Proskauer

newsletter

A report to clients and friends of the firm

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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 we review the U.S. Supreme Court's decision in *Montanile v. Board of Trustees of National Elevator Industries Health Benefit Plan* where the Supreme Court considered the scope of "appropriate equitable relief" in a case involving a health and welfare plan's claim for reimbursement from a participant who was injured by a third party and subsequently obtained monetary relief from that third party. The Supreme Court has taken on the issue four times, and its most recent decision has important implications for plan sponsors and fiduciaries. We review the Court's decision and provide several possibilities for plan sponsors and fiduciaries to consider to minimize the risk that this decision will prevent recovery.

As always, at the conclusion of the newsletter, we provide a brief overview of certain rulings, filings, and settlements of interest, including decisions on anti-assignment clauses, retiree health benefits, and the latest ruling in *Tatum v. R.J. Reynolds*, as well as an ACA reporting update.

The Ups and Downs of Recovering Third Party Payments after *Montanile v. Board of* Trustees *of National Elevator Industries Health Benefit Plan*[*]

By Joe Clark

As a means of controlling costs, many health and welfare plans contain provisions allowing them to seek reimbursement of benefits paid to a participant who is injured by a third party and subsequently obtains a monetary judgment or settlement from that third party. The issue of whether and how a plan can enforce such reimbursement provisions has been the subject of considerable debate, and the U.S. Supreme Court has taken on the issue four times. The Court's most recent decision, in *Montanile v. Board of Trustees of National Elevator Industries Health Benefit Plan*, arrived this past January. This article briefly summarizes the Supreme Court's prior decisions, the *Montanile* decision, and implications for plan sponsors and fiduciaries.

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Prior U.S. Supreme Court Precedent

The relevant legal history pertaining to reimbursement clauses begins over two decades ago, with the Supreme Court's ruling in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). In *Mertens*, the Court explained that the term "equitable relief" in ERISA Section 502(a)(3) is limited to "those categories of relief that were *typically* available in equity." 29 U.S.C. § 1132(a)(3). Three times since *Mertens*, the Court applied this approach to cases in which a plan fiduciary sought reimbursement for medical expenses after a participant or beneficiary recovered money from a third party.

First, in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), a plan sought reimbursement from a special needs trust, which was not in the participant's possession or control. Because the plan's claim for relief was against the participant personally, the Court held that the relief the plan was seeking was legal, not equitable, and thus not recoverable under Section 502(a)(3) of ERISA.

Next, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Court determined that the plan's reimbursement language was sufficient to create an equitable lien by agreement against settlement assets that the participant's lawyer had segregated from other assets. The Court reasoned that whether the remedy sought is legal or equitable depends on the basis for the plaintiff's claim, and the nature of the underlying remedies sought. Here, both factors pointed in favor of equitable relief – there was an equitable lien by agreement (the claim), and the plan sought specifically identifiable funds that were within the possession and control of the participant (the remedy).

Then, in *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the Court resolved a circuit split and held that equitable defenses such as unjust enrichment could not be asserted against a plan's equitable lien by agreement claim. In so ruling, the Court reaffirmed its *Sereboff* analysis and concluded that the plan's reimbursement claim was equitable in nature because the plan's terms created an equitable lien by agreement on third-party settlements, and the plan sought to enforce that lien against "specifically identifiable funds within the [beneficiaries' control]" – a portion of the settlement recovered by the beneficiaries.

The *Montanile* Decision

Background

The National Elevator Industry Health Benefits Plan (Plan) provides a prescribed plan of medical benefits to its participants and beneficiaries. The Plan also provides that it may demand reimbursement from a participant for the amount paid on his or her behalf where the need for such benefits is the result of an injury sustained by a third party (*e.g.*, motor vehicle accident), and the participant successfully obtains a judgment or settlement resulting in payment to the participant.[1] Furthermore, participants are required to notify the Plan and obtain its consent before settling third-party claims.

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[1] The plan specifically states that "amounts that have been recovered by a [participant] from another party are assets of the Plan . . . and are not distributable to any person or entity without the Plan's written release of its subrogation interest," and that any amounts a participant "recover[s] from another party by award, judgment, settlement or otherwise . . . will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan . . . and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person."

Robert Montanile, a Plan participant, was hit by a drunk driver and suffered injuries as a result of the accident. The Plan paid approximately $121,000 of Montanile's medical expenses, and Montanile signed an agreement affirming that he would reimburse the Plan for any recovery he obtained, whether by judgment or settlement. Montanile subsequently sued the drunk driver and obtained a $500,000 settlement. After paying his attorneys' fees and other costs, Montanile was left with a net recovery of approximately $240,000. The Plan sought reimbursement from Montanile of the benefits paid on his behalf. After it became clear that the Plan and Montanile would not reach agreement, Montanile's attorney advised the Plan that the remaining funds would be distributed to Montanile unless the Plan objected within fourteen days. The Plan did not object, and the remaining funds were distributed to Montanile.

The Plan subsequently sued Montanile for reimbursement under Section 502(a)(3) of ERISA, requesting that the district court enforce an equitable lien pursuant to the written Plan terms on any settlement funds or property in Montanile's possession. The district court granted summary judgment to the Plan because, even if Montanile had dissipated some or all of the funds, the Plan's equitable lien entitled it to reimbursement from Montanile's general assets. The Eleventh Circuit affirmed, reasoning that a plan can always enforce an equitable lien by agreement.

U.S. Supreme Court's Decision in Montanile

The Supreme Court granted certiorari to address the previously unanswered question of "whether a plan is still seeking an equitable remedy when the defendant, who once possessed the settlement fund, has dissipated it all, and the plan then seeks to recover out of the defendant's general assets." In an 8-1 opinion authored by Justice Thomas, the Court reversed, finding that the Plan's claim was not equitable in nature.

The Court's analysis began with the standard equity treatises which, according to the Court, made clear that: (i) a plaintiff could enforce an equitable lien only against specifically identified funds in the defendant's possession, or traceable items purchased with the funds (*e.g.*, a car); and (ii) expenditure of the entire identifiable fund on non-traceable items (*e.g.*, food) destroys an equitable lien, and any personal claim against the defendant's general assets would be a *legal*, not equitable, remedy. The Court accordingly held that the Plan could not enforce an equitable lien against Montanile's general assets because he had dissipated the entirety of the specifically identified fund on non-traceable assets.

In so ruling, the Court rejected three arguments advanced by the Plan. First, the Plan argued that while equity courts typically require plaintiffs to attach a lien to a specific, identifiable fund in the defendant's possession, *Sereboff* created an exception for equitable liens by agreement. The Court disagreed, observing that *Sereboff* "left untouched the rule that *all* types of equitable liens must be enforced against a specifically identified fund in the defendant's possession." Second, the Plan argued that *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011) overruled past precedent in favor of the Plan's interpretation of "equitable relief" as meaning "whatever relief a court of equity is empowered to provide in the particular case at issue, including ancillary legal remedies." The Court disagreed, finding that *CIGNA v. Amara* reaffirmed that relief seeking a lien or constructive trust was legal, not equitable, unless the funds sought were "particular funds or property in the defendant's possession." The Court also observed that *Amara's* analysis of Section 502(a)(3) was not essential to the outcome of that case. Third, the

Plan argued that the failure to permit plans to recover payment in cases such as these will leave them without effective remedies and will encourage participants to dissipate settlements as soon as possible. The Court explained that, in its view, plans have sufficient power and control at their disposal to develop safeguards to prevent such conduct.

Because the lower courts did not determine whether Montanile kept his settlement monies separate from his general assets, or dissipated the entirety of the funds on non-traceable assets, the Court remanded to the district court to make that determination consistent with its opinion.

Proskauer's Perspective

The Court's decision creates an obstacle for plans seeking reimbursement of medical expenses for which a third party is liable. In order to minimize the risk that this decision will prevent recovery, plan fiduciaries should consider implementing: (i) means to enable them to act quickly upon learning that a participant is obtaining or has obtained such funds; and (ii) safeguards to discourage or prevent participants from dispensing with funds subject to reimbursement. Some possibilities include the following:

- *Consider implementing detection procedures.* The *Montanile* decision highlights the need for plan fiduciaries to identify as early as possible situations in which a participant or beneficiary has (or is likely to) commence a lawsuit for recovery of medical expenses paid by the plan.
- *Consider intervening in the underlying action*. Once a plan administrator learns of a lawsuit, he or she should consider the most effective means of pursuing recovery, while taking into account practical considerations, including the amount at stake. This could include anything from simple correspondence with the attorneys to active intervention in the lawsuit. Plan counsel can assist in weighing the cost, risks and benefits of each approach.
- *Consider a third-party subrogation and recovery service.* Given the cost and time constraints associated with these types of recovery efforts, plan fiduciaries may wish to consider retaining outside providers to perform this function. These providers generally are able to more efficiently identify and track third-party litigation and implement recovery efforts.
- *Consider changes to plan language*. In order to discourage dissipation of recoverable assets, plans could implement several changes to plan terms. First, plans could impose consequences (e.g., termination of participation and offset of future claims) in the event recoveries are not returned. Second, plans could provide that upon receipt of medical benefits participants must sign a confession of judgment for the amount of benefits paid by the plan. Third, plans could try to establish a right to relief under Section 502(a)(2) of ERISA, which is not limited to equitable relief, by providing that amounts recovered by a participant from a third party are considered plan assets and the participant is, therefore, a fiduciary with respect to amounts recovered from third parties. Fourth, plans could try to establish contractual (rather than equitable) recovery rights for the plan, potentially outside of ERISA's preemptive reach.

As each of these options has unique advantages and disadvantages, plan administrators should seek advice of counsel as to whether and how to effectively implement them. Plan sponsors and fiduciaries also should keep in mind that although the *Montanile* decision

specifically addressed equitable relief in connection with health plan claims for reimbursement, the decision may have implications for other employee benefit plans. For example, it could impact the ability of pension and disability-benefit plans to recoup inadvertent overpayments. Plan sponsors and fiduciaries should consider whether certain of the courses of action described above are appropriate safeguards in these contexts as well.

Rulings, Filings, and Settlements of Interest

Anti-Assignment Provision Bars Surgery Center's $3.3 Million ERISA Benefits Claims

By Neil Shah

> A federal district court in California held that the ILWU-PMA Welfare Benefit Plan's anti-assignment provision barred Brand Tarzana Surgical Institute's claim for benefits and thus dismissed the Institute's claim for benefits. In so holding, the court rejected the Institute's argument that the plan waived the right to assert the anti-assignment provision as a defense by failing to raise the argument during the claims administration process because the anti-assignment provision is "irrelevant to the denial of a claim in the first instance," and only obtains significance once a party files suit or engages in conduct "so inconsistent with an intent to enforce the [anti-assignment provision] as to induce a reasonable belief that such right has been relinquished." The opinion is available at *Brand Tarzana Surgical Institute, Inc. v. International Longshore & Warehouse Union-Pacific Maritime Association Welfare Plan*, No. CV 14-3191 FML, slip op. (C.D. Cal. Mar. 8, 2016).

On Remand, District Court Rules for the Fiduciaries in Tatum v. R.J. Reynolds

By Neil Shah

> The R.J. Reynolds defendants have again prevailed against allegations that they breached their fiduciary duties by divesting the RJR 401(k) plan of funds invested in Nabisco stock. Following remand by the Fourth Circuit, the district court held that a hypothetical fiduciary "would" have divested the plan of the Nabisco investments in the same time and manner as defendants.

In March 1999, RJR Nabisco spun off its tobacco business (RJR) from its food business (Nabisco), the primary purpose of which was to reduce the negative impact that tobacco litigation (and being affiliated with the industry in general) was having on RJR Nabisco's stock price. In conjunction with this transaction, the RJR Nabisco 401(k) plan spun-off its RJR-related assets and liabilities into a new RJR 401(k) plan. The resulting plan contained three non-diversified stock funds: two funds that invested in Nabisco stock, which were frozen to new investments, and one that invested in RJR stock.

It was subsequently determined that continued exposure to funds invested in Nabisco stock would be imprudent, and a decision was made to divest the RJR 401(k) plan of Nabisco investments. After the divestment was complete, Nabisco's stock price increased.

A group of participants subsequently filed a class action suit claiming that the RJR 401(k) plan fiduciaries breached their fiduciary duty of procedural prudence by failing

to properly investigate the decision to divest the Nabisco stock investments. Following a bench trial, the district found held that even though defendants breached their procedural duty of prudence, their decision to divest the RJR 401(k) plan of Nabisco investments was substantively prudent because a reasonable and prudent fiduciary "could" have undertaken the same action.

As we previously reported here, a divided panel of the Fourth Circuit reversed, holding that a plan fiduciary found to have breached its duty of procedural prudence may escape liability only if it proves by a preponderance of the evidence that an objectively prudent fiduciary "would" – not just that it "could" – have undertaken the same fiduciary action.

On remand from the Fourth Circuit, the district court again entered judgment in favor of the RJR 401(k) plan fiduciaries, and concluded that a reasonable and prudent fiduciary "would" have divested the plan of the Nabisco investments. Crediting defendants' expert, the court found that an objectively prudent fiduciary would have divested the plan of the Nabisco investments because the RJR 401(k) plan "included three single-stock funds, each of which is approximately four times as risky as a diversified portfolio of mutual funds, [and] two of which were non-employer single-stock funds," and because of the "considerable" litigation and bankruptcy risk resulting from the pending class action. The court discounted the relevance of favorable analyst recommendations as reflecting "[o]ptimism bias" in the general market, and as belied by the stock's poor performance. Finally, the court found that the six-month timeline for divestment, "while arrived at without investigation or research," was objectively reasonable because it allowed the plan to notify affected employees and provide them an opportunity to reallocate their investments.

The case is *Tatum v. R.J. Reynolds Tobacco Co.*, No. 1:02-cv-00373, 2016 WL 660902 (M.D.N.C. Feb. 18, 2016).

ACA Reporting Update – The Final Stretch

By Damian A. Myers

> After months of preparation and multiple iterations of (sometimes conflicting) IRS guidance, health coverage providers and applicable large employers are nearing the end of the 2015 reporting season under the Affordable Care Act (ACA). By way of background, the ACA added new Sections 6055 and 6056 to the Internal Revenue Code (the "Code"). Code Section 6055 requires that health coverage providers file with the IRS, and distribute to covered individuals, forms showing the months in which the individuals were covered by "minimum essential coverage." Code Section 6056 requires that applicable large employers (generally, those with 50 or more full-time employees and equivalents) file with the IRS, and distribute to employees, forms containing detailed information regarding offers of, and enrollment in, health coverage. These reporting requirements are, in most cases, satisfied using Forms 1094-B and 1095-B and/or Forms 1094-C and 1095-C, as applicable.

Although the original deadlines for distributing and filing the ACA reporting forms tracked the deadlines for Forms W-2 and W-3, the IRS extended the 2015 deadlines to provide health coverage providers and applicable large employers more time to prepare for the burdensome requirements under Code Sections 6055 and 6056. The applicable forms must now be distributed to employees and covered individuals by

March 31, 2016 and must be filed with the IRS by May 31, 2016 (if filing paper copies) or June 30, 2016 (if filing electronically). As coverage providers and employers put the finishing touches on the 2015 forms, they should consider the following:

- A "good faith compliance" standard will be applied to forms prepared in connection with the 2015 filing season. This means that the IRS will not penalize a coverage provider or employer for incorrectly completing a form as long as the form was completed based on a good faith interpretation of the ACA reporting regulations and instructions. However, in order for this good faith compliance standard to apply, the forms must be distributed and filed by the March 31, 2016 deadline. The IRS made clear in Notice 2016-04 that the March 31, 2016 deadline was firm and that no requests for extensions beyond that date would be granted. Therefore, it is better to be incorrect (albeit in good faith) than late.
- The IRS website contains a number of useful resources regarding ACA reporting, including updated versions of the forms and instructions, regulations and frequently asked questions. The IRS continuously revises this information, so it is best to periodically check for updates.
- The penalties associated with late filings under Code Sections 6055 and 6056 were recently increased based on inflation (See Rev. Proc. 2016-11). These increases are in addition to the increased penalties required under the Trade Preferences Extension Act of 2015 (as described here). The chart below summarizes the newest increases (note that lower penalties apply to entities with gross receipts of $5,000,000 or less).

Reason for Penalty	Standard Penalty	Maximum Penalty
Forms filed or provided late, but within 30 days	$50 per report	$529,500 (previously $500,000)
Forms filed or provided late, but by August 1	$100 per report	$1,589,000 (previously $1,500,000)
Forms filed or provided late, but after August 1, or not filed at all	$250 per report	$3,178,500 (previously $3,000,000)

Even though the 2015 ACA reporting season is coming to an end, health coverage providers and applicable large employers must continue to track offers of coverage and enrollment in preparation for 2016 ACA reporting. The IRS has noted that the 2016 forms and instructions will reflect substantial changes due to the end of 2015 transition relief and anticipated regulations related to affordability and conditional offers of coverage.

Sixth Circuit Rules that Employer Can Terminate Retiree Health Benefits

By Madeline Chimento Rea

> The Sixth Circuit ruled that retirees of Moen Inc. were not entitled to lifetime health benefits upon finding that an underlying collective bargaining agreement (CBA) did not create vested rights to these benefits. Moen and its predecessor were parties to several CBAs with a local affiliate of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America until Moen shut down its operations and terminated the last CBA. The closing agreement stated that healthcare coverage "shall continue" for retirees and their spouses as provided in the applicable CBA. Moen later decreased health benefits and the retirees sued, arguing that their healthcare benefits had vested. The district court certified a class of retirees and granted plaintiffs' motion for summary judgment.

The Sixth Circuit, in a split decision, reversed the district court's decision because the CBA did not promise lifetime, unalterable healthcare benefits. Rather, the Sixth Circuit explained that, among other things: (i) the term of each CBA was three years and contractual obligations ordinarily cease upon termination of the bargaining agreement, (ii) there were no specific durational limits, (iii) the CBAs explicitly vested pension benefits but not healthcare benefits, and (iv) the CBA included a reservation of rights clause that permitted the employer to unilaterally terminate benefits. Notably, however, the Sixth Circuit rejected Moen's argument that the Supreme Court's decision in *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2015) created a "clear-statement rule", *i.e.*, that in order to create a vested right to benefits, a CBA must contain a clear and explicit statement that health benefits are vested, and stated that courts can draw implications and inferences from the contract if they are grounded in ordinary principles of contract law. The case is *Gallo v. Moen Inc.*, No. 14-3633, 14-3918, 2016 WL 482196 (6th Cir. 2016).

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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