Hodgson Russ LLP
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EMPLOYEE BENEFITS DEVELOPMENTS SEPTEMBER 2011

Hodgson Russ Newsletter
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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

New Date for Medicare Part D Notices

Beginning this year, the annual enrollment period for Medicare Part D and Medicare Advantage will begin October 15 and end December 7. This means that plan sponsors must provide creditable (or non-creditable) coverage notices one month earlier than in prior years (October 15 rather than November 15). To reflect this change, the Centers for Medicare and Medicaid Services (CMS) revised the model Part D notices.

A common practice among employers who operate calendar year plans is to provide the required Part D notice as part of the annual open enrollment material. Beginning this year, plan sponsors may continue this practice only if the plan's open enrollment materials are distributed before October 15; otherwise, the Part D notice will need to be furnished separately.

Updated model notices are available on the CMS website. Plan sponsors should review the new notices and revise them as necessary to reflect the terms of their plan. Part D notices must also be furnished prior to the effective date of coverage for any Medicare-eligible individual who enrolls in the plan, if employer-sponsored coverage is terminated, if the plan sponsor's drug coverage changes from creditable to non-creditable (or vice versa), and upon request.

CASES

Circuit Court Holds That Limitation in Plan Document Not Mentioned in Summary Plan Description May Not be Relied Upon

The Court of Appeals for the Seventh Circuit held that the claims administrator of a long-term disability plan was not entitled to rely upon a limitation set forth in the plan document, but not mentioned in the summary plan description given to

participants, for the purpose of denying a claim for benefits. The plan document included a provision for a 24-month cap on benefits for those disabled due to sickness or with injuries primarily based upon self-reported symptoms, along with those disabled due to mental illness, alcoholism, or drug abuse. While the summary plan description noted the limitation on disabilities due to mental illness, alcoholism, or drugs several times, it made no mention of the limitation for disabilities based upon self-reported symptoms. Invoking the limitation for self-reported symptoms under the plan document, the claims administrator informed the participant that she would no longer receive benefits after 24 months. The participant brought suit challenging the denial of benefits.

The Seventh Circuit ruled in favor of the participant, explaining that while a summary plan description need not identify every possible contingency affecting a participant's eligibility for benefits, the self-reporting symptoms limitation was not an "idiosyncratic contingency" concerning only a few people, but a broad limitation on eligibility for benefits. As a result, the participant's benefits were reinstated, but the administrator was permitted to review her eligibility under the plan prospectively. Exactly when a limitation represents an idiosyncratic contingency or a broad limitation was not clearly answered by the Seventh Circuit. (*Weitzenkamp v. Unum Life Ins. Co. of America*, 7th Cir. 2011)

No Recoupment of QDRO Benefits Despite Sham Divorces

Affirming a lower court decision, the Court of Appeals for the Fifth Circuit ruled that a plan administrator may not recoup benefit payments from participants who allegedly obtained sham divorces so they could receive distributions of their retirement benefits while still employed. Under the Employee Retirement Income Security Act (ERISA), retirement benefits may be assigned to an alternate payee, such as an ex-spouse, under the terms of a domestic relations order (DRO) issued by a court. If the plan administrator determines that the DRO satisfies the criteria to be a qualified domestic relations order (QDRO), ERISA requires the plan to pay benefits in accordance with the terms of the QDRO.

In this case, the plan administrator claimed that a group of participants became concerned that financial problems affecting their employer might result in their pension plan being taken over by the Pension Benefit Guaranty Corporation, resulting in diminished benefits for participants upon retirement. In response, the participants allegedly obtained divorces solely for the purpose of obtaining immediate lump sum pension distributions from the company retirement plan. Under the terms of the plan, if a participant is at least 50 years old, an ex-spouse may receive a lump sum distribution of the benefits assigned to the ex-spouse under a QDRO, even if the participant is still employed. The participant would not otherwise be eligible to receive payment unless he or she actually terminated employment. By getting divorced, the participants and their spouses were able to obtain QDROs, assigning up to 100 percent of their benefits to the spouses.

Only after the plan had paid out benefits under the QDROs did the plan administrator determine that the couples had obtained divorces solely for the purpose of receiving payment of their pension benefits. Following divorce, the couples "essentially conducted themselves as if the divorce had never happened," including continuing to cohabitate and, in some cases, concealing the divorce from family and friends. Eventually, after collecting their benefits, the couples remarried.

With this knowledge in hand, the employer sued the couples for restitution of benefits paid, claiming that a plan administrator has the authority to refuse to qualify a DRO based on its determination that the underlying divorce is a sham. The Fifth Circuit rejected this assertion, holding that ERISA requires an administrator to determine that an order is a

QDRO if it satisfies all the statutory criteria, and that a participant's "good faith in obtaining a divorce is not among those criteria." The court emphasized that its reading of ERISA is in harmony with the reasoning of the Supreme Court and other appellate courts, which have described the qualification of a DRO as "a straightforward matter that requires the administrator to take DROs at face value and not to engage in complex determinations of underlying motives or intent." (*Brown v. Continental Airlines Inc.*, 5th Circ. 2011)

Provision in Bargaining Agreement Precludes Modification of Retiree Benefits

In 2005, Volvo Group North America LLC negotiated a specific provision relating to the retiree health benefits in a collective bargaining agreement. The negotiated agreement provided that Volvo would "continue coverage…. for the duration of this agreement," which ran from 2005 to 2008. The collective bargaining agreement also had provisions which limited Volvo's financial obligation to provide retiree medical insurance. The provision dealt with funding of a Voluntary Employee Benefit Association (VEBA) trust and a mechanism for Volvo and the Union to negotiate how to reduce health care costs if the VEBA became depleted. In 2008, when the collective bargaining agreement expired, Volvo announced that it would modify the retiree health benefits provided to those individuals who retired under that agreement. The employees sued, arguing that it was improper for Volvo to limit the retiree health coverage for the duration of the agreement. The Court of Appeals for the Fourth Circuit affirmed a lower federal court decision, ruling that Volvo was not permitted to make the unilateral changes. The Fourth Circuit found that while there was a durational clause, the provisions regarding funding and a mechanism for negotiation of future health care reductions clearly indicated that those procedures needed to be followed even after the expiration of the term of the agreement, and that it was improper for Volvo to unilaterally terminate coverage at the end of term of the agreement.

This case illustrates how important it is to review the total terms negotiated in a collective bargaining agreement. While the durational clause will be upheld in many situations, the courts will look at the complete agreement and may find that other terms of the collective bargaining agreement indicate that coverage was to be provided beyond the duration of the collective bargaining agreement. (*Quesenberry v. Volvo Trucks North America Retiree Healthcare Benefit Plan*, 4th Cir. 2011)

Stock Forfeiture Does Not Violate Wage and Labor Laws

The Court of Appeals for the First Circuit has ruled that Citigroup's Capital Accumulation Plan did not violate Colorado or Louisiana wage and labor laws. Under the plan, certain employees could elect to receive a portion of their earned commissions in the form of Citigroup stock at a 25 percent discounted price and on a tax-deferred basis. The tax-deferred feature existed because the stock was subject to a two-year vesting period. Certain employees resigned before the vesting period had been completed and Citigroup forfeited the restricted shares. In a series of cases filed in many states, the former employees claimed that the forfeiture of the stock violated wage laws because the forfeiture resulted in the loss of wages that were used to purchase the restricted stock. The First Circuit found that the plan did not violate the laws of Colorado or Louisiana in that unvested forms of compensation were not protected and were not owed to employees at the time of termination of their benefits. (Renaudin v. Citigroup Global Markets Inc. [*In re Citigroup Inc. Capital Accumulation Plan*

Litigation], 1st Cir. 2011)

Courts May Look to All Plan Documents in Determining Whether Administrator or Fiduciary Retains Discretionary Authority

Following a denial of long-term disability benefits by a plan's claims administrator, which was upheld by a United States District Court, the claimant appealed to the Court of Appeals for the District of Columbia Circuit. The claimant argued that the district court improperly deferred to the claims administrator's determination, rather than reviewing afresh her claim for disability benefits. In support of this argument, the claimant asserted that only the disability policy document was relevant in determining whether the claims administrator possessed discretionary authority to determine eligibility for benefits or to construe the terms of the plan. The claims administrator asserted that all policy documents should be considered together.

The D.C. Circuit agreed with the claims administrator, holding that the district court correctly ruled that all plan documents should be analyzed in determining whether an administrator or fiduciary possesses discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Having determined that all plan documents are relevant in determining the proper standard of review to be applied by courts to an administrator or fiduciary's decision to deny a claim for benefits, the D.C. Circuit held that the totality of plan documents conferred discretionary authority upon the claims administrator to determine benefits eligibility and to interpret plan terms.

The D.C. Circuit then applied the "reasonableness" standard, applicable when an administrator possesses discretionary authority, to hold that the claims administrator acted reasonably in crediting its own doctor's opinion over that of the claimant's doctor when denying the disability claim. (*Pettaway v. Teachers Ins. & Annuity Assoc.*, D.C. Circuit 2011)

Caution Needed in Dealing With Multiemployer Plans

Two recent federal court cases illustrate the caution and care needed in handling situations involving union-negotiated multiemployer plans. In one case, 30 years of apparent consent and waiver of explicit collective bargaining provisions did not protect a separate but related company from an obligation to make contributions to several collectively bargained multiemployer plans. In a second case, a company that purchased assets from another corporation that had delinquent multiemployer plan contributions may be forced to go to trial on the issue of whether the asset-purchase constituted a "substantial continuity of business" of the seller of assets. A trial finding of substantial continuity could obligate the purchaser to unwillingly assume liability for the unpaid plan contributions.

The first case involved double-breasted (i.e., one unionized and one non-union) construction businesses that shared offices, managing officers, employees, and supervisors; had similar owners; and at times worked on the same jobs. These arrangements had continued for 30 years with no issues between the non-union employer and the multiemployer benefit plans, to which the union company contributed on behalf of its union workers.

The 30-year honeymoon ended when the multiemployer plans began a process to collect plan contributions from the non-union employer on behalf of its employees who were performing union work. The plans and bargaining agreements require contributions on behalf of all employees performing covered employment and employed by the signatory (union) company or any related company. The employers did not have a material dispute regarding the relationship between the two companies. Their defense was based on the fact that the double-breasted operations had continued for 30 years with the union's full knowledge and with no objection or attempt to collect plan contributions for the non-union workers. In rejecting this defense, the court concluded that the 30 years of non-collection did not preclude the plan under its clear language and the clear language of the collective bargaining agreement from collecting contributions from the non-union company. (*Local Union 825 v. McRand Contracting Co., Inc.*, DNJ 2011)

The court in the second case rejected a motion for summary judgment and thus set the case for trial. At issue will be whether the purchaser "substantially continued" the seller's business to the extent that the purchaser could be treated as stepping into the shoes of the seller with respect to the bargained-for-but-unpaid multiemployer plan contributions.

A purchaser of assets can be held liable for plan contributions it never bargained for if there are substantial similarities between the businesses conducted by the seller and the purchaser. A careful examination of the facts of a particular transaction, as well as the case law, is important for any purchaser of business assets involving union-negotiated pension or health and welfare funds. (*Reed v. Envirotech Remediation Services, Inc.*, D. Minn. 2011)

Conflict of Interest Ruled Only a Factor in Benefit Denial

The Court of Appeals for the Eleventh Circuit recently reversed a district court's decision by upholding an insurer's denial of a long-term disability benefit claim. The Eleventh Circuit gave deference to the insurer's determination, despite the fact that the insurer had a structural conflict of interest as the insurer was both the plan administrator and the payor of benefits.

In this case, the employer's long-term disability plan delegated authority to the insurer to interpret the plan's terms and determine whether a claimant is disabled. While participating in the plan, the employee plaintiff began receiving long-term disability benefits after suffering a heart attack and later continued to receive benefits following knee surgery. The insurer ultimately terminated benefits after concluding that the plaintiff was no longer disabled under the terms of the plan, prompting the plaintiff to appeal the insurer's decision. The insurer denied the appeal after requesting that the file be reviewed by three independent medical specialists.

After exhausting the plan's appeals process, the plaintiff filed a complaint in district court. The district court concluded that the insurer's decision to deny benefits was arbitrary and capricious, mainly because of the insurer's structural conflict of interest. While the Eleventh Circuit recognized that a structural conflict existed, they also noted that "the burden remained on the plaintiff to show the decision was arbitrary; it is not the defendant's burden to prove its decision was not tainted by self-interest." In this instance, the Eleventh Circuit concluded that, based on the administrative record, the insurer possessed a reasonable basis for its benefits decisions and that the structural conflict of interest did not render those decisions arbitrary and capricious.

In *Metropolitan Life Insurance Company v. Glenn*, the United States Supreme Court noted that courts must take into account structural conflicts of interest. However, as this case demonstrates, courts continue to struggle with how to appropriately adjudicate this conflict. (*Blankenship v. Metropolitan Life Insurance Company*, 11th Cir. 2011)

Plan OK to Deny AD&D Benefit Under Intoxication Exclusion

The Court of Appeals for the Eighth Circuit ruled that an insurer was not arbitrary and capricious as plan administrator when it denied accidental death and dismemberment benefits to a widow based on the general exclusion for intoxication that appeared in the certificate of insurance. The widow was the named beneficiary of an accidental benefits plan that her husband, the covered employee, obtained through his employer. After the covered employee died as a result of a motorcycle accident, the plan administrator determined he was intoxicated at the time of the accident and denied coverage. The widow brought suit under the Employee Retirement Income Security Act (ERISA), alleging the plan administrator abused its discretion. Evidence presented included a certified toxicology report in which it was stated that the covered employee's blood alcohol content (BAC) was 0.128% at the time of the accident. The plan administrator moved for summary judgment, contending that it was justified in denying benefits based on the language of the policy. The federal trial court granted the motion, concluding that the summary plan description (SPD) was not deficient in apprising the average plan participant that benefits would be denied for injuries incurred as a result of operating a vehicle while intoxicated, and that even if it was deficient, the widow failed to establish that the covered employee had detrimentally relied on that information. The district court also concluded that it was not unreasonable for the plan administrator to deny benefits based either on the intoxication exclusion in the certificate of insurance or on similar exclusions in the SPD.

The widow appealed, contending that the trial court erred because the plan administrator's interpretation of the relevant policies was arbitrary and capricious, and not supported by substantial evidence. The Eighth Circuit disagreed with the widow and upheld the grant summary judgment in favor of the plan administrator. In reaching its decision, the appellate court concluded that based on the intoxication exclusion alone the plan administrator did not abuse its discretion as plan administrator when it denied benefits. (*River v. Edward D. Jones Co.*, 8th Cir. 2011)

Disability Plan's Administrative Review Deemed Exhausted

The Court of Appeals for the Ninth Circuit held that a plaintiff participant is excused from having to pursue administrative remedies under his employer's long-term disability plan because the plan failed to resolve his request for benefits in a timely fashion. As a general rule, an Employee Retirement Income Security Act (ERISA) claimant must exhaust available administrative remedies before bringing a claim in federal court. However, when a plan fails to establish or follow reasonable claims procedures consistent with the requirements of ERISA, a claimant need not exhaust available administrative remedies because his claims will be deemed exhausted.

At issue in this case was how long the disability plan had to adjudicate a claim for benefits. The Ninth Circuit noted that the timing rules regarding this issue are complex and depend on a number of factors, including the type of benefit claim, and whether or not the plan is a multiemployer plan. Generally, a disability claim must be resolved within 45 days, but certain plans may be permitted to resolve disability claims at a subsequent quarterly meeting. The disability plan in question is not a

multiemployer plan and did not resolve the claim within the 45 day period, but rather relied on the quarterly meeting extension. The Ninth Circuit noted that the Department of Labor regulations regarding this issue are unclear because they contain circular cross-references and intertwine the general timing rules with the timing rules for disability claims and multiemployer plans.

To resolve this ambiguity, the Ninth Circuit deferred to the U.S. secretary of labor's amicus brief filed on behalf of the participant. The brief stated that the quarterly meeting rule is only available for multiemployer plans. Because the plan in this case was not a non-multiemployer plan, the Ninth Circuit ruled that the plan was required to resolve disability claims within 45 days. Because the disability claim was not resolved within this time period, the plaintiff's administrative remedies were deemed exhausted. As a result, the district court's summary judgment ruling in favor of the plan was reversed and the case was remanded to the district court for further proceedings. This case serves as a reminder for plan administrators to be familiar with the proper and timely adjudication of claims in accordance with procedure. (*Barboza v. California Association of Professional Firefighters*, 9th Cir. 2011)

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