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Benefits Counselor – September 2019

POSTED:

Oct 3, 2019

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GENERAL EMPLOYEE BENEFITS

Ninth Circuit Allows Mandatory Arbitration of ERISA Claim

In *Dorman v. Charles Schwab Corp.*, No. 18 15281 (9th Cir. Aug. 20, 2019), the Ninth Circuit Court of Appeals held that claims brought under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") *can* be subject to mandatory arbitration after finding that its prior holding on such was no longer valid in light of subsequent U.S. Supreme Court case law.

The Ninth Circuit previously held in *Amaro v. Continental Can Co.*, 724 F.2d 747 (9th Cir. 1984), that ERISA claims could *not* be subject to mandatory arbitration. In that case, the court reasoned that arbitrators, who are not necessarily lawyers, lack a court's competence to interpret and apply federal statutes. However, in *American Express Co. v. Italian Colors Restaurant*, 570 U.S. 228 (2013), the U.S. Supreme Court ruled that arbitrators are competent to interpret and apply federal statutes, holding that there is nothing inherently unfair about arbitration—even arbitration on an individual basis—as long as individuals can vindicate their statutory rights. The Ninth Circuit, therefore, found *Amaro* was no longer good law because the *American Express* decision severely undercut the rationale applied in *Amaro*, and the two decisions were irreconcilable.

Meanwhile, in a sister, unpublished decision arising out of the same circumstances, the Ninth Circuit applied its new rule from the *Dorman* decision and found that the plaintiff's ERISA claims were subject to arbitration. The plaintiff was a participant in the Charles Schwab 401(k) plan, which contained a provision that required arbitration on an individualized basis for all claims except those arising out of a claim for benefits. The plaintiff sued for excessive fees under ERISA section 502(a)(2), and the court found that such claims were subject to the arbitration provision. However, an unpublished decision cannot be relied upon as precedent, so arbitration clauses in plan documents still have an uncertain future in the Ninth Circuit.

RETIREMENT PLAN DEVELOPMENTS

Seventh Circuit Holds Plan to Accelerated Withdrawal Liability, Finds Claim

Time-Barred

In *Bauwnes v. Revcon Technology Group, Inc.*, No. 1:18 cv 00707 (7th Cir. Aug. 13, 2019), the Seventh Circuit Court of Appeals held that a multiemployer plan's claim for withdrawal liability was time barred after the plan had spent over eleven years attempting to collect a participating employer's withdrawal liability.

In 2003, the participating employer, Revcon Technology Group, Inc. ("Revcon"), withdrew from the plan, incurring withdrawal liability. The plan's trustees initially demanded payments in installments in 2006, but after several missed payments in 2008, demanded immediate payment. When Revcon failed to pay, they accelerated the liability and sued for the entire amount, plus interest. Revcon then promised to cure its defaults and resume making installments in exchange for the trustees' dismissal of the lawsuit. The trustees agreed, Revcon cured its prior default, made three more payments, then defaulted again. This cycle of default, lawsuit, promise to cure, and voluntary dismissal was repeated four times (for a total of five).

Except for the amount of withdrawal liability due, the complaints for these five lawsuits were identical. Each referred to the debt's acceleration in 2008, but did not refer to the negotiations whereby the acceleration was revoked. However, the complaint for the sixth case that came before the Seventh Circuit only sought the delinquent payments Revcon had missed since the last voluntary dismissal, rather than the entire outstanding withdrawal liability. Revcon moved to dismiss the case, arguing that claim preclusion applied because the five previous complaints had demanded the entire outstanding withdrawal liability, which necessarily included the defaulted payments currently at issue. Revcon argued the Federal Rules of Civil Procedure's "two dismissal rule" therefore barred the trustees from raising any claims arising from the withdrawal liability. Revcon also argued that, because the trustees had first sought to collect the entire debt in 2008, the six year statute of limitations had expired in 2014. The trustees countered that they had revoked the 2008 acceleration of the withdrawal liability when they had voluntarily dismissed the first complaint, and each subsequent dismissal had had the same decelerating effect. The trustees further claimed the two dismissal rule did not apply because all parties had consented to the previous dismissals by stipulation "in spirit," although they were dismissals by notice.

On appeal, the trustees asked the court to create a federal common law rule that would allow them to decelerate the withdrawal liability they had previously accelerated, which would preserve the timeliness of their claim. However, the Seventh Circuit declined to do so because the Multiemployer Pension Plan

Amendments Act of 1980 (which amended ERISA) does not provide for deceleration. The court reasoned that, without some contractual or statutory foundation, there is no general principle of contract law that allows an accelerated debt to be decelerated. The court stated that the trustees, therefore, could not decelerate Revcon's withdrawal liability, and held that the trustees' claim was time-barred because the statute of limitations ran from the date when the trustees first accelerated the debt in 2008.

The court also noted that the trustees had other avenues via which they could have pursued the defaulted funds. Each time the trustees had filed a claim against Revcon, Revcon had agreed in writing to pay them in exchange for dismissing the lawsuit, which resulted in a series of enforceable settlement agreements. However, because the trustees did not plead breach of contract, the court did not address these issues.

The court's decision does not explain why it did not consider the settlement agreements to provide for contractual deceleration of the withdrawal liability. However, the court stated accelerated debts could be decelerated only when a contract or statute *expressly* authorizes deceleration, and the decision was not clear as to whether the settlement agreements expressly allowed for deceleration of the withdrawal liability.

ESOP Trustee and Selling Stock Owner Jointly Liable for Overvalued Shares

In *Pizzella v. Vinoskey*, No. 6:16 cv 00062 (W.D. Va. Aug. 2, 2019), the U.S. District Court for the Western District of Virginia held that the selling owner of stock and the independent trustee of an employee stock ownership plan ("ESOP") both violated their fiduciary duties under ERISA by approving the ESOP's purchase of the seller's stock at an inflated price. The court agreed with the Department of Labor ("DOL") in finding that the trustee violated ERISA by approving a prohibited party in interest transaction for more than adequate consideration, and by failing to meet its duties of prudence and loyalty. The court found the seller, who before the transaction owned 52% of the company's stock and was also the company's CEO, jointly liable because the seller acted as a knowing participant in a prohibited transaction, and was a co-fiduciary of the ESOP. As a result, the court imposed joint and several liability on the trustee and the seller for approximately $6.5 million, the amount it determined the ESOP overpaid for the stock.

The court found the trustee liable for several reasons: the trustee failed to show that its reliance on the independent appraisal performed for the transaction was

"reasonably justified" under the circumstances; it failed to identify and investigate several concerning features of the appraisal (among several other concerning items); and it did not confirm whether or how the independent appraiser addressed the issues in its final report. The court also cited other evidence illustrating the trustee's lack of prudence in relying on the appraisal, such as the generally rushed nature of the trustee's due diligence, and the trustee's failure to question whether the appraiser manipulated certain inputs to reach the estimated transaction price. The court concluded that the trustee's imprudence caused the ESOP to purchase the seller's stock for an amount exceeding its fair market value.

The court held the seller jointly and severally liable because the seller knew that the per-share price he received exceeded the stock's fair market value. The court noted that, although it could have reached the same conclusion if it had found that the seller had known the trustee had not arrived at the per share price through a good faith determination (*i.e.*, through a prudent process), it did not find that the seller had had actual or constructive knowledge thereof.

The court also determined that the seller, as an ESOP trustee, was a co fiduciary of the ESOP at the time of the transaction, and so should be held jointly liable as a co fiduciary for the independent trustee's breaches. By accepting a price above fair market value, the seller knowingly participated in the independent trustee's approval of a prohibited transaction. Further, the seller knew that the stock was overvalued but did not attempt to remedy the price. These facts added to the court finding the seller liable as a co fiduciary. The seller argued that he could not have taken steps to remedy the trustee's breaches because he had recused himself as an ESOP trustee during the course of the transaction. As there was no evidence the seller had formally recused himself, the court rejected this argument, and further noted the seller could not escape liability as a "delegating fiduciary" by simply ignoring the breach.

DOL Issues USERRA Guidance for Pension Plans

The DOL recently provided guidance in the form of frequently asked questions ("FAQs") on the pension rights of service members who take leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). The FAQs specifically provide information concerning the application of USERRA to pension plans that pay benefits as a percentage of employees' total earnings.

The FAQs describe the rules under USERRA that require reemployed service

members to be treated as though they have not had a break in employment for purposes of participation, vesting, and accrual of pension benefits. The FAQs also note that a reemployed service member's entire period of absence from employment due to or necessitated by military service must be treated as continuous employment. Further, the FAQs outline whether and when contributions are required, and how to calculate the employee's pension when an employee's compensation determines the amount of their contribution or benefit.

IRS Confirms Uncashed Retirement Checks Subject to Taxation, Withholding, Reporting

In Notice 2019 19, the Internal Revenue Service ("IRS") confirmed that retirees and plan sponsors must consider uncashed checks for taxable retirement benefits as income in the year they are received. A retiree's failure to cash a check does not alter the plan administrator's obligations to withhold tax and report the amount of the benefit in a Form 1099 R.

PBGC Multiemployer Plan Program Likely Insolvent by 2025; Single-Employer Plan Program Solvent

The PBGC released its annual long term projections regarding the financial condition of its Multiemployer Program and its Single-Employer Plan Program. These programs insure a minimum level of benefits for multiemployer and single-employer defined benefit pension plan participants. This year's projections continue to show a very high likelihood that the Multiemployer Plan Program will become insolvent during Fiscal Year ("FY") 2025, and remains a near certainty by the end of FY 2026. However, compared to last year's projections, there is a lower risk of insolvency during FY 2024. In contrast, the Single-Employer Plan Program likely will retain a surplus for the next decade.

HEALTH AND WELFARE PLAN DEVELOPMENTS

DOL Finalizes Mental Health Parity FAQs and Model Disclosure Form

The DOL published final guidance regarding the implementation of the Mental Health Parity and Addiction Equity Act ("MHPAEA") and its nonquantitative treatment limit and disclosure requirements. This guidance is the final version of the same FAQs and model disclosure request form the DOL published in proposed form in 2018. These final FAQs and model form remain largely the same as the proposed version, with certain clarifying changes.

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Three Departments Address ACA Out-of-Pocket Limit Rule and HDHP Minimum Deductible Rule for Drug Coupons, Allow Excluding Coupons from Out-of-Pocket Limit Even If No Generic Equivalent

The DOL, the Department of Health and Human Services ("HHS"), and the Department of the Treasury have rolled back a rule published earlier this year and will now allow plans to exclude the value of drug manufacturer coupons from annual out of pocket maximums, even when no generic equivalent is available. These Departments issued the guidance after plan sponsors of high deductible health plans questioned whether their plans could also exclude the value of the coupons, or whether doing so would violate the requirement that high deductible plans not cover services until participants had met their deductible.

In previous guidance published in April 2019 (the Notice of Benefit and Payment Parameters for 2020, or the "2020 NBPP Final Rule"), HHS addressed how drug manufacturers' coupons count toward the annual limitation on cost-sharing. Specifically, the 2020 NBPP Final Rule provided that, for plan, years beginning on or after January 1, 2020, plans and issuers could exclude the value of coupons from the annual limitation on cost-sharing when a medically appropriate generic equivalent is available.

However, plan sponsors questioned whether this rule implies that, in other circumstances, group health plans and issuers are required to count such coupon amounts toward the annual limitation on cost sharing. Such a requirement could create a conflict with prior IRS guidance for high deductible health plans that requires a high deductible health plan to disregard drug discounts and other manufacturers' and providers' discounts in determining if the participant has satisfied their minimum deductible for the high deductible health plan, and only allows amounts actually paid by the individual to be taken into account for that purpose. Therefore, a high deductible health plan sponsor could comply either with the requirement under the 2020 NBPP Final Rule for limits on cost sharing, or the IRS rules for minimum deductibles for high deductible health plans, but not with both rules simultaneously.

HHS, in consultation with the DOL and the Department of the Treasury, stated that it intends to address the conflicting rules in the forthcoming Notice of Benefit and Payment Parameters for 2021. Until the 2021 rule is issued and effective, the Departments have announced a nonenforcement policy applicable to any group health plan that excludes the value of drug manufacturers' coupons from the annual limitation on cost-sharing, including when there is no generic equivalent.

USPSTF Recommends Non-FDA-Approved Medication to Reduce Risk of Breast Cancer

On September 3, 2019, the U.S. Preventive Services Task Force ("USPSTF") published an updated recommendation for medication to reduce the risk of breast cancer. The updated recommendation is consistent with the prior recommendation, except it now includes another type of medication, non FDA approved aromatase inhibitors, as among those that can be prescribed as preventive care. Under the Affordable Care Act ("ACA"), nongrandfathered health plans are required to cover preventive services recommended by the USPSTF with an "A" or "B" rating, among others, without cost sharing.

If aromatase inhibitors still do not have FDA approval for risk reduction of primary breast cancer by the date when plans would need to begin covering them as preventive care under the ACA (*i.e.*, plan years beginning on or after October 1, 2020), plans may have a basis to decline to treat aromatase inhibitors as preventive care as a reasonable medical management technique because there are other preventive care drug options for the relevant population that are FDA approved.

The USPSTF took similar action in June 2019 when it recommended two preventive medications for providers to prescribe for certain individuals at high risk of HIV, but one of the two is not yet FDA approved for such use. As with the breast cancer medication, if the HIV medication does not receive FDA approval by the date when plans would need to begin covering it under the ACA (*i.e.*, plan years beginning on or after July 1, 2020), plans may have a basis to decline to treat the medication as preventive care as a reasonable medical management technique because there is another preventive care drug option for the relevant population that is FDA approved.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. For plans that obtained an extension for filing their Form 5500, the Form 5500 must be filed by October 15, 2019.

SAR Deadline for Calendar Year Plans. Plan administrators who must distribute Summary Annual Reports ("SARs") must distribute them to participants and beneficiaries within nine months of the plan's year-end (*e.g.*, for plan years that

ended December 31, 2018, the SAR was due September 30, 2019). However, if a plan has received an extension for filing its Form 5500 (*i.e.*, due by October 15, 2019), the nine month SAR deadline is extended to November 30, 2019.

Retirement Plan Compliance Deadlines and Reminders

Retirement Plan QDIA Notice. Plan sponsors of defined contribution plans that, as a result of a participant's failure to make an investment election, invest participant contributions in a qualified default investment alternative ("QDIA") must provide an annual notice to all participants at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019, and December 1, 2019.

Retirement Plan Automatic Enrollment Notice. Plan sponsors of defined contribution plans with an eligible automatic contribution arrangement or a qualified automatic contribution arrangement must provide an annual notice to all participants on whose behalf contributions may be automatically made to the plan at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019, and December 1, 2019. Plan sponsors may combine the automatic enrollment notice with the QDIA notice.

Safe Harbor 401(k) Plan Notice. Plan sponsors of safe harbor 401(k) plans must provide participants with an annual safe harbor notice that describes the safe harbor contribution and other material plan features at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019, and December 1, 2019. Plan sponsors may combine the safe harbor notice with other required notices, such as the QDIA notice.

Health Plan Compliance Deadlines and Reminders

Medicare Part D Notice of Creditable Coverage. All group health plans that offer prescription drug coverage to Medicare eligible employees (under either an active plan or a retiree plan) must provide an annual creditable coverage disclosure notice to their Medicare eligible participants and dependents no later than October 15, 2019. The Centers for Medicare and Medicaid Services ("CMS") provides a model notice that can be accessed through the CMS website at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html. Plan sponsors should review the model notice to ensure it accurately reflects the provisions of their plan.

Health Plan Open Enrollment Requirements.

- Plan sponsors of group health plans must issue a new summary of benefits and coverage ("SBC") to participants and beneficiaries covered under the plan in conjunction with open enrollment. Group health plans without open enrollment must issue the SBC no later than 30 days prior to the beginning of the plan year (December 1, 2019, for calendar year plans).

Plan sponsors of health reimbursement arrangements ("HRA") must offer participants an annual opportunity to opt-out and waive all future reimbursements from their HRA. This notice of opt out can be provided with open enrollment.