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# Employee Benefits for Employers

**Jackson Lewis**  
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## A Note from the Editor

We're pleased to present the new edition of our newsletter. Our lead piece, by Ashley Abel and Robert Wood, reviews how evolving jurisprudence interpreting ERISA's remedial provisions might affect disputes over conversion rights in life-insurance plans. There has been increased claims volume in this area, accompanied by changes to the courts' approach to ERISA remedies. Our authors offer many helpful insights for employers considering how these issues may affect the workforce. Keith Dropkin contributes a practical piece that offers guidance on implementing cost-savings programs that encourage employees to opt-out of employer-sponsored benefits programs. Our review of recent developments offers brief updates on ERISA and employee-benefits law, including links to our blog, Benefits Law Advisor, for more in-depth discussion. Be sure to check out the schedule of our group's upcoming speaking engagements to see if there's one near you — we are always glad to see friends and clients. Finally, we appreciate any feedback you might have about the newsletter. We're always looking for ways to improve it, so please feel free to share your thoughts with us.

- Charles F. Seemann III

## Surcharge and Life Insurance Plans: Plugging the Dike against Rising Tide of Employer Fiduciary Liability after *Amara*

By Ashley Bryan Abel ([AbelA@jacksonlewis.com](mailto:AbelA@jacksonlewis.com)) and Robert M. Wood <sup>1</sup> ([WoodR@jacksonlewis.com](mailto:WoodR@jacksonlewis.com))

Until the United States Supreme Court decided *CIGNA Corp. v. Amara*,<sup>2</sup> in 2011, jurists had uniformly interpreted the Court's earlier guidance under the Employee Retirement Income Security Act (ERISA)<sup>3</sup> as prohibiting, with only minor exceptions, virtually any form of monetary relief for breach of fiduciary duty under the "catch-all" section of ERISA's civil remedies provisions. That section authorizes "appropriate equitable relief."<sup>4</sup>

In *Amara*, the Supreme Court informed us, albeit in *dicta*,<sup>5</sup> that the entire federal judiciary, in so finely circumscribing ERISA relief for a breach of fiduciary duty, had misinterpreted the Court's earlier rulings. Indeed, the Court stated that "equity chancellors developed a host of other 'distinctively equitable' remedies — remedies that were 'fitted to the nature of the primary

right' they were intended to protect."<sup>6</sup> Accordingly, the Court reasoned, merely because such remedies may result in a monetary award does not exclude them from the limits of appropriate equitable relief under ERISA.<sup>7</sup> Distinguishing its prior case law, the Court explained, "[I]nsofar as an award of make-whole relief is concerned, the fact that the defendant in this case, unlike the defendant in *Mertens [v. Hewitt Assocs.]*, is *analogous to a trustee makes a critical difference*."<sup>8</sup>

The Court noted the monetary relief ordered by the District Court in *Amara* may be cognizable under ERISA through three "traditional" equitable remedies:

- reformation,
- estoppel, and
- surcharge.



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The first two remedies are not particularly new to ERISA jurisprudence. Estoppel, for instance, has been around for years, but is subject in most jurisdictions to enhanced burdens of proof that courts determined were warranted based upon the Congressional policies underlying the enactment of ERISA.<sup>9</sup>

Surcharge is quite another matter. Between ERISA's enactment in 1974 and the date of the *Amara* decision, there had been scant substantive discussion of surcharge as an ERISA remedy in reported case law, much less cases giving it any serious credence — with none adopting it as an available remedy. Moreover, unlike the ERISA policy-driven limitations many courts have placed upon the remedy of estoppel, the Supreme Court appeared to set out a remarkably simple set of elements for stating a surcharge claim: *a breach of fiduciary duty that causes actual harm*.<sup>10</sup>

In the wake of *Amara*, employers have experienced an increase in the number of fiduciary-based claims. Included among these are ERISA breach-of-fiduciary-duty claims alleging errors in the administration of life insurance plans. Many such cases involve conversion, porting, or continuation of coverage provisions (hereafter, “continuation” provisions).<sup>11</sup> In other words, plaintiffs are blaming their employers for being denied claims for life insurance benefits (e.g., in failing to provide accurate or timely information about continuation requirements), which failures resulted in the rejection of an application for benefits by the life insurer.

While there are fiduciary liability risks associated with the administration of any kind of plan, surcharge claims under life insurance plans seem to provide particularly tempting targets for the ERISA plaintiffs' bar. First, a substantial (and relatively undisputed) amount of money is often at issue. Whereas denied claims for health or disability claims commonly involve less than \$100,000 in benefits, the value of disputed benefits under life plans may reach seven figures. Second, group life insurance policies are complex, and seldom read, documents.

As Chief Justice John Roberts noted in a 2010 Supreme Court decision, “People make mistakes. Even administrators of ERISA plans.”<sup>12</sup> The problem, surprising to many employers, is that an employer's unintentional mistakes (often made by a relatively low-ranking human resources or benefits department employee) can be actionable as breaches of fiduciary duty under ERISA, apparently making employers strictly liability (or

nearly so) for the equivalent of make-whole compensatory damages.

In essence, a breaching fiduciary has become the insurer for the amount of life insurance coverage lost because of the fiduciary's acts or omissions.<sup>13</sup> We discuss below a few examples where employers had to defend allegations of misadministration of ERISA life insurance plans, sometimes unsuccessfully.

## Failure to Provide SPD, Individual Continuation of Coverage Notice at Termination of Employment

A common theme in cases seeking to recover from an employer the value of lost life insurance benefits involves the allegation that the employer failed to provide:

- a) general notice of the availability of continuation coverage as part of a summary plan description (“SPD”) of the group life policy, or
- b) specific notice to a separated employee that his or her coverage was about to terminate and that continuation options, such as conversion to individual coverage, were available.

Generally, employers have prevailed in cases alleging only that employers always must give affirmative, individualized notice of coverage termination or continuation, at least where the life insurance policy language does not place a clear duty on the employer to provide such notice.<sup>14</sup>

However, frequently underlying these decisions is the presumption that the employer distributed summary plan descriptions including accurate information on coverage termination and continuation options.<sup>15</sup> Not only is this a statutory requirement (29 U.S.C. § 1024(b)), it is *the* means by which ERISA requires participants to be informed about their coverage, including any opportunity for conversion coverage at the end of their employment. Failing in this obligation, employers have lost legal challenges regarding conversion rights.<sup>16</sup> With *Amara*-style make-whole relief, the employer then effectively becomes the life insurer for the amount of coverage at issue, plus attorneys' fees under ERISA, 29 U.S.C. § 1132(g).

Of course, that ERISA does not require employers to provide an affirmative continuation notice to employees when their life insurance coverage is about to

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lapse does not mean doing so is a bad idea. In *Harris-Frye v. United of Omaha Life Ins. Co.*,<sup>17</sup> the daughter and beneficiary of a deceased participant in the Mid-South Carpenters Regional Council Health and Welfare Fund sued the Fund's Board of Trustees after the insurer of the union's life insurance plan denied her claim for benefits on the ground the policy had lapsed. Among other things, the plaintiff asserted the insured participant did not know the policy had lapsed, because automatic deduction of premiums for the group coverage continued thereafter, and would have timely converted to individual coverage had he known otherwise. The District Court held the plaintiff had failed to demonstrate the Fund's Board was liable for the value of the life insurance benefits she sought. The court relied, in part, on the undisputed fact that the third-party administrator for the plan provided the insured participant with a COBRA notice regarding his health benefits that also addressed his life insurance coverage. This letter stated, "Please note that if your health coverage terminates, or if you elect COBRA continuation coverage, your life insurance with Mid-South Carpenters Regional Council Health and Welfare Fund ... will terminate. You may be eligible to convert your life insurance policy by completing the Mutual of Omaha Term Life Portability Request Form that is enclosed." The court therefore granted the Board's motion for summary judgment.

Further, that the ERISA statute does not require such individualized notice does not mean the duty to do so cannot arise from the plan documents themselves. If the plain language of the policy requires a separate notice to each employee of the right to conversion, the person or entity charged with that duty must do so or risk liability under fiduciary obligations.<sup>18</sup>

## Misrepresentations Regarding Life Plan Terms

Prior to *Amara*, courts routinely rejected many claims for misrepresentation about plan or policy terms. As observed above, courts had interpreted the Supreme Court's ERISA jurisprudence as precluding money damages or make-whole relief. Historically, the limited exception to this rule was in jurisdictions that recognized the doctrine of estoppel in ERISA claims. Estoppel's high bar included proof of reasonable and detrimental reliance, as well as additional elements, taking into consideration the special nature of ERISA (such as rules for "extraordinary circumstances" and

ambiguous plan terms).<sup>19</sup>

Fiduciary duties under ERISA generally are interpreted as requiring that fiduciaries provide "complete and accurate information in response to participants' questions."<sup>20</sup> In *Brenner v. Metropolitan Life Ins. Co.*,<sup>21</sup> the widow of an insured employee of Southern Medical Group, Inc., sued Southern Medical and the insurer of its employee life plan after the insurer denied the plaintiff's life insurance claim on the ground that coverage lapsed nine months after the insured failed to meet the "actively at work" provision for continued coverage and did not file for conversion to a personal policy. After the insured stopped working and throughout his declining health, the employer's Human Resources Director repeatedly assured the beneficiary, the wife of the insured, that the employee's coverage was secure. However, facts demonstrated the Human Resources Director simply did not understand the policy. She admitted at deposition that she knew about the policy's conversion provision, but did not think the employee could afford the premiums of a converted policy. She simply continued to pay the premiums for the employee in the erroneous belief that he "would continue to be covered under the policy as long as SMG continued to 'keep him on the SMG Plan,' and did not realize that his enrollment would automatically be terminated nine months after he stopped working."<sup>22</sup> The District Court denied the employer's motion for summary judgment.

Cases demonstrating employers' exposure to fiduciary liability resulting from inadvertent, unintentional mistakes is rife. Even where an employee was provided with accurate information in summary plan descriptions, liability may not be precluded in the face of actual misrepresentations.<sup>23</sup>

## Failure to Provide Complete Information Where Employer "Should Have Known" Participant Needed Assistance

In *Rainey v. Sun Life Assurance Co.*,<sup>24</sup> the beneficiary of a deceased employee of CHS/Community Health Systems, Inc. sued CHS and the insurer of its employee life plan after the insurer paid only \$150,000 of the plaintiff's claim for \$934,000. The insurer concluded the insured was ineligible for additional accidental death and dismemberment ("AD&D") coverage because she was not working the minimum number of hours required for AD&D coverage. The plaintiff al-

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leged CHS made material misrepresentations to the insured when its automated enrollment systems allowed her to enroll for the additional coverage. The District Court agreed:

Further, as Plaintiff asserts, the contours of the Sixth Circuit's jurisprudence on benefit misrepresentation is founded on the recognition that the duty to inform is a constant thread in the relationship between beneficiary and trustee; it entails not only a negative duty not to misinform, *but also an affirmative duty to inform when the trustee knows that silence might be harmful....* Silence in the face of a participant's initial enrollment might indeed be harmful *where the participant lacks sufficient information to make valid elections.*<sup>25</sup>

The Magistrate Judge rejected the employer's argument that the insured participant knew she was working less than 32 hours per week and should be held to inquiry notice that she was thus ineligible for the AD&D coverage because the summary plan description clearly said so. Yet, nothing showed the employer actually had provided the insured participant with the summary plan description. The Magistrate concluded the insured participant had been harmed by her employer's failure to alert her that she was not eligible for the AD&D coverage its enrollment system had allowed her to elect. The Magistrate stated:

In a light most favorable to Plaintiff, it is reasonable to presume that Ms. Rainey's decision not to pursue additional insurance coverage was, at least in part, due to her reasonable belief that she was enrolled in the Plan at the amounts she elected through CHS' web benefits portal.... *Notwithstanding a lack of evidence regarding Ms. Rainey's thought process in deciding not to purchase additional insurance*, it is abundantly clear that Ms. Rainey elected to forego a portion of her monthly income, to her detriment, based upon her belief that she was eligible for the benefits represented to her by CHS.<sup>26</sup>

Accordingly, the Magistrate recommended the plaintiff's motion for summary judgment against CHS be granted. The District Judge agreed and found CHS liable to the plaintiff in the amount of \$784,000.00 under the remedy of surcharge.

## Lessons Learned

Recent case law provides significant lessons for plan administrators.

1. Employers should distribute summary plan de-

scriptions routinely as required by federal law (no later than 90 days after a person becomes a participant, earlier if some action may be required or may be desirable by the employee). They should keep records of each distribution.

2. Employers should read and understand, in detail, their life insurance policy and SPD provisions about continuation rights and their (or plan administrators') obligations, if any, to send a post-employment notice and/or form to a former employee/participant (as well as, possibly, covered dependents, if applicable). Such obligations also may appear in "instruction manuals" or other directives provided to the plan sponsor by the insurer.

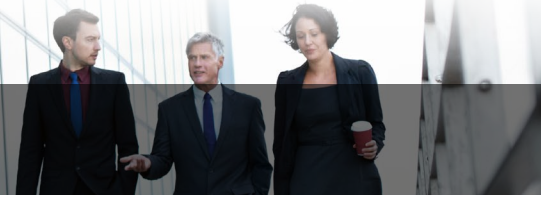
3. If the employer or a company official is listed as a named "Plan Administrator" in the group life policy and SPD, it should understand that this carries with it legal, fiduciary obligations, not the least of which is to provide copies of certain plan- and policy-related documents upon request by the employee or former employee (or his or her representative). Additional, less explicit responsibilities for communication and notification also may have to be satisfied to avoid misrepresentations that conflict with the plan documents.

4. Employers should train benefits and human resources personnel on the group life policy language and on the duty to speak accurately to participants on benefits issues. Retaining memoranda of such communications also can be key to avoiding legal liability.

5. Employers should consider providing a notice, or form, or both, regarding continuation rights to departing employees/participants (whether required by the policy or not) as part of a COBRA notice or other materials provided at the time employment ends. After all, the employer typically is paying all or part of the premiums for this coverage, a portion of which allows for continuation rights with no requirement for evidence of insurability, which is a meaningful "benefit" for employees.

6. The attorneys of the Jackson Lewis Employee Benefits practice group have extensive experience with these and other issues in the new world of ERISA fiduciary liability arising from the *Amara* decision. We would be pleased for the opportunity to provide further advice and assistance on these and other issues

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## ENDNOTES

<sup>1</sup> Adapted with permission from Bloomberg BNA Tax Management Memorandum, Vol. 57, No. 4, (February 22, 2016) (“Are Employee Life Insurance Benefit Plans Worth the Risk of Litigation After *CIGNA Corp. v. Amara*?” by Robert M. Wood). Copyright 2016 The Bureau of National Affairs, Inc. (800-372-1033), [www.bna.com](http://www.bna.com).

<sup>2</sup> 563 U.S. 421 (2011).

<sup>3</sup> *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985).

<sup>4</sup> 29 U.S.C. § 1132(a)(3) (authorizing a civil action “by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.”).

<sup>5</sup> See *Montanile v. Board of Trustees of the National Elevator Indus. Health Ben. Plan*, 136 S.Ct. 651, 660 n.3 (2016) (“the Court’s discussion of §502(a)(3) in *CIGNA* was not essential to resolving that case”) (emphasis added). Thus, while avoiding the word itself, the Court has confirmed that the *Amara* decision’s discussion of equitable remedies was legal “dicta.”

<sup>6</sup> *Amara*, 463 U.S. at 440 (citing 1 S. Symons, Pomeroy’s Equity Jurisprudence § 108, pp. 139-140 (5th ed. 1941)).

<sup>7</sup> *Amara*, 463 U.S. at 441 (“[T]he fact that this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief. Equity courts possessed the power to provide relief in the form of monetary ‘compensation’ for a loss resulting from a trustee’s breach of duty, or to prevent the trustee’s unjust enrichment.”).

<sup>8</sup> *Id.* at 442 (emphasis added).

<sup>9</sup> See, e.g., *Pisciotta v. Teledyne Industries, Inc.*, 91 F.3d 1326, 1331 (9th Cir. 1996) (noting the Ninth Circuit “has imposed two additional prerequisites on a plaintiff attempting to allege a claim of equitable estoppel in an ERISA action,” that the relevant plan terms are ambiguous and that “representations” were made to the plaintiff “involving an oral interpretation” of the ambiguous terms); *Curcio v. John Hancock Mutual Life Ins. Co.*, 33 F.3d 226, 235 (3d Cir. 1994) (“[t]o succeed under this theory of relief, an ERISA plaintiff must establish (1) a material representation, (2) reasonable and detrimental reliance upon the representation, and (3) extraordinary circumstances”).

<sup>10</sup> *Amara*, 563 U.S. at 444.

<sup>11</sup> Although insurance policies may vary, “conversion” generally refers to changing coverage from the employer’s group policy after employment ends to a personal or individual policy; “continuation” generally refers to limited, defined circumstances under which a participant maintains coverage under the group policy; and “porting” generally refers to limited circumstances under which a participant may effectively keep coverage under the terms of the group policy even though he or she is no longer an employee of the original sponsor of the life plan. Because all three concepts result, in one way or another, in “continued” coverage, we use herein the word “continuation” as a convenient shorthand description of all three forms of coverage.

<sup>12</sup> *Conkright v. Frommert*, 559 U.S. 506, 509 (2010).

<sup>13</sup> It remains to be seen what impact the U.S. Supreme Court’s *Montanile v. Board of Trustees of the National Elevator Indus. Health Ben. Plan*, 136 S.Ct. 651 (2016), will have on remedies provided for breaches of fiduciary duty under 29 U.S.C. §1132(a)(3). By describing the *Amara* decision’s discussion of equitable remedies under 1132(a)(3) as “not essential to resolving that case” (*Montanile*, 136 S.Ct. at 660 n.3), “it is arguable the High Court announced a retreat from the broad and amorphous claims, like surcharge, mentioned in *Amara*. Perhaps some members of the Court recalled their language from almost twenty years ago, in *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996), noting the “competing congressional purposes” of ERISA, “such as Congress’ desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.”

<sup>14</sup> See, e.g., *Harris v. Aetna Life Ins. Co.*, 2013 U.S. Dist. LEXIS 158255 at \*12-\*13 (D.S.C. Nov. 5, 2013) (granting summary judgment to employer as “plan administrators are not required to provide notice of a participant’s right of conversion unless the plan requires such notice”) (citing *Canada Life Assurance Company v. Estate of Harvey Lebowitz, et al.*, 185 F.3d 231, 235-36 (4th Cir. 1999) (“Although it is unclear whether ERISA requires written notice of the right of conversion, since the plain language of Canada Life’s Policy documents requires such written notice, Canada Life was required to give Lebowitz written notice.”)).

<sup>15</sup> *Walker v. Federal Express Corp.*, 492 F. App’x 559, 562-63 (6th Cir. 2012) (affirming district court’s holding on summary judgment for employer that “ERISA does not require post-termination notice of life insurance conversion rights,” where the plaintiff-beneficiary produced no evidence the employer failed to provide the deceased employee with a summary plan description with adequate information about conversion of coverage).

<sup>16</sup> *Rainey v. Sun Life Assurance Co.*, 2014 U.S. Dist. LEXIS 113549 at \*22-\*25 (M.D. Tenn. Aug. 15, 2014) (rejecting defense that plaintiff was on inquiry notice that her circumstances precluded her eligibility for coverage because the summary plan description plainly so stated, as employer produced no evidence that plaintiff ever received a summary plan description).

<sup>17</sup> 2015 U.S. Dist. LEXIS 126787 (E.D. Tenn. Sept. 21, 2015).

<sup>18</sup> *Canada Life Assurance Co. v. Estate of Lebowitz*, 185 F.3d 231, 235-36 (4th Cir. 1999) (“Although it is unclear whether ERISA requires written notice of the right of conversion, since the plain language of Canada Life’s Policy documents requires such written notice, Canada Life was required to give Lebowitz written notice.”).

<sup>19</sup> See cases cited *supra* note 9.

<sup>20</sup> *Teisman v. United of Omaha Life Ins. Co.*, 908 F. Supp. 2d 875, 883 (W.D. Mich. 2012).

<sup>21</sup> 2015 U.S. Dist. LEXIS 36044 (D. Mass. Mar. 3, 2015).

<sup>22</sup> *Id.* at \*6-\*7. The Human Resource Director further admitted she did not think conversion was an option given the employee’s bad health. As the Court noted, this admission further demonstrated her lack of understanding about the policy, which did not require evidence of insurability for conversion. *Id.* at \*7 n.1.

<sup>23</sup> *Page v. Unimerica Ins. Co.*, 2015 U.S. Dist. LEXIS 97850 at \*30-\*31 (S.D. Ohio July 27, 2015) (reciting a litany of misleading actions and communications that created a question of fact precluding summary judgment, despite evidence that the employee was provided with clear information in plan documents addressing his eligibility for continued coverage).

<sup>24</sup> 2014 U.S. Dist. LEXIS 113549 (M.D. Tenn. Aug. 15, 2014).

<sup>25</sup> *Rainey*, 2014 U.S. Dist. LEXIS 113549 at \*22 (emphasis added).

<sup>26</sup> *Id.* at \*26-\*27 (emphasis added).



## Practical Law Employee Benefits & Executive Compensation: Expert Q&A on Health Insurance Opt-Outs with Keith A. Dropkin

The Expert Q&A was first published by Practical Law on its Practical Law Employee Benefits & Executive Compensation web service

An Expert Q&A with Keith A. Dropkin of Jackson Lewis P.C. addressing the pitfalls and other complications for employers that offer their employees incentives to “opt-out” of group health plan coverage.

Aiming to control benefit costs, some employers offer incentives, such as additional pay, to entice employees to decline or “opt-out” of their group health plans. The offer is made with the expectation that the employer’s overall savings in health plan expenses will exceed the aggregate additional compensation paid to those employees who opt-out. If the opt-out provision is not designed properly, however, the employer may incur unanticipated taxes or penalties.

Practical Law asked Keith A. Dropkin of Jackson Lewis P.C. to address some of these hidden pitfalls and other complications in offering an opt-out benefit. Keith is a Principal in the White Plains, New York, office of Jackson Lewis P.C. He counsels clients regarding various benefit issues including fiduciary obligations, corrections under the DOL and IRS compliance programs, the drafting and design of pension and welfare benefit plans, managing withdrawals from multiemployer pension plans, and benefit matters arising in mergers and acquisitions. Keith is admitted in New York and California.

### Cafeteria plans allow employees to decline coverage. Is that the same as an opt-out benefit?

A cafeteria plan (also known as a “Section 125 plan”) allows employees to pay for certain benefits, such as health insurance premiums, on a pre-tax basis (see [Practice Note, Cafeteria Plans](#)). Employees who elect coverage will have their share of the premium deducted from pay before any deductions are made for taxes. Employees declining coverage will have no such deduction and therefore will have greater taxable income.

An opt-out incentive is different in that the employer offers the employee additional compensation for declining a benefit. For example, assume that an employer provides a group health plan that requires an employee contribution of \$200 per month. In a typical cafeteria plan, if the employee waives coverage, the employee will continue to receive the \$200 in taxable compensation. However, in a cafeteria plan that offers an opt-out benefit, the employer may offer an additional \$50 per month in compensation to employees who waive coverage (in addition to not deducting the \$200 premium); that additional \$50 would be the opt-out benefit.

### Must the opt-out benefit be offered through a cafeteria plan?

Unless the opt-out benefit is made available through a cafeteria plan, the mere offer of cash or increased compensation would be taxable to all employees offered the choice, even employees who elect the health plan coverage instead of the cash. This is due to the federal income tax doctrine known as the “constructive receipt” rule, in which any employee who is offered the choice between nontaxable benefits and cash compensation is treated as if he had received the cash (even if the employee elects the tax-free benefits), unless an exception applies. Section 125 of the [Internal Revenue Code](#) (Code) ([26 U.S.C. § 125](#)) provides one statutory exception to this rule for the election of benefits through a cafeteria plan.

The following excerpt from the 2007 proposed cafeteria plan regulations explains how the constructive receipt rule operates when an employer offers an employee a choice between cash and nontaxable benefits outside a cafeteria plan:

Section 125 is the exclusive means by which an employer can offer employees an election between taxable and nontaxable benefits without the election itself resulting in inclusion in gross income by the

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employees. Section 125 provides that cash (including certain taxable benefits) offered to an employee through a nondiscriminatory cafeteria plan is not includible in the employee's gross income merely because the employee has the opportunity to choose among cash and qualified benefits ... through the cafeteria plan.

However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the section 125 requirements, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made. An employee who has an election among nontaxable benefits and taxable benefits (including cash) that is not through a cafeteria plan that satisfies section 125 must include in gross income the value of the taxable benefit with the greatest value that the employee could have elected to receive, even if the employee elects to receive only the nontaxable benefits offered.

(Prop. Treas. Reg. §1.125-1(b)(1).) (Taxpayers may rely on these regulations for guidance pending the issuance of final regulations.)

Accordingly, if an employer does not use a cafeteria plan as the vehicle for offering the opt-out incentive, it must report the foregone opt-out payments of those who elect coverage as imputed income subject to employment taxes and income tax withholding.

## Can employees entitled to Medicare be offered an opt-out benefit?

An employer that is large enough to be subject to the Medicare Secondary Payer (MSP) rules is prohibited from offering any "financial or other benefits as incentives" for an individual entitled to Medicare "not to enroll, or to terminate enrollment, in" a group health plan that would otherwise be a primary plan ([42 C.F.R. § 411.103](#)). The MSP rules generally apply to the group health plan of an employer with at least 20 full-time and/or part-time employees. Employers offering an improper incentive to Medicare beneficiaries are subject to a penalty of up to \$5,000 per violation.

This MSP rule would seem to preclude offering opt-out benefits to Medicare beneficiaries. However, representatives from the [U.S. Department of Health and Human Services](#) (HHS) have provided [informal guidance](#) indicating that such an offer is not a violation if

the opt-out benefit is:

- Offered under the same conditions to employees regardless of age or Medicare status.
- Provided under a bona fide cafeteria plan meeting the requirements of Code Section 125 ([26 U.S.C. § 125](#)).

Further guidance from the HHS on this issue would be welcome. In the interim, employers subject to the MSP rules:

- Should be cautious in offering opt-out benefits to Medicare-eligible employees.
- May wish to seek the advice of legal counsel.

## Does the opt-out benefit impact the calculation of a plan's affordability for purposes of determining whether an employer may be subject to penalty taxes under the ACA?

One way in which an "applicable large employer" under the [Affordable Care Act](#) (ACA) may become subject to employer mandate penalties is if at least one full-time employee obtains a subsidy on the health insurance marketplace (also known as the "health insurance exchange") because the employer's coverage was not "affordable" ([26 U.S.C. § 4980H\(b\)](#)) (see [Affordable Care Act \(ACA\) Toolkit](#) and [Employer Mandate Toolkit](#)). Generally, coverage is deemed affordable to an employee if the employee's required contribution for self-only coverage under the plan does not exceed 9.5% (indexed to 9.66% in 2016) of the employee's household income (or wages under one of the employer mandate affordability safe harbors under Code Section 4980H).

For example, if an employee's required contribution for self-only coverage is \$200 per month, the employee's testing income/wages could be no less than \$2,105.26 per month (\$200 is 9.66% of \$2,105.26) for the coverage to be considered affordable.

With respect to opt-out payments, [IRS Notice 2015-87](#) provides that the opt-out amount must be counted as part of the employee's required contribution if the opt-out arrangement was adopted after December 16, 2015. As a result, if under the previous example the employer adopts a \$50 per month opt-out benefit beginning in 2016:

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- The employee contribution amount would be deemed to be \$250 per month.
- The income/wages threshold would rise to \$2,588 per month (\$250 is 9.66% of \$2,588).

The IRS anticipates that this rule will also apply to opt-out arrangements adopted on or before December 16, 2015 once final regulations are issued incorporating the rule.

As the above example illustrates, offering an opt-out benefit may make an employer more susceptible to:

- Failing the ACA's affordability standard.
- Incurring the related penalty under Code Section 4980H(b) (26 U.S.C. § 4980H(b)).

## May an insurance carrier's minimum participation requirements impact the offering of opt-out benefits?

Insurance carriers typically have minimum employee participation requirements in their contracts. Offering opt-out benefits may result in the employer failing to meet the minimum participation requirements or violating other terms of the service contract. Accordingly, fully insured plans should consult with the insurer when considering whether to implement an opt-out benefit.

## Does offering an opt-out benefit raise any discrimination issues?

Offering opt-out benefits primarily to employees with a high claims risk constitutes prohibited health status discrimination under the ACA and the [Health Insurance Portability and Accountability Act](#) (HIPAA). Although the regulations permit more favorable rules for reduced premiums or contributions based on an adverse health factor (referred to as "benign discrimination"), the DOL, HHS, and IRS take the view that offering opt-out benefits only to employees with a history of high-cost claims is not permissible benign discrimination. The reasoning is that:

- The foregone opt-out effectively increases the premium or contribution for the employees with a high claims risk that elect coverage.
- Providing cash as an alternative to health coverage for high risk employees is an eligibility rule that discourages participation in the group health plan

based on an adverse health factor.

Sponsors of self-insured medical plans also should be aware of the nondiscrimination eligibility test under Code Section 105(h)(3)(A) ([26 U.S.C. § 105\(h\)\(3\)\(A\)](#)). Generally, a self-insured plan must satisfy either of two numerical tests regarding the percentage of eligible employees enrolled in the plan or a nondiscriminatory classification test.

## Should opt-out payments be paid in a lump sum or installments throughout the year?

An employer should consider spreading the opt-out payments over the plan year. Paying the opt-out payment up-front in a lump sum creates the risk that an employee who elects the opt-out benefit may:

- Later terminate employment midyear.
- Receive the same amount as an employee who remained employed throughout the plan year.

Furthermore, an employee who opts-out and later incurs a HIPAA "special enrollment" event (for example, the loss of other coverage or acquiring a new dependent) may be entitled to enroll in the plan midyear, despite receiving an opt-out payment.

## What are the employer takeaways?

Employers should keep in mind the following in offering employees incentives to opt out of group health plan coverage:

- The opt-out benefit should be set out in a cafeteria plan to avoid taxation on all employees offered the choice, including those employees who decline the opt-out and elect the benefit.
- Employers large enough to be subject to the MSP rules should be cautious in offering opt-out benefits to Medicare-eligible employees.
- In determining whether the ACA's affordability requirement for minimum essential coverage is satisfied, employers should factor in the cost of any opt-out payments, unless the opt-out arrangement falls under transition relief for arrangements adopted on or before December 16, 2015.
- Insurance carriers should be consulted before implementing an opt-out benefit.
- Opt-out benefits should not be limited to employ-



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ees with a high claims risk.

- Spreading opt-out payments over the plan year

reduces certain risks relating to employees terminating employment or becoming entitled to enroll midyear.



## Recent Developments

### Plan's Equitable Recovery Limited to Identifiable Funds in Participant's Possession

In *Montanile v. Board of Trustees*, No. 14-723 (Jan. 20, 2016), the Supreme Court considered whether a medical-benefits plan can recoup payments made on behalf of an injured participant, where the participant receives a tort recovery for the injuries that necessitated the medical treatment. The Supreme Court held ERISA's remedial provisions, which contemplate "equitable relief," did not authorize the plan to obtain a judgment against Montanile's general assets. *Montanile* is discussed in detail in our Benefits Law Advisor blog [post](#).

### ERISA Preempts Vermont Health-care Database Law

In *Gobeille v. Liberty Mutual Ins. Co.*, No. 14-181 (March 1, 2016), the Supreme Court issued its first decision involving ERISA preemption in over a decade. In *Gobeille*, the Court held that ERISA preempted a Vermont law requiring medical insurers (among other entities) to report claims data to the state for use in the state's healthcare database. An in-depth discussion is available at the [Benefits Law Advisor](#).

### High Court Hints at Greater Protection for ESOP Fiduciaries

The Supreme Court issued its second ruling in *Amgen Inc. v. Harris*, No. 15-278 (Jan. 25, 2016), remanding the case to the district court to consider whether plaintiffs could plead any cognizable theory of recovery. In *Amgen*, employees asserted ERISA fiduciary claims against various fiduciaries of the company's employee stock ownership plans ("ESOPs"), claiming that the fiduciaries violated ERISA's prudence requirements by retaining the ESOP's employer-stock holdings during a downturn. The Court embraced the "plausibility" pleading standard it enunciated previously, adding that the plaintiffs must plausibly allege that the fiduciaries had an alternative course of action that would not do more harm than good to the plan. For details, see our [post](#).

### Court Declines Review of ERISA Plan's Venue-Selection Provision

Without comment, the Supreme Court declined to review a Sixth Circuit decision enforcing a venue-selection provision in an ERISA plan, in *Smith v. AEGON Cos. Pension Plan*, No. 14-1168 (Jan. 11, 2016). The Sixth Circuit has jurisdiction over Kentucky, Ohio, Michigan, and Tennessee.

### Excessive-Fee Claims against Service Provider Rejected

In *McCaffree Fin. Corp. v. Principal Life Ins. Co.*, 811 F.3d 998 (8th Cir. 2016), the court affirmed dismissal of ERISA claims against a plan's investment service provider. There, the plan sponsor accused the provider of charging excessive fees in violation of ERISA's fiduciary requirements. Joining the Seventh and Eleventh Circuits, the Eighth Circuit held that the service provider was not acting as a fiduciary when negotiating its compensation with the plan sponsor. Accordingly, ERISA's fiduciary duties did not attach to the provider's actions in setting the fees.

### Employer's Wellness Program Survives EEOC Challenge

A federal district court rejected the EEOC's claims that the employer's wellness program violated the Americans with Disabilities Act (ADA) in *EEOC v. Flambeau, Inc.*, 2015 U.S. Dist. LEXIS 173482 (W.D. Wis., Dec. 30, 2015). The EEOC claimed the employer violated the ADA when it conditioned participation in its health plan upon a risk assessment and biometric screening test. The court concluded that the employer gathered information to administer and underwrite insurance risks associated with the health plan. Accordingly, the program fell within the ADA's safe harbor exemption. For more details, see our blog [post](#).

### Two Federal Circuits Take Narrow View of ERISA's Church-Plan Exemption

In *Kaplan v. Saint Peter's Healthcare System*, No. 15-

# Employee Benefits for Employers



1172, the Third Circuit considered an issue of first impression: whether a plan sponsored by a church-affiliated organization is exempt from ERISA under Section 3(33)(A) as a “church plan.” In rejecting an appeal by the plan sponsor (a hospital affiliated with the Roman Catholic Church), the *Kaplan* court held that the statutory exemption requires that the plan be established by a “church,” not merely a church-affiliated entity. On March 18, the Seventh Circuit reached the same result in *Stapleton v. Advocate Health Care Network*, No. 15-1368. Similar appeals are pending in the Ninth and Tenth Circuits. For details, see our blog [post](#).

## IRS Describes Its New Determination Letter Procedure

In its Announcement 2015-19, the IRS eliminated the staggered five-year determination letter remedial amendment cycles for individually designed plans, although plans may still seek a determination letter upon inception and termination. Since then, the IRS has begun issuing guidance on implementing changes to the determination letter program. Recent guidance (Rev. Proc. 2016-6) revised IRS procedures for issuing determination letters, including a clarification that determination letters issued to individually designed plans after January 4 will not include an expiration date. According to this guidance, the IRS will continue to accept Cycle A determination letter applications from February 1, 2016, to January 31, 2017. At a recent meeting with benefits-industry professionals, IRS representatives informally indicated changes later this year to the Employee Plans Compliance Resolution System (i.e., the IRS’s program for correcting operational and documentary plan errors) based, in part, on the changes to the determination letter program.

## IRS Notice 2016-16: Mid-Year Changes to Safe Harbor 401(k) Plans

With IRS Notice 2016-16, the IRS is allowing a number of mid-year changes to 401(k) plans, so long as a

given change is not specifically prohibited by the Notice and: (i) employees receive updated safe-harbor notices describing the change 30-90 days before the effective date of the change; and (ii) employees have a reasonable opportunity to update deferral elections at least 30 days before the effective date of the change. In the case of a retroactive change, an opportunity to change a deferral election must be provided as soon as practicable, but no later than 30 days after the date the change is adopted. Mid-year changes that are still prohibited by the Notice include: (A) an increase to the years of service required to fully vest in safe harbor contributions under a Qualified Automatic Contribution Arrangement (QACA); (B) further restriction of the group of employees eligible to receive safe harbor contributions; (C) a change to the type of safe harbor plan (e.g., from a traditional 401(k) safe harbor plan to a QACA 401(k) safe harbor plan); and (D) with a limited exception, the modification or addition of a formula used to determine matching contributions (or a modification to the definition of compensation used to determine matching contributions) if the change increases the amount of matching contributions (including discretionary matching contributions). For more information, see our blog [post](#).

## Small Business Health Care Tax Credit

The IRS’s Health Care Tax Tip 2016-20 provides guidance on the small business health care tax credit available under the Affordable Care Act to qualifying small employers (i.e., those with fewer than 25 full-time equivalent employees, who pay an average wage of less than \$51,600 and pay at least half of their employees’ health insurance premiums, and (in general) who purchase a Qualified Health Plan from a Small Business Health Options Program Marketplace). The credit percentage is 50 percent of employer-paid premiums (35 percent for tax-exempt employers) and employers may claim the credit for only two consecutive taxable years beginning (with certain exceptions) in 2014 and beyond.

# Employee Benefits for Employers



## Featured Lawyer: Raymond Turner



By William H. Payne ([William.Payne@jacksonlewis.com](mailto:William.Payne@jacksonlewis.com))



**Raymond Turner**, Of Counsel in our Dallas office, is one of the benefits practice group's taxation gurus. Before devoting his practice to employee benefits and compensation, Mr. Turner, who is a board-certified tax practitioner in Texas, did absolutely *everything* tax-related, including corporate and partnership work, mergers, acquisitions, and other transactional matters, international tax, and benefits. Beginning in 1988, he decided to concentrate on ERISA, employee benefits, and executive compensation, where his broader background would bring added perspective to his work for clients.

In one of his more unusual engagements, Mr. Turner once provided legal advice to a foreign government on the privatization of its social security system. Even though he cannot disclose the details of his international adventures, he was willing to answer some non-life threatening questions.

### With the presidential primaries in full swing, people are talking about the tax code. Do you like hearing Americans talking tax theory?

Yes, but it's amusing because it's such a perennial topic — for example, the politically impossible “flat tax.” The Internal Revenue Code does not just raise revenue, it subsidizes and punishes selected behaviors. We politically disagree on which behaviors should be singled out, but our society is not going to give up the practice and, frankly, our tax system is pretty efficient in conferring economic awards and punishments, compared to the alternatives. Then, there are the politicians who effectively want you to believe that investment (the only source of jobs) really is not affected by tax rates — as if investment decisions are made on a before-tax basis. Really?

### The legal profession, or at least its publishing arm, has a lot to say about Millennials. What's your take on the millennial generation?

Personally, I think the legal profession is relatively free of the entitlement mentality that supposedly characterizes Millennials. If law school doesn't weed that out, the job market and law firm economics will do so soon enough. My Millennial son, who coincidentally is working hard in law school

right now, has some of the traits you read about. But we've tried to make sure he learned history and literature and engaged with grandparents and, we hope, he'll end up with some of the best of multiple generations: a little Baby Boomer “question authority” from his old man, a little Greatest Generation right stuff, and, maybe, assorted virtues from the great people of history.

### If some sort of apocalypse were to befall the world, what skills do you have for a post-benefits society?

Doesn't sound like any land of the living. As a lawyer, if there were no benefits field, I would like to be in a varied kind of practice — maybe even as an in-house counsel dealing with everything. I've always had a very broad practice, both within the general tax area in my early practice years and after, concentrating on benefits. I think the analytical, communication and people skills you develop after doing private practice as long as I have are quite transferable if you're otherwise adaptable. Writing a book or two would also be on my agenda.

### Do you think the Benefits practice is in danger of becoming a cult?

We have a special dispensation and tend to be in our own isolated world in any large firm. But I think the practice is closer to a medieval trade guild, given how one has to learn this stuff.

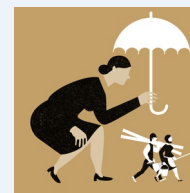
# Employee Benefits for Employers



## Media...

- **Joy Napier-Joyce, Collin O'Connor Udell, Frank Alvarez, Joe Lazzarotti, Kathryn Russo, Paul DeCamp, Michael Neifach, Amy Peck, Jessica Feinstein, Cynthia Liao, David Jones, Amy Worley, Howard Bloom, Ashley Abel, and Jason Gavajian** comment on Wolters Kluwer's *Employment Law Daily's* "2015 review—2016 forecast: High Court rulings and beyond"
- **Joe Lazzarotti** comments on the IRS's announcement on preferential tax treatment for employer-provided identity theft benefits in *SHRM's* "[IRS OKs Excluding ID Protection Benefits from Taxable Income](#)"
- **Charles Seemann** discusses the U.S. Supreme Court's two recent ERISA cases in Bloomberg BNA's Pension and Benefit Blog's "[Supreme Court Addresses Two ERISA Cases In One Week](#)"
- **René Thorne** is quoted in *Law 360's* "[Attorneys React To High Court ERISA Reimbursement Ruling](#)"
- **Robert Perry** authored "[A troubling expansion of successor liability](#)," published in Wolters Kluwer's *Employment Law Daily*

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## UPCOMING SEMINARS

### APRIL

***Affordable Care Act Update***, Joy Napier-Joyce at the Annual Labor and Employment Law Symposium, Massachusetts

***How Do the Recent U.S. Supreme Court Decisions Impact My Benefit Plans?*** Natalie Nathanson at SHRM's Utah Annual Conference

***Given Intense Judicial Scrutiny Required of Proposed Class Action Settlements including Close Watch on Attorney Fees, What are the Best Strategies for Securing Class Settlement Approval?*** Charles Seemann at the American Conference Institute's Cross-Industry Interdisciplinary Summit on Defending and Managing Class Actions, New York

***Affordable Care Act Subsidy Notices and Appeals: Ensuring Employers Aren't Penalized***, Natalie Nathanson for the National Business Institute's Advanced Human Resource Law webcast

### MAY

***The State of the Affordable Care Act***, Joy Napier-Joyce at the Jackson Lewis Corporate Counsel Conference, Washington, D.C.

***The Stakes are Rising: The Increased Risk of Fiduciary Liability for Employee Pension and Health and Welfare Plans***, René Thorne at the Jackson Lewis Corporate Counsel Conference, Washington, D.C.

### JUNE

***Employee Benefits***, Charles Seemann at New Mexico Human Resource Association's 2016 New Mexico Labor and Employment Law Conference, New Mexico

***ERISA Litigation***, René Thorne at American Conference Institute's 12th Annual National ERISA Litigation Conference, Illinois

***Roundup of Benefits-Related Cases in the Supreme Court***, Charles Seemann at the Worldwide Employee Benefits Network's Chicago Chapter, Illinois

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