EMPLOYEE BENEFITS DEVELOPMENTS JUNE 2015

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Cases

Supreme Court: Plan Fiduciaries Have a Continuing Duty to Monitor Plan Investments. In 2007, participants and beneficiaries under a 401(k) plan sued the plan fiduciaries and the plan sponsor to recover damages for alleged losses suffered by the plan from alleged breaches of fiduciary duties. The participants and beneficiaries argued those fiduciary duties were breached in connection with three mutual funds added to the plan's investment lineup in 1999 (the 1999 funds), as well as three mutual funds added to the plan's investment lineup in 2002. They argued the plan fiduciaries and the plan sponsor acted imprudently by offering higher priced retail-class mutual funds as plan investments when materially identical and, importantly, lower-priced institutional-class mutual funds were available.

At issue in the case is whether the plan participants and beneficiaries filed their lawsuit on a timely basis with respect to the 1999 funds, as the lawsuit was filed more than six years after the 1999 funds were first added to the plan's investment fund lineup. The Employee Retirement Income Security Act of 1974 (ERISA) requires a breach of fiduciary duty complaint to be filed no more than six years after "the date of the last action which constitutes a part of the breach or violation" or "in the case of an omission, the latest date on which the fiduciary could have cured the breach or violation."

At the federal district court level, the filing of the lawsuit was determined to have been untimely as to the 1999 funds because those funds were added to the plan's investment lineup more than six years prior to the filing of the lawsuit, and because the circumstances had not sufficiently changed within the six-year statutory period to obligate the plan fiduciaries and the plan sponsor to review the 1999 funds and convert them to lower-priced institutional-class funds.

An appeal was filed, and the U.S. Court of Appeals for the Ninth Circuit affirmed the district court's decision with respect to the 1999 funds. The Ninth Circuit, like the district court, held that the claims were untimely because the participants and beneficiaries had not established a change in circumstances that might trigger an obligation to review and to change investments within the six-year statutory period.

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Following a petition for certiorari, the Supreme Court agreed to review the case and, in its published opinion, unanimously decided to vacate the Ninth Circuit's decision. The Court held that because a fiduciary has a continuing duty to monitor trust investments and remove imprudent ones, and because that duty exists separate and apart from the duty to exercise prudence in selecting investments at the outset, a plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones. Accordingly, so long as the alleged breach of the continuing duty to properly monitor investments occurred within six years of the lawsuit, the claim is timely. The Court held that the Ninth Circuit erred by applying a six-year statutory bar solely based on the initial selection of the 1999 funds. The Court remanded the case to the Ninth Circuit to consider petitioners' claims that respondents breached their continuing duty to monitor within the relevant six-year period, but the Court declined to express its view on the scope of that duty.

The Court's decision in this case, at its core, is not particularly groundbreaking. The case serves to remind plan sponsors and fiduciaries that there are fiduciary duties beyond the mere prudent selection of plan investments with reasonable fee arrangements. Even after a plan investment is selected, there is a continuing duty to monitor the selected investment. But the decision in *Tibble* leaves unresolved the question of what standards should be applied in determining whether a plan fiduciary can be said to have breached that continuing duty to monitor. *Tibble v. Edison International* (US Sup. Ct. 2015)

Employees Challenge Dave and Buster's Workforce Realignment. As most large employers are by now painfully aware, a failure to offer affordable medical coverage to full-time employees and their dependents can lead to stiff tax penalties starting in 2015. An employee is full-time if he or she is credited with at least 30 hours or service per week or, if the monthly equivalent is used, 130 hours of service per month.

It didn't take much time (if it took any time at all) for employers to understand that capping (or reducing) an employee's hours to prevent full-time status would keep benefit costs in check, and reduce or eliminate exposure to the play-or-pay penalties. At the same time, attorneys and legal scholars began debate on the issue of whether a workforce realignment strategy of this kind, if implemented for the purposes containing benefits costs and reducing exposure to the so-called "play-or-pay" penalties, could expose an employer to litigation and liability risks under section 510 of ERISA.

The discussion is no longer academic. A recent class action suit filed in May, 2015 alleges that Dave and Buster's violated federal law when it reduced the hours of many of its full-time employees in an effort to contain the cost of health care coverage and reduce its exposure to the play-or-pay penalties under the Affordable Care Act.

In her complaint, the plaintiff alleges that she worked an average of 30-45 hours a week at a Dave and Buster's store in Manhattan from her start date in 2006 through May of 2013 when her hours were reduced to under 30 per week, and that she and others who were similarly situated lost coverage under the plan because of the reduction in hours. According to the complaint, these were actions taken in furtherance of a nationwide plan to "right size" the number of full-time and part-time employees. These actions, the complaint alleges, were taken with the intent and the purpose, in whole or in part, of interfering with the attainment of rights under the Dave and Buster's medical plan in violation of section 510 of ERISA.

The allegations of the complaint should not be taken as fact, and we fully expect that Dave and Buster's will mount a vigorous defense of its actions.

Among other things, section 510 of ERISA prohibits an employer from taking adverse employment action for the purpose of interfering with the attainment of any right to which a participant or beneficiary may become entitled under an employee benefit plan that is governed by ERISA. To establish a violation of section 510, a complainant must prove that the employer's adverse employment action was motivated by a specific intent to interfere with benefits. Although the statute expressly refers to participants (i.e., individuals enrolled for coverage under a plan), some courts have held that employees and former employees who are not participants may sue if they were eligible for participation and would have achieved participation if not for the employer's adverse employment action.

If true, the facts in this case represent the highest risk scenario for employers who have implemented (or plan to implement) a workforce realignment that involves a reduction in hours in response to ACA coverage mandates, because the focus of the suit appears to be on participants who lost health care coverage because of a reduction in their hours. The practice of limiting the hours of new employees to prevent benefit eligibility, which is arguably the lowest risk scenario, does not appear to be at issue in this case at this point. Reducing or capping hours for employees who were eligible for coverage (but not enrolled), is a higher risk practice, which also does not appear to be an issue in the case at this point.

The publicity associated with the case against Dave and Buster's will, in itself, increase litigation risk. Employers that have implemented (or plan to implement) workforce alignment strategies motivated by the so-called play-or-pay mandate should check in with ERISA counsel for guidance.

Agency Guidance

New Guidance Regarding Preventive Services and Provider Non-Discrimination. The Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) have issued two more Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act (ACA). A complete set of the FAQs is available at www.dol.gov/ebsa/healthreform. Below is a summary of the recently issued guidance.

Preventive Care Services

The ACA requires non-grandfathered group health plans to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, certain preventive care services. This recent guidance clarifies a number of issues related to preventive care services, including several issues related to contraceptive care.

For example, this new guidance clarifies that if a plan covers some forms of oral contraceptives, some types of IUDs, and some types of diaphragms without cost sharing, but excludes completely other forms of contraception, that the plan will not comply with the ACA. Plans must cover without cost sharing the full range of FDA-identified contraceptive methods. Although a plan may use reasonable medical management techniques to encourage a participant to use specific services within the chosen contraceptive method, plans must have an easily accessible, transparent, and sufficiently expedient exceptions process. Furthermore, if the participant's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the plan must cover that service or item without cost sharing.

The guidance also clarifies that if a plan offers hormonal contraceptives, it may not limit that coverage to oral contraceptives. The guidance indicates that the plan must also cover without cost sharing injectables, implants, the vaginal contraceptive ring, the contraceptive patch, emergency contraception (Plan B/Plan B One Step/Next Choice), emergency contraception (Ella), and IUDs with progestin.

Provider Non-Discrimination

The Departments restated their current non-enforcement approach to the provider non-discrimination rule. That is, until further guidance is issued, the Departments will not take any enforcement action against a group health plan with respect to this rule as long as the plan is using a good faith, reasonable interpretation of the statutory provision.

Under the provider non-discrimination rule, insured and self-insured medical plans may not discriminate against any health care provider that is acting within the scope of its license under applicable state law with respect to both participation and coverage. Until regulations are issued, group health plans and health insurance issuers are expected to implement the requirements of this provision using a good faith, reasonable interpretation of the law.

IRS Advises Administrators to Obtain and Retain Hardship Distribution and Plan Loan Documentation. In recent editions of *Employee Plans Newsletter* and a companion newsletter, *Retirement News for Employers*, the Internal Revenue Service (IRS) informed plan sponsors that they must obtain and retain records relating to hardship distributions and plan loans. According to the IRS, failure to obtain and retain these documents may require a correction under the Employees Plan Compliance Resolution System.

For hardship distributions, the IRS states that these documents must be retained in the records of the plan sponsor:

- Documentation of the hardship request, review, and subsequent approval.
- Financial information and documentation substantiating the employee's immediate and heavy financial need.
- Documentation to support the hardship distribution in accordance with plan provisions.
- Proof of the actual distribution and related tax distribution reporting on Form 1099-R.

For plans that have used the safe harbor method for hardship distributions, it would still be necessary to obtain from the participant documentation of the underlying financial need—for example, documentation that a permissible hardship expense is being incurred by the participant. Apparently it has been the practice of many plans to allow participants to self-certify that these factors exist.

With respect to plan loans, the IRS indicates that similar records should be obtained and retained, including:

- The loan application, review, and subsequent approval.
- Executed plan loan note.
- If the loan is for more than five years, documentation that proves that the loan proceeds were used to purchase or construct a primary residence.
- Evidence of loan repayments.

- Evidence of collection activities with any loans that have gone into default and related tax distribution reporting on Form 1099-R .

For loans with repayment periods in excess of five years, the plan sponsor must obtain documentation of the home purchase before the loan is approved. Again, self-certification is not permitted.

The IRS, through these newsletters, is taking the position that self-certification is not appropriate and actual documentation must be obtained and retained by the plan; the plan must obtain the documentation and not rely that the participant will be able to provide the backup documentation at a later date. The IRS is also informing plan sponsors that this information will be requested as a part of an audit. Several comments have been delivered to the IRS questioning whether these steps are required under current the law and regulations and indicating that this position is inconsistent with prior statements made by the IRS. For now, plan sponsors should take steps consistent with the IRS position to avoid issues in an audit.

Employee Plans Newsletter, http://www.irs.gov/pub/irs-tege/epn_2015_4.pdf, and Retirement News for Employers, http://www.irs.gov/pub/irs-tege/rne_0415.pdf