define an "age." Further, the district court refused to follow a recent holding in the Fourth Circuit Court of Appeals that indicated the definition of normal retirement age by reference to years of service was acceptable. The district court stated that the holding was dictum, and the Fourth Circuit had reached that conclusion only after the plaintiff had largely abandoned the contention that the definition did not define an age. Further, the district court also felt the Fourth Circuit decision was only persuasive authority and that the decision did not consider or discuss the arguments in front of the district court. Given the long litigation history of this case, we can expect to see additional developments in the future. However, plan sponsors should be leery of defining normal retirement age solely by reference to years of service. (*Laurent v. PricewaterhouseCoopers LLP*, S.D.N.Y., 2013)

"Satisfactory to Us" Plan Language Insufficient to Warrant Use of Deferential Standard of Review

An employee applied and paid for long-term disability insurance benefits under a group policy arrangement made available by her employer. The employee was granted a disability leave in 2006. Shortly after leaving her job, the employee filed a claim for disability benefits. The insurance company denied the employee's request for benefits because there was "insufficient objective evidence to substantiate" a disability that precluded her from performing her duties with her employer. The insurance company never examined the employee, but it did rely on video surveillance and a review of her medical history in denying the claim.

The employee filed suit in state court, challenging the insurer's denial of benefits on state law grounds. The insurer removed the lawsuit to federal district court and the court dismissed the claims based on ERISA preemption. The employee amended her complaint to add ERISA claims and filed a motion asking the district court to apply the less deferential de novo standard of review in its evaluation of her ERISA claims. That motion was denied and the court subsequently granted the insurer's summary judgment motion. The court held that the insurer's decision to deny benefits was not arbitrary and capricious and complied with ERISA's requirements.

The employee appealed the district court's decision. The Court of Appeals for the First Circuit ruled that the denial of benefits was subject to the less deferential de novo review standard. The court concluded the plan language requiring proof of disability "satisfactory to us" does not state with sufficient clarity "that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary." For that reason, the "satisfactory to us" language was determined to be insufficient to warrant application of the more deferential "arbitrary and capricious" standard of review. Because the evidence in the case did not fully resolve whether the insurer justifiably rejected the disability claim, the First Circuit vacated the judgment and remanded the case to the district court. (*Gross v. Sun Life Assurance Co. of Canada*, 1st Cir. 2013)

Can Personal Injury Lawyers Be Liable to Medical Plans?

The U.S. District Court for the Eastern District of New York recently held that a medical plan can enforce a lien against attorneys' fees received in connection with a settlement that is subject to the plan's third party recovery provision. (*Kolh's Department Stores v. Fred Castelli and Lite and Russell*, E.D.N.Y, August 2013)

In this case, a participant in the self-insured medical plan maintained by his employer incurred medical expenses of $63,732 as a result of injuries sustained in a motor vehicle accident. The participant filed a personal injury action against the parties responsible for the injury and received a sum of money from the responsible parties in settlement of his claim.

The medical plan sponsored by the participant's employer paid for his medical care and then sought reimbursement from the participant and his attorneys pursuant to the following provision in the medical plan document:

If you receive a benefit payment from the plan for an injury caused by a third party, and you later receive any payment for that same condition or injury from another person, organization, or insurance company, we have the right to recover any payments made by the plan to you.

You agree as follows:

You will reimburse the plan immediately upon recovery. Once we make or are obligated to make payments on your behalf, we are granted and you are required and consented to, an equitable lien by agreement or constructive trust on the proceeds of any payment, reimbursement, settlement, or judgment received by you from third parties or any other source.

When the participant and his attorneys refused to reimburse the medical plan for the medical expenses it had paid, the plan administrator sued the participant and his attorneys seeking to recover the benefits paid in connection with the accident.

The participant and his attorneys asked the court to dismiss the lawsuit on the following grounds, among others:

- New York General Obligations Law Section 5-335 prohibits a plan from enforcing third party recovery provisions of the kind at issue.
- The medical plan does not have a lien against the settlement proceeds.
- The medical plan does not have the legal authority to assert a lien over the legal fees earned by the attorneys because the attorneys were not participants in the plan and, therefore, are not governed by the terms of the plan.

The court rejected each of these arguments, holding that the New York law at issue cannot be enforced against a self-insured plan that is subject to ERISA (i.e., the state law at issue is preempted by ERISA); that the subrogation language in the document was sufficient to create a lien in favor of the medical plan; and that ERISA authorizes relief against an attorney-at-law when the attorney holds or exercises control over disputed settlement funds on behalf of a client who is a participant in a medical plan.

This case is of particular interest because, as the district court notes, it appears the Second Circuit has not specifically addressed whether a plan beneficiary's lawyer is a proper defendant in an ERISA claim.

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