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The ERISA Litigation Newsletter

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Editor's Overview

This month's newsletter discusses how to avoid liability under ERISA through plan design, including statute of limitations provisions, venue provisions, and anti-assignment provisions. Courts have generally enforced these provisions as long as they are reasonable, and written and administered properly. This article discusses the provisions in general, what is considered reasonable, and how they can be properly administered.

As always, be sure to review the section on Rulings, Filings, and Settlements of Interest including, IRS guidance on premium reimbursement arrangements, recent case law on COBRA-notice for Same-Sex spouses, White House recommendations on in-Plan Roth rollovers, and recent case law from the Ninth Circuit on spousal consent under top-hat plans.

Avoiding Liability through ERISA Plan Design: Statute-of-Limitations Periods, Venue Provisions and Anti-Assignment Clauses*

By: Stacey Cerrone

When designing ERISA plans, limiting liability is an important priority. Fortunately, plan sponsors have certain tools at their disposal that can potentially reduce the risk of being sued, or being liable if a suit is brought. These tools include contractual limitations periods, venue provisions and anti-assignment clauses. Courts have generally enforced these provisions as long as they are reasonable, and written and administered properly.

Contractual Limitation Periods:

The statute of limitations for benefit claims is ordinarily governed by analogous state law. However, plan sponsors may seek to shorten the limitations period by prescribing one in the plan document. Recent case law developments indicate that these plan contractual limitations periods should be enforced if they provide participants with a reasonable opportunity to commence a lawsuit.

In *Heimeshoff v. Hartford Life & Accident Insurance Company*134 S. Ct. 604 (2013), the Supreme Court unanimously concluded that a plan's limitation period was enforceable, even though the contract's limitation period was shorter than the applicable statute of limitations. The Court said that a plan limitations period should be enforced so long as it is reasonable. There have been some rulings since *Heimeshoff that provide some guidance as to what is* "*reasonable.*"

In *Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund*, 2014 U.S. Dist. LEXIS 18156 (E.D. Mo. Feb. 13, 2014), the court, relying on *Heimeshoff,* found that a claim for welfare benefits was barred by a plan limitations provision that required a participant to file a lawsuit within two years of being notified of the benefit denial. The plaintiff's claims were initially denied in December 2008 and January 2009. After appealing, plaintiff was informed in July 2009 that her appeals were also denied. Plaintiff did not commence her lawsuit until January 2012, two and one half years after the final denial. In granting the motion to dismiss, defendant rejected plaintiff's contention that the court must use the Missouri 10 year limitations period. The court held that, under *Heimeshoff*, the limitations period in the policy overrode state law and thus the two-year contractual limitations period applied. In addition, because plaintiff was informed of the limitation period in the letter denying her claim, the court found that it could not ignore the plan's "clear mandate" that suits be filed within two years of the denial of the appeal, and dismissed the lawsuit.

Contrasting Munro is the ruling in Nelson v. Standard Insurance Company No. 13CV188-WQH-MDD, 2014 WL 4244048, at *3 (S.D. Cal. Aug. 26, 2014), where the court declined to enforce, on motion to dismiss, a plan limitations provision because of concerns that, in light of delays in administering the claim, the plaintiff may not have had an adequate opportunity to commence a lawsuit. The limitations provision in question ran from the earlier of either (1) the date the administrator received proof of loss or (2) the time within which proof of loss was due to the administrator. The defendant sought to dismiss the complaint because suit was not commenced until more than three years from the date the proof of loss was filed. The parties disagreed both as to when the limitations period started and when the participant's claim accrued: defendant contended that the claim accrued 100 days before the three year limitations period expired; while plaintiff contended that there was still no final denial of the claim when the defendant's alleged limitations period expired.

The court concluded that it could not evaluate, based on the complaint alone, when the contractual limitations period began to run or when plaintiff's claim had accrued. It also concluded that there were factual questions as to whether the limitations period should be equitably tolled. But the court also stated that, even if defendant's version of the facts was correct, it was unclear whether 100 days was a reasonable period within which to require plaintiff to commence a lawsuit, and observed that defendant had provided no legal support to suggest that it was. The court accordingly denied the motion to dismiss.

Read together, these cases suggest that, to be reasonable, a limitations period specified in an ERISA plan should be long enough to include some amount of time to file a lawsuit *after* the administrative process is completed. Based on the existing law, one can assume that a participant must have more than 100 days to file suit in order for the limitations period to be deemed reasonable.

Plan Venue Provisions:

One of Congress' goals in enacting ERISA was to remove jurisdictional and procedural obstacles that hindered plan participants and beneficiaries from pursuing claims for benefits promised to them by their employers. Consistent with that goal, ERISA broadly provides that suits may be commenced where the plan is administered, where the breach took place or where the defendant resides or may be found. Notwithstanding the congressional design, courts with increasing frequency have allowed plans to limit the venue in which a claim for benefits may be brought. In so ruling, courts generally have relied on a combination of two arguments. First, that ERISA § 502(e)(2) provides where an action under the statute "may be brought," not where it must be brought, and "[i]f Congress had wished to prevent parties from waiving ERISA's venue provision by private agreement, it could have done so through an express provision in the statute." Second, that enforcing a plan's forum selection clause advances a uniform administrative scheme as it allows a plan to centralize claims against it in one federal jurisdiction.

By way of example, the Sixth Circuit recently held that an ERISA plan's venue selection was enforceable and, in so ruling, refused to give deference to the Department of Labor's contrary position. *See Smith v. AEGON Cos. Pension Plan*, No. 14-0256, 2014 U.S. App. LEXIS 19668 (6th Cir. Oct. 14, 2014). Plaintiff brought suit against the corporate successor of his former employer, AEGON, in the U.S. District Court for the Western District of Kentucky, alleging that AEGON wrongfully eliminated his enhanced compensation benefits. The district court dismissed plaintiff's complaint because plaintiff's pension plan contained a venue selection clause that stated that a participant shall only bring an action in the Federal District Court in Cedar Rapids, Iowa.

On appeal, the DOL submitted an amicus brief arguing that venue selection clauses are incompatible with ERISA. A split panel of judges declined to afford deference to (what the majority labeled) the DOL's attempted "regulation by amicus." First, the majority concluded that the DOL had no more expertise than the Court when it came to determining whether federal statutes proscribe venue selection. Second, the majority noted that the DOL had never brought an enforcement action in connection with an ERISA-governed plan's venue selection clause, and it had never promulgated any regulation or interpretive guidance related to such clauses. Because of this, the majority found that the DOL's position in its amicus brief lacked the longevity and consistency necessary to be granted deference. Ultimately, the majority found that the DOL's "amicus brief in this case can only be characterized as . . . an expression of mood."

The majority also noted that most courts faced with this issue found that venue selection clauses in ERISA-governed plans were enforceable; and explained that if Congress wanted to prohibit such clauses, it could have done so. Further, the majority stated that "[i]t is illogical to say that, under ERISA, a plan may preclude venue in federal court entirely [via an arbitration clause], but a plan may not channel venue to one particular federal court."

Anti-Assignment Clauses

While nothing in ERISA prohibits assignments, neither does it mandate assignments. Courts have thus uniformly recognized the enforceability of anti-assignment clauses. These clauses have become particularly useful to plans in light of a recent increase in ERISA benefit claims and lawsuits brought by out-of-network providers bringing claims through assignments by participants. These claims are particularly problematic for plans because the out-of-network providers typically seek through litigation higher reimbursement amounts than they could negotiate for with the plan directly.

In *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc., et al.*, No. 12-17604, 2014 WL 55651325 (9th Cir. 2014), the Ninth Circuit held that valid assignees of claims for benefits did have Article III standing to file ERISA benefit claims regardless of whether the assignee exercised its contractual right to seek payment from the assignor prior to filing suit. But it also held that a plan's anti-assignment clause would preclude standing to sue.

Plaintiff Spinedex's patients executed assignments of rights assigning to Spinedex their rights to payment and benefits under their respective plans. Defendant United Healthcare, Inc. denied some of these claims, after which Spinedex filed suit against United and the various plans for improper denial of benefits and breach of fiduciary duty under ERISA.

On appeal, United argued that Spinedex lacked Article III standing because it failed to show that it suffered the requisite injury-in-fact, as it never sought payment directly from its patients despite having the contractual right to do so. The Ninth Circuit disagreed, holding that: (1) an assignee stands in the shoes of its assignors and may bring any claim that the assignor had the right to assert; (2) United wrongly focused on the injury suffered by beneficiaries after the assignment, rather than whether there was an injury-in-fact at the time of the assignment to Spinedex; and (3) since the beneficiaries had the right to file suit for denial of benefits at the time of the assignment, Spinedex had standing as the assignee.

The court affirmed the district court's dismissal of Spinedex's breach of fiduciary duty claims, noting that the assignment did not contain the right to assert a breach of fiduciary duty claim. It remanded the case to determine whether an individual beneficiary has standing to bring a fiduciary duty claim despite assigning away his right to bring benefit claims.

The court dismissed, however, claims against one of the defendant plans because the plan contained an anti-assignment clause.

A District Court in New Jersey held that an ERISA Plan's anti-assignment provision was enforceable and thus that the provider lacked standing to sue under ERISA. In *Neurological Surgery Associates, P.A. v. Aetna Life Insurance Company, et. al*., 2014 BL 154982, D.N.J., No. 2:12-cv-05600-SRC-CLW, (June 4, 2014), plaintiff alleged that the Plan participant executed an assignment of benefits which conferred on the provider beneficiary status. Aetna, acting as the plan administrator, argued that the plan contained an anti-assignment provision requiring that coverage may be assigned only with its consent, which it did not give. As such, Aetna argued that the provider lacked standing to sue because the provider sued as an assignee under an invalid assignment against the anti-assignment provision.

In the absence of Third Circuit precedent, the district court followed a Circuit Court majority view holding anti-assignment clauses trump provider assignments. (citing *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.,* 371 F.3d 1291, 1295 (11th Cir. 2004), *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan.*, Inc., 49 F.3d 1460, 1464-65 (10th Cir. 1995) and *Davidowitz v. Delta Dental Plan of Cal., Inc.,* 946 F.2d 1476, 1478 (9th Cir. 1991)). The district court reasoned that Congress considered assignment of both pension and welfare plan benefits, and while consciously deciding to prohibit pension plan assignments, it remained silent on welfare benefits. As such, Congress had not prohibited anti-assignment clauses in welfare plans, but instead intended to allow the free marketplace to work out competitive, cost effective, structures to reduce medical expenses. Therefore, the district court granted Aetna's motion, holding that the plan's anti-assignment provision was valid and enforceable and that the provider lacked standing to sue under ERISA.

View from Proskauer:

Given the recent trend favoring enforcement of plan provisions that conflict with statutory or case law procedural rules, plan administrators may benefit from reviewing their plans to consider amendments inserting such provisions. In combination, the three tools identified in this article may provide plan sponsors with an arsenal that, with proper plan administration, can be used to limit the risks of defending claims and lawsuits. Whether it makes sense to do so will depend upon the type of benefits offered, the plan's administrative process, and other considerations unique to each individual plan.

Rulings, Filings, and Settlements of Interest

IRS Clarifies Prior Guidance on Premium Reimbursement Arrangements; Provides Limited Relief

By Damian A. Myers

- Continuing its focus on so-called "premium reimbursement" or "employer payment plans", the Internal Revenue Service (IRS) released IRS Notice 2015-17 on February 18, 2015. In this Notice, which was previewed and approved by both the Department of Labor (DOL) and Department of Health and Human Services (collectively with the IRS, the "Agencies") clarifies the Agencies' perspective on the limits of certain employer payment plans and offers some limited relief for small employers.

  Prior guidance, released as DOL FAQs Part XXII and described in our November 7, 2014 Practice Center Blog entry, established that premium reimbursement arrangements are group health plans subject to the Affordable Care Act's (ACA's) market reforms. Because these premium reimbursement arrangements are unlikely to satisfy the market reform requirements, particularly with respect to preventive services and annual dollar limits, employers using these arrangements would be required to self-report their use and then be subject to ACA penalties, including an excise tax of $100 per employee per day.

  Since DOL FAQs Part XXII was released, the Agencies' stance has been the subject of frequent commentary and requests for clarification. With Notice 2015-17, it appears that the Agencies have elected to expand on the prior guidance on a piecemeal basis, with IRS Notice 2015-17 being the first in what may be a series of guidance. The following are the key aspects of Notice 2015-17:

  - *Wage Increases In Lieu of Health Coverage*. The IRS confirmed the widely-held understanding that providing increased wages in lieu of employer-sponsored

health benefits does not create a group health plan subject to market reforms, provided that receipt of the additional wages is not conditioned on the purchase of health coverage. Quelling concerns that any communication regarding individual insurance options could create a group health plan, the IRS stated that merely providing employees with information regarding the health exchange marketplaces and availability of premium credits is not an endorsement of a particular insurance policy. Although this practice may be attractive for a small employer, an employer with more than 50 full-time employees (i.e., an "applicable large employer" or "ALE") should be mindful of the ACA's employer shared responsibility requirements if it adopts this approach. ALEs are required to offer group health coverage meeting certain requirements to at least 95% (70% in 2015) of its full-time employees or potentially pay penalties under the ACA. Increasing wages in lieu of benefits will not shield ALEs from those penalties.

- *Treatment of Employer Payment Plans as Taxable Compensation*. Some employers and commentators have tried to argue that "after-tax" premium reimbursement arrangements should not be treated as group health plans. In Notice 2015-17, the IRS confirmed its disagreement. In the Notice, the IRS acknowledges that its long-standing guidance excluded from an employee's gross income premium payment reimbursements for non-employer provided medical coverage, regardless of whether an employer treated the premium reimbursements as taxable wage payments. However, in Notice 2015-17, the IRS provides a reminder that the ACA, in the Agencies' view, has significantly changed the law, including, among other things, by implementing substantial market reforms that were not in place when prior guidance had been released. The result: the Agencies have reiterated and clarified their view that premium reimbursement arrangements tied directly to the purchase of individual insurance policies are employer group health plans that are subject to, and fail to meet, the ACA's market reforms (such as the preventive services and annual limits requirements). This is the case whether or not the reimbursements or payments are treated by an employer as pre-tax or after-tax to employees. (This is in contrast to simply providing employees with additional taxable compensation not tied to the purchase of insurance coverage, as described above.)

- *Integration of Medicare and TRICARE Premium Reimbursement Arrangements*. On the other hand, although the Notice confirms that arrangements that reimburse employees for Medicare or TRICARE premiums may be group

health plans subject to market place reforms, the Agencies also provide for a bit of a safe harbor relief from that result. As long as those employees enrolled in Medicare Part B or Part D or TRICARE coverage are *offered* coverage that is minimum value and not solely excepted benefits, they can also be offered a premium reimbursement arrangement to assist them with the payment of the Medicare or TRICARE premiums. (The IRS appropriately cautions employers to consider restrictions on financial incentives for employees to obtain Medicare or TRICARE coverage.)

- *Transition Relief for Small Employers and S Corporations.* Although many comments on the prior guidance concerning employer payment plans requested an exclusion for small employers (those with fewer than 50 full-time equivalent employees), the IRS refused to provide blanket relief. The IRS notes that the SHOP Marketplace should address the small employers' concerns. However, because the SHOP Marketplace has not been fully implemented, no excise tax will be incurred by a small employer offering an employer payment plan for 2014 or for the first half of 2015 (i.e., until June 30, 2015). (This relief does not cover stand-alone health reimbursement arrangements or other arrangements to reimburse employees for expenses other than insurance premiums.) This is welcome relief to small employers who adopted these arrangements notwithstanding the Agencies' prior guidance that they violated certain ACA marketplace provisions.

In addition to granting temporary relief to small employers, the IRS also provided relief through 2015 for S corporations with premium reimbursement arrangements benefiting 2% shareholders. In general, reimbursements paid to 2% shareholders must be included in income, but the underlying premiums are deductible by the 2% shareholder. The IRS indicated that additional guidance for S corporations is likely forthcoming.

The circumstances under which premium reimbursement arrangements are permitted appears to be rapidly dwindling, and the IRS indicated that more guidance will be released in the near future. Employers offering these arrangements should consult with qualified counsel to ensure continuing compliance with applicable laws.

Same-Sex Spouse Has No Standing to Assert COBRA Notice Claim

By Lindsey Chopin

- A New Jersey federal district court held (in an unpublished opinion) that a former plan participant's same-sex spouse who never enrolled in the benefit plan did not have standing to assert a claim alleging that his spouse's employer failed to provide proper and timely notice of coverage under COBRA. The court reasoned that plaintiff lacked statutory standing because he could not plead that he was a participant or beneficiary of the plan as is required to sue for benefits under ERISA § 402(a)(1). The court also rejected plaintiff's arguments that he had standing because his "spouse had intended to designate Plaintiff as a beneficiary," and that he fell within an exception to the participant or beneficiary requirement that is made when the complained-of conduct causes a former participant or beneficiary to *lose* their status because, here, Plaintiff never enjoyed that status. The case is *Sacchi v. Luciani, et al.*, No. 14-3031, 2015 U.S. Dist. LEXIS 19002 (D.N.J. Feb. 18, 2015).

White House Budget Recommends Elimination of in-Plan Roth Rollovers of After-Tax Contributions

By Damian A. Myers

- As reported here, the Internal Revenue Code currently permits a plan design that allows plan participants to convert non-Roth after-tax contributions to Roth contributions through in-plan Roth rollovers. This design would allow a participant to maximize deferrals to a defined contribution plan while limiting future tax liability. However, among the White House's Fiscal Year 2016 budget proposals, which were released in February 2015, is a proposal that would eliminate the ability to convert after-tax contributions to Roth contributions through an in-plan Roth rollover. This change would be effective for distributions made after December 31, 2015. Of course, there is no guarantee that this proposal will be enacted by Congress. We will provide updates as further developments occur.

Ninth Circuit: Spousal Consent Not Required Under Top-Hat Plans

By Joseph Clark

- The Ninth Circuit held that a participant's brother, rather than his spouse, was the proper beneficiary of benefits under a profit sharing plan. In so holding, the Court found that: (a) the participant's first wife, who was designated as the primary beneficiary, had waived her rights to benefits as part of the couple's divorce; and (b) the participant's second wife had no rights to the benefits, since she was not a named beneficiary and top-hat plans are exempt from ERISA's spousal consent requirements. The case is *E & J Gallo Winery v. Rogers*, 2015 WL 738265 (9th Cir. Feb. 23, 2015) (unpublished).

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