EMPLOYEE BENEFITS DEVELOPMENTS SEPTEMBER 2015

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September 30, 2015

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Agency Guidance

IRS Issues New Draft Form 1095-C and Instructions. On August 6, 2015, the IRS published its most recent updates to Form 1095-C and the instructions for Forms 1094-C and 1095-C. Beginning in early 2016, applicable large employers will be required to report on the affordable coverage offered to certain employees using Forms 1094-C and 1095-C. Specifically, by the end of January, applicable large employers must send a copy of the completed IRS Form 1095-C to all full-time employees (and, additionally, all non-full-time employees, if they are actually covered under a self-insured health plan). Applicable large employers must also file a copy of the Forms 1095-C along with Form 1094-C with the IRS by the end of February (if filing by paper), or the end of March (if filing electronically).

These IRS forms are critically important for applicable large employers because the information they provide, in part, relates to the potential assessment of penalties under IRS Code Section 4980H(a) and (b), the so called "play or pay" or "employer mandate" rules. The recently issued draft IRS form and instructions are very similar to the draft forms and instructions issued by the IRS earlier this year. However, there is a change to the 1095-C, and there are some additional clarifications in the instructions. The new draft of IRS Form 1095-C now contains a new box titled "plan start month." The instructions note that this box is optional for the 2015 Form 1095-C, and the employer may leave it blank. To complete the box, the employer would enter the two-digit number (01 through 12) indicating the calendar month during which the plan year begins of the health plan under which the employee is offered coverage (or would be offered coverage if the employee were eligible to participate in the plan). If there is no health plan under which coverage is offered to the employee, the employer should enter "00."

In addition to this change in Form 1095-C, the instructions for Forms 1094-C and 1095-C include additional clarification on the reporting and filing requirements. These additional clarifications include information on: the increased penalties for late, incomplete, or inaccurate filing and reporting; the procedure for requesting an extension or waiver; reporting offers of COBRA coverage; and reporting for employees during a break in service.

The IRS warns that these are just draft forms and instructions and may be subject to additional changes prior to the 2016 filing deadlines (based on coverage provided in 2015). Nonetheless, employers should review the Instructions for Forms 1094-C and 1095-C and begin gathering the necessary information to complete these forms.

SEC Adopts Final Rules Regarding Pay Ratio Disclosure. The Securities and Exchange Commission (SEC) recently approved final rules for the disclosure of chief executive officer pay ratios required under the Dodd-Frank Act of 2010. The final rules require the reporting company to provide disclosure of the annual total compensation of the median of all employees (other than the CEO), the annual total compensation of the CEO, and the ratio between the two. The final rule comes almost two years after the issuance of the proposed rule which generated a large number of comments, most of which were critical of the proposed rule. Many of the comments focused on the complexity and large burdens that would imposed under the regulations, including the very high estimated cost of compliance. The final rule offered minimal relief in response to those comments.

The final rules provide a slightly delayed implementation date. For calendar year reporting companies, the final rules require the first disclosure to be made in the 2018 proxy based on 2017 fiscal year compensation. This is one year later than some had expected. The final rules also allow for the employee population to be determined as of any time during the last fiscal quarter of the corporation (instead of the last day requirement of the proposed rule). One larger concession toward reducing cost of compliance is that companies no longer need to perform an annual determination of the median employee. The determination of the median employee only needs to be done once every three years. Further, limited exclusions for certain non-U.S. employees based on data privacy laws limitations and up to five percent of worldwide employment is provided under the final regulations.

The rules require a determination of the compensation utilizing the definition of "total compensation" for SEC reporting rules—a definition of compensation not readily computed. The SEC rules allow for certain simplifying approaches for determining the compensation.

While the implementation date may seem far off, reporting companies should take some preliminary actions in order to be ready to comply with the implementation date.

Cases

Fifth Circuit Affirms Dismissal of ERISA Challenges to Pension De-Risking via Annuity Contract Purchase. Many plan sponsors have been implementing strategies designed to transfer the liability risk associated with sponsoring and maintaining a defined benefit pension plan from the sponsor to a third party. One such pension "de-risking" strategy involves transferring the liability risk to an insurer (for example, if benefits are annuitized under an annuity contract purchased from an insurance company).

In a case recently decided by the U.S. Court of Appeals for the Fifth Circuit, two classes of plaintiffs challenged the legality under the Employee Retirement Income Security Act of 1974 (ERISA) of transferring $7.4 billion of pension benefit obligations to a group insurance annuity contract. The plaintiffs appealed their case to the Fifth Circuit following a decision at the federal district court level in which plaintiffs' claims that the annuity purchase violated ERISA's fiduciary requirements were dismissed. In its unpublished decision, the Fifth Circuit unanimously upheld the district court dismissal

of the ERISA claims.

In reaching its decision, the Fifth Circuit considered and rejected plaintiffs' claims that the plan fiduciaries breached their ERISA duty to disclose by failing to give notice of "the possibility that benefit obligations could be transferred to an insurance-company annuity absent a plan termination or spin-off/merger," or that participants could suffer a "loss of benefits," i.e., a loss of federal protections under ERISA and the Pension Benefit Guaranty Corporation (PBGC), in connection with such a transfer.

The Fifth Circuit also held that the decision to annuitize and amend the pension plan terms to provide for an annuity transaction "was a sponsor function of plan design, authorized under ERISA," and that the decision to transfer pension assets outside ERISA coverage is a "sponsor decision immune from fiduciary obligations." The Fifth Circuit, however, did consider and ultimately rejected a series of ERISA breach allegations surrounding the implementation of the annuity purchase. The court held that the *plan sponsor* did not violate its ERISA fiduciary duties by entering into an annuity transaction that resulted in the partial transfer of pension obligation from an ongoing pension plan. The court also rejected claims that the *plan fiduciaries* violated their ERISA fiduciary duties during the implementation of the annuity purchase by:

- Failing to hold the annuity contract within the plan as a plan asset
- Failing to obtain consent of the affected participants
- Failing to communicate with the affected plan participants
- Violating plan terms when plan assets for purposes other than for the exclusive benefit of plan beneficiaries and participants, as well as reasonable expenses of administering the plan
- Failing to select more than one annuity provider

Finally, in considering the plaintiffs' claim that the plan's annuity amendment represented "intentional interference with rights" of the participants whose pension benefits were being transferred away from the plan, the Fifth Circuit held that plaintiffs failed "to allege a viable right with which the amendment interfered," and therefore failed to state a claim. The court rejected the plaintiffs' argument that there is a protected right to continue participation in the plan until benefits have been paid in full and could find no support for the notion that ERISA protections and PBGC benefits are rights to which a plan participant is entitled.

For now, the decision in this case seems to lend support to the practice of pension de-risking through the purchase of group annuity contracts from insurance companies. Whether legal challenges in other circuit courts might be pursued, and whether other statutory and regulatory efforts to regulate and restrict pension de-risking strategies may be forthcoming (particularly in light of the IRS's recent prohibition on offering lump sum windows to retirees in pay status), remains to be seen. *Lee v. Verizon Communications, Inc.* (5th Cir. 2015)

Third Circuit Rules Final Benefits Denial Letters Must Include Time Limits for Judicial Review. Under a recent decision by the U.S. Court of Appeals for the Third Circuit, a benefit plan administrator erred by failing to include written notice of the plan's one-year contractual limitations period for seeking judicial review of a denial of benefits. As a result, a lawsuit contesting a denial of benefits that otherwise would have been time-barred under the benefit plan's contractual limitations provision may be filed under New Jersey's six-year statute of limitations for breach of contract claims.

The case in question concerns a doctor seeking reimbursement under a health plan for treatment of a patient's severe back pain. After properly working through the plan's claims review procedures, the doctor eventually received a letter from the patient's insurance company denying his final appeal for payment on the grounds that the medical procedure performed was not a covered benefit because it was "medically investigational." The letter included a statement informing the doctor of his right to bring a civil action under ERISA if he was not satisfied with the decision. Neither the final denial letter nor any of the other earlier denials mentioned that, under the plan, the doctor had only one year from the date of the final benefits denial to seek judicial review.

Nearly 19 months after receipt of the final denial letter, the doctor sued the insurance company for unpaid benefits. The district court hearing the case dismissed the doctor's claims, holding that the one-year limit was not unreasonable, and that, despite the lack of written notice of the limit in the denial letter, the doctor had actual notice of the time limits. In reaching this conclusion, the court noted that, although there was no evidence that the doctor himself was aware of the deadline, his attorneys had knowledge of the deadline well in advance of the expiration of the one-year time period; the doctor's counsel had received oral notice of the time limit and a copy of the plan document in connection with an appeal of benefits denial by another health provider, which dealt with the same patient and the same plan.

On appeal, the Third Circuit put aside the question as to whether the doctor could be found to have received notice of the time limit through his law firm and focused instead "on the issue the district court avoided," namely, whether the plan administrator violated its obligations under ERISA by failing to include the plan-imposed time limit in the final denial letter. The court analyzed the language in the Department of Labor regulations that requires a plan administrator to provide a claimant with written notification of any adverse benefit determination. In these notifications, the administrator must set forth "a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a)" of ERISA (29 C.F.R. § 2560.503-1(g)(1)(iv)). The court sided with the doctor's interpretation of the regulation, holding that it requires an administrator to inform claimants in their adverse benefit determinations of plan-imposed time limits for bringing civil actions. Absent the required notification to the doctor of the one-year deadline in the plan, the applicable statute of limitations for a lawsuit was determined to be the state's six-year deadline for breach of contract actions. The court vacated the order of dismissal and remanded the case to the district court for further proceedings. *Mizra v. Ins. Adm'r of Am., Inc.* (3d Cir. 2015)

Action to Recover Supplemental Pension Benefit Overpayment Survives Motion to Dismiss. Pfizer, Inc. sponsored the Pharmacia Corporation Supplemental Pension Plan, an ERISA pension plan. Virginia Weldon was a participant in the Plan.

Weldon commenced benefits under the Plan in 2003 and had elected to receive benefits for a period of three years. When benefits to Weldon continued into 2006, she contacted a Plan service provider regarding the continuation of payments. The service provider informed Weldon that she would continue to receive payments for the remainder of her lifetime. It was not until late 2009 that it was discovered that benefit payments to Weldon should have ceased after the December 2005 pension payment. A letter demanding repayment of $1,329,455.70 in pension overpayments was sent to Weldon at that time. After additional letters were exchanged between the parties over several years, Pfizer and the Plan commenced an action against Weldon in 2014.

Included in the claims brought by the Plan against Weldon were causes of actions for enforcement of the terms of the Plan and for restitution. The court dismissed the Plan's action for enforcement of the terms of the Plan because the Plan did not include a provision requiring an overpayment to be repaid to the Plan.

The court denied Weldon's motion to dismiss the Plan's equitable claim for restitution, thus allowing that cause of action to proceed to the next stage of litigation. However, the court noted that the Plan's ultimate relief, if any, would be limited to recovering specifically identifiable overpaid funds (or the identifiable proceeds thereof) still in Weldon's possession and control. It remains to be seen whether the Plan will be able to "trace" funds in this manner.

Key Takeaway: It is recommended that plan sponsors review their plans to determine whether each plan requires participants and beneficiaries to repay the plan if an overpayment is made to the participant or beneficiary. If a plan includes a repayment provision, an argument can be made that the plan has a contractual right to recover an overpayment and that no tracing of overpaid amounts is required. If the plan does not include a repayment provision, plan sponsors may wish to consider amending the plan to include such a provision. *Pharmacia Corp. Supplemental Pension Plan v. Weldon* (E.D. Mo. 2015)