EMPLOYEE BENEFITS DEVELOPMENTS JANUARY 2016

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January 29, 2016

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IRS Guidance Addresses Numerous ACA Issues Related to HRAs. Just before the New Year, the IRS issued Notice 2015-87 (Notice), addressing the application of Affordable Care Act (ACA) market reform rules to different types of employer health care arrangements. In last month's newsletter, we discussed how unconditional opt-out payments may affect the affordability calculation under the Employer Shared Responsibility provisions of the ACA. As noted in the previous article, such unconditional opt-out payments may have the effect of making employer provided coverage less affordable. Unlike the unconditional opt-out payments, however, the Notice also indicates that employer contributions to Health Reimbursement Arrangements (HRAs) may have the effect of making employer provided coverage more affordable.

The following example illustrates this concept:

The employee contribution for health coverage under the major medical group health plan offered by the employer is generally $200 per month. For the current plan year, the employer makes newly available $1,200 under an HRA that the employee may use to pay the employee share of contributions for the major medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage.

The $1,200 employer HRA contribution reduces the employee's required contribution for the coverage. The employee's required contribution for the major medical plan is $100 ($200 - $100) per month because 1/12 of the $1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA to pay the employee share of contributions for the major medical coverage.

The Notice explains that employer HRA contributions count toward an employee's required contribution only to the extent the amount of the employer's annual HRA contribution is required under the terms of the arrangement or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

In addition to the affordability calculation guidance described above, the Notice confirms certain earlier guidance related to HRAs and cafeteria plans. For example, although retiree-only HRAs may be used to purchase individual market medical coverage, HRAs for current employees may not be used to purchase, or be integrated with, individual medical policies. Also, although current employees may not purchase individual medical policies with funds from HRAs or through cafeteria plans, current employees may purchase individual policies for excepted benefits, such as stand-alone vision or dental policies through such arrangements.

The Notice also offers new guidance regarding reimbursements from integrated HRAs. Under prior guidance, the IRS stated that general purpose HRAs for current employees must be "integrated" to be in compliance with the ACA market reform provisions. To be integrated, current employees must be eligible for, and enrolled in, a non-HRA group health plan (such as an employer's group health plan). The Notice provides that if an employee is enrolled in single-only coverage under an employer's group health plan, the integrated HRA may only be used to reimburse the employee's eligible expenses (not the expenses of a spouse or dependent child who is not enrolled in group health coverage).

Under transition relief associated with this new guidance, the IRS will not treat HRAs in place prior to December 16, 2015 as failing to be integrated for plan years beginning before January 1, 2017, solely because the HRA covers expenses of an employee's family even if those family members are not also enrolled in the employer's group health plan. In light of the new guidance, employers who sponsor HRAs should review their plans to determine if any amendments are needed.

IRS Confirms Additional Plan Changes Generally Not Required for *Obergefell* Ruling. Following the Supreme Court's ruling in *United States v. Windsor* that Section 3 of the Defense of Marriage Act was unconstitutional, the IRS issued several pieces of guidance addressing the impact of *Windsor* on employee benefit plans. In particular, that guidance provided that a same-sex marriage that was validly entered into in a state whose laws authorized the marriage would be recognized for federal tax purposes, even if the married couple was domiciled in a state that did not recognize the validity of the marriage.

Following *Windsor* and the issuance of the IRS guidance, the Supreme Court held in *Obergefell v. Hodges* that the Fourteenth Amendment (i) requires a state's civil marriage laws to apply to same-sex couples on the same terms and conditions as opposite-sex couples, and (ii) prohibits a state from refusing to recognize a lawful same-sex marriage performed in another state on the ground of its same-sex character.

The IRS recently issued Notice 2015-86 to provide guidance on the application of the Supreme Court's decision in *Obergefell*. Because the IRS already announced as part of its earlier guidance that it would recognize any same-sex marriage validly entered into in a state whose laws authorized the marriage, the Notice provides that qualified retirement plans are not required to make additional changes to their terms or their operations as a result of *Obergefell*. However, a plan sponsor of a qualified retirement plan may make certain discretionary amendments as a result of *Obergefell*. For example, if a participant with a same-sex spouse commenced receiving a single life annuity before June 26, 2013 (i.e., the date of the *Windsor* decision), a plan could be amended to allow the participant to elect a qualified joint and survivor annuity as of a new annuity starting date. Any such amendment would be subject to the Internal Revenue Code's nondiscrimination requirements and restrictions on plan amendments that increase the liabilities of the plan while the plan is underfunded.

The Notice also confirms that federal tax law does not require any changes to the terms of health or welfare plans as a result of *Obergefell*. However, other applicable law may require changes to the terms and/or operation of a health or welfare plan. Depending on the terms of a cafeteria plan, the Notice also provides that a participant with a same-sex spouse may be permitted to revoke an existing election and submit a new election.

CASES

Recovery of Benefit Plan Overpayments - What the Supreme Gave it Hath Taken Away. Benefit overpayments can (and often do) result from pension calculation errors that inflate a participant's lump sum distribution or monthly pension payment. Overpayment scenarios are common in the disability and group health plan contexts as well. For example, group health plans often contain third party recovery provisions – so-called subrogation clauses – that require a participant to reimburse the plan for medical expenses paid on the participant's behalf if the participant later recovers money from a third party for his or her injuries.

The United States Supreme Court in *US Airways v. McCutchen* made it clear that a plan can enforce a properly crafted third party recovery provision. However, in a recent case – *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan* - the Supreme Court, resolving a split among the federal Courts of Appeal, delivered an opinion that will significantly impair a plan's right to enforce these provisions. In this case 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, exceeded $120,000. Montanile sued the drunk driver and received a settlement of $500,000. Pursuant to the plan's subrogation clause, the Board of Trustees requested reimbursement of the medical expenses paid on Montanile's behalf. Montanile's attorney refused the demand for repayment and informed the Board that the settlement funds held in the attorney's trust account would be paid to Montainile unless the Board objected. When the Board failed to object, the attorney released the funds to Montainile. Six months later the Board sued Montanile for reimbursement but by then the settlement proceeds had been dissipated.

The Court in *Montanile* held that when an ERISA-plan participant wholly dissipates a third party settlement on nontraceable items, the plan fiduciary may not bring suit to attach the participant's separate assets. Broadly read, the Court's ruling stands for the proposition that a plan may pursue recovery of benefit plan overpayments only against specifically identified funds that remain in a participant's possession, or against traceable items that the participant purchases with the funds. In *Montanile*, the Court ruled that the Board's claim would have been enforceable if the Board had sued to enforce the lien when the settlement proceeds were still within Mr. Montanile's possession and control.

Employers that maintain self-funded medical plans should take the following steps in light of the ruling in *Montanile* :

- Ensure that plan documents and SPDS have carefully crafted third party recovery provisions;
- Develop a procedure for identifying and monitoring claims that may implicate the plan's third party recovery provisions. The early identification of claims that relate to traumatic injuries sustained in accidents, or that involve medical problems that are known to be related to defective or dangerous products, is an essential element of any effective recovery program. For example, cases involved hospitalization, especially admissions for traumatic injuries, should be identified and followed up.

- Once a potential third party recovery scenario has been identified, the participant and his or her attorney should be promptly notified of the plan's third party recovery provisions and their obligations with respect to any subsequent recovery.
- Once a potential third party recovery scenario has been identified, consider requiring participants and their attorneys to sign reimbursement agreements as a condition of the payment of benefits. The plan document and SPD should contain appropriate language apprising participants of this requirement.
- If the terms of the plan require cooperation with the plan (e.g., the execution of a reimbursement agreement) as a condition of the payment of claims, work closely with the claims administrator to be sure that claims are "pended" if cooperation is not forthcoming. Some medical plans employ a "pay and chase" approach in which claims are paid first with recovery later. Plans that "pay and chase" are now at greater risk.
- Where a significant amount of money is at stake, file suit to enforce the lien before the funds are dissipated. Do not delay.

Participant Bargaining Power not Relevant in Determining Top Hat Status of Plan. A former executive of a Pennsylvania non-profit failed in his claim that the promised benefit he seeks under his employer's deferred compensation plan is entitled to the full protections of the Employee Retirement Income Security Act of 1974 (ERISA). Certain nonqualified deferred compensation plans, commonly called "top hat" plans, are exempt from the vesting and non-forfeiture provisions of ERISA. To qualify for the exemption, the plans must be unfunded and must be maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

The employee in this case was a participant in his employer's nonqualified supplemental benefit plan, where he accrued a vested benefit of almost $60,000. Following his separation from service, the employee applied for a lump sum distribution of his account balance, but failed to receive payment. Eventually, he received a letter from the plan administrative committee, informing him that his benefit had been forfeited because he had not entered into a written post retirement service agreement. The employee sued, alleging various ERISA and breach of contract claims. His employer moved for partial summary judgment on the basis that the plan was a top hat plan exempt from ERISA's "substantive protections," and the district court granted the motion.

The decision turned on a determination of whether the plan is maintained primarily for the purpose of providing deferred compensation for "a select group of management or highly compensated employees." The court determined that the plan satisfied this requirement because it covered a very small percentage of employees and limited participation to management employees who were highly paid. The court explicitly rejected the employee's claim that it must also consider whether the participants had sufficient "bargaining power" with respect to the plan. The employee's argument rested on an Opinion Letter issued by the U.S. Department of Labor in 1990 (Opinion Letter 90-14A). This letter expressed the view that Congress provided relief from ERISA's "substantive rights and protections" for top hat plans, because it recognized that "certain individuals, by virtue of their position or compensation level, have the ability to affect or substantially influence, through negotiation or otherwise, the design and operation of their deferred compensation plan." Addressing the cases relied upon by the employee, the court rejected the argument that bargaining power is an element in determining whether a deferred compensation plan is a top hat plan, declaring that it "declines to be the first" federal court to apply such a test. *Sikora v. UPMC* (W.D. Pa., 2015)

Posthumous Amendment of QDRO Upheld as Valid. A District Court judge has ruled that a pension fund must honor a qualified domestic relations order (QDRO) that was amended after the death of a participant's former wife to provide for a reversion of the wife's benefit to the participant. As part of a divorce settlement, the participant's wife was awarded 50% of the participant's vested interests in a union pension fund. The 2002 QDRO awarding the benefit to the wife did not provide for the possibility that she might predecease the participant. Unfortunately, the wife died in 2011, before the participant's retirement. As a result, she never received any benefits in the union pension plan. In 2014, the participant decided to retire, setting a retirement date in early 2015. When he applied to the pension fund for his benefits, he was advised that he was entitled to only 50% of his pension, because the QDRO included no provision for a reversion to the participant on his former wife's death. The fund claimed that the 50% that would have been paid to the wife had she survived, would revert to the fund under what it claimed was the default rule for QDROs. The rule stated that "upon the Alternate Payee's death before benefits commenced to him or her, the Alternate Payee's assigned benefit will be forfeited and will revert to the [Plan/Participant]." The rule did not explain the circumstances under which the benefit would revert to the plan, as opposed to the participant.

Following the fund's decision, the participant obtained an amended QDRO, which provided that all of the former wife's benefit would revert entirely to the participant in the event the wife should predecease the participant before any benefits were paid to her. The fund refused to honor the amended QDRO, on the basis that an amended QDRO cannot retroactively reverse a result that had already occurred. The participant sued under ERISA, claiming that the fund's denial was arbitrary and capricious. The court agreed, stating that the original QDRO's failure to take into account the possibility that the wife might predecease the participant appears to be an obvious oversight, which can be corrected by a domestic relations court. Noting that other courts have held that ERISA does not prohibit application of posthumous QDROS, the court upheld the validity of the amended QDRO, even though it was entered after the wife's death. The court found that the fund's refusal to recognize that the wife's interest terminated on her death and reverted to the participant as required by the amended QDRO was arbitrary and capricious. *Cingrani v. Sheet Metal Workers' Local 73 Pension Fund* (N.D. Ill., 2015)

District Court Upholds Plan's Forum-Selection Clause. An employee worked for his employer for approximately 35 years before retiring in 1985, and was a participant in his employer's pension plan. When he passed away in 2009, his spouse, who was designated as the beneficiary, began receiving monthly pension payments. Subsequently, the spouse received an email offering her the option to instead receive a lump sum benefit. She accepted the lump sum option, but she passed away just a few weeks later without having collected her lump sum benefit. Her children attempted to collect the lump sum benefit. However, the plan informed them that their mother's lump sum benefit election was cancelled because she died prior to the benefit commencement date. Therefore, her children were ineligible to receive the lump sum payment. They later discovered that the relevant plan provision, under which the lump sum election would be cancelled if the recipient died prior to the benefit commencement date, was not added to the plan until months after the lump sum election was supposedly "final," and approximately one month after her children first inquired about collecting the lump sum benefit.

The surviving spouse's estate and the children (plaintiffs) filed suit in state court, asserting five state law claims (a breach of contract claim and four tort claims). The plan had the case removed to federal court on the basis of federal question jurisdiction, alleging that plaintiffs' claims were all completely preempted by ERISA. Because the plan contains a forum-selection clause directing all litigation to be filed in the United States District Court for the Northern District of Georgia, the plan filed alternative motions in which it argued the court should either dismiss the case or transfer it there. Even if the

court found that the forum-selection clause is unenforceable, the plan argued that the plaintiffs claims must be dismissed because they are preempted by ERISA, and because Plaintiffs failed to exhaust administrative remedies prior to filing suit.

The court agreed that plaintiffs' breach of contract claim is completely preempted by ERISA because "it is, in essence, a claim for recovery of benefits due under the terms of an ERISA-governed employee benefit plan." And because the lawsuit states a claim arising under federal law, removal was proper. The court also rejected plaintiffs' argument the plaintiffs are not "participants" and "beneficiaries" and therefore have no standing to pursue an ERISA claim.

The court also determined that the forum-selection clause contained in the plan is enforceable, justifying transfer of the case to the United States District Court for the Northern District of Georgia. Plaintiffs argued that the forum-selection clause is unenforceable because it was not a "bargained for" provision, and is contrary to public policy. But the court rejected this argument based on binding case law precedent that holds forum-selection clauses are "presumptively valid and enforceable" even when they are "not the product of an arms-length transaction."

The transferee court is left to decide the remaining substantive issues of the case, including whether plaintiffs' tort claims also are preempted by ERISA, and what will be the appropriate course of action, given the plaintiffs' alleged failure to exhaust administrative remedies under the terms of the plan. *Keever v. NCR Pension Plan*, S.D. Ohio 2015.