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EMPLOYEE BENEFITS DEVELOPMENTS
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RULINGS, OPINIONS, ETC.

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Employee Benefits

IRS Issues Guidance on Expanded In-Plan Roth Rollover Rules

The Small Business Jobs Act of 2010 enacted rules under which 401(k), 403(b), and governmental 457(b) plans may provide for in-plan rollovers to designated Roth accounts of contributions that were "otherwise distributable" and eligible for rollover. Starting in 2013, the in-plan Roth rollover rules were further modified by the American Taxpayer Relief Act of 2012 (ATRA) to allow those transfers even if the participant is not then able to withdraw the amounts from the plan. Thus, for example, for salary deferral amounts in these plans, the age 59 1/2 restriction on distributions no longer restricts the ability to make an in-plan Roth rollover. In response to questions raised by ATRA's expansion of the in-plan Roth rollover rules, the IRS issued new guidance in the form of *IRS Notice 2013-74*. Highlights from the new guidance include:

• Otherwise *nondistributable* amounts must be fully vested to be eligible for an in-plan Roth rollover.

• In-plan Roth rollovers of otherwise *nondistributable* amounts may not use the 60-day rollover rule (it must be made by direct rollover), and a § 402(f) notice is not required for a participant making an in-plan Roth rollover of an otherwise*nondistributable* amount.

• The following contributions (and earnings thereon) may now be rolled over to a designated Roth account in the same plan: elective deferrals, matching contributions, and nonelective employer contributions (including QNECs, QMACs, and safe harbor contributions).

• If an amount is rolled over to a designated Roth account, the amount rolled over and applicable earnings remain subject to the distribution restrictions that were applicable to the amount before the in-plan Roth rollover.

• Because an in-plan Roth rollover of an otherwise *nondistributable* amount must be made by a direct rollover, no mandatory 20 percent withholding applies. And no part of the rollover may be subject to voluntary withholding.

• The deadline for adopting a plan amendment that permits in-plan Roth rollovers of otherwise *nondistributable* amounts is extended to the later of the last day of the first plan year in which the amendment is effective or December 31, 2014. The extended amendment deadline also applies to (i) a plan amendment that permits elective deferrals under the plan to be designated as Roth contributions, (ii) a plan amendment that provides for the acceptance of rollover contributions by designated Roth accounts, and (iii) a plan amendment that permits in-plan Roth rollovers of some or all otherwise distributable amounts.

• Sponsors of safe harbor plans are permitted to make a mid-year change to provide for in-plan Roth rollovers of otherwise *nondistributable* amounts during a temporary period that ends December 31, 2014.

• An employee's ability to make an in-plan Roth rollover is not a section 411(d)(6) protected benefit and can be eliminated as long as the elimination does not have the effect of discriminating significantly in favor of highly compensated employees.

Proposed Regulations Issued for Excepted Benefits

The Departments of the Treasury, Labor, and Health and Human Services recently issued proposed regulations that generally expand the definition of HIPAA excepted benefits. This is welcome news for employers because excepted benefits are generally exempt from the health reform requirements that were added to ERISA, the Internal Revenue Code, and the Public Health Services Act by the Patient Protection and Affordable Care Act (ACA). The proposed regulations specifically address how employee assistance programs (EAPs), limited wraparound coverage, and limited-scope dental and vision benefits may qualify as excepted benefits.

EAPs as Excepted Benefits. EAPs are typically programs offered by employers that provide employees with a wide range of benefits, often including short-term substance abuse or mental health counseling, financial counseling, and legal services. Unless the EAP qualifies as an excepted benefit, to the extent it provides benefits for medical care, the EAP would generally be considered group health plan coverage subject to HIPAA and ACA requirements. To qualify as an excepted benefit, the EAP must meet the following criteria:

• The EAP may not provide significant benefits in the nature of medical care,

• The EAP's benefits may not be coordinated with the benefits under another group health plan,

• No employee premiums or contributions may be required as a condition to participate in the EAP, and

• There may be no cost-sharing under the EAP.

These criteria are intended to ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage and ensure that EAP coverage does not unreasonably disqualify an otherwise eligible employee from being eligible for a premium tax credit for enrolling in coverage through a health care marketplace.

Limited Wraparound Coverage. The ACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits. Often employer sponsored group health plans offer expanded provider networks and cover items and services beyond the essential health benefits required under the ACA. Understandably, the additional benefits and coverage typically come with a higher cost to employees. Because group coverage available through an employer may be unaffordable for some employees, those employees may choose to obtain less expensive (and more limited) coverage though a health care marketplace. These proposed regulations provide that, under limited circumstances, employers may offer wraparound coverage to certain lower income employees who obtain subsidized coverage through a health care marketplace. This approach, when taking into account the marketplace coverage and the wraparound coverage, would allow employers to provide such employees with overall coverage comparable to their group health plan coverage. Under these proposed regulations, limited wraparound coverage is an excepted benefit if these conditions are met:

• The coverage may only wrap around non-grandfathered individual health insurance that does not consist solely of excepted benefits,

• The limited wraparound coverage must provide benefits beyond those offered by the individual health insurance coverage. Specifically, it must provide either benefits that are in addition to essential health benefits or reimburse the cost of out-of-network health care providers, or both,

• The limited wraparound coverage may not be an integral part of a group health plan. That is, the plan sponsor offering the limited wraparound coverage must sponsor another group health plan meeting the minimum value. Only individuals eligible for coverage under the primary plan would be eligible for the limited wraparound coverage,

• The total cost of the limited wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage includes both the employer and employee contributions, and

• The limited wraparound plan may not discriminate on the basis of eligibility, benefits, or premiums based on a health factor of an individual. The limited wraparound coverage may not impose any preexisting condition exclusion. Also, the limited wraparound plan may not discriminate in favor of highly compensated individuals.

Dental and Vision Benefits. Under prior guidance, dental and vision benefits were considered excepted benefits if they were limited in scope and were either:

• Provided under a separate policy, certificate, or contract of insurance, or

• Otherwise not an integral part of a group health plan. The prior guidance provided that benefits were not an integral part of a plan if participants had the right to elect not to receive coverage and, if they did elect coverage, they were required to pay an additional premium or contribution for it.

Under these proposed regulations, the requirement for participants to pay an additional premium or contribution for limited-scope dental or vision benefits is eliminated.

These proposed regulations will be effective for plan years beginning in 2015. Employers should review their dental, vision, and EAP plans to determine if any changes are needed to meet the expended definition of excepted benefit.

CASES

Supreme Court Upholds Plan Limitation Period

In *Heimeshoff v. Hartford Life & Accident Insurance Co.*, the U.S. Supreme Court unanimously upheld an ERISA long-term disability plan's limitation that a participant be required to bring any suit for benefits no later than three years after proof of loss is due. The court's decision confirms that an ERISA plan may establish a contractual limitations period for bringing an action under ERISA Section 502(a)(1)(B) to recover benefits due under the terms of the plan - even when the limitations period could potentially expire prior to the participant's cause of action accruing because the participant has not exhausted his administrative remedies under the plan's administrative review procedures - so long as the limitations period is not unreasonably short or otherwise contrary to ERISA.

ERISA does not specify a statute of limitations for bringing a claim for benefits under a plan pursuant to ERISA Section 502 (a)(1)(B). In this vacuum, courts have generally applied the limitations period under the most analogous state law. Attempting to avoid the uncertainty that would follow from being subject to varying limitations periods under state law, some ERISA plans have adopted limitations periods of their own. Courts of appeals have reached opposite conclusions on the enforceability of plans' contractual limitations periods.

Claims for benefits under an ERISA plan are subject to a two-tiered remedial scheme. In the first instance, a participant's claim for benefits is reviewed by the plan's administrator. If the administrator denies the participant's claim, a participant may file an administrative appeal. Courts of appeals have generally held that participants must exhaust their administrative remedies prior to filing suit. Thus, a participant's cause of action under ERISA does not accrue until the plan denies a participant's administrative appeal. The second tier of ERISA's remedial scheme involves judicial review of the decision reached at the administrative level. In most instances, the reviewing court will defer to the administrative determination unless the court finds that determination to be unreasonable.

Julie Heimeshoff was a senior public relations manager for Wal-Mart Stores. Heimeshoff stopped working after her physician diagnosed her with lupus and fibromyalgia. She then filed a claim for long-term disability benefits under Wal-Mart's long-term disability plan. Hartford Life and Accident Insurance Company was the administrator for the long-term disability plan.

Heimeshoff filed suit to recover long-term disability benefits under the plan nearly three years after Hartford issued its final administrative denial of her claim (but more than three years after her proof of loss was due). Hartford and Wal-Mart moved to dismiss Heimeshoff's suit as time-barred under the plan's limitations period requiring any suit be commenced no later than three years after proof of loss is due. The district court granted the motion to dismiss, and the court of appeals affirmed the district court's dismissal.

The Supreme Court held - and Heimeshoff did not seriously contend otherwise - that the three-year limitations period was not unreasonably short. The court noted that even when the administrative review process requires more time than usual, a participant would be left with one year to file suit. In most cases, moreover, a participant would have two years in which to bring suit following administrative review.

Heimeshoff's central argument was that upholding the long-term disability plan's limitations period was contrary to ERISA in that it threatened to undermine ERISA's two-tier remedial scheme. To this end, the first main claim advanced by Heimeshoff was that participants would sacrifice the benefits of administrative review to preserve additional time for filing suit. The court quickly discarded this argument, noting that a court's review is generally limited to the administrative record, and that the administrative decision would generally be upheld unless that determination was unreasonable.

The second main argument advanced by Heimeshoff for the limitations period undermining ERISA's two-tier remedial scheme was that upholding the limitations period endangered judicial review of administrative determinations. Noting that the time limits prescribed by ERISA call for prompt administrative review of benefits claims, the court stated that those participants who find themselves barred from bringing suit due to a three-year limitations period likely failed to be diligent in pursuing their ERISA rights. And, in those circumstances where administrative review is deliberately prolonged to prevent a participant from timely bringing suit, the court stated that equitable doctrines such as waiver or estoppel could be invoked to prevent the plan's limitations period from being used as a defense to the participant's claim.

While the *Heimeshoff* case relates to a long-term disability plan, nothing in the court's holding can be construed to limit its applicability to other ERISA plans. Going forward, ERISA plan sponsors may wish to create plan limitations periods in which to bring an action for benefits pursuant to ERISA Section 502(a)(1)(B). For this purpose, it is recommended that plan sponsors consult their ERISA attorney to determine the reasonableness of any limitations period being considered before amending any plans to include a limitations period.

Delay Dooms Disability Claim

The U.S. District Court for the District of Massachusetts held that a participant could not pursue her claim for benefits because she failed to exhaust the plan's administrative remedies. In this case, the plaintiff participant went on a disability leave of absence to receive a laparoscopic procedure. Although the participant initially qualified for and received disability benefits, ultimately she was notified she no longer met the definition of disability under the group policy and that her disability benefits would be terminated. The termination letter also notified the participant she had a right to appeal the claim within 180 days. Though the participant's attorney initially requested information from the plan following the denial of benefits, the appeal process was not invoked until five and a half months after the expiration of the 180 day appeal period. As a prerequisite to bringing a suit to recover benefits, a claimant must exhaust the administrative remedies available under an ERISA plan. Because the participant failed to file an appeal within the 180-day period, the participant forfeited any right she had to an administrative appeal and consequently any right she would have had to seek judicial relief under ERISA. This case highlights the value of clearly communicated claims procedures. (*Pingiaro v. Standard Ins. Co.*, D. Mass. 2013)

Failure to Request Arbitration Bars Challenge to Withdrawal Liability Assessment

A collective bargaining agreement required that an employer contribute to both a multiemployer fringe benefit fund and to a multi-employer pension fund. The employer had become delinquent in making contributions to the multiemployer fringe benefit fund. When the employer became delinquent, the union local sent a letter suspending the collective bargaining agreement and informing the members of the local that they must cease working for the employer. Eventually, the employer made up the delinquent fringe benefit contributions. However, the multiemployer pension plan trustees had sent a withdrawal liability assessment. The employer had not made any payments on the withdrawal liability assessment and had not requested arbitration. The multiemployer pension fund filed an action to collect the withdrawal liability, and the employer defended, stating it had not withdrawn from the fund. The parties disagreed whether the collective bargaining agreement had expired pursuant to its terms. However, the District Court for the Eastern District of Missouri, assuming the collective bargaining agreement had expired, found that all time periods for challenging the withdrawal liability assessment issued by the fund had expired. The court found that even if the collective bargaining agreement had not expired, the employer's ability to challenge the withdrawal through arbitration was no longer timely. Therefore, the withdrawal liability must stand because the law requires that disputes over a withdrawal liability be resolved through arbitration.

While there may be some question over the expiration of the collective bargaining agreement in this situation, this case illustrates that an employer must timely file a request for arbitration or it will be precluded from challenging withdrawal assessment even if it may possess valid grounds for the challenge. (*Brown v. Capital Restoration & Painting Co.*, E.D. Mo, 2013)

District Court Unimpressed by Claim of "People's Court" Decision on Divorce

A Maryland District Court charged with deciding whether a retired union worker's first wife was entitled to spousal benefits in her ex-husband's union pension plans was not swayed by the claim that Judge Joseph Wapner once concluded on "The People's Court" television show that the worker's Mexican divorce was illegal. The union worker married his first wife in Chile in 1975. Shortly after their divorce in Mexico in 1983, the ex-husband married his second wife in California. Twenty-three years and three children later, the union worker divorced his second wife in 2006. In connection with the divorce, the second wife obtained a qualified domestic relations order awarding her benefits in her ex-husband's pension plans. Both the ex-husband and the second wife began receiving benefits on his retirement in 2010.

In 2011, the worker's first wife contacted the union pension fund, claiming benefits on the basis that the Mexican divorce was illegal, making her the legal spouse. In support of her claim, the ex-wife stated that both the Social Security Administration and Judge Wapner concluded the divorce was not legal. Responding to the first wife's claims, the union fund notified the union worker and his second wife that the initial determination regarding the second marriage was invalid and that repayment of benefits would be required. Ultimately, the question as to the validity of the Mexican divorce ended up in district court. Unmoved by the alleged determination of an invalid divorce by "The People's Court," the district court

noted that the first wife waited almost 30 years to challenge the divorce, during which time the husband remarried and raised three children with his second wife. The court found that permitting a challenge to the validity of the second marriage now "would be plainly inequitable" and held that the first wife had no claim to benefits under the union plans. (*Board of Trustees of the Master, Mates & Pilots Pension Plan v. Carney*, D. Md., 2013)

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