Proskauer

newsletter

A report to clients and friends of the firm

Edited by Stacey C.S. Cerrone and Russell L. Hirschhorn

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in this issue

For the latest insights on developments in the world of employee benefits, executive compensation & ERISA litigation, visit our blog at www.erisapracticecenter.com.

Editor's Overview

This month's newsletter focuses on how Plan Trustees can appropriately settle ERISA breach of fiduciary duty claims in order to achieve "complete peace." The article provides a check list and discusses strategies for handling settlement of fiduciary breach claims including, barring future claims by non-settling parties, baring future claims by non-settling co-defendants, protecting against future claims with adequate insurance coverage, and moving on after settlement.

As always, be sure to review the section on Rulings, Filings, and Settlements of Interest including, the Supreme Court's decision to review the subsidy issue, the IRS closing the "loophole" on in health care reform; new FAQ's regarding premium reimbursement arrangements and marketplace dumping; the 2015 Proxy voting updates; and the DOL's focus on audits and enforcement actions.

How to Settle an ERISA Breach of Fiduciary Duty Case and Sleep at Night: A Checklist for Plan Trustees to Consider*

By Myron D. Rumeld & Anthony S. Cacace[1]

Plan trustees often look to settle ERISA fiduciary breach claims brought against them as a way to put the past behind them. Assuming there is enough fiduciary liability insurance coverage available to pay the proposed settlement sum, the trustees may be prepared to put aside their desire to vindicate themselves for a challenged course of conduct, avoid the risks of a horrific outcome that exceeds insurance coverage limits—potentially causing them to use personal assets to satisfy a judgment against them—and move on. Unfortunately, however, ERISA is structured in a manner that creates obstacles to achieving the goal of "complete peace."

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First, ERISA accords standing to bring fiduciary breach claims to multiple parties, not all of which may have participated in the lawsuit being settled. A settlement of the claims alleged may not extinguish the rights of the other parties with standing to sue, thereby leaving the settling trustees subject to additional liability exposure.

Second, courts in some jurisdictions have taken a rather expansive view of the right of parties defending ERISA fiduciary breach claims and other claims brought on behalf of plans to file third-party claims against other parties who contributed to the losses suffered by the plans. As a result, even after settling the claims brought directly against them, trustees may face exposure from third-party claims.

Notwithstanding these obstacles, there are a number of litigation strategies that trustees can pursue in order to potentially reduce or eliminate these risks of continued exposure following a settlement. Although the effectiveness of these strategies will vary, depending on the circumstances presented, trustees are well-served by considering each of them with their attorneys, before determining whether, and under what conditions, they wish to enter into a settlement.

Barring Future Claims by Non-Settling Parties with Standing to Bring Direct Claims against the Settling Trustees

Under ERISA's statutory scheme, there are three categories of plaintiffs who have standing to sue plan trustees for breach of fiduciary duty: (i) the U.S. Department of Labor (DOL); (ii) participants and beneficiaries of the plan; and (iii) co-fiduciaries of the plan. See 29 U.S.C. § 1132(a)(2); ERISA § 502(a)(2). Rare is the case when trustees are settling a lawsuit in which all three categories are the plaintiffs. As a result, before agreeing to settle claims brought against them, the trustees should consider their potential exposure to "copy-cat" claims brought by other parties who to date have not sued them.

In some instances, the trustees can gain comfort from a potential statute of limitations defense. Absent allegations of fraud or concealment, which will extend the limitations period, ERISA breach of fiduciary duty claims will expire on the earlier of three years from when a plaintiff has actual knowledge of the claim or six years from when the claim accrued. Unfortunately, there is considerable uncertainty as to how these statute of limitations rules apply. For example, in the cases of investment losses, courts are not consistent in their rulings about whether a claim accrues from the time of the original investment that precipitated the losses, or when the losses were actually experienced. As a result, even where substantial time has elapsed since the events giving rise to the fiduciary breach claims, it may be difficult to reach the conclusion that all residual claims are necessarily time-barred.

In the absence of a blanket protection from the statute of limitations, trustees may wish to consider other strategies for protecting against future claims, including the following:

- *Define Settled Claim as Being Brought on Behalf of the Plan*. Be sure to define plaintiffs in your case as having brought the lawsuit in a representative capacity on behalf of the plan and seeking relief that would inure to the benefit of the plan. See Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (holding that ERISA fiduciary breach claims are brought in a representative capacity on behalf of the plan as a whole). Although there is no case law explicitly endorsing this principle, crafting the settlement agreement in this fashion should increase the likelihood of a court to find that a subsequent claim seeking relief on behalf of the plan is barred.

- *Settle on a Class-Wide Basis*. Where a claim has been brought by a single participant, the trustees may wish to consider structuring the settlement such that it is conditioned on the court first certifying a class of participants. This way, the release entered into in consideration for the settlement payment will bind all plan participants. Furthermore, a class settlement that is approved by the court as fair and reasonable will likely satisfy the DOL that no further action should be taken against the trustees.
- *Request an Order Barring Claims of Other Potential Claimants*. Ordinarily, a bar order is entered into for the purpose of facilitating partial settlement by barring the claims of other, non-settling defendants. However, there is some authority, pursuant to the All Writs Act, for barring claims of non-parties. The All Writs Act grants authority to enjoin and bind non-parties to an action when needed to preserve the court's ability to reach or enforce its decision in a case over which it has proper jurisdiction. *See, e.g., In re Baldwin-United Corp.*, 770 F.2d 328, 338 (2d Cir. 1985). In the context of ERISA settlements, where there are multiple parties with the ability to pursue the same claims, courts have sometimes been willing to bar claims by these potential plaintiffs for the sake of facilitating a settlement that is viewed to be in their best interests. *See, e.g., In re Worldcom, Inc. ERISA Litig.*, 2005 WL 3107725, at *4 (S.D.N.Y. 2005). Note that a bar order will need court approval because, much like a class action, the court needs to determine the agreement's fairness to all parties and to give the non-settlers the opportunity to object to the order and non-parties a chance to potentially file a claim. *See In re Masters Mates & Pilots Pension v. Riley*, 957 F.2d 1020, 1025 (2d Cir. 1992).
- *Secure Assurances from the DOL*. It is frequently the case that, during the pendency of a fiduciary breach lawsuit brought by the plan's fiduciaries or plan participants, the DOL conducts a parallel investigation of the same claims. The defendant trustees can ill afford the risk of a lawsuit commenced by the DOL sometime after the first lawsuit has been settled. If the DOL has been kept apprised of the litigation proceedings, and is accorded an opportunity to review the terms of the contemplated settlement, the DOL may communicate in advance its willingness to close its administrative file if the settlement is consummated.

Barring Future Claims by Non-Settling Co-Defendants

If the trustees are not the only party being sued for breach of fiduciary duty to recover certain losses suffered by the plans, it is important that the trustees protect themselves from potential third-party claims by other defendants. Consider, for example, the following familiar scenario: the funds suffer investment losses and participants sue both the trustees and the investment consultant for breach of fiduciary duty. The trustees are prepared to reach a settlement of the claims brought against them, but no settlement has yet been reached with the investment consultant. If the trustees proceed with the settlement, they may remain at risk of the investment consultant pursuing third-party claims against the trustees. Although under ERISA, each fiduciary is jointly and severally liable for the full amount of the losses proximately caused by the breach, in the case of third-party claims a court will typically apportion liability among the breaching fiduciaries based on the proportional share of each fiduciary's responsibility for the losses caused. Thus, if a court were to determine that the proportional liability of the trustees was greater than the amount paid in settlement of the claims against them, the trustees will ultimately be responsible for a greater sum than the settlement amount.

There are two ways to avert this risk. First, the settling trustees may insist on conditioning the settlement on a bar order that bars the non-settling defendants from pursuing third-party claims against the trustees. A less cumbersome solution may be to condition the settlement agreement on a commitment by the settling plaintiffs that they will draft or amend any claims against other defendants to provide that the damages they are seeking to recover are reduced by any damages that the defendant would be able to recover via a third-party claim against the trustees. Framing the claims this way should serve to immediately extinguish any third-party claims brought against the trustees. *See, e.g., In re Ivan F. Boesky Sec. Litig.*, 948 F.2d 1358, 1368-69 (2d Cir. 1991) (approving settlement agreement that barred contribution and indemnification claims between the settling defendants and non-settling defendants with a provision that gave the non-settling defendants an appropriate right of set-off from any judgment imposed against them). *See also In re Worldcom*, 2005 WL 3107725, at *4. Such a provision will also serve to protect the trustees against third-party claims brought by entities that have not yet been sued or have not been sued in the same legal proceedings.

Protecting against Future Claims with Adequate Insurance Coverage

Assuming that the trustees wish to proceed with a settlement, but cannot completely extinguish the risk of collateral claims, the trustees should make certain that there is still insurance coverage available to them in the event that additional claims are pursued against them. Whether such protection exists will depend on the terms of the coverage release that the trustees enter into as a condition for the insurance carrier's contribution to the settlement. The trustees, with assistance from their counsel, should ensure that the release applies only to the claim(s) being settled, and does not extend to other claims, including claims arising from the same underlying events. Even this protection will only work, however, if there is adequate remaining coverage within the policy limits. Furthermore, if the trustees subsequently replace their coverage, they will need to make sure that the prior coverage extends to claims based on events preceding the date of the coverage. In short, before entering into any settlement agreement, the trustees should direct their counsel to review carefully their remaining coverage protection.

Life after Settlement

In settling a breach of fiduciary duty case, trustees must also be careful not to give anything away in settlement that will prohibit them from continuing to serve as trustees (if they still so desire) in the same way that they had served in the past. In some cases, particularly when the DOL is involved, the plaintiff may seek to condition a settlement on the trustees resigning their responsibility, either for a particular plan or for all plans. The decision whether to accept these conditions is a personal one that has to be based on each trustee's unique circumstances.

Even narrowly crafted settlements that do not bar future service as a trustee may still result in constraints on the settling trustees' ability to conduct their existing responsibilities. For example, the contemplated agreement may prohibit the settling trustees from taking any action with respect to the events giving rise to the underlying claims, including the pursuit of claims against other plan fiduciaries or professionals. If the settling trustees are still actively serving the plan, they may wish to consider whether they can effectively fulfill their responsibilities notwithstanding these restraints. The answer may depend on whether there are other non-settling, unencumbered trustees who can fulfill these responsibilities, and thereby allow the settling trustees to recuse themselves from these activities.

The View from Proskauer

Settling fiduciary breach claims is often viewed by trustees as a bitter pill to swallow, as it requires them to abandon their right to defend themselves when they feel they have done nothing wrong. Swallowing this pill becomes even more uncomfortable when the reality sets in that, notwithstanding the settlement, there may still be risks of a second lawsuit. In our experience, this risk has proven to be very small, as it is the rare case where we find the need to re-litigate a settled claim brought by a new plaintiff. But prudence dictates that, before any case is settled, the trustees pursue all practical means, with the aid of their counsel, to reduce this risk to the barest minimum. If nothing else, doing so should allow us all—trustees and counsel alike—to sleep a little better at night.

Rulings, Filings, and Settlements of Interest

SCOTUS to Review Subsidy Issue

By Peter Marathas and Stacy Barrow

> On November 7, the U.S. Supreme Court announced it was going to review *King v. Burwell*. At issue in the case is whether Fourth Circuit correctly determined that the IRS did not exceed its authority when it released a rule in 2012 providing that federal subsidies under the Affordable Care Act are available in both state and federally operated exchanges, but rather was simply clarifying the statute by also providing subsidies in federal exchanges.

While the Supreme Court often waits for a true "split in the federal circuits" to review a case, it has the authority, when it deems appropriate, to hear cases that present important national issues. The administration had asked the Supreme Court to wait until further action was taken in the lower courts on the issues, particularly in the *Halbig v. Burwell* case, where the entire Federal Circuit Court for the District of Columbia has agreed to review an earlier ruling by a three-judge panel that the IRS had exceeded its authority. The Administration was hopeful that after the Halbig en banc review the full panel would reverse the *Halbig* decision and there would be no split in the circuit (at least for now).

But the Supreme Court has elected not to wait. It will hear *King* in the current term. This means that unless the President and Congress can work together to craft a compromise to affect a fix to the statutes, the Supreme Court will decide whether federal subsidies are available in the 36 federal exchange states.

A Supreme Court decision ruling that the IRS had exceeded its authority by authorizing subsidies in federal exchanges would be disastrous for the Affordable Care Act and the millions of lower paid people who are currently receiving subsidies under federal exchanges. It also would mean that pay-or-play penalties, which are triggered only if subsidies are received by full-time employees, would not apply with respect to individuals residing in those 36 states.

We will provide future updates as they become available.

IRS to Close "Loophole" on "Sub-Standard" Plans without Hospitalization or Physician Services Coverage

By Paul M. Hamburger, Stacy Barrow and Tzvia Feiertag

> On November 4, 2014, the Internal Revenue Service ("IRS") announced that it intends to close a perceived "loophole" in health care reform. This so-called loophole allows employers to offer low cost health plans that don't cover inpatient hospitalization services or physician services (or both). If that coverage were treated as "minimum value" coverage, then employers could avoid all pay-or-play penalties with low cost coverage and covered individuals would not be able to benefit from premium assistance or subsidies in the health insurance Marketplace.

In Notice 2014-69, the IRS announced that it will be closing this loophole so that these types of plans (called "Non-Hospital Plans" or "Non-Physician Services Plans") would not be treated as "minimum value" coverage for health care reform purposes.

Here's what that means.

Background

Under health care reform's "pay-or-play" penalty scheme, applicable large employers (generally those with 50 or more full-time employees or employee equivalents) are subject to two penalties: the "A" penalty which applies if an employer makes no offer of "minimum essential coverage" to at least 95% (70% in 2015) of full-time employees; and the "B" penalty which applies if the employer offers minimum essential coverage that is unaffordable or does not provide "minimum value."

Separately, if an employee is covered by affordable "minimum value" coverage, the employee is not eligible for a premium tax credit or subsidy to purchase insurance coverage in the health care reform Marketplace.

"Minimum value" coverage refers to coverage where the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of those costs. Generally, employers may determine whether a plan meets the minimum value requirement by applying a minimum value (MV) calculator provided by the Department of Health and Human Services or by fitting within a safe harbor defined by HHS.

The "Non-Hospital Plans" or "Non-Physician Services Plans" which are the subject of the latest IRS announcement were designed and promoted to provide "minimum value" coverage under the MV calculator without covering inpatient hospitalization and physician services.

Intended Approach

The bottom line is that the government agencies have all determined that Non-Hospital Plans and Non-Physician Services Plans do ***not*** provide minimum value for health care reform purposes. This is because the agencies believe that inpatient hospitalization services are "fundamental benefits that are nearly universally covered, and historically have been considered integral to coverage, under typical employer-sponsored group health plans."

According to Notice 2014-69, this government position will be included in new regulations coming out in 2015. Once regulations are finalized, employers won't be

allowed to use the MV calculator (or any other permitted method) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides minimum value.

What does this IRS Notice Mean?

Once this new rule is final, it means that Non-Hospital/Non-Physician Services Plans will not be treated as "minimum value" plans for premium subsidy purposes or pay-or-play purposes. Therefore, even if individuals have this coverage, they could go to the Marketplace and get a premium tax credit or subsidy. In turn, that could subject an employer to a "B" penalty (the $3,000 "unaffordable coverage" penalty), as the plan will not provide minimum value. Employers presumably could still avoid the "A" penalty for failing to offer coverage to at least 95% of full-time employees (70% in 2015).

What about "skinny" plans?

Although this IRS announcement is sometimes reported as targeting "skinny" plans, that is not entirely true. Non-Hospital/Non-Physician Services Plans are low cost plans, like the so-called "skinny" plans. However, unlike Non-Hospital/Non-Physician Services Plans, skinny plans do not purport to provide "minimum value" and thus are unaffected by the Notice. Skinny plans, along with Non-Hospital/Non-Physician Services Plans, may continue to be offered as a method for employers to avoid the mandate's "A" penalty (i.e., by offering "minimum essential coverage"); however, neither skinny plans nor Non-Hospital/Non-Physician Services Plans will qualify for purposes of avoiding the "B" penalty. Employers considering offering Non-Hospital/Non-Physician Services Plans or skinny plans should consult with legal counsel prior to implementation.

Transition Relief

Because this is a new rule, the IRS is providing some transition relief. The new rule won't apply to an employer's plan for plan years beginning on or before March 1, 2015 if the relief applies. Transition relief generally applies if an employer has entered into a binding written commitment before November 4, 2014, to adopt a Non-Hospital Plan or Non-Physician Services Plan based on the employer's reliance on results generated by the CMS minimum value calculator (available online). The relief also applies to an employer that has begun enrolling employees in a Non-Hospital/Non-Physician Services Plan prior to November 4, 2014.

Moreover, to qualify for transition relief, employers cannot explicitly state or imply that a Non-Hospital/Non-Physician Services Plan precludes an employee from obtaining a subsidy, and must timely correct any prior disclosures that made such a statement or implication.

Employers that are contemplating Non-Hospital Plans or Non-Physician Services Plans should carefully consider the guidance contained in the Notice before entering into a new contract to offer these types of plans.

New Agency FAQs Drive a Stake Further into the Heart of Premium Reimbursement Arrangements and Eliminate a Common Executive Perk

By Peter Marathas and Damian A. Myers

> In clear and unambiguous terms, the U.S. Departments of Labor ("DOL") and Health and Human Services and the Internal Revenue Service ("IRS") (the "Agencies")

drove a stake into the heart of two suspect health insurance strategies that have been promoted to business owners across the country. In addition, the guidance may spell trouble for a common reimbursement strategy used by employers for executives and other key employees.

Building upon prior guidance, the Agencies have eliminated any reasonable argument that employers can (i) establish any arrangement in which they reimburse employees for obtaining individual insurance coverage either on the Marketplace or directly from an insurer or (ii) provide incentives to high-cost claimants to drop employer coverage and obtain individual insurance. The guidance, issued on November 6, was released as DOL FAQs Part XXII.

Premium Reimbursement Arrangements

With the advent of Marketplace access for individuals, certain promoters of benefits products pitched to employers an idea that sounded "too good to be true": eliminate employer sponsored health insurance and establish accounts to reimburse employees for the cost of individual insurance coverage. An employer subject to the "pay-or-play" requirements of the Affordable Care Act ("ACA") would be subjected to the so-called "A Penalty" of $2,000 per full-time employee, but even factoring in the cost of the non-deductible penalty with the amount of the premium reimbursed, the employer would save premium subsidy and administrative costs.

In September 2013, the DOL and IRS addressed this idea and said that health reimbursement arrangements (HRA) not integrated with a group health plan or employer payment plans (collectively, "premium reimbursement arrangements") are themselves group health plans and therefore violate the ACA because, among other things, the preventive services and annual limitations requirements could not be met. See DOL Technical Release 2013-03, IRS Notice 2013-54. The September 2013 guidance left open the idea that employers could reimburse individual coverage on a post-tax basis.

The new guidance, however, states that premium reimbursement arrangements are group health plans whether payment or reimbursement is provided on a pre-tax or post-tax basis. Therefore, employers are no longer permitted to reimburse employees or pay insurers directly for individual health insurance policies.

We note that this guidance has far-reaching implications. While the Agencies' clear focus was on the marketeers who continued to promote these reimbursement strategies after the previous guidance, the inclusion of post-tax arrangements into the mix may well spell trouble for employers who routinely reimburse executives and others for their individual insurance costs. This happens in a number of situations, including when an executive or sales person or other employee lives or has family that lives in a part of the country where the group health plan does not provide good coverage.

Marketplace Dumping

Another suspect recommendation to employers (especially with self-insured plans) is that they identify high-cost claimants and provide a cash incentive for them to drop employer coverage and obtain individual insurance coverage on the Marketplace. Proskauer has been asked to comment on this approach in the past and has noted our belief that the *suggestion* would violate various federal laws, including ERISA's

nondiscrimination rules (added by HIPAA in 1996). In the FAQ, the Agencies note that this practice discriminates based on one or more health factors for two reasons. First, the offer of cash actually *increases* the premium because the individual with an adverse health factor must forgo the cash to elect group health coverage. Thus, the individual with an adverse health factor effectively pays a higher premium than those without the adverse health factor. Second, although the HIPAA nondiscrimination rules allow "benign discrimination" (i.e., discrimination that helps individuals with adverse health factors), this practice discourages enrollment in the group health plan and is, therefore, not benign.

What Employers Should Do

1. Reject any proposal that involves (i) incurring the "A Penalty" and reimbursing individual premium costs or (ii) identifying high-cost claimants and incenting them to move to Marketplace insurance;
2. Those who have are in the process of implementing these strategies should immediately stop and consider consulting with qualified counsel as to whether they might be able to recoup costs incurred; and
3. Immediately evaluate any arrangement in which an executive or other employee is reimbursed (on a pre- or post-tax basis) for individual insurance coverage (**Note**, however, that reimbursements on a pre- or post-tax basis for premiums for other *group health insurance* such as a spouse's plan or COBRA coverage are still permitted).

ISS, Glass Lewis Release 2015 Proxy Voting Updates; Espouse Nuanced Review of Equity Compensation Practices

By Andrea Rattner, Joshua Miller and Gary Tashjian

> Proxy advisory firms Institutional Shareholder Services, or ISS, and Glass Lewis released their 2015 executive compensation proxy voting updates that may be particularly relevant for public companies that intend to submit new or amended equity compensation plans for stockholder approval in the coming proxy season. Overall, the updated guidelines suggest that ISS and Glass Lewis will engage in a more nuanced review of equity compensation plan design and grant practices than in prior years.

ISS 2015 Updates

As part of its 2015 United States Proxy Voting Guideline Updates (available here), ISS has adopted a multi-factor scorecard evaluation model in connection with equity compensation plan proposals. Under this Equity Compensation Scorecard, ISS will analyze equity compensation plan proposals using multiple factors, both positive and negative, related to three categories:

- plan cost, relative to industry/market cap peers, under two Shareholder Value Transfer (SVT) measurements – one based on the sum of new shares requested, shares remaining for future grants and outstanding unvested/unexercised grants, the other based only on new shares requested plus shares remaining for future grants;

- plan features, including the use of automatic single-trigger vesting upon a change in control, discretionary vesting authority, liberal share recycling and minimum vesting periods; and
- grant practices, based on six factors: (i) three-year burn rate relative to industry/market cap peers; (ii) vesting requirements in CEO equity grants over the past three years; (iii) estimated plan duration based on sum of shares remaining and new shares requested, divided by the average annual shares granted over the prior three year period; (iv) proportion of recent CEO equity grants/awards that are subject to performance conditions; (v) whether the company has a clawback policy; and (vi) whether the company has post-exercise/vesting share retention requirements.

ISS will generally recommend voting against a new or amended equity plan if the combination of the foregoing factors indicates that the plan is "not, overall, in shareholders' interests". However, as in prior years, the presence of certain egregious practices (e.g., option repricing without shareholder approval, vesting in connection with a liberal change in control definition, a pay-for-performance disconnect and other problematic pay practices) standing alone generally will justify a negative vote recommendation. ISS' 2015 policy updates are effective for meetings on or after February 1, 2015.

Glass Lewis 2015 Updates

In addition to providing additional detail on the factors it considers in assessing compensation committee performance, Glass Lewis' 2015 United States Policy Guidelines (available here) contain a few notable updates related to its shareholder say-on-pay vote recommendation process.

First, Glass Lewis has introduced guidance on the impact of "one-off" equity compensation awards granted outside of the company's regular equity compensation program. Reasoning that such awards can undermine both the pay-for-performance link and the integrity of the company's equity program, Glass Lewis nonetheless acknowledges that a one-off award may be appropriate in certain circumstances. However, in assessing the appropriateness of a one-off award, Glass Lewis will look at whether the award is performance-based and whether the company disclosed a sufficient justification for the award, including why the award is necessary and the reasons that existing awards are insufficient.

Second, Glass Lewis notes that it will generally recommend approval of tax-qualified employee stock purchase plans based on the costs of the plan (taking into account the number of shares, discounts, participation levels and so on), except in "extreme" cases or an ESPP with an evergreen provision that automatically increases the number of shares available for issuance each year.

Finally, Glass Lewis has made clear that qualitative factors, such as an effective overall incentive structure, relevance of selected metrics and reasonable long-term payout levels could result in a recommendation in favor of the say-on-pay proposal, even where the Glass Lewis quantitative-based models suggest a pay-for-performance disconnect.

Implications for 2015 Proxy Season

Although certain egregious pay practices will continue to justify negative vote recommendations, the 2015 updates to each of the ISS and Glass Lewis policies adopt a more multi-factored, nuanced approach to say on pay and equity compensation proposals than in prior years. As the analysis and assessment of executive compensation arrangements and equity plan practices continues to evolve from year to year, compensation committee members and their consultants and legal advisors should consider reviewing and adapting pay arrangements and processes that can best attract, retain and incentivize key personnel while at the same time, can pass muster with shareholders and proxy advisory firms.

Contributing Employers to Multiemployer Plans Are Not Off the Hook – Tracking the Full-Time Status of Employees

By Robert Projansky and Emily Erstling

> Contributing employers to multiemployer plans were relieved by the Treasury Department's interim guidance stating that they will not be subject to the employer shared responsibility payments under the Affordable Care Act ("ACA") with respect to employees for whom they contribute to a multiemployer plan that provides minimum value, offers dependent child coverage and is affordable. (See our blog posting here.) Since relief is provided for all employees for whom contributions are made to a multiemployer plan, regardless of whether coverage is offered, the question of whether an employee is full-time is largely irrelevant to the relief. That led many employers to believe mistakenly that they do not have to determine the full-time status of these employees, allowing these employers to avoid the administrative complications associated with tracking employees who, in many industries, are variable hour employees. Unfortunately, this belief is not well-grounded.
>
> Rather, it appears that contributing employers still need to determine which employees are full time in order to properly comply with IRS reporting requirements. Under the ACA, employers, plans and health insurance issuers are required to report certain information to the IRS and furnish certain information to participants annually, pursuant to Code Sections 6055 and 6056. The IRS recently released drafts of Forms 1094-C and 1095-C, which employers may use to report this information and furnish to participants, and draft instructions for the forms. While these draft forms and instructions leave many open questions regarding how contributing employers to multiemployer plans will complete the forms, they clearly require employers to report the number of their full-time employees. They must also calculate whether minimum essential coverage has been offered to the applicable percentage of full-time employees in their workforce.
>
> While this reporting is not required until early 2016 and much remains subject to further clarification, employers contributing to multiemployer plans who thought they did not have to worry about capturing this information should begin implementing procedures to ensure that they are capturing the necessary information, since the form filed in 2016 will relate to 2015 employment and coverage.
>
> Contributing employers should review draft forms 1094-C and 1095-C and monitor future changes to the draft forms and instructions, and multiemployer plan administrators should be prepared to field questions from contributing employers regarding these reporting requirements.

DOL's New Audit Focus? Health Plan Claims and Appeals and Hard to Value Assets

By Robert Projansky and Emily Erstling

> In recent talks and appearances, representatives of the U.S. Department of Labor have issued a warning about new areas of focus of DOL audits and enforcement actions. While there are a number of different enforcement priorities, we discuss two of them—health plan claims and appeals and valuation of hard to value assets—here because these are areas in which the DOL has traditionally not spent significant time on audit. In addition, these issues share the common characteristic of being able to be "cleaned up" in advance of an audit if plan fiduciaries take some common sense steps.

Health Plan Claims and Appeals

As most know, the DOL has been paying careful attention to ACA, HIPAA and mental health parity compliance in its audits of late. In fact, just the other day the DOL issued updated compliance tools for these laws.

What is perhaps more interesting is that we are likely to see an expansion of scrutiny to other health plan matters, particularly claims and appeals.

DOL representatives have expressed concern that the complexity of health and welfare benefits adjudication creates an inherent risk of error (or, worse, fraud). The DOL is also concerned that benefits are being systematically denied at the initial claim level, because, more often than not, participants do not appeal the initial claims determinations. Further, the DOL is questioning whether plans are providing sufficient and understandable information regarding the reasons for denial of a claim, such that participants can adequately avail themselves of the appeals process.

Based on these DOL statements, we anticipate that DOL investigators may begin to spend more time reviewing whether claims and appeals are being handled on a timely basis in accordance with the plan's claims and appeals procedures. In the case of health plans that are subject to an annual audit, we would not be surprised if the DOL starts looking to confirm that the independent auditor is sampling the claims payment process with a focus on this issue.

The good news is that it appears that there are common sense action steps that can be taken before the DOL comes knocking on the door. For example:

- Review your plan documents/summary plan descriptions to confirm that they accurately describe the claims and appeals process.
- Confirm that claims and appeals are being addressed in practice in a timely manner, whether you have an insured plan or use an "administrative services only" arrangement.
- Consider conducting review of a sample claim and appeal denial letters to ensure that the letters are understandable and clearly explain the reasons for denials.

Hard to Value Assets

Completely switching gears, we note that another area in which the DOL appears to be focused relates to hard to value assets. Recently, the DOL sent letters to a number of plans in the New York metropolitan area who reported on their Forms 5500 that they held assets whose value was neither "readily determinable on an

established market" nor set "by an independent third party appraiser." These letters noted that the plans had reported such hard to value assets and "reminded" recipients of the existence of the DOL's Voluntary Fiduciary Correction Program.

On first glance, one might conclude that the letter was much ado about nothing, because the DOL had not actually concluded that any particular recipient of this letter had violated any rules. However, we would not be quite so dismissive. Rather, we view these letters as a reminder of the DOL's position on the fiduciary obligations of a plan administrator with respect to the valuation of hard to value assets.

In that regard, some readers will recall that several years ago the Boston office of the DOL issued an enforcement letter to a plan concluding that it violated its fiduciary obligations by uncritically accepting the value reported by the general partner of a partnership in which the plan had invested, without any further inquiry (the reported value happened to be at cost).

While the DOL has not focused heavily on the issue of plan fiduciaries' valuation of hard to value assets in recent years, it looks like the DOL's approach may be about to change. The combination of the New York "reminder" letter and some recent comments by DOL representatives regarding the DOL's enforcement priorities suggests that the DOL will be taking a much closer look at whether and how plan administrators are confirming the valuation of hard to value assets.

That being the case, it may be advisable for plan administrators to get ahead of this issue by taking a fresh look at how plan assets are being valued. Rather than blindly accepting the reported value of an asset, plan administrators should implement procedures—presumably something between blind acceptance and formal annual third party appraisals of every asset in every complex investment vehicle—that will satisfy the DOL. For example, plan administrators should consider asking, among other questions:

- Does the fiduciary (or someone such as an investment consultant advising the fiduciary) review valuation procedures of the manager/general partner of hard to value investments for reasonableness?
- Does the procedure identify specific methodologies for each type of investment?
- Are the valuation policies reviewed regularly? Are exceptions reported?
- Is there any inquiry into who serves as the auditor for the investment vehicle? Is the entire process documented?

An additional resource for other ideas in evaluating valuation procedures is the American Institute of CPAs' (AICPA) publication titled "Valuing and Reporting Plan Investments," available here.

We should ask these questions of ourselves before the DOL asks them of us.

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits, Executive Compensation & ERISA Litigation Practice Center. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

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