EMPLOYEE BENEFITS DEVELOPMENTS DECEMBER 2014

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Cases

Can a Medical Plan Enforce a Third-Party Recovery Provision Appearing Only in an SPD? Group health plans are often required to cover medical expenses associated with injuries caused by a third party's negligence. These injuries can be serious and the associated benefits substantial. To ensure that these costs are borne by the party at fault and not the plan, a group health plan should have a carefully crafted third-party recovery provision that would require a participant to reimburse the plan for medical expenses paid by the plan in connection with an illness or injury caused by a third party if the participant later secures a settlement or money judgment from that third party. The Supreme Court in *US Airways v. McCutchen* made it clear that a plan can enforce a properly crafted third party recovery provision. The rule presumes, of course, that the third-party recovery language is a "term of the plan." The issue, therefore, is whether a third-party recovery provision that appears only in an SPD is a "term of the plan." In *Cigna Corp. v. Amara*, the Supreme Court noted that statements in an SPD do not themselves constitute the terms of the plan. Aggrieved participants have seized on this statement to challenge a plan's right to enforce any provision that appears only in a document that is meant to function as an SPD. A fair reading of *Amara*, however, does not lead to the conclusion that the terms of an SPD can never represent the terms of a plan. The Supreme Court in *Amara* did not have the occasion to consider whether a plan can enforce an SPD that is incorporated into the official plan document by reference or that serves as the only document that sets forth the rights and obligations of plan participants. Two recent court cases citing the Supreme Court's ruling in *Amara* and involving facts that appear to be quite similar arrived at different conclusions on this issue. In *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile*, the Eleventh Circuit Court of Appeals ruled that the plan could enforce a third-party recovery provision that appeared only in the SPD. The U.S. District Court for the Central District of California in *Mull v. Motion Picture Industries Health plan and Board of Directors* came to the contrary conclusion.

Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile

This case involved the National Industry Health Benefit Plan, a jointly sponsored health and welfare fund established and maintained pursuant to the terms of a trust agreement and bargaining agreement. Among other things, the trust agreement authorized the establishment of the plan, provided for the management of the plan by the trustees, governed plan contributions, and created general rules for claim management. However, neither the trust agreement nor collective bargaining agreement detailed the specific type, amount, and duration of the benefits, or the basis on which the payment of benefits was to be made. Under the terms of the trust, these details were to be set forth in a "Plan of Welfare Benefits." The medical benefits provided by the plan were documented as part of the National Elevator Industry Health Benefit Plan Summary Plan Description, which was 87 pages long and contained detailed information regarding eligibility for health benefits, the extent of specific types of benefits, and claim-filing procedures. The SPD also contained a third-party recovery provision. Neither the trust agreement nor the collective bargaining agreement had a similar provision.

Robert Montanile, a participant in the plan, was injured in an automobile accident involving a drunk driver. His initial medical expenses, paid by the plan, totaled approximately $121,000. He sued the drunk driver and received a settlement of $500,000. After the settlement, the trustees requested reimbursement of the medical expenses paid on Montanile's behalf. When settlement discussions reached an impasse, the plan sued Montanile to enforce the third-party recovery provision detailed in the plan's SPD. Montanile, citing *Amara*, argued that the plan could not enforce the recoupment provision because neither the trust agreement that authorized the establishment of the plan nor the collective bargaining agreement contained a similar provision and the only document that did – the SPD – was not part of the plan. The court disagreed, holding that the SPD was a critical part of the official plan document because the SPD was the only document that detailed Montanile's benefit entitlement (and, likewise, his or her obligation to honor the plan's third-party recovery provisions); and the trust agreement contemplated that the rights and obligations of plan participants and beneficiaries would be set forth in the SPD.

Mull v. Motion Picture Industries Health Plan and Board of Directors

Like *Montanile*, the plan in this case – the Motion Picture Industry Health Plan – was established and maintained pursuant to the provisions of a trust agreement, setting forth the terms and conditions under which the plan was to be established and maintained. Like *Montanile*, the trust agreement did not detail the benefits to be provided by the plan but contemplated that these details would be provided in a separate "Plan of Benefits." Details concerning the benefits provided by the plan, including the plan's third-party recovery provision, were published as part of the plan's SPD, which, it appears, was the only document that detailed the benefit entitlement of the plan's participants. Presumably, this document was the "Plan of Benefits" referenced in the trust agreement.

Mull involved a participant who sustained severe injuries in an auto accident. The participant underwent multiple surgeries, missed substantial time from college, and endured physical and mental pain and suffering. As compensation for her injuries, she received a $100,000 settlement, representing the limit of insurance coverage maintained by the negligent party, even though the value of her claim was substantially above that amount. The plan paid $148,000 in expenses and demanded that the participant pay her entire settlement to the plan as reimbursement for those benefits pursuant to the recoupment provision set forth in the SPD. When the participant refused to pay, the plan began recouping the unreimbursed amount from future benefits provided by the plan. It appears the plan also refused to pay medical bills for other enrolled family members who were not parties to the third-party settlement.

In *Mull* the court held that the recoupment provision at issue was not enforceable because it was documented as part of the SPD, and not in any document containing the terms of the plan. In *Mull*, the court determined that the trust agreement was the only formal plan document, and because the trust agreement did not contain a recoupment provision, the plan could not recover the benefits it had paid on the participant's behalf. In support of its holding that the SPD was not part of the formal plan document, the court found that the fiduciaries of the plan did not allege that the trust agreement incorporated the SPD as part of the plan; that in response to a request for plan documents, the plan furnished only trust agreement; and that the SPD could not be considered a plan document because it lacked features that ERISA requires of plan documents.

Action Steps

To avoid the result in *Mull* and other cases like it, medical plan sponsors should maintain a plan document structure that includes a plan document (e.g., a so-called "wrap" document) and a separate SPD; the same document should not purport to be both the plan document and SPD. In addition, and perhaps more importantly, the plan document (or trust agreement) should state in no uncertain terms that the language of the SPD is, at least in part, the language of the plan.

401(k) Plan Service Providers Avoid Fiduciary Status. Two recent court decisions provide a significant victory to financial institutions that provide services to 401(k) plans. The cases involve whether a service provider is a fiduciary as a result of its role in determining what investment options are on the "menu" of available investment options that a plan that uses the service provider's platform to operate a 401(k) plan. Plaintiffs have been alleging that the fees charged on some of these investment products were excessive. They also claim that the financial institution/service provider was a fiduciary in determining what investment options were on the menu and, therefore, breached its fiduciary duties by charging excessive fees. In decisions in the U.S. Court of Appeals for the Third Circuit and U.S. District Court for the Southern District of Iowa, the courts rejected the plaintiff's arguments. In both cases, the Department of Labor had filed an amicus brief arguing that the service providers were serving as fiduciaries. The courts found that when the service provider determines the menu of available investment options, the service provider was not acting as a fiduciary. This was because the trustees of the 401 (k) plan have the final say over what choices are available on the actual menu of investment choices offered to plan participants and that the trustees could terminate the service provider and select a different service provider if they thought the fees were excessive. As a result, the plan trustees were the party making the actual decision on selecting the investment choices and exercising their fiduciary duties. (*Santomenno v. John Hancock Life Ins. Co.*, 3d Cir., 2014; *McCaffree Fin. Corp. v. Principal Life Ins. Co.*, S.D. Iowa, 2014).

Rulings, Etc.

IRS Liberalizes Allocation Rules for Direct Rollovers of After-Tax Amounts. It has been the IRS's position that if a participant's account balance in a qualified retirement plan, a 403(b) plan, or a governmental 457(b) plan includes pre-tax (i.e., taxable) and after-tax (i.e., non-taxable) amounts, and if the participant elects a *direct* rollover of only a portion of an eligible rollover distribution, then each portion of the distribution will include an allocable portion of the after-tax contributions. This IRS position has effectively blocked a participant from allocating and directly rolling over pre-tax and after-tax amounts to different destinations (e.g., directly rolling pre-tax amounts to a traditional IRA and directly rolling after-tax amounts to a Roth IRA).

Note that a different allocation result could and still can be achieved if the participant instead opts to take direct receipt of the eligible rollover distribution (and be subject to the required 20 percent tax withholding), and then uses the 60-day rollover rules to move amounts into an eligible recipient plan. By taking advantage of the Code Section 402(c)(2) rule that treats distribution amounts that are rolled over as consisting first of pre-tax amounts, the participant can roll over the pre-tax amounts included in the distribution to one destination, such as a traditional IRA. The remaining amount of the distribution would be after-tax, which the participant could either roll over into, for example, a Roth IRA or retain without incurring any tax liability. This approach, as a practical matter, is available only to taxpayers with enough funds outside of the plan to be able to roll over the entire amount distributed, including the 20 percent mandatory withholding the distribution deducted from the distribution and paid to the IRS.

The IRS recently issued IRS Notice 2014-54 and related proposed regulations under which a participant now will be able to direct after-tax and pre-tax amounts that are simultaneously disbursed to multiple destinations so as to allocate them to specific destinations. Under the new guidance:

- All disbursements of benefits from the plan to the recipient that are scheduled to be made at the same time (disregarding differences due to reasonable delays to facilitate plan administration) are treated as a *single distribution* without regard to whether the recipient has directed that the disbursements be made to a single destination or multiple destinations.
- If the pre-tax portion of the amount treated as a single distribution is *less than* the amount of the distribution that is directly rolled over to one or more eligible retirement plans, the entire pre-tax amount is assigned to the amount of the distribution that is directly rolled over. In that case, if the direct rollover is to two or more plans, the recipient may select how the pre-tax amount is allocated among these plans by informing the plan administrator of the allocation prior to the time of the direct rollovers.
- If the pre-tax portion of the amount treated as a single distribution *equals or exceeds* the amount of the distribution that is directly rolled over to one or more eligible retirement plans, the pre-tax amount is assigned to the portion of the distribution that is directly rolled over up to the amount of the direct rollover (so that each direct rollover consists entirely of pre-tax amounts). Any remaining pre-tax amount is next assigned to any 60-day rollovers (that is, rollovers that are not direct rollovers) up to the amount of the 60-day rollovers. If the remaining pre-tax amount is less than the amount rolled over in 60-day rollovers, the recipient can select how the pre-tax amount is allocated among the plans that receive 60-day rollovers.
- If, after the assignment of the pre-tax amount to direct rollovers and 60-day rollovers, there is a remaining pre-tax amount, that amount is includible in the distributee's gross income. If the amount rolled over to an eligible retirement plan exceeds the portion of the pre-tax amount assigned or allocated to the plan, the excess is an after-tax amount.

The new rules published in Notice 2014-54 and the related proposed regulations generally apply to distributions made on or after January 1, 2015. However, under transition rules included with the new guidance, for distributions made on or after September 18, 2014, taxpayers are permitted to apply a reasonable interpretation of the Code Section 402(c)(2) rules for allocating after-tax and pre-tax amounts among disbursements made to multiple destinations.

IRS Publishes Updated Safe Harbor Special Tax Notices. Within a reasonable period of time before making an eligible rollover distribution, Code Section 402(f) requires plan administrators of qualified retirement plans to provide the distributee with a written notice that explains, among other things, the rules under which the distributee may elect to have the distribution paid in the form of a direct rollover to an eligible retirement plan, the rules that require the withholding of tax on the distribution if the distribution is not paid in a direct rollover, and the rules under which the distributee may defer tax on the distribution if it is contributed in a rollover to an eligible retirement plan within 60 days of the distribution.

The IRS publishes, and from time to time updates, "safe harbor" notices plan administrators may use to satisfy the 402(f) notice requirement. The recently published IRS Notice 2014-74 amends the two versions of the 402(f) safe harbor notices published in Notice 2009-68. One version of the safe harbor notice is for payments not from a designated Roth account, and the other version is for payments from a designated Roth account. Notice 2014-74 updates the safe harbor notices for law changes since 2009 that affect the content of the safe harbor notices, including explanations relating to:

- Distributions that take the form of in-plan Roth rollovers, including in-plan Roth rollovers of amounts not otherwise distributable; and
- The amendments with respect to the allocation of pre-tax and after-tax amounts apply to plans that apply the guidance in Notice 2014-54 (see "IRS Liberalizes Allocation Rules for Rollovers of After-Tax Amounts" in this newsletter).

Plan administrators should review their 402(f) notices and, where appropriate, make the notice changes relevant to their plans.

Agencies Issue FAQs Regarding Premium Reimbursement Arrangements. The Departments of Labor, Health and Human Services, and the Treasury (the agencies) issued another set of frequently asked questions (FAQs) regarding the implementation of the Affordable Care Act (ACA). This recent guidance, the twenty-second in a series of FAQs that the agencies have published, focuses on the compliance of premium reimbursement arrangements. In September 2013, the Departments of Labor and Treasury published guidance on the application of ACA market reform provisions to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (Health FSAs), and employer payment plans. This guidance clarified that such arrangements are subject to group market reform provisions, including the prohibition on annual dollar limits. To avoid violating these market reform rules, account-based reimbursement plans are generally required to qualify as excepted benefits or be integrated with a group health plan that complied with these rules. Importantly, this guidance stated that an employer health care arrangement cannot be integrated with individual market policies to satisfy the ACA market reform requirements. Such an arrangement may be subject to penalties. Under this newly published guidance, the agencies amplify and expand the scope of their prior guidance. Two areas where the guidance was expanded are described below.

- No Cash Reimbursement for Individual Policies. Under the FAQs, the agencies state that an employer may not use an arrangement that provides cash reimbursement for the purchase of an individual market policy regardless of whether the employer treats the money as pre-tax or post-tax to the employee.
- No High-Claims Risk-Only Opt-Out Benefits. The guidance provides that it will be considered discriminatory under the Health Insurance Portability and Accountability Act for an employer to offer a choice between enrollment in the standard group health plan or cash, if such an offer is limited to only employees with a high-claims risk. The guidance

also notes that, depending on the facts and circumstances, such an arrangement may also violate the cafeteria plan non-discrimination rules.

In light of this new guidance, employers are encouraged to review their health care arrangements, including arrangements in employment agreements, to determine if they comply with ACA market reform provisions.

All the FAQs on the ACA may be found by clicking on the FAQs tab on the left side of the Department of Labor's Employee Benefit Security Administration's website at www.dol.gov/ebsa. You may go directly to this recent release at http://www.dol.gov/ebsa/faqs/faq-aca22.html.

Failing to Cover In-Patient Hospitalization Services Does Not Provide Minimum Value Under ACA Guidance. The Departments of Health and Human Services (HHS) and the Treasury recently issued guidance stating their position that group health plans that do not provide coverage for in-patient hospitalization services or substantial coverage of physician services will not satisfy the minimum value requirement under the Affordable Care Act (ACA). Beginning in 2015, applicable large employers may be subject to a penalty if they fail to offer affordable, minimum value health coverage to their full-time employees. Under the final regulations issued by HHS, an employer could utilize an online minimum value calculator to determine if a benefit design satisfied this minimum value requirement. In reliance on this tool, certain companies would design and promote low-cost plans that excluded in-patient hospitalization services or substantial coverage of physician services, and yet were still determined to provide minimum value by the online calculator. Under this new guidance (and promised forthcoming regulations), such benefit designs will not be considered to provide the minimum value required by the ACA. However, because of the timing of this guidance, the departments provide some conditional temporary relief for employers who had already entered into a binding services agreement or began enrolling employees in these types of plans prior to November 4, 2014. Employers who have adopted health plans that exclude in-patient hospitalization services or substantial coverage of physician services should determine whether they qualify for the transitional relief and begin the process of redesigning their benefit plans. (IRS Notice 2014-69)

IRS Issues Final and Proposed Rules for Cash Balance and Hybrid Pension Plans. After a four year delay, the Internal Revenue Service (IRS) published final regulations covering cash balance and hybrid pension plans and proposing additional regulations. The final regulations provide guidance on a key issue in cash balance/hybrid plans, which is the determination of a "market rate of return." Generally, the final regulations allow as an interest crediting rate:

- A fixed single annual interest crediting rate as high as six percent (increased from five percent under the proposed regulations).
- An interest crediting rate tied to U.S. federal government bonds with certain margins.
- Rates tied to the three pension funding segment rates.
- A rate based on cost of living indices with a margin of up to three percent.
- Rates based on return on plan assets or mutual funds.
- Minimum interest crediting rates are allowed.

These final regulations apply to plan years that begin on or after January 1, 2016. In the proposed regulations the IRS issued transition rules dealing with plans that need to modify their terms to comply with the new final regulations.

Sponsors of cash balance plans and other hybrid plans should review the interest crediting rate utilized under their plans to see if they comply with the new rules and whether a transition to new rates will be required for the 2016 plan year. (T.D. 9693 http://www.irs.gov/irb/2014-41_IRB/ar07.html)