

# Employee Benefit ■ Plan Review

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**OCTOBER 2017**

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*Steven A. Meyerowitz*

**ASK THE EXPERTS**

*Marjorie M. Glover  
and David Gallai*

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# Employee Benefit Plan Review

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## What's an Employer to Do?

In this issue of *Employee Benefit Plan Review*, we consider a variety of issues employers may need guidance on, including whether to inquire about a potential employee's criminal history, what to do about drug testing in the workplace in an age of medical marijuana, how to handle an employee with chronic pain, and how to attract and retain employees. And we have much more!

### APPLICANT/EMPLOYEE CRIMINAL HISTORIES

In our "Feature" article, "New FEHA Regulations Limit Employer Consideration of California Applicant/Employee Criminal Histories," Linda Auerbach Allderice, John H. Haney, and Juan M. Rodriguez, attorneys at Holland & Knight LLP, discuss new California Fair Employment and Housing Act (FEHA) regulations, which relate to an employer's consideration of California applicant/employee criminal histories when making employment decisions. Under the regulations, if an employer's policies or practices of considering criminal histories create an "adverse impact" on individuals on the basis of a FEHA protected class, this may constitute a FEHA violation—but not necessarily. The regulations set forth detailed burden-shifting procedures for determining whether there is a FEHA violation, as well as defenses available to employers. Although the regulations do not prohibit consideration of criminal histories, the California Legislature is considering a statewide "ban-the-box" bill—AB 1008—which would set forth numerous prohibitions and procedural requirements regarding the collection and consideration of criminal histories when making employment decisions.

### ZERO TOLERANCE DRUG-TESTING POLICIES

In an important new decision, the Massachusetts Supreme Judicial Court recently held that a qualifying patient who has been terminated from employment for testing positive for marijuana as a result of her lawful medical marijuana use may state a claim of disability discrimination under that state's anti-discrimination statute. In our lead "Focus" article, "Are Zero Tolerance Drug-Testing Policies About to Go Up in Smoke?," Nathaniel M. Glasser, an attorney at Epstein Becker & Green, P.C., discusses the decision, which has significant implications for

employers that drug test for marijuana use because 29 states plus the District of Columbia have enacted legislation legalizing medical or recreational marijuana use, or both.

### EASING THE PAIN

The workplace is fraught with potential obstacles—obstacles for the employer and the employee. Chronic pain does not have to be one of them. In our next "Focus" article, "How to Ease the Pain," Cindy Leyland, a PAINS Project Manager at the Center for Practical Bioethics, looks at what role HR directors can play in negotiating for comprehensive pain management programs as part of employee health benefits, which can play a major role in adding quality to an employee's life, decreasing both their absenteeism and presenteeism and increasing worker productivity.

### ATTRACTION & RETENTION

Our final "Focus" article, "Attraction & Retention: Employer's Needs – Part I," the first part of a three-part series, looks at two key driving forces in today's workforce that are making it challenging for an employer to not only recruit top talent, but also to keep employees engaged once they are hired. The first is the low unemployment rate and the second is the new majority generation in the workforce today: millennials. In this series, Bobbi Kloss, the Director of Human Capital Management Services for the Benefit Advisors Network, explores a number of points, including the two primary conditions that exist today that can disrupt recruiting and retention management practices, the impact these two forces have on employers, as well as suggested ways that employers could be responding to this convergence. The second and third parts of the article will appear in upcoming issues of *Employee Benefit Plan Review*.

### AND MORE...

In this issue, we also have three columns, "Ask the Experts," "From the Courts," and "Benefits Update," by Marjorie M. Glover and David Gallai of Norton Rose Fullbright US LLP, Norman L. Tolle of Rivkin Radler LLP, and Lori Welding Jones of Thompson Coburn LLP, respectively.

Enjoy the issue!

Steven A. Meyerowitz  
Editor-in-Chief  
October 2017

Submit questions to Employee Benefit Plan Review via email to smeyerowitz@meyerowitzcommunications.com. Answers by the columnists, Marjorie M. Glover and David Gallai, may appear in an upcoming issue.

### STATUTE OF LIMITATIONS FOR IRS AUDIT OF PLAN

**Q** My company recently acquired a subsidiary that sponsors its own defined contribution plan, and we have some concerns about a potential tax audit of that plan for some issues going back to 2010, 2011, and 2012. Can the Internal Revenue Service (IRS) audit the plan going that far back?

**A** It depends. The statute of limitations for assessment of taxes generally expires three years from the date that the plan administrator or employer files a complete and accurate Form 5500. A Form 5500 is deemed to be filed on the later of the date the form is filed or the date the form is due (ignoring any filing extension). The statute of limitations increases to six years in certain circumstances, such as when there is a substantial understatement of taxes (more than 25 percent). There is no limitations period with respect to filing a false or fraudulent return, willfully attempting to evade tax, or failing to file a return.<sup>1</sup>

Note also that there is no statute of limitations on plan disqualification. Therefore, if the IRS disqualifies a plan, the tax effects of the disqualification apply only to years within the statute of limitations. But a plan can still be disqualified even if the event causing the disqualification happened outside of the statute of limitations. This is under a theory that the qualification error that occurred outside of the statute of limitations caused the assets of the plan to be tainted throughout the subsequent years that are within the statute of limitations.

Accordingly, if your company is concerned about any plan qualification error, you should see whether it may be able to be corrected through the IRS *Employee Plans Compliance Resolution System*.<sup>2</sup>

### ACCOUNTABLE PLAN RULES FOR REIMBURSEMENT OF BUSINESS TRAVEL EXPENSES

**Q** My company would like to reimburse employees for business travel expenses under an accountable plan, so that the employees will not be taxed on the reimbursements under the Internal Revenue Code (Code). We understand that in order to do so, the accountable plan will need to

meet certain requirements. What are those requirements?

**A** Employees who pay expenses in connection with the performance of their services as an employee, and who are reimbursed under an arrangement that qualifies as an “accountable plan,” will not be taxed on the reimbursements under the Code.<sup>3</sup>

For amounts paid under an arrangement to be treated as paid under an “accountable plan,” three main requirements must be satisfied: a business connection requirement, a substantiation requirement, and a return of excess requirement.

- (1) *Business Connection Requirement.* The expenses must be only for items that are allowable as deductions under Code Section 161 through Section 199, which are the itemized deductions for individuals and corporations. Also, they must be paid or incurred in connection with the performance of services as an employee of the employer.<sup>4</sup>
  - You mentioned that your company would like to use an accountable plan to reimburse employee travel expenses. Code Section 162(a)(2) provides for the deduction of ordinary and necessary traveling expenses while away from home in the pursuit of a trade or business.<sup>5</sup> If deductible business travel expenses are paid or incurred in connection with the performance of services as an employee of the reimbursing employer, they will satisfy the business connection requirement.<sup>6</sup>
- (2) *Substantiation Requirement.* The travel away from home must be substantiated by the employee submitting sufficient information regarding the amount, time, place, and business purpose of the expenses.<sup>7</sup> Substantiation must be provided within a reasonable period of time after the expense is paid or incurred by the employee.<sup>8</sup>
- (3) *Return of Excess Requirement.* The employee must return any reimbursement paid in excess of the substantiated expenses within a reasonable period of time.<sup>9</sup>

If a reimbursement arrangement does not satisfy all of these requirements, it will be treated as a “non-accountable plan,” and all amounts paid under the arrangement will generally be taxable.<sup>10</sup>

If all of the requirements for an accountable plan are met, amounts treated as paid under the accountable plan are excluded from the employee’s gross income, are not reported as wages or other compensation on the employee’s Form W-2, and are exempt from the withholding and payment of employment taxes.<sup>11</sup> 🌐

### NOTES

1. See Internal Revenue Code § 6501.
2. See Rev. Proc. 2016-51.
3. Code § 62(a)(2)(A), Treas. Reg. § 1.62-2(c)(4).
4. Treas. Reg. § 1.62-2(d)(1).
5. Code § 162(a).
6. Treas. Reg. § 1.62-2(d)(1).
7. Treas. Reg. § 1.62-2(e); Code § 274(d); Treas. Reg. § 1.274-5T(b)(2).
8. Treas. Reg. § 1.62-2(e)(1).
9. Treas. Reg. § 1.62-2(f).
10. Treas. Reg. § 1.62-2(c)(3)(i).
11. Treas. Reg. § 1.62-2(c)(4).

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# New FEHA Regulations Limit Employer Consideration of California Applicant/Employee Criminal Histories

LINDA AUERBACH ALLDERDICE, JOHN H. HANEY, AND JUAN M. RODRIGUEZ

New regulations under the California Fair Employment and Housing Act (FEHA), which relate to an employer's consideration of California applicant/employee criminal histories when making employment decisions, took effect on July 1, 2017.<sup>1</sup> Employers covered by FEHA, that is, employers with five or more employees, should closely evaluate current policies and practices for California applicants/employees to ensure compliance with these new regulations.

## CURRENT RESTRICTIONS REGARDING CONSIDERATION OF APPLICANT/EMPLOYEE CRIMINAL HISTORIES

Currently, employers are prohibited from collecting or considering the following types of criminal histories when making employment decisions for California applicants/employees:

- An arrest or a detention that did not result in a conviction;<sup>2</sup>
- Referral to or participation in a pre-trial or post-trial diversion program;<sup>3</sup>
- A conviction that has been judicially dismissed, sealed, expunged, or statutorily eradicated pursuant to law;<sup>4</sup>
- An arrest, detention, processing, diversion, supervision, adjudication, or court disposition that occurred while a person was subject to the process and jurisdiction of a juvenile court law;<sup>5</sup> and
- Certain marijuana-related convictions, as specified in California Labor Code Section 432.8, that are older than two years.<sup>6</sup>

## NEW RESTRICTIONS REGARDING CONSIDERATION OF APPLICANT/EMPLOYEE CRIMINAL HISTORIES

If an employer's policies or practices of considering criminal histories of California applicants/employees create an "adverse impact" on individuals on the basis of a FEHA protected class,<sup>7</sup> this may constitute

a FEHA violation (but not necessarily).<sup>8</sup> The new regulations, which became effective on July 1, 2017, set forth detailed burden-shifting procedures for determining whether there is a FEHA violation, as well as defenses available to employers.

## APPLICANT/EMPLOYEE BEARS INITIAL BURDEN OF PROVING 'ADVERSE IMPACT'

An applicant/employee bears the initial burden of demonstrating that an employer policy or practice of considering certain criminal convictions has an adverse impact on individuals on the basis of a FEHA protected class.<sup>9</sup>

For purposes of the new regulations, "adverse impact" is defined as "[a] substantially different rate of selection in hiring, promotion, or other employment decision which works to the disadvantage of members of a race, sex, or ethnic group," which definition is borrowed from the Equal Employment Opportunity Commission's (EEOC) *Uniform Guidelines on Employee Selection and Procedures*.<sup>10</sup>

An applicant/employee may establish an "adverse impact" through:

- (1) Using state- or national-level conviction statistics showing substantial disparities in the conviction records or one or more FEHA protected classes; or
- (2) Offering "any other evidence that establishes an adverse impact."

State- or national-level conviction statistics are presumptively sufficient to establish an adverse impact. However, this presumption can be rebutted if the employer can show that there is a reason to expect a markedly different result after accounting for any particularized circumstances such as the geographic area encompassed by the applicant/employee pool, the particular types of convictions being considered, or the particular job at issue.<sup>11</sup>

### IF APPLICANT/EMPLOYEE PROVES ‘ADVERSE IMPACT,’ BURDEN SHIFTS TO EMPLOYER

If the applicant/employee proves an adverse impact, the burden shifts to the employer to establish that the policy or practice is justifiable because it is “job-related and consistent with business necessity.”<sup>12</sup>

**An employer must be able to demonstrate that the policy or practice that has an adverse impact is “appropriately tailored.”**

As an initial matter, this requires the policy or practice to bear a demonstrable relationship to successful performance on the job and in the workplace, and measure the person’s fitness for the specific position(s), not merely to evaluate the person in the abstract.<sup>13</sup> More specifically, an employer must be able to demonstrate that the policy or practice that has an adverse impact is “appropriately tailored,” considering at least the following:

- (1) The nature and gravity of the offense or conduct;
- (2) The time that has passed since the offense or conduct and completion of the sentence; and
- (3) The nature of the job held or sought.<sup>14</sup>

If the employer uses “bright-line” policies or practices, that is, policies that do not consider individualized circumstances, an employer must show that:

- (1) These policies or practices distinguish between applicants/employees that do and do not pose an unacceptable level of risk; and
- (2) The convictions being used to disqualify, or otherwise adversely

impact the status of the applicant/employee, have a direct and specific negative bearing on the person’s ability to perform the duties or responsibilities necessarily related to the position.<sup>15</sup>

If the employer does not use “bright-line” policies or practices, then the employer must conduct an individualized assessment of the circumstances and qualifications of the applicants/employees excluded by the conviction screen. The assessment must involve the following:<sup>16</sup>

- (1) Notice to the adversely impacted employees/applicants, before an adverse action is taken, that they have been screened out due to a criminal conviction;
- (2) A reasonable opportunity for the individuals to demonstrate that the exclusions should not be applied due to their particular circumstances; and
- (3) The employer’s consideration of additional information that might warrant an exception to the exclusion.

### SPECIAL NOTICE REQUIREMENTS

Before taking an adverse employment action against an adversely impacted individual based on criminal histories obtained by a source *other than* the applicant/employee, the employer must give the impacted individual notice of the disqualifying conviction and a reasonable opportunity to present evidence that the information is factually inaccurate.<sup>17</sup>

### REBUTTABLE DEFENSE

The regulations provide for a rebuttable defense that the employer complied with federal or state laws or regulations that prohibit individuals with certain criminal records from holding certain positions or mandate a screening process employers are required or permitted to use before employing individuals in such positions.<sup>18</sup>

### LESS DISCRIMINATORY ALTERNATIVES

Even if an employer demonstrates that its policies or practices are job-related and consistent with business necessity, adversely impacted employees/applicants may still prevail if they can show that there is a less discriminatory policy or practice that serves the employer’s goals as effectively as the challenged policy or practice.<sup>19</sup>

The regulations provide the following potential examples of less discriminatory alternatives: a more narrowly targeted list of convictions, or another form of inquiry that evaluates job qualification or risk as accurately without significantly increasing the cost or burden on the employer.

### CALIFORNIA LEGISLATURE CONSIDERING STATEWIDE BAN-THE-BOX LAW

Notably, although the new regulations do not provide for an outright prohibition on considering criminal histories, the California legislature is considering a statewide “ban-the-box” bill—AB 1008—which would set forth numerous prohibitions and procedural requirements regarding the collection and consideration of criminal histories when making employment decisions. Employers with California employees should closely monitor this bill, which, if enacted, would require a further assessment of policies and practices to ensure compliance. 🌐

### NOTES

1. The new regulations, known as the “Consideration of Criminal History in Employment Decisions Regulations,” were developed by the California Fair Employment and Housing Council (FEHC) beginning in 2016, and were approved by the California Office of Administrative Law earlier this year.
2. Cal. Lab. Code §432.7.
3. *Id.*
4. *Id.*
5. *Id.*
6. Cal. Lab. Code §432.8.
7. The FEHA protected classes are as follows: race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military



and veteran status of any person. *See* Cal. Gov. Code §12940(a).

8. 2 Cal. Code Reg. §11017.1(a).
9. 2 Cal. Code Reg. §11017.1(d).
10. *Id.*; 29 C.F.R. 1607 (1978).
11. *Id.*
12. 2 Cal. Code Reg. §11017.1(e)(1).
13. *Id.*
14. *Id.*
15. 2 Cal. Code Reg. §11017.1(e)(2)(A).
16. 2 Cal. Code Reg. §11017.1(e)(2)(B).
17. 2 Cal. Code Reg. §11017.1(e)(3).

18. 2 Cal. Code Reg. §11017.1(f).
19. 2 Cal. Code Reg. §11017.1(g).

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## Are Zero Tolerance Drug Testing Policies About to Go Up in Smoke?

NATHANIEL M. GLASSER

In an important recent decision,<sup>1</sup> the Massachusetts Supreme Judicial Court recently held that a qualifying patient who has been terminated from employment for testing positive for marijuana as a result of her lawful medical marijuana use may state a claim of disability discrimination under that state's anti-discrimination statute. Much like a similar decision<sup>2</sup> in Rhode Island, this holding has significant implications for employers that drug test for marijuana use because 29 states plus the District of Columbia have enacted legislation legalizing medical or recreational marijuana use, or both.

### BACKGROUND

The plaintiff received an offer of employment conditioned on her passing a mandatory drug test. Before taking the test, the plaintiff told her would-be supervisor that she would test positive for marijuana because she was a qualifying medical marijuana patient under Massachusetts law and used marijuana to treat her Crohn's disease and irritable bowel syndrome.

The supervisor assured her that her medicinal use of marijuana would not be an issue with the company.

After submitting a urine sample for the mandatory drug test, the plaintiff completed her first day of work without incident.

At the conclusion of that day, however, she was terminated for testing positive for marijuana. She was told that the company did not consider whether the positive test was due to the lawful medicinal use of marijuana because it followed federal, not state, law.

### COURT'S HOLDING AND RATIONALE

The court rejected the plaintiff's claims under the Massachusetts Medical Marijuana Act,<sup>3</sup> finding there to be no private right of action under the statute, which merely decriminalizes medical marijuana use and does not provide express employment protections.

Nonetheless, the court allowed the plaintiff's disability discrimination claim to proceed. In so holding, the court rejected the employer's

arguments that the plaintiff could not be a qualified handicapped person under the statute because the only accommodation she sought (possession and use of marijuana) is a federal crime, and that the plaintiff was discharged because she tested positive for an illegal substance, not because of her disability.

Rather, the court concluded that, at least in some circumstances, an employer may have an obligation to accommodate the off-duty use of marijuana for medicinal purposes. Like the Rhode Island trial court in *Callaghan v. Darlington Fabrics Corporation*, the Massachusetts court determined that the medical marijuana act implicitly recognizes that off-site medical marijuana might be a permissible accommodation of an individual's disability, and further concluded that the fact that marijuana may be illegal under federal law does not make it *per se* unreasonable as an accommodation.

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**The court rejected arguments that the federal classification of marijuana as a controlled, and thus illegal, substance should preempt the state law classification.**

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The court rejected arguments that the federal classification of marijuana as a controlled, and thus illegal, substance should preempt the state law classification.

First, the court noted that only the plaintiff, and not the employer, risked federal prosecution for using marijuana, and therefore the legality of its use should not impact a determination of its reasonableness as an accommodation.

Second, the court concluded that to adopt the federal classification would be to improperly reject the determination of Massachusetts voters to legalize the drug for medical use.

Notably, just because the plaintiff may proceed on her disability discrimination claim does not mean she ultimately will succeed. This decision comes at the motion to dismiss stage, and the employer still has the opportunity to demonstrate on summary judgment or at trial that accommodating the plaintiff's marijuana use would constitute an undue hardship.

### Wherever employers operate, it is clear that they must take added precautions in administering their drug-testing policies.

#### KEY TAKEAWAYS

This decision is the first in any state in which the applicable medical marijuana act merely decriminalizes to permit a disability discrimination claim to proceed on such facts. The decision calls into question whether, even in these states, employers may maintain zero tolerance marijuana testing policies. Prior to this year, decisions<sup>4</sup> in other jurisdictions have held that employers operating in such jurisdictions may enforce such policies and take adverse action against medical marijuana users simply for testing positive. With claims in Rhode Island and now Massachusetts surviving motions to dismiss, these decisions may indicate a trend by courts to provide greater protections for lawful medical marijuana users. Indeed, even more recently, the U.S. District Court for the District of Connecticut held that federal law does not preempt a Connecticut state medical marijuana law's anti-discrimination, and permitted an applicant who uses medical marijuana to pursue her state claim for disability discrimination after being rejected for testing positive for marijuana use.<sup>5</sup>

Wherever employers operate, it is clear that they must take added precautions in administering their drug-testing policies. Although employers may continue to prohibit the on-duty use of or impairment by marijuana, employers must consider the following when testing for marijuana:

- Employers should review their drug-testing policies to ensure that they:
  - (a) Set clear expectations of employees;
  - (b) Provide justifications for the need for drug-testing; and
  - (c) Expressly allow for adverse action (including termination or refusal to hire) as a consequence of a positive drug test.
- Employers may consider or be required to adjust or relax certain hiring policies to accommodate lawful medical marijuana users.
- When an individual tests positive ostensibly because marijuana is used to treat a disability, employers, particularly those in Massachusetts, may be required to engage in the interactive process. First, however, employers should evaluate whether the individual has a qualified disability that warrants an accommodation and whether the individual's use of medicinal marijuana would allow rather than hinder the individual's ability to perform the essential functions of the job.
- Employers concerned with the application of federal law may, during the interactive process, explore whether another equally effective medical alternative to marijuana use may enable the individual to perform the essential functions of the job. Note, however, employers in states requiring accommodation of medical marijuana use may be prohibited from exploring these alternatives.

- When no such alternative exists or can be agreed upon, employers who cannot accommodate even lawful, off-duty medicinal marijuana use must be prepared to demonstrate that such accommodation would constitute an undue hardship.
- Any such decision should be well-documented and well-coordinated by the relevant stakeholders.
- In any case, hiring managers should be trained not to provide assurances as to whether and how marijuana use may be accommodated. If an applicant or employee discloses marijuana use, that disclosure should immediately be referred to the human resources department and addressed by a human resources professional in coordination with counsel.

### Clearly, employers enforcing zero-tolerance policies should be prepared for future challenges to such policies.

Clearly, employers enforcing zero-tolerance policies should be prepared for future challenges to such policies. In Massachusetts as well as in those states prohibiting discrimination against or requiring accommodation of medical marijuana users, such challenges are now more likely to survive a motion to dismiss. 🌟

#### NOTES

1. *Barbuto v. Advantage Sales and Marketing, LLC*, 78 N.E.3d 37 (Mass. 2017).
2. *Callaghan v. Darlington Fabrics Corp.*, C.A. No. PC-2014-5680 (R.I. Super. Ct. May 23, 2017), available at <http://www.healthemploymentandlabor.com/files/2017/06/Callaghan-v.-Darlington-Fabrics.pdf>.
3. Massachusetts Legislature, Chapter 369 of 2012.

4. Ross v. Ragingwire Telecommunications, Inc., 70 Cal. Rptr. 3d 382 (2008); Coats v. Dish Network, L.L.C., 303 P.3d 147 (Colo. Ct.App. 2013); Johnson v. Columbia Falls Alum. Co. LLC, No. DA 08-0358 (Mont. March 31, 2009); Roe v. Teletech Customer Care Management (Colorado), LLC, No. 38531-7-II (Wash. Ct.App. Sep. 15, 2009).

5. Noffsinger v. SSC Niantic Operation Co., No. 3:16-cv-01938 (D. Conn. Aug. 8, 2017).

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# How to Ease the Pain

CINDY LEYLAND

Imagine receiving a call from your IT director telling you, “I need to tell you something; I’m addicted to crack cocaine.”

A human resources (HR) director’s first inclination likely would be to connect the IT director with the company’s Employee Assistance Program (EAP). Considering the pronouncement, this was a mandatory referral. In the actual case, the referral was one of the best decisions I ever made as an HR director. The employee was admitted into an inpatient recovery center, and three months later, he returned to his position. The EAP referral played a major role in his recovery, and we were both grateful.

## EMPLOYEE ASSISTANCE PROGRAMS

An EAP program is a voluntary, employer-sponsored service offering free and confidential counseling referrals to employees with personal or work-related problems, such as in this case substance abuse, as well as problems in their marriage or family, financial problems, grief, and other emotional or psychological issues. In 2009, more than 75 percent of U.S. organizations sponsored EAPs, covering more than 300 million employees. An EAP that offers comprehensive prevention and early intervention services is a valuable employee benefit and proven to support worker productivity, decrease absenteeism, and reduce business costs.

## CHRONIC PAIN

What about an employee who lives with chronic pain? What if that IT director had instead said, “I’m in so much pain every day that I can barely focus on my work.”? Would an EAP referral make a difference?

The 2015 National Pain Strategy<sup>1</sup> published by the U.S. Department of Health and Human Services (HHS) declares that “chronic pain is a biopsychosocial condition that often requires integrated, multi-modal and interdisciplinary treatment, all components of which should be evidence-based.”

Per NIH Medline *Plus*,<sup>2</sup> chronic pain may arise from an initial injury, such as a back sprain, or there may be an ongoing cause, such as illness, trauma from an accident or

even a virus. However, there may also be no clear cause. Other health problems, such as fatigue, sleep disturbance, decreased appetite, and mood changes, often accompany chronic pain. Chronic pain may limit a person’s movements, which can reduce flexibility, strength, and stamina. This difficulty in carrying out important and enjoyable activities can lead to disability and despair.

The under-treatment of chronic pain is a major public health issue and one of tremendous impact on healthcare, raising concerns for employers and third-party payers. In 2011, the Institute of Medicine published *Relieving Pain in America*,<sup>3</sup> a report on the scope and impact of chronic pain. Their findings were staggering. At least 100 million Americans live with chronic pain (more than all those with cancer, diabetes and heart disease). In humanistic terms, the costs of chronic pain are incalculable. Worldwide studies indicate one in three chronic pain sufferers are unable or less able to maintain an independent lifestyle due to their pain. Between one-half and two-thirds of people with chronic pain are less able or unable to exercise, enjoy normal sleep, perform household chores, attend social activities, drive a car, walk or have sexual relations. One in four reports that relationships with family and friends are strained or broken. In economic terms, the costs, when combining cost of care and loss of productivity, are estimated to be \$560–\$635 billion annually.

Pain is the number one reason people seek medical care, a major driver of healthcare costs and emergency room admissions, and the leading cause of disability in the United States. Employers across the country are increasingly aware of the cost of chronic pain to them in business terms. Absenteeism and the loss of good employees have been recognized for some time as costs to business. More recently, concerns have emerged about “presenteeism,” that is, the impact of chronic pain on employees who are at work but unable to work to their capacity or focus as necessary because of persistent pain.

## OPIOIDS AND CHRONIC PAIN

The Centers for Disease Control and Prevention<sup>4</sup> (CDC) has declared a U.S. opioid

epidemic in that more than six out of 10 drug overdose deaths involve an opioid, with 91 Americans dying every day from an opioid overdose. Many people who live with chronic pain rely on opioids to help mitigate the effects of their pain so they can continue to work and enjoy some level of quality in their life.

For example, a 46-year old male with sickle cell anemia is able to work and participate in family life with the help of 90 mg of oxycodone each day for his pain. He is a union painter and can maintain a full-time job as long as he takes that medication. Recently, his daily dosage was decreased to 60 mg to be in compliance with the newly issued CDC Opioid Prescribing Guideline for Chronic Pain, which recommends dosages of less than 90 MME/day (morphine milligram equivalent). With that change, this patient spiraled down into once again being bedridden and unable to work because of his uncontrolled pain. He is not addicted to the opioid medication; his quality of life and ability to work are dependent upon the pain-relieving role of it. Working with his physician and engaging in a comprehensive chronic pain management plan that included both prescription medication and complementary therapies allowed him to get back to work—and to life.

Although most people who use opioids for chronic pain control do not abuse or misuse their medication, for those who do, increased absenteeism, higher health care costs and more claims of disability can be a reality, disrupting the workplace. Abuse or misuse of any substance, whether prescribed or illicit drugs or alcohol, can create problems for the employer.

#### WIN-WIN-WIN

So what role can an HR director play in these situations?

Chronic pain is a complex condition that requires a comprehensive response. What is “comprehensive pain management?” One educational brief defines it as follows:

Comprehensive pain management is a clinical approach that combines biomedical, psychosocial (some argue including spiritual care) and physical rehabilitation services, including some CAM (complementary and alternative medicine) therapies—including chiropractic care. It is evidence-based, with functional restoration providing the evidence base for this model. Its focus is not on pain scores; its focus is on functionality and wellness. It is individualistic and by definition must be consistent with the patient’s goals and values and accepted clinical practice. It is developed through a shared decision-making model. Formulaic, recipe-like approaches do not result in comprehensive pain management.

Negotiating for comprehensive pain management in employee health insurance benefits and as part of an Employee Assistance Program is an essential first step for HR directors. Additionally, ongoing employee education about the company’s drug policy is important. That education should include the role of prescription pain medication in the policy, information about potential abuse, and how to safely store and dispose of these medications.

Employee Assistance Programs are especially important in managing an employee who lives with chronic pain. Given the sometimes constant presence of unrelieved or only partially relieved pain, it is not surprising that it can become all-consuming to those living with the condition. Research has demonstrated that “pain catastrophizing”—a particular style of thinking where people catastrophize their pain and imagine the worst possible outcomes—actually increases pain and utilization of health care services and also leads to worse

patient outcomes, for example, diminished functionality and sense of well-being.

Research has also shown that training and practice in skills such as relaxation, goal setting, and thinking in new ways, such as those provided by chronic pain self-management programs (CPSMP), can correct these harmful beliefs and improve outcomes. By educating patients about their condition, engaging them actively in their treatment, providing training and practice in the skills mentioned previously, and also giving chronic pain patients a sense of control over their condition, outcomes are improved.

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### Negotiating for comprehensive pain management in employee health insurance benefits and as part of an Employee Assistance Program is an essential first step for HR directors.

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The CPSMP developed at Stanford University is evidence-based and has proven that it neutralizes catastrophizing pain, leads to better outcomes, and minimizes disability. Even though these training approaches have proven efficacious for those living with chronic pain, a number of factors can impact sustainability of positive outcomes. Two key factors in patient-level successful adoption and continued use of the CPSMP include appropriate peer support and understanding and support by employers and others in the workplaces. The lack of both peer and workplace supports may cause those who participate in CPSMP to relapse or may decrease the long-term effectiveness of the training.

By including CPSMPs as an EAP option, employers can play a major role in adding quality to an employee's life, decrease both their absenteeism and presenteeism, and increase worker productivity. This sounds like a win all the way around!

The workplace is with fraught with potential obstacles—obstacles for the employer and the employee.

Chronic pain does not have to be one of them. 🌀

### NOTES

1. [https://iprcc.nih.gov/National\\_Pain\\_Strategy/NPS\\_Main.htm](https://iprcc.nih.gov/National_Pain_Strategy/NPS_Main.htm), last accessed Sept. 5, 2017.
2. <https://medlineplus.gov/magazine/issues/spring11/articles/spring11pg5-6.html>, last accessed Sept. 5, 2017.
3. <https://www.nap.edu/catalog/13172/relieving-pain-in-america-a-blueprint-for-transforming-prevention-care?gclid=CjwKCAjw8IXMRRB>

8EiwAg9fgMKnWlcQr34HMriPuPOyFQ0Fzmc8eAp3HbmcZwZWd29qstvbC4rVlkgxoCa2cQAvD\_BwE, last accessed Sept. 5, 2017.

4. <https://www.cdc.gov/drugoverdose/epidemic/index.html>, last accessed Sept. 5, 2017.

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# Attraction & Retention: Employer's Needs—Part I

BOBBI KLOSS

In today's workplace, there is a convergence of forces that are creating challenges to an employer's ability to attract and retain qualified employees. As we all know, employees are the lifeblood of any good company. Without them, a company simply does not exist. In fact, Sir Richard Branson, Founder of The Virgin Group has been quoted as saying, "Take care of your employees and they'll take care of your business."

But why does this matter? Because more than 70 percent of U.S. employees are disengaged, according to Gallup,<sup>1</sup> costing businesses up to \$550 billion in lost productivity per year while \$11 billion is lost annually to employee turnover. These figures should certainly perk up everyone in a human resources (HR) or management position.

This first part of a three-part series, looks at two key driving forces in today's workforce that are making it challenging for an employer to not only recruit top talent, but also to keep an employee engaged once they are hired. The first is the low unemployment rate and the second is the new majority generation in the workforce today: Millennials. It is estimated that 51 percent of Millennials are planning to leave their company in the next two years, compared to 37 percent of GenXers and 25 percent of Baby Boomers.

Throughout this series, a number of points will be explored and discussed fully, including the two primary conditions that exist today that can disrupt recruiting and retention management practices. Interestingly, when these practices operate simultaneously they can wreak havoc on an organization.

Another point that will be developed is the impact these two forces have on employers, as well as suggested ways that employers could be responding to this convergence.

Also to be discussed in this series will be how health and welfare advisors are positioned in today's market with a diversification of HR offerings to meet their clients' needs to respond to these challenges.

## THE CONVERGENCE OF FORCES

A key employment indicator for job growth and unemployment is found at the Bureau

of Labor Statistics (BLS), a division of the Department of Labor providing statistics in labor economics, showing employment growth, pay and benefits, and other economic labor data. Employers can use these statistics to see where the labor market is currently as well as determining trends. Statistics are available both nationally and statewide, and there is the ability to drill down into the information by market segments (that is, by local and industry, as well as see what the available workforce population looks like).

The BLS unemployment rate statistics, at least as of June 2017, indicate that we have had a declining unemployment rate. While slowly decreasing since its 10-year recession high of 10 percent in October 2009, it has reached a record 10-year low of 4.3 percent in May 2017. This means there are fewer people available for the open jobs.

BLS statistics also show that the available labor force is impacted not only by the population that is available to work but also by the population that is moving out of the labor force, such as baby boomers heading into retirement. According to Pew Research Center 10,000 boomers reach age 65 every day. While the Baby Boomers are moving out, the Millennials are moving in. In 2015, the Millennials moved full swing to become the largest generation in the workforce. By 2030, Millennials will make up 75 percent of the workforce.

Additional statistics that employers need to consider are focused on turnover, which has increased nearly 35 percent. Employees are averaging about four years at a given company, as reported by a recent Willis Towers and Watson Study. According to the Conference Board 2016 Job Satisfaction Survey only 49.6 percent of U.S. workers are satisfied with their jobs. The survey findings state "the rapidly declining unemployment rate, combined with increased hiring, job openings, and quits, signals a seller's market, where the employer demand for workers is growing faster than the available supply."

## WHAT DOES THIS MEAN FOR EMPLOYERS?

We have a tight labor market coupled with a new generation moving into the workforce.



The C-suite is asking HR for ways to remain relevant in order to attract top talent and keep employees at the organization in today's highly competitive market.

HR knows that individually employers cannot change a declining unemployment rate, but they can work with the challenges it brings in the competition for talented labor. Employers have to compete either locally, state-wide, or nationally for employees. Traditionally, they have offered an attractive compensation and benefits package to position themselves as an employer of choice.

Yet, employers today are finding that this way of operating is no longer effective. Salary and benefits do not seem to have the same draw that they used to for attracting top talent. A recent Korn-Ferry employer study found that while five years ago the benefits package was the carrot to hiring employees, today, company culture is the first draw for candidates. The second attraction for a candidate is career progression or the ability to move up in the company and the compensation package,

which used to be first priority among employees, is now third place in a candidate's priority.

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### Unlike previous generations, for Millennials, the job is just a job and a paycheck is just a paycheck.

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To clarify what we are seeing is that with Millennials entering the job force, they are bringing a new personality to attraction and retention. Unlike previous generations, for Millennials, the job is just a job and a paycheck is just a paycheck. The job is a stepping stone to advancing their career and a paycheck creates no sense of loyalty and definitely does not bind them to any organization. To engage Millennials, a successful opportunity sits within an organization that celebrates them as an employee *and* an individual.

For employers struggling with the challenge of a limited labor force, the

key to success will be in adapting to the needs of the new workforce generation, the Millennials. But for some employers, determining how to adapt may be easier said than done. This also might raise a variety of questions:

- What do you change;
- How much do you change;
- Where do you start; and
- How much is this likely to cost.

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This series will continue in upcoming issues of *Employee Benefit Plan Review*. 🌐

#### NOTE

1. <http://www.gallup.com/services/178514/state-american-workplace.aspx>, last accessed Sept. 5, 2017.

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## Fourth Circuit Upholds Claim Fiduciary's Interpretation of Suicide Exclusion in Case Stemming from Former Navy Seal's Death

The plaintiff's husband, a former Navy SEAL, had been deployed to Iraq, Afghanistan, and Kuwait. During that time, he was exposed to enemy gunfire and blasts from mortar fire. Upon retirement from the military, he was diagnosed with post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and chronic traumatic encephalopathy.

Despite seeking treatment, he was found dead in the driver's seat of his car with a gunshot wound to his head. The death was ruled a suicide. According to the plaintiff, during his military service, her husband had experienced sub-concussive blasts that had injured his brain and had impaired his ability to resist the impulse to kill himself. Thus, the plaintiff contended, he had not been sane at the time of his death.

At the time of his death, the plaintiff's husband was working for a company and participated in its employee benefit plan, which provided basic and supplemental life insurance through group policies funded and administered by Unum Life Insurance Company of America.

After her husband died, the plaintiff applied for benefits under both policies. Unum granted benefits under the basic policy, but denied benefits under the supplemental policy, based on the suicide exclusion in that policy.

The plaintiff sued Unum.

The U.S. District Court for the Eastern District of Virginia affirmed the denial of benefits and granted summary judgment to Unum. Applying the abuse of discretion standard of review, the district court first found the suicide exclusion valid. Then, the district court ruled that Unum had reasonably interpreted the plan term "suicide" to include sane and insane suicide and decided that Unum had substantial evidence to support its conclusion that the exclusion applied.

The plaintiff appealed to the U.S. Court of Appeals for the Fourth Circuit. First, she argued that the suicide exclusion in the supplemental life insurance policy violated Virginia

law prohibiting insurers from using suicide as a defense to the payment of life insurance benefits unless the insurer included "[a]n express provision ... limiting the liability of the insurer to an insured who, whether sane or insane, dies by his own act within two years from the date of the policy." According to the plaintiff, the absence of the phrase "whether sane or insane" in Unum's suicide exclusion nullified the exclusion.

The plaintiff also argued that, because the suicide exclusion in the Unum policy did not include a clause specifying that suicide could be "sane or insane," the exclusion did not apply to suicides committed by insane persons, such as her husband.

The Fourth Circuit affirmed the district court's decision in favor of Unum.

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### The Fourth Circuit affirmed the district court's decision in favor of Unum.

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In its decision, the circuit court ruled that Unum's exclusion sufficiently complied with Virginia law because a policy only had to provide "sufficient notice of an exclusion and its limit of two years to comply with the statute." A valid suicide exclusion did not need to use any "magic" words to comply with the Virginia law, the circuit court said.

The Fourth Circuit then rejected the plaintiff's other argument, deciding that it was not unreasonable for Unum to interpret "suicide" to mean any non-accidental, self-inflicted death. The circuit court said that because people could reasonably understand the term "suicide" to include any non-accidental, self-inflicted death regardless of mental state, it would "defer to Unum's interpretation."

The circuit court ruled that because Unum had reasonably interpreted the suicide exclusion to encompass insane suicide, whether the plaintiff's husband was sane at the time of his

death had no bearing on the outcome of the plaintiff's lawsuit. There was substantial evidence in the record to support Unum's conclusion that the suicide exclusion applied, the Fourth Circuit concluded. [*Collins v. Unum Life Ins. Co. of America*, 2017 U.S. App. Lexis 12060 (4th Cir. July 6, 2017).]

## California Federal Court Permits Plaintiff in ERISA Suit to Proceed Under a Pseudonym

The plaintiff in this case, appearing anonymously as John Doe, filed a lawsuit against Lincoln National Life Insurance Company alleging violations of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, the plaintiff alleged that, since June 12, 2013, he had been disabled, as defined under the Marin Individual Practice Association Long Term Disability Plan, due to "multiple serious physical health problems, including HIV and HIV associated neurocognitive decline," yet Lincoln National had terminated his claims under the plan effective September 9, 2015.

Concurrently with the filing of his complaint, the plaintiff filed an *ex parte* motion seeking leave from the district court to proceed under a pseudonym due to the sensitive and confidential nature of his HIV and psychiatric health issues.

The district court granted the plaintiff's motion to proceed under a pseudonym.

In its decision, the district court explained that a party may preserve his or her anonymity in judicial

proceedings in special circumstances when the party's need for anonymity outweighed prejudice to the opposing party and the public's interest in knowing the party's identity. Simply put, the district court added, courts had to weigh the party's need for anonymity against the risk of prejudice to the defendant and the public's interest in the case.

Here, the district court observed, the plaintiff feared that proceeding under his true name would expose him to harassment, embarrassment, and discrimination. The district court noted that the plaintiff represented that he had "maintained the confidentiality of his HIV and psychiatric health issues," except to a limited circle of family, friends, medical personnel, and insurers.

The district court acknowledged that public discourse, understanding, and acceptance of these issues had improved in recent years, but said that it recognized that society continued to place "at least some stigma on those diagnosed with HIV," and fear of negative treatment due to HIV remained "reasonable and understandable." Moreover, the district court added, the plaintiff's decision to maintain the confidentiality of his status implicated "significant privacy concerns" that demonstrated the plaintiff's need for anonymity.

Next, the district court found that no prejudice to Lincoln National existed at this point of the litigation, reasoning that the plaintiff had provided sufficient information in the complaint, such as his claim number and the dates of his communications with Lincoln National, to allow Lincoln National to ascertain his identity. Therefore, the district court said, Lincoln National had no need for the plaintiff to disclose his identity in a public forum.

The district court, noting that Lincoln National had not yet been served and, therefore, had not had the opportunity to respond to the plaintiff's motion, added that if Lincoln National could identify any prejudice that would attach as a

result of the plaintiff's prosecution of this action anonymously, it could raise that so that the district court could evaluate the propriety of continuing to allow the action to proceed anonymously or whether any prejudice could be mitigated.

Finally, the district court decided that the public interest was not advanced by publication of the plaintiff's identity. It found that the public did not need to know the plaintiff's real name to understand the nature of his claims or the legal proceedings in this action. Rather, the district court concluded, the public interest was "better served" by allowing the plaintiff to advance anonymously, rather than subject him to the uncomfortable position either of dismissing what might be legitimate claims or publicly disclosing highly confidential medical information that could "place him in harm's way." [*Doe v. Lincoln National Life Ins. Co.*, 2017 U.S. Dist. Lexis 117110 (N.D. Cal. July 26, 2017).]

## Eighth Circuit Upholds Plan Administrator's Interpretation of Ambiguous Language in Accident Insurance Policy

While the plaintiff's husband was on his delivery route, driving his employer's truck, the truck was struck by an oncoming vehicle that crossed the center divider. The plaintiff's husband died on impact.

The plaintiff filed a claim for accidental death and spousal benefits under a blanket accident insurance policy that had been issued to her husband's employer by National Union Fire Insurance Company of Pittsburgh, Pennsylvania. The policy was governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The insurer denied the claim pursuant to a policy provision that excluded coverage if the insured "was operating a conveyance he had been hired to operate." It reasoned that because the plaintiff's husband had been hired to operate the conveyance he was driving and because he was operating it at the time of the accident, the exception to coverage applied and there was no coverage.

For her part, the plaintiff argued that coverage was required because her husband died as a result of being struck by a conveyance that he had not been hired to operate and that he was not operating at the time of the accident.

The plaintiff sued and, applying the abuse of discretion standard of review, the U.S. District Court for the Eastern District of Arkansas upheld National Union's denial of benefits and dismissed the complaint.

The plaintiff appealed to the U.S. Court of Appeals for the Eighth Circuit, which affirmed.

In its decision, the Eighth Circuit noted that, at the time of the accident, the plaintiff's husband was operating one conveyance and was struck by another one. It then ruled that the exception in the National Union policy was "ambiguous" because it was not clear whether the conveyance it referred to that precluded coverage was the one operated by the plaintiff's husband or the one that struck him. The circuit court explained that when, as here, the terms of a plan were susceptible to multiple, reasonable interpretations, an administrator's choice among the reasonable interpretations was not an abuse of discretion.

The circuit court then held that although the plaintiff's interpretation of the policy was a reasonable one, National Union's interpretation was equally reasonable. The circuit court deferred to National Union's interpretation, concluding that it had not abused its discretion in denying the plaintiff's claims for accidental death and spousal benefits. [*Donaldson v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2017 U.S. App. Lexis 13258 (8th Cir. July 24, 2017).]

## Court Rejects Mental Health Parity Act Claim Stemming from Denial of Coverage for Therapeutic Wilderness Program

The plaintiff in this case, a full-time employee of NextEra Energy, Inc., and a participant in its employee health plan, said that his son, who was covered by the plan as a beneficiary, had suffered from "mental health issues" including "depression, low self-esteem, suicidal ideation, and drug use." The plaintiff added that his son's therapist had recommended that his son be treated in an intensive, in-patient setting and that the plaintiff and his spouse had chosen to send their son to a wilderness program in Utah that the plaintiff characterized as a mental health service provider.

The plaintiff's application for the program to be covered under the NextEra health plan was denied and Cigna Health and Life Insurance Company, the plan's claims

administrator, upheld the denial following the plaintiff's internal appeal. According to the plaintiff, the denial was "based exclusively on the plan's exclusion for all wilderness-related treatment without regard to the services' medical necessity."

The plaintiff sued Cigna under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act), which is incorporated in the Employee Retirement Income Security Act of 1974 (ERISA). He argued that, by categorically refusing to cover therapeutic wilderness programs, Cigna dismissed out of hand their "individual *bona fides*" or the "individual medical needs of [] particular insured[s]," while a plan compliant with the Parity Act would evaluate these factors case-by-case.

Cigna moved to dismiss, and the U.S. District Court for the Southern District of Florida granted Cigna's motion.

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**The district court then decided that the plaintiff's argument was "not persuasive."**

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In its decision, the district court explained that Congress had enacted the Parity Act "to end discrimination in the provision of insurance coverage for mental health and substance use disorders as compared to coverage for medical and surgical conditions in employer-sponsored group health plans." The Parity Act imposes liability on group insurance plans that institute treatment limitations that are "more restrictive" on "mental health or substance use disorder benefits" "than the predominant treatment limitations applied to substantially all [covered] medical and surgical benefits" or that are separately "applicable only with respect to mental health or substance use disorder benefits."

The district court then decided that the plaintiff's argument was "not persuasive." It said that he mischaracterized what undisputed documents showed to be "a mere application of generalized criteria" as, instead, a "blanket exclusion for services at wilderness treatment centers." According to the district court, neither the summary plan description (SPD) nor Cigna's standards contained any terms that limited coverage of a residential program *because* it was conducted in the wilderness. Rather, the district court added, under the heading "Mental Health and Substance Abuse," the SPD stated, in part, that "[c]overage under the [p]lan for treatment of mental health and substance abuse is essentially the same as coverage for physical illnesses and injuries under the medical plan." The district court said that this principle was "entirely consistent with the Parity Act."

The district court pointed out that Cigna indeed excluded coverage for wilderness programs, but the district court determined that it was not because of their location. The district court said that, instead, Cigna applied certain broader criteria to deny coverage for wilderness programs. Among the criteria that wilderness programs did not meet were the requirements that they provide a multidisciplinary team and consistent supervision by licensed professionals.

The district court further observed that the Parity Act targeted limitations that discriminated against mental health and substance abuse treatments *in comparison* to medical or surgical treatments, and that the plaintiff's claim did not allege such a comparison but, rather, considered wilderness programs "in isolation" and rested on the fact that coverage for a mental health treatment was sought and denied. In ruling that the plaintiff had not stated a valid claim for relief under the Parity Act, the district court concluded that, if the plaintiff's allegations adequately stated a claim under the Parity Act, then a violation of the Parity Act

would occur whenever a plan denied coverage for *any* mental health or substance abuse treatment, regardless of the plan's terms. [*Welp v. Cigna Health and Life Ins. Co.*, 2017 U.S. Dist. Lexis 113719 (S.D. Fla. July 20, 2017).]

## Successful ERISA Plaintiff Is Awarded His Attorneys' Fees

**T**he plaintiff in this case worked as a full-time controller for the Renaissance Insurance Agency from November 3, 2008 to May 18, 2011. On January 6, 2011, the plaintiff injured his back lifting a backup power supply while at work. He was diagnosed with a lumbar region sprain, muscle spasms, and sciatica, and he stopped working on May 18, 2011.

As a Renaissance employee, the plaintiff was insured under a group long-term disability policy issued by Northwestern Mutual Life Insurance Company. The plaintiff submitted a claim on July 15, 2011, reporting that his back injury prevented him "from sitting, standing, walking, driving, and concentrating for prolonged periods of time without experiencing a lot of pain &/or difficulty."

Between September 2011 and January 2012, the plaintiff continued to visit chiropractors, pain specialists, and physicians, all of whom confirmed that the plaintiff's disability precluded him from working. On January 16, 2012, another chiropractor indicated that the plaintiff was limited to sitting for four hours a day and to standing and walking for two hours a day, but believed that the plaintiff's condition would improve and that he could return to work on July 6, 2012. Based on these medical records,

Northwestern's reviewing physician determined that the plaintiff was capable of working in a sedentary position.

By letter dated July 9, 2013, Northwestern informed the plaintiff that his LTD claim was being closed because his records did not support a disability under the "own occupation" or "any occupation" test. The plaintiff appealed the decision and asked for review by a second doctor. After being assigned to review the plaintiff's records, another physician also found that the records "[did] not support that [the plaintiff] would be precluded from sedentary-level work."

Northwestern informed the plaintiff that it was upholding its claim decision, and he sued the insurer under the Employee Retirement Income Security Act of 1974 (ERISA).

Following a bench trial, the U.S. District Court for the Central District of California awarded the plaintiff benefits for the remainder of the first 24 months of his disability under the plan—nine days total—but also found that the plaintiff had failed to show by a preponderance of the evidence that he was disabled from "all occupations" after July 18, 2013.

The plaintiff appealed to the U.S. Court of Appeals for the Ninth Circuit, which vacated the part of the district court judgment denying the plaintiff his long-term disability benefits and remanded the case for further proceedings. The district court then entered judgment for the plaintiff, and he asked the district court to award attorneys' fees.

The district court granted the plaintiff's request.

In its decision, the district court explained that, in any action brought by a plan participant, beneficiary, or fiduciary under ERISA, the court in its discretion may allow a reasonable attorneys' fee to either party. The district court added that a successful ERISA participant who prevailed in a lawsuit to enforce rights under the plan "ordinarily" should recover an attorneys' fee unless special

circumstances would render such an award unjust.

The district court then decided that the plaintiff was entitled to his attorneys' fees, even though Northwestern had not acted in bad faith in denying the plaintiff's claim.

In determining the amount of attorneys' fees the plaintiff was entitled to receive, the district court presumed that the lodestar figure—the plaintiff's lawyers' reasonable hourly rate multiplied by the reasonable hours they expended on his behalf—represented a reasonable fee.

It noted that:

- The plaintiff's lead counsel requested an hourly rate of \$675 for 144.5 hours he spent on the case;
- The plaintiff's lead counsel said that he spent an additional four hours reviewing and responding to Northwestern's opposition to the plaintiff's fee request; and
- Another of the plaintiff's attorneys requested an hourly rate of \$450 per hour for 3.8 hours he spent on the case.

The district court then ruled that the hourly rates of \$675 and \$450 were reasonable because they reflected the "prevailing market rate in this community for [the lawyers'] levels of experience."

The district court also found that the 144.5 hours and 3.8 hours the plaintiffs' two lawyers spent preparing for and litigating the case were "reasonable." The lawyers' time sheets did "not appear to be excessive, redundant, nor otherwise unnecessary" and were "not duplicative."

The district court next decided that four hours was reasonable for reviewing Northwestern's opposition to the plaintiff's fee request. The district court concluded that the plaintiff's lead counsel should be compensated using the hourly rate of \$675 per hour multiplied by the 148.5 hours he spent working on the case, for a total fee of \$100,237.50. The district court

awarded the plaintiff's other lawyer \$1,710 (\$450 per hour times 3.8 hours).

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### Lastly, the district court ruled that prejudgment interest should be added to the benefits owed to the plaintiff.

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Lastly, the district court ruled that prejudgment interest should be added to the benefits owed to the plaintiff, at a rate equal to the average one-year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System for the calendar week preceding the due date of any past due benefit payment, compounded annually. [*Armani v. Northwestern Mutual Life Ins. Co.*, 2017 U.S. Dist. Lexis 117203 (C.D. Cal. July 24, 2017).]

## Sixth Circuit Upholds Decision Limiting Long-Term Disability Benefits When Disability Stemmed from Abuse of Opioids Taken Pursuant to Prescription

**T**he plaintiff in this case received long-term disability benefits on the basis of her treating rheumatologist's diagnosis of pain, fatigue, and

cognitive problems associated with lupus and fibromyalgia. However, subsequent treating physicians and independent medical experts expressed doubt over the initial diagnosis and opinion, instead attributing the plaintiff's disabling fatigue and cognitive problems to her "massive" prescription opioid regimen for lupus and fibromyalgia.

On the basis of these later medical opinions, plan administrator United of Omaha Life Insurance Company determined that the plaintiff was disabled due only to the effects of her opioid regimen—not lupus and fibromyalgia—and invoked a provision in the long-term disability plan that limited benefits to 24 months when the disability was due to "substance abuse," defined as "any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a mental disorder."

Within 24 months, the plaintiff exhausted all of her administrative remedies within United of Omaha's claims and appeals procedures and her benefits were terminated.

The plaintiff then brought suit in the U.S. District Court for the Middle District of Tennessee under the Employee Retirement Income Security Act of 1974 (ERISA). She contended that the plan language did not apply in the case of opioids taken pursuant to a doctor's prescription.

The district court granted United of Omaha's motion for judgment on the administrative record, reasoning that there was substantial evidence to support United of Omaha's determination that the plaintiff was disabled due to her opioid regimen, and that it was neither arbitrary nor capricious for United of Omaha to invoke the 24-month substance abuse limitation in the plan once it determined that her disability was due to her opioid regimen.

The plaintiff appealed to the U.S. Court of Appeals for the Sixth Circuit.

The circuit court affirmed the district court's decision, concluding that it had properly determined that United of Omaha had not abused its discretion in interpreting the plan language. [*Blount v. United of Omaha Life Ins. Co.*, 2017 U.S. App. Lexis 11779 (6th Cir. June 30, 2017).] 🌐

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## Benefit Issues Impacting Older Workers

**M**en and women in the United States are delaying retirement or re-entering the workforce after normal retirement age in increasing numbers. According to a Pew Research Center report, the number of Americans over age 65 who are employed rose from 12.8 percent in May 2000 to 18.8 percent in May 2016.<sup>1</sup> The Pew Research Center report also notes that older workers are working longer hours. In May 2000, 46.1 percent of workers age 65 and older were working part-time (less than 35 hours a week as defined by the Bureau of Labor Statistics). By May 2016, only 36.1 percent of workers age 65 and older were working part-time.<sup>2</sup>

There are a number of factors that may be driving this trend, including improved life expectancies and quality of life, the increase in the Social Security normal retirement age, the elimination of employer-provided retiree medical benefits, and uncertainty regarding the solvency of government retirement programs, such as Social Security and Medicare.

Regardless of the reason, the increased presence of older Americans in the workforce has created a number of interesting benefit issues for employers with respect to retirement and medical plans.

### DEFINED BENEFIT PLANS

#### Separation from Service

Qualified defined benefit plans, commonly known as pension plans, typically require a separation from service on or after retirement age (normal or early) for benefits to commence. Issues often arise with respect to older workers who want to both start their pension benefits and continue working. An example is an employee whose current plan benefit is not sufficient to support the employee and spouse. The employee may ask the employer to “retire” with the understanding that the employee will resume part-time employment after a specified period of absence.

Such a fact pattern may put the defined benefit plan at risk of disqualification by the Internal Revenue Service (IRS). Even if the employee is processed as a retiree on the employer’s payroll system and coded as a new employee upon the scheduled return, in the

event of a plan audit, the IRS may take the position that no separation from service has occurred and that the plan administrator has failed to follow the terms of a plan. Although such a failure is grounds for disqualification of the plan, the IRS will typically impose penalties in lieu of such drastic action. If there is such a prearranged plan for the employee to return to employment after “retirement,” it does not matter whether the gap period is one day or six months.

If a retired employee returns to employment without a prearrangement between the employee and employer, there is no issue. For example, if a retiree is brought back to work after the replacement unexpectedly resigns, there is no qualification issue. However, in such a case, it is advisable to document the facts and circumstances with respect to the rehired employee, in case the termination is questioned by the IRS in an audit.

#### In-Service Distributions

To avoid the separation from service issue, some defined benefit plans have been amended to include a provision permitting the distribution of plan benefits while an older employee is still working. Such distributions are commonly referred to as “in-service distributions.”

The Pension Protection Act of 2006 revised the Internal Revenue Code to permit in-service distributions at age 62. However, before adopting such a provision, a plan sponsor must weigh the possible adverse impact on the workforce.

For example, such a provision could create an incentive for an older worker to start benefits early, creating the possibility that the worker will have insufficient income for support throughout the retirement years. Such a provision could also encourage an older worker to switch from a full-time schedule to part-time work, allowing the participant to supplement retirement benefits with part-time earnings.

The result could wreak havoc on an employer’s workforce.

#### Suspension of Benefits

Another possible issue with rehiring older employees involves the suspension of benefits. ERISA permits, but does not require, a defined



benefit plan to suspend the payment of retirement benefits if a retiree continues to work beyond normal retirement age or is rehired after a *bona fide* retirement. If a defined benefit plan includes a suspension of benefits provision and benefits are suspended, the participant is not entitled to any adjustment of the retirement benefit for the “missed” benefit payments during the period of reemployment (or continued employment beyond normal retirement age). However, ERISA prohibits a suspension of benefits if a participant works fewer than 40 hours per month. ERISA also requires that a notice be provided to a participant prior to the suspension of benefits.

### Recalculation of Accrued Benefits

When a retiree is rehired, the plan administrator must consider the impact on the participant’s accrued benefit. Most defined benefit plans require 1,000 hours of service during a plan year for the accrual of benefits for such plan year. If a rehired employee works more than 1,000 hours during the plan year, additional actuarial services will be required to recalculate the employee’s benefits when the employee again retires. It will be important to review the provisions of the plan so that benefits are accurately calculated for rehired employees. In some cases, it may be possible for the plan sponsor to regulate a participant’s hours to avoid this issue.

### DEFINED CONTRIBUTION PLANS

Fewer issues arise if an employer maintains a defined contribution plan, such as a 401(k) plan, and an older worker continues employment beyond normal retirement age or is reemployed by the employer.

### Separation from Service

Section 401(k)(2)(B) of the Internal Revenue Code provides that salary deferral contributions under a 401(k) plan can only be distributed to a participant upon death,

disability, hardship, separation from service, or attainment of age 59½.

Thus, as with defined benefit plans, an issue arises if an older worker terminates and is immediately rehired or rehired within a prearranged period. The IRS may argue that no separation from service has occurred and that distributions have been improperly made from the 401(k) plan, risking disqualification of the plan.

### MEDICAL PLANS

#### Medicare Penalty

Generally, a Medicare penalty applies if an individual does not apply for Medicare coverage at age 65. However, the Medicare penalty will not apply if an individual fails to apply for Medicare because the individual is covered under the employer’s medical plan. Similarly, the Medicare penalty will not apply if an individual fails to apply for Medicare because the individual is covered under the spouse’s medical plan. These exceptions apply only if an individual is covered under an employer’s medical plan due to the active employment of the individual or the spouse.

Thus, these exceptions do not apply if an individual fails to apply for Medicare because the individual is covered under a retiree medical plan maintained by a former employer.

#### Medicare Secondary Payer Rules

The impact of the Medicare Secondary Payer Rules on older employees depends on the size of the employer.

Generally, the Medicare secondary payer rules prohibit an employer from reducing health benefits offered to current employees due to their eligibility for Medicare based on age. Provided the employer has 20 or more employees, the employer medical plan is the primary payer and Medicare is the secondary payer. However, if the employer has

fewer than 20 employees, Medicare will be the primary payer and the employer medical plan is the secondary payer with respect to medical claims made by Medicare-eligible employees.

#### Medicare and Retiree Medical Plans

The Medicare Secondary Payer Rules only apply to medical plan coverage for active employees. Thus, in the case of employer-provided retiree medical plans, Medicare is the primary payer for Medicare-eligible retirees and the employer’s retiree medical plan is secondary. Given this fact, there are several ways that retiree medical plans can coordinate with Medicare.

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### The Medicare Secondary Payer Rules only apply to medical plan coverage for active employees.

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For example, a retiree medical plan can be designed as a bridge plan that provides medical coverage from the time an employee retires until the employee becomes eligible for Medicare.

Alternatively, a retiree medical plan can be designed as a supplemental plan that provides retirees with coverage for out-of-pocket expenses not otherwise covered by Medicare, including the cost of co-insurance and deductibles.

#### Medicare and COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires continued medical plan coverage for a specified period after an employee terminates employment. The period of COBRA coverage can be shortened due to certain events such as becoming entitled to Medicare depending on when the terminated employee first became

entitled to Medicare. If an employee first becomes entitled to Medicare before termination of employment, then Medicare coverage will not shorten the period of COBRA coverage. However, if the employee first becomes entitled to Medicare after termination of employment, COBRA coverage will cease as of the effective date of Medicare coverage. For this purpose, Medicare “entitlement” is defined as eligibility plus Medicare enrollment.

### Medicare and Health Savings Accounts

If an employee participates in a high-deductible medical plan with a health savings account (HSA), neither the employee nor the employer is permitted to make additional contributions to the HSA after the employee begins any type of Medicare coverage. Once an employee begins to receive

Social Security retirement benefits, the employee will automatically be enrolled in Medicare Part A coverage at age 65. Thus, if an employee wants to continue to contribute to an HSA, he must forgo Social Security benefits.

### AGE DISCRIMINATION IN EMPLOYMENT ACT

The Age Discrimination in Employment Act (ADEA) provides that an employer may not deny the opportunity to participate in benefit plans because of age. Under ADEA, an employer may not reduce a benefit due to age unless the cost of the benefit increases with age. An example is life insurance. An employer will not violate ADEA if it spends the same per-employee amount on life insurance for older and younger workers even though the level of life insurance coverage provided to older employees is lower.

This list of issues is not intended to be exhaustive. However, it does reflect some of the additional considerations that an employer may encounter in designing benefits for older workers. 🌟

### NOTES

1. DeSilver, Drew, *More older Americans are working, and working more, than they used to*, The Pew Research Center (June 20, 2016).
2. *Id.*

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