Proskauer

ERISA Newsletter

Fourth Quarter 2018

Editor's Overview

As we closed the door on 2018, we were met by two surprising decisions—one from a panel of the Second Circuit addressing employer stock drop litigation, and one from a federal district court in Texas declaring the entire Affordable Care Act unconstitutional. We first address the Second Circuit's decision where a panel may have cracked open the proverbial door on ERISA employer-stock drop litigation when it concluded that plaintiffs had pled a plausible breach of fiduciary duty claim that satisfied the Supreme Court's *Dudenhoeffer* pleading standard. It remains to be seen whether the decision will stand; IBM has since filed a petition for rehearing asking the full Court to review the decision. Even if it does stand at the Circuit, it may present an issue ripe for Supreme Court review given the contrary conclusions reached by other circuits. Next, we review a decision from the Northern District of Texas concluding that the Affordable Care Act's individual mandate is unconstitutional and that, a result, the entire Act is invalid. As discussed below, the decision, if upheld, would be expected to have a significant impact on health care delivery.

The balance of the Newsletter addresses guidance under 403(b) plans, the requirements for Massachusetts Health Insurance Responsibility Disclosure Forms, mental health parity litigations over wilderness therapy litigation, and ERISA implications for firing a whistleblower.

Second Circuit Revives Dismissed ERISA Stock-Drop Suit

By The ERISA Litigation Group

The Second Circuit reinstated a claim for breach of fiduciary duty under ERISA brought by participants in IBM's 401(k) plan who suffered losses from their investment in IBM stock. *Jander v. Retirement Plans Committee of IBM, et al.* 2018 WL 6441116 (2d Cir. Dec. 10, 2018). In so ruling, the Second Circuit became the first circuit court since the Supreme Court's decision *in Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), to allow such a claim to survive a motion to dismiss. According to media reports, this has sparked renewed hope within the ERISA plaintiffs' bar in the viability of these claims. Below, we briefly review the Supreme Court and Circuit Court precedent leading up to the Second Circuit's IBM decision, the IBM decision itself, and its potential implications going forward.

The Supreme Court's Decisions in Dudenhoeffer v. Fifth Third and Amgen v. Harris

In *Dudenhoeffer*, a unanimous Supreme Court held that there are no unique pleading standards for employer stock claims under ERISA, but never the less provided more rigid criteria for satisfying these standards, particularly in claims alleging that insider fiduciaries breached their fiduciary duties by failing to act on non-public information to prevent losses from investments in allegedly overvalued employer stock. The Supreme Court held that, to satisfy the pleading requirements, the plaintiff must allege an alternative action that the plan fiduciary could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances could not have viewed as more likely to harm the fund than to help it. Three considerations informed the Court's development of this standard: (1) fiduciaries are not required to break the law, (2) disclosures under ERISA could conflict with the letter and objectives of insider trading and other securities laws, and (3) acting on inside information could cause a drop in the stock price and do more harm than good to the stock already held by the plan.

The Supreme Court subsequently confirmed that the *Dudenhoeffer* standard sets a high bar. In *Amgen Inc. v. Harris*, 136 S. Ct. 758 (2016), the Court ruled that the Ninth Circuit erred by permitting a breach of fiduciary duty claim to proceed without first determining whether the complaint contained facts and allegations supporting a claim that removal of the Amgen stock fund was an alternative action that no prudent fiduciary could have concluded would cause more harm than good.

Four Circuit Courts Have Affirmed Judgments Dismissing ERISA Stock-Drop Claims

Following *Amgen*, four circuit courts—the Second, Fifth, Sixth, and Ninth Circuits—had occasion to consider whether a 401(k) plan participant satisfied the *Dudenhoeffer* standard by alleging an alternative action that a plan fiduciary could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances could not have viewed as more likely to harm the fund than to help it. All four circuits concluded that the participants had failed to satisfy this standard and affirmed the dismissal of the claims. In each case, the court held that a prudent fiduciary could have concluded that a premature disclosure of negative company information outside normal corporate channels of communication would do more harm than good to a plan. *Laffen v. Hewlett-Packard Co.*, 721 F. App'x 642, 644–45 (9th Cir. 2018); *Martone v. Robb*, 902 F.3d 519, 526–27 (5th Cir. 2018); *Graham v. Fearon*, 721 F. App'x 429, 437 (6th Cir. 2018); *Saumer v. Cliffs Nat'l Res. Inc.*, 853 F.3d 855, 861 (6th Cir. 2017); *Loeza v. John Does 1-10*, 659 F. App'x 44, 45–46 (2d Cir. 2016); *Whitley v. BP, P.L.C.*, 838 F.3d 523, 529 (5th Cir. 2016); *Rinehart v. Lehman Bros. Holdings Inc.*, 817 F.3d 56, 68 (2d Cir. 2016). The courts reasoned that a prudent fiduciary could have concluded that an unusual disclosure of negative news by a plan fiduciary before the issues had been fully investigated would spook the market into believing that problems at the company were worse than they actually were and thus harm plan participants already invested in the company stock fund. The Ninth Circuit also concluded that public disclosure of allegations that are not yet fully investigated would be inconsistent with the objectives of the securities laws. *In re HP*, 2015 WL 3749565, at *7 (N.D. Cal. June 15, 2015), *aff'd sub. nom Laffen*, 721 F. App'x 642.

The Second Circuit's *IBM* Decision

In IBM, the plaintiff alleged that the defendants knew of, and should have disclosed to plan participants, certain accounting irregularities—for which the defendants themselves were allegedly responsible. According to the complaint, the failure to disclose left IBM's stock price artificially inflated and harmed participants when the irregularities were eventually disclosed and the price of the stock declined by more than $12 per share.

The district court had twice dismissed the participants' claim based on its finding that the complaint lacked context-specific allegations as to why a prudent fiduciary could not have concluded that plaintiff's proposed alternatives were more likely to do harm than good and therefore failed to satisfy the Dudenhoeffer pleading standard.

On appeal, the Second Circuit reversed and concluded that the plaintiff had pled a plausible claim. The Court first explained that the Supreme Court's Dudenhoeffer test was not clear because it initially asked whether a prudent fiduciary in the same circumstances would not have viewed an alternative action as more likely to harm the fund than to help it, and then reframed the question as whether a prudent fiduciary could not have concluded that the action would do more harm than good by dropping the stock price. According to the Court, the use of the "would not have" phrase considers the conclusions that an "average prudent fiduciary" may reach, and the use of the "could not have" phrase suggests a more restrictive standard requiring consideration of whether "any prudent fiduciary" could conclude that the alleged alternative actions would do more harm than good.

The Court found it unnecessary to decide which formulation applies because, in the Court's view, the Complaint's allegations satisfied either standard. According to the Court, the plan participant pled a plausible fiduciary breach claim because: (i) the plan fiduciaries allegedly knew that company stock was artificially inflated; (ii) the defendants were "uniquely situated to fix [the accounting irregularities] inasmuch as they had primary responsibility for the public disclosures that had artificially inflated the stock price to begin with" and disclosure could have been made within IBM's quarterly SEC filings; (iii) the failure to promptly disclose the truth allegedly caused reputational harm to the company that exacerbated the harm to the stock price; (iv) the stock traded on an efficient market and there was thus no need to fear that disclosure would result in an overreaction by the market; and (v) disclosure of the truth was inevitable. Accordingly, the Court reversed the district court's judgment dismissing the complaint and remanded the case for further proceedings.

Proskauer's Perspective

The Second Circuit's ruling in *IBM* contrasts sharply with every other court that has considered this issue, even within the Second Circuit. Perhaps most significantly, the Court's view that disclosure could have occurred within the securities laws' normal reporting regime conflicts with earlier circuit court decisions (including the Second Circuit) clearly holding that public disclosures on behalf of a company, *e.g.*, SEC filings, are made in a corporate, and not fiduciary, capacity and thus are not a basis for ERISA fiduciary liability.

IBM has since petitioned the Circuit for rehearing *en banc*. We are hopeful that the full circuit or, if necessary, the Supreme Court will ultimately reject the approach taken by the panel in *IBM* in much the same way that the Supreme Court ruled in *Amgen* that the Ninth Circuit erred by permitting a similar claim to proceed without first determining whether the complaint contained facts and allegations satisfying the *Dudenhoeffer* standard.

District Court Declares Entire Affordable Care Act Unconstitutional – What It Means for Employers and Plan Sponsors

By Robert Projansky, Paul M. Hamburger and Damian A. Myers

In a surprising turn of events, on Friday, December 14th, a district court judge in the Northern District of Texas declared that the Affordable Care Act's ("ACA") individual mandate is unconstitutional and that, a result, the entire ACA is invalid. Although the ACA remains in effect for the time being and an immediate appeal to the 5th Circuit is a near certainty, the decision, if upheld, could be expected to have a significant impact on health care delivery. Following a high-level summary of the litigation, we highlight the major implications this ruling could have on employers and plan sponsors.

Background

At this point, readers may be asking themselves the question – "Haven't we been through this before?" The answer is yes, sort of. In 2012, the United States Supreme Court (the "Supreme Court") issued its landmark ruling in Nat'l Fed'n of Indep. Businesses v. Sebelius ("NFIB") declaring that although Congress' passage of the ACA's individual mandate (i.e., the requirement that certain individual obtain health coverage or face a penalty) would be unconstitutional under the U.S. Constitution's Interstate Commerce Clause, the legislation was permitted under Congress' taxing authority. Importantly, in NFIB, the Court recognized the importance of ACA's individual mandate component, noting that Congress would not have passed the ACA without the individual mandate.

Various other challenges to the ACA were made in the intervening years, and for the most part, these challenges failed. Nevertheless, in 2017, Congress passed the Tax Cuts and Jobs Act ("TCJA"). Though the TCJA left the ACA largely intact, it "zeroed-out" the ACA's individual mandate tax for years beginning on and after January 1, 2019. In other words, beginning January 1, 2019, even though the ACA still includes the individual mandate, there is no longer a tax to be imposed on individuals who choose not to obtain health coverage.

Shortly after the TCJA was passed, two individuals and twenty states commenced litigation (Texas v. United States) in the Northern District of Texas seeking to have the ACA declared unconstitutional. The plaintiffs argued that in the absence of a tax component within the individual mandate, the individual mandate could no longer stand as an exercise of Congress' taxing authority. Instead, the individual mandate would need to be considered under the U.S. Constitution's Interstate Commerce Clause, and the Supreme Court already held in NFIB that the individual mandate would be unconstitutional in that regard. Further, the plaintiffs argued that because the individual mandate is inseverable from ACA, as noted by the Supreme Court in NFIB, the entire ACA must be invalidated.

The defendants (led by a coalition of intervening states) disagreed, arguing that Congress' intent in passing the TCJA was to eliminate the individual mandate, and because the TCJA was passed through budget reconciliation, the only pathway to achieve that result was to eliminate the tax component. Thus, the defendants argued that even if the individual mandate would be unconstitutional under the Interstate Commerce Clause, Congress essentially removed (or severed) the individual mandate from the ACA. To now say that the individual mandate was inseverable would be counter what Congress intended to do, the defendants argued.

In a Memorandum Opinion and Order issued on December 14th, the district court ruled in favor of the plaintiffs, holding that the individual mandate, in the absence of a tax component, is unconstitutional and, therefore, the entire ACA is invalid. The district court explained that the individual mandate and its tax component are two separate things, and noted that it was unwilling to infer what Congress' intent was beyond simply providing a tax cut. The district court did not issue a stay of its ruling.

Implications for Employers and Plan Sponsors

Given that the district court did not enjoin the ACA and an appeal to the 5th Circuit Court of Appeals is likely, employers and plan sponsors should maintain the status quo until this litigation is resolved (most likely by the Supreme Court). Nevertheless, should the district court's ruling be upheld, the key implications for employers and other group health plan sponsors are summarized below.

- No Employer Shared Responsibility. Large employers (i.e., those with 50 or more full-time employees) would no longer need to offer coverage to 95% percent of their full-time workforces in order to avoid significant penalties under the employer-shared responsibility mandate. This would provide employers and plan sponsors more flexibility when determining which groups of employees are eligible for benefits. Additionally, large employers would no longer be required to offer coverage meeting the minimum value and affordability standards. Reporting under the ACA would no longer be required either.
- Preexisting Condition Exclusions. Presumably, invalidation of the ACA's prohibition on preexisting condition exclusions would resurrect the HIPAA portability rules in place prior to the ACA. Under the HIPAA portability requirements, preexisting condition exclusions could be applied only to individuals who do not have sufficient creditable coverage under another health plan.

- Cost-Sharing Design. Plans would be given greater flexibility to apply cost-sharing on participants. For example, preventive services could be subject to cost-sharing. There would be no limits on out-of-pocket maximum levels. Emergency care received at an out-of-network facility could be subject to cost-sharing at a higher level than care received at an in-network facility. Finally, plans could again apply annual and lifetime dollar limitations.
- Coverage of Adult Children. Employers and plan sponsors would no longer be required to extend health coverage to dependent children until age 26. Prior to the ACA, many plans extended coverage only to adult dependent children who were enrolled in school up to a certain age. Plans could revert back to that design, subject to Michelle's Law (the requirement that coverage continue for up to twelve months when a dependent child leaves school for medical reasons).
- Administrative Changes. Various administrative reforms under the ACA would also no longer apply. For example, plans would not need to distribute summaries of benefits and coverage. Also, enhanced claims and appeals procedures would no longer be required, including the need to offer voluntary external review.
- Tax Implications. Perhaps the most significant tax implication is that tax on high-cost health care (the so-called "Cadillac Tax") would finally be invalided after several legislative delays. Other impacts would be the removal of the Medicare surcharge for high-earners, elimination of the contribution limit on health flexible spending accounts, and reduced penalty for non-qualifying health savings accounts. Other non-health plan-related taxes, such as the medical device tax and the health insurance tax, would also be eliminated.

Many of the plan design and administrative changes that were mandated by the ACA remain popular. Thus, even if the district court's decision is upheld, employer and plan sponsors have the discretion to keep some of the mandated changes in place even without the ACA. Additionally, it is possible that while the litigation works its way through various levels of appeal, that Congress will pass legislation reinstating many of the ACA's popular provisions (e.g., the prohibition on preexisting conditions, coverage of adult children, free preventive care, and limits on cost-sharing). Individual states might also pass new coverage and administration mandates that would apply to fully insured group health plans. In fact, many states already have, among other coverage requirements, adult dependent coverage requirements, limits on cost-sharing, and external review mandates.

All of this creates a large amount of uncertainty, so as noted above, employers and plan sponsors should consider maintaining the status quo until the dust settles.

Highlights from the Employee Benefits & Executive Compensation Blog

Affordable Care Act

Massachusetts Health Insurance Responsibility Disclosure Form Must Be Filed by November 30 and Annually Thereafter

By Damian A. Myers and Annie (Chenxiaoyang) Zhang

Massachusetts recently published guidance regarding its new Health Insurance Responsibility Disclosure (HIRD) annual filing, which is due for the first time on November 30, 2018 and then annually thereafter. This new HIRD form replaces one that was suspended in 2014 because it became unnecessary due to the ACA's reporting requirements.

The new HIRD requirement consists of a relatively simple employer filing requirement (i.e., employees are no longer required to complete a form) and is intended to help Massachusetts determine who might be eligible for premium assistance under the state's MassHealth Program. The filing requirement applies to every employer that has (or had) six or more Massachusetts-based employees during any month in the 12 months prior to November 30 of the filing year. An individual is considered an employee for this purpose if the employer including the individual in the quarterly wage report filed with the Massachusetts Department of Unemployment Assistance. Similar to the ACA reporting forms, HIRD forms are filed on an EIN-by-EIN basis. This means that a separate form must be filed for each company with its own EIN.

The HIRD disclosure form requests information regarding health plan eligibility requirements (such as cumulative service requirements or waiting periods), health plan design, and costs associated with maintaining the health plan. Although employers can hire their current payroll providers, insurance providers, or consultants to complete these forms, ultimate responsibility for completing the forms is on the employers. For employers with a unionized workforce receiving coverage through a union plan (which likely is intended to include a multiemployer plan), it appears that the HIRD firm simply requires identification of the union. Additionally, Massachusetts has provided some guidance related to professional employer organizations (PEOs), which often file payroll reports with Massachusetts on behalf of their client employers. Though PEOs may assist their client employers, the guidance makes clear that the client employers themselves are ultimately responsible for completing the HIRD forms.

Most payroll providers operating in Massachusetts already file reports through Massachusetts' MassTaxConnect system, so employers with Massachusetts-based employees should consider contacting their provider to determine what assistance is available. To the extent that employers need assistance completing the forms, employers should consider contacting benefits consultants or legal counsel.

403(b) Plans

Treasury and IRS Issue Eagerly-Awaited Guidance on Hardship Distributions – with a Few Surprises

By Paul M. Hamburger, Steven Einhorn and Jennifer Rigterink

Last Friday, the IRS issued eagerly-awaited proposed regulations regarding hardship distributions under section 401(k) and 403(b) plans (the "Proposed Regulations"). The Proposed Regulations primarily address hardship distribution issues raised by the Bipartisan Budget Act of 2018 (the "Budget Act"). (For our earlier blog entry summarizing these issues, click here.) At the same time, the Proposed Regulations address related hardship distribution issues implicated by the 2018 Tax Cuts and Jobs Act (the "Tax Act") and recent disaster relief guidance. Plan sponsors should review the Proposed Regulations carefully. Even before the Proposed Regulations are finalized, plan sponsors will need to consider administrative and plan amendment changes to conform to the new rules.

As a general rule, there are two key components for a permissible hardship distribution: (1) the withdrawal must be made due to an immediate and heavy financial need; and (2) the amount of the withdrawal must be limited to the amount necessary to satisfy that financial need. Existing regulations provide detailed rules for how plan participants can prove each requirement is met when requesting a withdrawal. The Proposed Regulations would modify and relax many of these rules to conform to new law changes.

Elimination of Six-Month Contribution Suspension Requirement

Under current "safe harbor" hardship distribution regulations, participants who take a hardship distribution are prohibited from making future contributions to the plan and other employer-sponsored plans for six months. Congress determined that this rule prevents participants from replenishing their accounts after a hardship distribution and directed the IRS to issue regulations to fix the problem. As directed by the Budget Act, the Proposed Regulations eliminate the six-month contribution suspension requirement.

The elimination has an interesting effective date. It may be applied on the first day of the first plan year beginning after December 31, 2018 (January 1, 2019 for a calendar year plan) even if the distribution was made in the prior plan year. For example, assume a calendar-year plan provides for hardship distributions under the pre-2019 safe harbor standards and a participant took a hardship distribution in the second half of the 2018 plan year. The plan may be amended either to end the suspension period for contributions as of January 1, 2019 or to continue the suspension for the originally-scheduled six months.

Separately, the Proposed Regulations indicate that for *distributions made* on or after January 1, 2020 (regardless of the plan year), a 401(k) plan may not provide for a suspension of contributions as a condition to obtaining the distribution. In other words, after 2019 the suspension period is not available even as an optional design matter.

Practice Point on 409A Implications: Plan sponsors should consider the potential impact of this new rule on their nonqualified deferred compensation plans subject to Code Section 409A. Under the Section 409A regulations a nonqualified deferred compensation plan is allowed to cancel a participant's nonqualified plan deferral election if a participant takes a 401(k) hardship distribution. This Section 409A rule was intended to allow nonqualified deferred compensation plans to conform to the six-month suspension rule. Depending on when a plan sponsor eliminates the 401(k) suspension period, there could be related consequences for administration of the nonqualified deferred compensation plan.

No Need to Take Available Plans Loans Before a Hardship Distribution

Another existing safe harbor rule to demonstrate that a requested hardship distribution is necessary is that the participant must take all plan loans otherwise available before taking the hardship distribution. Consistent with the Budget Act, the Proposed Regulations would remove this requirement effective for hardship distributions made in plan years beginning after December 31, 2018. Unlike the elimination of the six-month suspension period, however, the elimination of this requirement is not mandatory. Plans could continue to impose a requirement that participants take plan loans before being eligible for a hardship distribution.

New Circumstances for Hardship Distributions

Under current IRS hardship distribution safe harbor regulations, an employee is considered to have an immediate and heavy financial need if the need falls into one of six categories of hardship events. The Proposed Regulations modify the permitted safe harbor events in several ways that participants and plan administrators will likely find helpful:

Before the Tax Act, a participant could take a hardship distribution for expenses to repair damage to the participant's principal residence if the damage qualified for a casualty loss deduction under Code Section 165. Through 2025, the Tax Act eliminated the casualty loss deduction unless the loss was due to a federally-declared disaster. In what many believed to be an unintended consequence, this change resulted in many participants being ineligible to take a hardship distribution if their homes were damaged for reasons other than federally-declared disasters. The Proposed Regulations would restore the casualty loss hardship distribution event to the pre-Tax Act standard.

Hardship distributions for qualifying medical, educational, and funeral expenses include those expenses incurred by a participant's "primary beneficiary" (someone named as a beneficiary and who has an unconditional right, upon the employee's death, to all or part of the employee's plan account). This modification incorporates the prior guidance issued by the IRS in Notice 2007-7 that permitted plans to allow hardship distributions for medical, tuition, and funeral expenses incurred on behalf of a primary beneficiary.

Under a new category of permitted hardship distribution events, participants could take a hardship distribution due to expenses and losses (including loss of income) incurred after federally-declared disasters (as long as the participant's home or principal place of business at the time of the disaster was located in an area designated for federal assistance). This change would allow many plans to offer immediate assistance to affected participants without having to wait for the IRS or Congress to take specific action in response to the disaster.

These changes generally apply for distributions made in post-2018 plan years; however, they may be applied to hardship distributions made on or after a date as early as January 1, 2018. This allows plan sponsors to conform their plans retroactively to actual operational activity. For example, if a plan continued to allow for casualty loss hardship distributions without regard to the changes imposed by the Tax Act, it could be retroactively amended to conform to the new Proposed Regulation rule.

Expansion of Sources for Hardship Distributions

Consistent with the Budget Act, the Proposed Regulations expand the sources available for hardship distributions to include earnings on elective deferrals, QNECs, QMACs, and earnings on QNECs and QMACs. The preamble to the Proposed Regulations also confirms that safe harbor 401(k) employer contributions (and earnings thereon) are also available sources for hardship distribution.

Plan sponsors would not be required to expand the available sources for hardship distributions. Instead, they could continue to limit the amounts available for hardship distributions consistent with the prior rules. However, plan sponsors should coordinate with their recordkeepers to make sure their design decisions will be implemented properly.

***Special Consideration for 403(b) Plans*:** Under the Proposed Regulations, earnings on pre-tax deferrals made to a 403(b) plan continue to be ineligible for hardship distributions. However, QNECs and QMACs would be eligible for hardship distributions in a section 403(b) plan that is not in a custodial account. QNECs and QMACs in a section 403(b) plan that is held in a custodial account would continue to be ineligible for hardship distributions.

Plan Administrators May Rely Solely on New Participant Representation

The Proposed Regulations would eliminate the current rule that the determination of whether a distribution is necessary to satisfy a financial need is based on all the participant's relevant facts and circumstances. Instead, for hardship distributions made on and after January 1, 2020, a participant must represent (in writing or *by electronic means*) that the participant has insufficient cash or liquid assets to satisfy the financial need. A plan administrator could rely on the representation in the absence of actual knowledge to the contrary.

Applicability Date and Deadline to Amend Plans

The Proposed Regulations generally apply to hardship distributions made in plan years starting after December 31, 2018, unless an exception otherwise applies (for example, the revised list of safe harbor expenses may be applied to distributions made on or after January 1, 2018 and the elimination of the six-month suspension could be applied to suspension periods in place as of the beginning of the 2019 plan year).

***Special Note – Plan Amendment Required*:** Plans that permit hardship distributions will need to be amended to reflect these new hardship distribution rules once the regulations are finalized. These amendments would be treated as qualification requirement amendments and subject to an extended due date for plan amendments. The final date is to be determined; however, the general rule is that plans have until the end of the second calendar year beginning after the issuance of an IRS-issued "Required Amendments List" reflecting the new rules. That is the outside date for amendments, however. Plan sponsors should consider plan amendments well in advance of any final deadline.

IRS Announces Transition Relief From The Once-In-Always-In Requirement For Excluding Part-Time Employees Under 403(b) Plans

By Steven Einhorn and Caroline Cima

The IRS recently issued Notice 2018-95 to provide transition relief to 403(b) plans that erroneously excluded part-time employees from eligibility to make elective deferrals when the employees should have been eligible to participate under the "once-in-always-in" requirement ("OIAI"). Under the OIAI requirement, once an employee is eligible to make elective deferrals, the employee may not be excluded from eligibility for making elective deferrals in any later year on the basis that the employee is a part-time employee. The IRS issued Notice 2018-95 to provide transition relief because many employers that sponsored 403(b) plans did not realize that the OIAI requirement applied to the part-time exclusion.

Background

403(b) plans are subject to a "universal availability requirement," which generally requires that if any employee has the right to make elective deferrals under an employer's 403(b) plan, the right to make elective deferrals must be universally available to all employees. However, there are certain narrow categories of employees that may be excluded from eligibility for making elective deferrals under 403(b) plans without violating the universal availability requirement. 403(b) plans may require that employees make annual contributions greater than $200, and may also exclude:

employees who are eligible to make elective pre-tax contributions to certain other employer defined contribution plans;

nonresident aliens with no U.S. source income;

certain students (*i.e.*, students providing services described in Section 3121(b)(10) of the Internal Revenue Code of 1986, as amended (the "Code")); and

part-time employees who normally work fewer than 20 hours per week, which is sometimes referred to as the "part-time exclusion." The Notice 2018-95 transition relief only applies to plans that improperly applied the part-time exclusion.

In July 2007, the IRS issued final regulations under Code Section 403(b) (the "Final Regulations") which included guidance regarding the part-time employee exclusion. According to the Final Regulations, 403(b) plans can only exclude this category of employees if all employees in that category are excluded (*i.e.*, if the plan allows one employee who normally works fewer than 20 hours per week to make elective deferrals under the plan, all employees who qualify as part of that group must be eligible to make elective deferrals under the plan, which is referred to as the "consistency requirement"). Additionally, for purposes of excluding part-time employees, the Final Regulations impose three distinct conditions that employers must satisfy for an employee to be excluded.

A "first-year" exclusion condition: Employers must reasonably expect the employee to work fewer than 1,000 hours for the 12-month period beginning on the date the employee's employment commenced;

A "preceding-year" exclusion condition: The employee actually worked fewer than 1,000 hours of service for the preceding measurement period (*i.e.*, each plan year following the employee's first year of employment, or, if the plan so provides, the plan can look to the 12-month periods based on the date the employee commenced employment instead of looking to plan years) (defined in Notice 2018-95 as an "Exclusion Year"); and

An OIAI requirement: Once the employee fails to meet the first-year exclusion or has been credited with at least 1,000 hours of service in any applicable 12-month measurement period, the employee must be allowed to participate in making elective deferrals under his employer's 403(b) plan. Then, once allowed to participate in making elective deferrals, the employee cannot later be excluded from eligibility to make elective deferrals on the basis that the employee's hours significantly dropped, which is referred to as the "once-in-always-in" or OIAI requirement.

In practice, many 403(b) plan sponsors did not apply the OIAI requirement. Many employers applied the first-year exclusion condition for an employee's first year and applied the preceding-year exclusion condition separately for each succeeding Exclusion Year, but did not apply the OIAI requirement to prevent an employee who failed to meet either the first-year exclusion condition or the preceding-year exclusion condition from being excluded in all subsequent Exclusion Years.

Transition Relief under Notice 2018-95

In response to requests from 403(b) plan sponsors, Notice 2018-95 provides for a transition relief period for plans that did not properly apply the OIAI requirement. This "Relief Period" provided under Notice 2018-95 begins with tax years beginning after December 31, 2008 (which is generally the effective date for the Code Section 403(b) Final Regulations). If a 403(b) plan provides that the preceding-year exclusion is determined on a plan year basis, the Relief Period ends on the last day of the last plan year that ends before December 31, 2019. If a 403(b) plan provides that the preceding-year exclusion is determined based upon an employee's anniversary year, the Relief Period will end on different dates for different employees based upon the date of each employee's anniversary of employment, but no later than December 31, 2019.

Notice 2018-95 provides the following transition relief from the OIAI requirement:

1. *Relief regarding plan operations*: During the Relief Period, 403(b) plans will not be treated as failing to satisfy the conditions of the part-time exclusion if the plans were not operated in compliance with the OIAI requirement. However, this relief does not apply to 403(b) plans' failure to properly apply other conditions of the part-time exclusion (*i.e.*, the "first-year" and "preceding-year" exclusion conditions) nor to the consistency requirement.
2. 2. *Relief regarding plan language*: Notice 2018-95 provides different relief for 403(b) plans that have adopted plan documents that are covered by an IRS opinion or advisory letter (*e.*, prototype or volume submitter plans) versus 403(b) plans that use individually designed plan documents.

During the Relief Period, 403(b) plans that adopted an IRS pre-approved plan document will not be treated as failing to satisfy the conditions of the part-time exclusion, and the plans will not be treated as having failed to follow plan terms, merely because the plan document does not match plan operations with regard to the OIAI requirement.

During the Relief Period, 403(b) plan sponsors whose plan documents use individually designed plan documents must amend their plans' language to reflect the plans' operation with respect to the OIAI requirement prior to April 1, 2020. Thus, if during the Relief Period, a 403(b) plan did not properly apply the OIAI requirement, the plan must be amended to reflect how it was actually operated.

Both pre-approved 403(b) plans and individually designed 403(b) plans that provide for the part-time exclusion must include explicit language concerning the OIAI requirement prior to April 1, 2020.

3. *A "fresh-start opportunity" for plans*: Notice 2018-95 provides a fresh-start opportunity under which 403(b) plans will not be treated as failing to satisfy the conditions of the part-time exclusion, if the OIAI requirement is applied as if it first became effective January 1, 2018.

Employers that sponsor 403(b) plans that exclude part-time employees for purposes of eligibility for elective deferrals should carefully consider how the OIAI requirement applies to their plans and whether any changes will be necessary to either their procedures or plan documents.

Mental Health Parity Act

District Court Dismisses Wilderness Therapy Lawsuit

By Kyle Hansen

A federal district court in Florida granted Aetna's motion to dismiss claims that it violated ERISA and the Mental Health Parity and Addiction Act of 2008 (MHPAA) by refusing to cover the cost of wilderness therapy programs in Colorado and Utah. The court determined that the plaintiffs failed to state a plausible claim under their respective plans because they did not allege facts sufficient to show that the wilderness therapy programs qualified for coverage under the terms of their plans.

One of the plans covered treatment performed at a "residential treatment facility" and listed detailed requirements a facility must meet to qualify for coverage. The court found that the complaint did not contain sufficient information to show that the wilderness program met those requirements; there were no allegations that the program had licensed behavioral providers on site at all hours, or that access to necessary medical services was always available, among other things. The other plan covered "residential treatment services," defined in relevant part as services that are licensed in accordance with the laws of the "appropriate legally authorized agency." The court dismissed the claims because the complaint alleged that the wilderness plan was licensed under Utah law as an "outdoor youth treatment program," rather than as a "residential treatment service," thus failing to meet the plan's requirements.

The court also dismissed the MHPAA claims due to a lack of factual allegations to support them. First, plaintiffs brought a categorical challenge that Aetna "excluded all coverage for mental health treatment received at residential treatment center programs," but covered medical and surgical services received at skilled nursing facilities. The court found, however, that the plans' terms plainly provided coverage for treatment by residential treatment center programs. Second, plaintiffs alleged that the plans did not impose similar definitional requirements for skilled nursing facilities and residential treatment facilities. The court determined that those allegations were insufficient because the complaint did not allege what criteria Aetna required of skilled nursing facilities. Third, plaintiffs argued that Aetna used different standards in assessing medical services rendered at residential treatment center programs than the standards used to assess services rendered at skilled nursing facilities. The court found this allegation "conclusory" and "unsupported by anything in the complaint."

The case is *H.H. v. Aetna Insurance Co.*, 2018 WL 6614223 (S.D. Fla. Dec. 13, 2018).

ERISA Section 510

ERISA Implications for Firing A Whistleblower

By Neil V. Shah

The Ninth Circuit unanimously concluded that a trustee and lawyer for certain multiemployer funds violated ERISA § 510 by unlawfully firing a whistleblower in the funds' collections department, but, in a split decision, concluded that the retaliation did not amount to a breach of fiduciary duty. The whistleblower was cooperating with a DOL criminal investigation of one of the trustees and had raised concerns to another trustee and the funds' third-party administrator that the trustee under investigation was actively hindering the funds' efforts to collect contributions from certain contributing employers. After the trustee and the funds' counsel, who were carrying on a romantic relationship, caught wind of the investigation, they set in motion votes by the full board of trustees to place the whistleblower on administrative leave and ultimately to terminate her employment. The Secretary of Labor filed a civil enforcement action against the trustee and the funds' counsel, alleging that they engaged in unlawful retaliation under ERISA § 510 and a breach of fiduciary duty under ERISA § 404. The Secretary settled similar claims against the full board of trustees and other third-parties. Following a bench trial, the district court entered judgment in favor of the Secretary and against the trustee and funds' counsel on both claims.

The Ninth Circuit unanimously affirmed the district court's ruling that the trustee and counsel engaged in unlawful retaliation in violation of Section 510. The Court held that the whistleblower's cooperation with the DOL was quintessential protected activity, and that defendants were liable because they arranged the vote by the full board of trustees that resulted in the whistleblower's termination, they influenced the vote by recommending the whistleblower's termination, and the trustee had the authority to remove other union trustees or have their positions with the union terminated.

However, the Ninth Circuit, in a split decision, reversed the district court's ruling that the retaliation against the whistleblower constituted a breach of fiduciary duty. In so ruling, the Court concluded that the district court failed to address the threshold question of whether the union trustee was acting in a fiduciary capacity when he engaged in the challenged conduct, i.e., placing the whistleblower on leave or terminating her employment. The dissenting judge opined that the trustee's effort to terminate the whistleblower was a fiduciary act because it was "inextricably intertwined" with management and administration of the funds, it was designed to shield the trustee's role in the funds' mismanagement from additional scrutiny, and a contrary result would subvert ERISA's goal to safeguard plan assets.

The case is *Acosta v. Brain*, Nos. 16-56529, 16-56532, 2018 WL 6314617 (9th Cir. Dec. 4, 2018).

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