Proskauer

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A report to clients and friends of the firm

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Editor's Overview

The employee benefits issues to be considered by the U.S. Supreme Court continue to be of great significance to plan sponsors and fiduciaries. This month we review the Court's employee benefit decisions from 2013 and also take a look at what is to come in 2014.

As always, please be sure to review the Rulings, Filings and Settlements section for last month's highlights in the areas of health care reform, PBGC premiums, ERISA stock-drop litigation, contractual limitations periods, and appellate procedure.

A Retroactive and Prospective Review of US Supreme Court Employee Benefits Decisions*

By Russell L. Hirschhorn

Having settled into the new year, we reflect on decisions from the US Supreme Court in 2013 that are likely to have a significant impact in the world of pension and welfare employee benefits and, in some cases, already have had such an impact. The issues addressed by the Supreme Court are wide-ranging and are both substantive and procedural. They include same sex marriage benefits, welfare plan reimbursement provisions, statute of limitations and class certification. Looking ahead into 2014, we see that the Supreme Court already has agreed to decide several significant benefits issues, including issues pertaining to ERISA stock-drop litigation, the so-called contraceptive mandate under the Affordable Care Act, and whether FICA applies to reduction-in-force

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related severance pay. A more complete analysis of the issues discussed below can be found on Proskauer's blog, www.erisapracticecenter.com.

2013 Supreme Court Decisions

Section 3 of DOMA Unconstitutional

By now, it is well known that the Supreme Court ruled unconstitutional the section of the Defense of Marriage Act that defined "marriage" and "spouse" as excluding same-sex partners on the ground that it violated the Equal Protection Clause. *United States v. Windsor*, 133 S. Ct. 2675 (2013). As a result, same-sex marriages will be recognized for purposes of federal laws, protections, and obligations. Since the Court's ruling, the IRS and DOL have both adopted a "place of celebration" rule, meaning that same-sex couple legally married in any jurisdiction will be recognized as spouses for federal tax purposes even if the couple resides in a jurisdiction that does not recognize the validity of their marriage. This "place of celebration" rule is welcome news for plan sponsors who may now administer their benefit plans in a uniform manner with regard to covered same- and opposite-sex married couples.

Welfare Plan Reimbursement Clauses

For years, health plan sponsors and administrators had grappled with confusing and inconsistent rulings regarding their right to enforce plan reimbursement provisions in the face of common and state law equitable defenses. The reimbursement provisions typically are designed to enable a plan to recover previously paid medical benefits when the participant receives a recovery from another source, such as a person responsible for a participant's injury or illness. In *US Airways, Inc. v. McCutchen*, 133 S.Ct. 1537 (2013), the Supreme Court resolved much of this confusion by ruling that the terms of a plan's reimbursement provision, if clearly written, will trump competing equitable defenses. The Court left room for application of equitable defenses, however, as a means to interpret ambiguous plan reimbursement provisions. As a result of the Court's ruling, a properly drafted a reimbursement clause should allow a plan to recover the full amount of the medical costs it paid without qualification.

Statute of Limitations

In another case involving an employee welfare plan, the Supreme Court held that a contractual limitations clause that governs the length of the limitations period as well as when it begins is enforceable as long as the limitations period is reasonable and there is no controlling statute to the contrary. *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S.Ct. 604 (2013). As a result of the Court's ruling, employers should consider including in their plans reasonably crafted limitations periods for bringing claims, as well as rules concerning the accrual of claims, and then publishing such provisions in benefit statements and summary plan descriptions. These provisions may prove particularly effective for limiting exposure to claims for pension benefits, which are frequently brought long after participants retire, by which time relevant evidence may no longer be readily retrievable.

Class Certification

The Supreme Court ruled in *Comcast Corp. v. Behrend*, 133 S.Ct. 1426 (2013) that, in order to obtain class certification, plaintiffs carry the burden of establishing not only that they have proof of classwide liability, but also that their potential damages are tied to their theory of liability and are capable of classwide proof. Although Comcast was an antitrust lawsuit, it is likely to have an impact on class certification proceedings across all disciplines, including claims under ERISA. At a minimum, the Supreme Court's ruling should make considerations of damages a component of the class certification analysis. This alone represents a considerable departure from the approaches of many lower courts, which have tended to focus exclusively on liability issues when addressing a class certification motion.

Supreme Court Decisions Expected by June 2014

Presumption of Prudence in Employer Stock Litigation

Over the past two decades, participants in 401(k) plans and employee stock ownership plans (ESOPs) have increased the frequency in which they have mounted challenges to plan fiduciaries' decisions to continue allowing investment in an employer stock fund. The complaints in these cases generally contain two principle claims—a claim that the plan fiduciaries breached their fiduciary duties by: maintaining an employer stock fund when was imprudent to do so, and making misrepresentations and/or failing to disclose material information about the risks associated with investment in an employer stock fund. With respect to the first claim, all circuit courts to have considered the issue, have applied a presumption of prudence with respect to the decision to continue allowing investment in an employer stock fund. The circuit courts are not, however, in agreement as to the types of allegations needed to rebut the presumption and whether the presumption should be applied at the motion to dismiss stage. The Supreme Court recently agreed to address the latter issue, and it is expected that, in so doing, it will conduct a more fulsome evaluation of the presumption itself. *Fifth Third Bancorp v. Dudenhoeffer* (U.S. No. 12-751).

Contraceptive Mandate

The Supreme Court agreed to review two of the numerous lawsuits challenging the Affordable Care Act's requirement that group health plans and insurers cover, without cost-sharing, contraceptives and/or abortifacients. The plaintiffs in these suits are secular, for-profit corporations and their owners, who assert that being forced to comply with the Contraceptive Mandate would violate both their First Amendment religious rights and the Religious Freedoms Restoration Act. All courts addressing the various contraceptive mandate suits have struggled with the issue. Over the past year, a circuit split developed: some circuits adopted a "pass through" theory that allowed corporations to assert the free exercise rights of their owners, and held that the contraceptive mandate places a substantial burden on their religious freedoms. Other circuits, in contrast, have rejected the argument that secular, for-profit corporations are protected by the free exercise clause, and have held that the owners are not burdened by the mandate, since it is the corporation, not the owners, who would be funding this coverage. *Sebelius*

v. Hobby Lobby Stores and *Conestoga Wood Specialties Corp. v. Sebelius* (U.S. No. 13-354, 13-356).

Applicability of FICA to RIF-Related Severance Pay

It is anticipated that the Supreme Court will once and for all put to rest the question of whether severance payments made to former employees pursuant to an involuntary reduction-in-force are wages for the purposes of Social Security and Medicare withholding under FICA. *United States v. Quality Stores, Inc.* (U.S. No. 12-1408). The issue has become particularly relevant given the increase in workforce reductions over the past several years. The Supreme Court's decision to consider the issue provides a reminder to employers to consider filing protective refund claims to preserve their rights and prevent the statute of limitations from expiring on tax refund claims for still open years.

The View From Proskauer

While it will take time for the full impact of last year's Supreme Court's decisions to be seen, some of the Court's rulings should provide plan sponsors and fiduciaries with additional mechanisms for prosecuting and defending lawsuits on behalf of plans. Depending on the outcome of some of this year's rulings, however, we could see an expansion of claims and legal exposure in certain areas.

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Rulings, Filings, and Settlements of Interest

U.S. Supreme Court: A Decision on the Merits Triggers the Time to Appeal Irrespective of a Pending Contractual or Statutory Attorneys' Fee Application

By Todd Mobley

> The U.S. Supreme Court ruled in a unanimous opinion that an unresolved claim for attorney's fees does not prevent a decision on the merits of an ERISA suit from becoming final for purposes of the deadline to file a notice of appeal to a federal appellate court. *Ray Haluch Gravel Co. v. Cent. Pension Fund of Operating Eng'rs*, No. 12-992, 2014 U.S. LEXIS 646. In so ruling, the Court resolved a split among the circuit courts as to whether an appeal of a decision on the merits should proceed before there has been a final ruling on a corollary application for attorneys' fees, and whether the resolution of that

issue should depend on whether the claim for attorneys' fees was based on contract or statute.

In the case before the Court, several multiemployer employee benefits funds affiliated with the International Union of Operating Engineers, Local 98 (the "Funds") commenced a suit under ERISA seeking payment of delinquent contributions from Ray Haluch Gravel Co. (the "Company"). The Funds also sought attorney's fees and costs pursuant to the applicable collective bargaining agreement and ERISA. On the merits, the district court ruled that the Funds were entitled to some, but not all, of the unpaid contributions. About one month later, the district court awarded attorney's fees (also in an amount less than that sought by the Funds). The Funds appealed from both decisions within thirty days of the district court's ruling on attorney's fees, thereby calling into question whether the appeal was still timely as to the ruling on the underlying merits.

The First Circuit determined that the appeal was timely. While acknowledging the general rule that an unresolved issue of fees does not prevent a decision on the merits from being final, the First Circuit found that the matter before it constituted an exception—here, the issue of attorney's fees was part of the merits, because the CBA provided for the payment of such fees "as an element of damages in the event of a breach."

The Supreme Court reversed and found the appeal was untimely. It concluded that considerations of consistency and predictability required that the general rule apply regardless of whether the entitlement to fees is asserted under a statute or contract. It also was of the view that the Funds' attempt to carve-out an exception to the general rule for "fee claims authorized by contract" was an attempt to relitigate an issue that it had already decided nearly thirty years ago in *Budinich v. Becton Dickinson & Co.*, 486 U.S. 196 (1988). There, the Court held that a decision on the merits is final for the purposes of appeal notwithstanding that fact that the issue of attorney's fees remains to be determined.

Although the underlying claims in the case arose under ERISA, litigants across all disciplines ought to take comfort from the Supreme Court's decision to create a clear rule concerning the time to appeal a decision on the merits.

Departments Release New FAQ Guidance on ACA and MHPAEA Implementation Issues

By Stacy Barrow

> On January 9, 2014, the Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") published the eighteenth installment of a series of answers to Frequently Asked Questions regarding implementation of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The FAQ provides guidance on a number of issues, including new recommendations made by the U.S. Preventive Services Task Force and how they affect the ACA's preventive care requirement, limits on participant cost-sharing (i.e., out-of-pocket limits), expatriate health plans, wellness programs, fixed-indemnity insurance, and guidance on the ACA's impact on the MHPAEA.

The FAQ generally confirms previous Department guidance on the issues addressed and does not significantly change the application of these rules and mandates to employer-sponsored group health plans. We will release additional commentary specific to key areas addressed in the FAQ in the coming days. In the meantime, the FAQ, along with others in the series, can be found here.

Recent Guidance on Fixed Indemnity Plans—FAQ's Relax Standards

By Peter Marathas

> As previously reported, the federal agencies responsible for drafting the rules implementing the Affordable Care Act (ACA) (the U.S. Labor Department, the U.S. Department of Health and Human Services and the U.S. Treasury Department (together, the "Departments")) on January 9, 2014 issued FAQ Part XVIII, regarding implementation of the market reform provisions of the ACA.

These FAQs are part of the government's efforts to provide so-called "subregulatory guidance," to provide relatively quick helpful guidance in response to issues and trends affecting group health plans and insurers. FAQ Part XVIII includes new relaxed rules for fixed indemnity plans that meet certain key requirements. A fixed indemnity plan generally pays a fixed dollar amount upon the occurrence of a covered illness or injury, rather than an amount based on expenses actually incurred by the individual. For example, it might pay $100 upon admission to a hospital for particular treatments. These fixed indemnity plans can be designed to fit within the category of "excepted benefits" that are generally exempt from many of the market reform requirements of the ACA.

In an earlier FAQ, FAQ Part XI, the Departments had indicated that a fixed indemnity plan could not pay on a "per-service basis." Instead, it would have to pay benefits on a "per-period basis." For example, if an individual was injured, the preferred way to pay the benefit was to pay a certain amount per day regardless of the services provided as opposed to reimbursing different amounts for different services. By contrast, a plan that covers doctors' visits at $50 per visit, surgical procedures at $75 per procedure, or prescription drugs at $15 per prescription would not be considered to be a fixed indemnity plan under FAQ Part XI (and would not be an excepted benefit) because the payments would be provided on a per-service basis.

In the new FAQ Part XVIII, the Departments have signaled a change in course: they are considering drafting regulations that permit a fixed indemnity

plan to reimburse on a per-service basis and still be considered excepted benefits if the plan:

- Is sold only to individuals who have other health coverage that is minimum essential coverage;
- Does not coordinate between the provision of benefits and an exclusion of benefits under any other health coverage;
- Pays benefits in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and
- Includes a prominently displayed notice informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual mandate.

Until the regulations are written, the Departments have indicated that fixed indemnity plans that pay on a per-service basis will continue to be considered to be excepted benefits as long as the requirements described above are met.

New FAQs on ACA Extend Fully-Insured Expatriate Health Plan Transitional Relief by "At Least" Another Plan Year and Clarify Scope, 6-Month Requirement

By Tzvia Feiertag

- As reported, the U.S. Labor Department, the U.S. Department of Health and Human Services and the U.S. Treasury Department (together, the "Departments") recently issued additional FAQs regarding implementation of the market reform provisions of the Affordable Care Act (ACA). FAQs 6 and 7 include new guidance on the temporary transitional relief issued last year (discussed in our blog post) that applies to plan sponsors of certain insured expatriate health plans and provides a broad exemption from most of ACA's market reform requirements.

  Highlights from the new guidance include:

  - *Transitional Relief Extended by "At Least" Another Plan Year*

    The FAQ provides that plans and insurers may rely on the temporary transitional relief at least through plan years ending on or before December 31, 2016 (i.e., 2014 through 2016 for calendar year plans). This effectively extends the transition relief by at least one plan year. Although the transitional relief was not extended indefinitely, it at least eliminates any concern for a while and may be a signal that the Departments intend eventually to make the relief permanent.

- *6-Month Requirement Applies on a Rolling Basis to Expatriates Residing Outside of Their Home Country or the U.S.*

  To meet the transitional relief, initially, the Departments stated that an expatriate health plan must be limited "to primary insureds who reside *outside of their home country* for at least six months of the *plan year*" and their covered dependents. Now, for the purposes of the transitional relief, the Departments define an "insured expatriate health plan" as "an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents".

The FAQ clarifies that the transitional relief extends to an individual residing outside of the U.S., which , effectively, expands the definition of expatriate health plan to allow plans to cover employees who permanently reside in a country outside the U.S. ("foreign locals"). This seems to mean that employers who wish to maintain a single plan for U.S. expatriates and foreign locals may do so and retain the plan's status as an expatriate health plan for purposes of the transitional relief. The FAQ also clarifies that the six-month requirement is not tied to a plan year and applies on a *rolling basis* over a 12-month period, which can fall within a single plan year or across two consecutive plan years. This should be welcome relief for employers with plans covering expatriates whose assignments overseas are for periods between plan years. The relief should also streamline employers' ability to provide coverage to their expatriates.

- *Transitional Relief Extended to "Essential Health Benefits" Package (and Other) Requirements*

  The FAQ also extends the scope of the ex-pat transitional relief to apply to the requirement for insurers in the individual or small group market to cover "essential health benefits", as long as plans and insurers comply with pre-ACA law rules governing individual and group market rules.

- *Additional Guidance Expected*

Stay tuned for additional guidance or regulations. The Departments will continue to consider "narrowly tailored" guidance for fully-insured expatriate health plans "that takes into account the ability of such coverage to reasonably comply" with ACA's market reform and other comprehensive coverage mandates. Fortunately, any new regulations or guidance that is more restrictive will not be applicable to plan years ending on or before December 31, 2016.

New FAQs Provide Guidance Regarding Effect of ACA on the MHPAEA

By Todd Mobley

- As previously reported, the federal agencies responsible for drafting the rules implementing the Affordable Care Act ("ACA") (the U.S. Department of Labor, the U.S. Department of Health and Human Services, and the U.S. Treasury Department) recently issued FAQ Part XVIII, regarding implementation of the market reform provisions of the ACA. Question 12 in FAQ Part XVIII includes guidance as to the effect of the ACA on the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

  The MHPAEA amended ERISA, the Internal Revenue Code, and the Public Health Safety Act to provide greater parity between mental-health and substance-use disorder benefits and medical and surgical benefits. More specifically, the MHPAEA mandates that financial requirements (e.g., copayments, coinsurance, or deductibles) and treatment limitations (e.g., limitations on the frequency of treatment, number of out-patient visits, or amount of days covered for in-patient stays) applicable to mental-health and substance-use disorder benefits generally can be no more restrictive than the requirements and limitations applied to medical and surgical benefits (the "Parity Regulations"). The MHPAEA applies to (1) plans sponsored by private- and public-sector employers with fifty-one or more employees and (2) the health-insurance issuers selling coverage to those employers. Importantly, the MHPAEA does not require that plans and issuers cover mental-health and substance-use disorder benefits—compliance is only required where a plan or issuer chooses to provide such benefits.

  However, the ACA expanded the MHPAEA's reach by including mental-health and substance-use disorder services as one of the ten essential health benefit ("EHB") categories. Accordingly, non-grandfathered health plans in the individual and small group markets must comply with the Parity Regulations. Additionally, section 1563 of the ACA extends MHPAEA protection to the individual market with regard to both grandfathered and non-grandfathered coverage. Thus:

  - non-grandfathered individual and small group market coverage must provide mental-health and substance-use disorder benefits that comply with the Parity Regulations, unless such coverage is subject to the Department of Health and Human Services' November 14, 2013 transitional policy (providing conditions under which certain individual or small group market coverage will not be considered out-of-compliance with the ACA's market reform provisions);

  - grandfathered individual market coverage is not subject to the EHB provisions and therefore not required to provide mental-health or substance-use disorder benefits; however, to the extent that policies do cover these benefits, such coverage must comply with the Parity Regulations; and

grandfathered small group market coverage is required to comply with neither the EHB provisions nor the MHPAEA.

Recent Guidance on Wellness Programs Clarifies Premium Surcharges for Tobacco Use

By Stacy Barrow

> As previously reported, the federal agencies responsible for drafting the rules implementing the Affordable Care Act (ACA) (the U.S. Labor Department, the U.S. Department of Health and Human Services and the U.S. Treasury Department (together, the "Departments")) on January 9, 2014 issued FAQ Part XVIII, regarding implementation of the market reform provisions of the ACA.

These FAQs are part of the government's efforts to provide so-called "subregulatory guidance" – that is, guidance providing relatively quick helpful answers to respond to issues and trends affecting group health plans and insurers. FAQ Part XVIII includes guidance for employers sponsoring wellness programs that contain tobacco cessation components, and on the "reasonable alternatives" required to be made available under health-contingent wellness programs.

By way of background, on June 3, 2013, the Departments issued final regulations, effective for plan years beginning on or after January 1, 2014, regarding nondiscriminatory wellness programs that are part of group health coverage (the "Final Regulations"). The Final Regulations explain the new ACA rules that increase the maximum permissible reward under a health-contingent wellness program from 20 percent to 30 percent of the cost of group health plan coverage, and further increase the maximum reward to 50 percent for programs designed to prevent or reduce tobacco use. The FAQs address several issues that have been raised since the publication of the Final Regulations.

Premium Surcharges for Tobacco Use

The FAQs clarify that if a group health plan provides a reasonable opportunity to avoid a tobacco use surcharge at the beginning of a plan year (e.g., a tobacco cessation educational program), the plan is not required to provide another opportunity to avoid the surcharge that year to a participant who declined the initial opportunity. The FAQs note that nothing prevents the plan from providing another opportunity that year for a participant to avoid the surcharge, or for prorating rewards for those who complete the reasonable alternative later that plan year after having declined it initially.

As a reminder, group health plans that impose a surcharge on tobacco users may do so only as part of a wellness program that complies with the Final Regulations. One requirement of a compliant wellness program is that it must be reasonably designed to promote health or prevent disease (i.e., the wellness program cannot consist solely of a premium surcharge for tobacco

users). Given this requirement, and that the program must provide a reasonable alternative to all tobacco users, many employers require completion of an educational program as the alternative to being tobacco-free. The Final Regulations contain an example of a compliant tobacco cessation program that offers an educational program as its reasonable alternative standard. In the example, the plan makes an educational program available or assists individuals in finding such a program (instead of requiring an individual to find a program unassisted), and does not require individuals to pay for the cost of the program.

Involvement of a Participant's Physician

Certain wellness programs require individuals to attain a particular outcome with respect to a health factor to earn a reward (or avoid a surcharge). For example, a group health plan might require participants to have a body mass index (BMI) of less than 30 to earn a reward (or avoid a surcharge). This type of wellness program is an outcome-based wellness program (as is a program that imposes a surcharge on tobacco users). A participant who cannot attain the desired outcome must be allowed to satisfy a reasonable alternative standard. The participant may also involve his or her doctor, who might recommend an alternative, such as a weight reduction program (an activity-only program).

The FAQs clarify that the plan must provide a reasonable alternative standard that accommodates the recommendations of the participant's doctor with regard to medical appropriateness; however, the plan is not required to accept the specific alternative offered by the participant's doctor. For example, assume that a participant's doctor advises that an outcome-based wellness program's standard for obtaining a reward is medically inappropriate for the participant. The doctor suggests a weight reduction program (an activity-only program) instead. The FAQs provide the plan some discretion with regard to selecting the program, indicating that "many different weight reduction programs may be reasonable for this purpose, and a participant should discuss different options with the plan."

On the other hand, assume that a group health plan pays a reward for participants with cholesterol below a specified level and specifies that the wellness program's physician designates the required alternative for participants with cholesterol in excess of the specified level. This program would fail the requirements for wellness programs because it does not provide the participant with an opportunity to comply with a different alternative standard recommended by the participant's doctor.

Note that in general, an activity-only program is required to provide a reasonable alternative only if it is unreasonably difficult or medically inadvisable for the participant to attempt to satisfy the program's requirements. In other words, a participant generally cannot involve a personal physician in an activity-only program unless the initial standard or the reasonable alternative is unreasonably difficult or medically inadvisable.

Reasonable Alternative Standard Language

The Final Regulations included model language that would notify participants of the availability of reasonable alternatives. The FAQs clarify that employers are permitted to modify the regulatory sample language if they wish. In particular, plan sponsors should consider modifying the language to reflect the details of their wellness programs, such as contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that an alternative program is available, without describing its terms, this statement is not required. Also, in all cases, the notice must include the other required regulatory content, even if the language is modified.

District Court Upholds Validity of IRS Rule Authorizing Premium Tax Credits to Individuals Who Enroll in Health-Care Coverage through Federally-Facilitated Exchanges

By Todd Mobley

> A district court in the District of Columbia recently held that the Internal Revenue Service's ("IRS") rule authorizing premium tax credits to individuals who enroll in health-care coverage through federal exchanges was unambiguously consistent with the "text, structure, and purpose" of the Affordable Care Act ("ACA"). *Halbig v. Sebelius*, No. 13-cv-0623, 2014 U.S. Dist. LEXIS 4853 (D.D.C. Jan. 15, 2014).

The Exchanges, Premium Tax Credits, and Challenged IRS Rule

To facilitate the purchase of "minimum essential" health-insurance coverage (which the ACA requires that most Americans either obtain or pay a tax penalty for failing to do so (the "Individual Mandate")), the ACA provides for the establishment of American Health Benefit Exchanges ("Exchanges"). As explained by the U.S. Department of Health and Human Services ("HHS"), the Exchanges act as "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage . . . ." Currently, sixteen states and the District of Columbia have elected to establish Exchanges ("State-run Exchanges"). Because the remaining thirty-four states have currently declined to do so, HHS has (pursuant to its authority under the ACA) stepped-in and created Exchanges on their behalf ("Federally-facilitated Exchanges").

In furtherance of the ACA's goal to provide coverage to low- and middle-income individuals, the ACA authorizes federal tax credits to offset the cost of coverage purchased through an Exchange ("Premium Tax Credit"). Once an individual's eligibility for a Premium Tax Credit has been approved, the Exchange through which the individual enrolls arranges for payment of the credit to the individual's insurer. This payment, in turn, lowers the individual's net cost of coverage. At issue in *Halbig* was whether Premium Tax Credits could be available in Federally-facilitated Exchanges to the same extent as

they are available in State-run Exchanges. The ACA statutory language literally provides that Premium Tax Credits are available only to individuals enrolled "through an Exchange established by the State."

However, on May 23, 2012, the IRS promulgated a final regulation interpreting the ACA as authorizing Premium Tax Credits for individuals who enroll in coverage through both State-run and Federally-facilitated Exchanges ("IRS Rule"). The IRS explained that other relevant ACA provisions, as well as the legislative history, clarified that the IRS Rule was consistent with congressional intent, notwithstanding the literal statutory terms.

Halbig v. Sebelius

The plaintiffs, individuals and employers residing in states with Federally-facilitated Exchanges, commenced this suit under the Administrative Procedure Act, seeking a declaration that the IRS Rule is arbitrary, capricious, contrary to the ACA and, thus, invalid. The plaintiffs also sought an injunction prohibiting application of the IRS Rule.

The individual plaintiffs argued that, without Premium Tax Credits, the cost of health-care coverage (relative to their income) would be high enough to exempt them from the Individual Mandate, to which they are ideologically opposed. However, if Premium Tax Credits are available to them through Federally-facilitated Exchanges, they must comply with the Individual Mandate or pay a penalty. The employer plaintiffs, on the other hand, argued that without Premium Tax Credits they would be exempt from the "play or pay" penalty under the ACA, which is triggered when a full-time employee receives a Premium Tax Credit through an Exchange. The amount of that tax is based on, and (as the court noted) presumably used to offset, the Premium Tax Credit issued to the employee.

The court dismissed the employer plaintiffs from the suit on the ground that their claims were barred by the Anti-Injunction Act ("AIA"). The AIA provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person . . . ." However, the claims asserted by the individual plaintiffs were not so barred because they sought to enjoin a penalty, not a tax.

The plaintiffs' central argument was that, because the ACA authorizes Premium Tax Credits for eligible individuals who enroll "through an Exchange established by the State," Congress intended to limit the availability of Premium Tax Credits to individuals residing in states with State-run Exchanges. Thus, according to the plaintiffs, the Premium Tax Credits should not be available to individuals enrolling for coverage in states with Federally-facilitated Exchanges.

The court disagreed, finding that the plaintiffs' reading of the ACA was too narrow. The court explained that, after considering other relevant provisions, including cross-referenced provisions providing that each State "shall" establish an Exchange, the ACA makes clear that "where a state does not

actually establish an Exchange, the federal government can create an 'Exchange established by the State . . . ' *on behalf of* that state." The court also relied on numerous other cross-referenced provisions in the ACA to conclude that the ACA required (or, at least, assumed) that Premium Tax Credits would be available on Federally-facilitated Exchanges.

Ultimately, the court found that the language, structure, and purpose of the ACA demonstrated that Congress intended for Premium Tax Credits to be made available on both State-run and Federally-facilitated Exchanges. Because the court found that "Congress has directly spoken to the precise question" at issue, "the court, as well as the [IRS], must give effect to the unambiguously expressed intent of Congress." The court held that the "IRS has done exactly that by promulgating regulations authorizing the provision of tax credits to individuals who purchase health insurance on [F]ederally-facilitated Exchanges as well as those who purchase insurance on [S]tate-run Exchanges."

This case and others like it are important for employers to watch. If *Halbig* is eventually reviewed by the Supreme Court, for example, and if the Supreme Court disagrees with the district court's position and finds that the IRS exceeded its authority in implementing the IRS Rule, employers operating in the thirty-four states in which the Federally-facilitated Exchanges have been established will be exempt from the play-or-pay penalties under the ACA that are assessed when full-time employees are not offered affordable coverage and receive a Premium Tax Credit on the Federally-facilitated Exchange. For now, at least according to the district court's decision, this is not the case. But that court likely will not have the final word on this very important ACA issue.

The PBGC Changes Flat-Rate Premium Due Date for Large Plans

By Justin Alex

The PBGC finalized a proposed rule that changes the flat-rate premium due date for large plans to the same as their variable-rate due date, which is 9.5 calendar months after the beginning of the premium payment year (October 15th for calendar-year plans), effective as of the 2014 plan year. Large plans are plans that had 500 or more participants for whom premiums were payable for the plan year preceding the current premium payment year. The PBGC indicated that it will finalize other aspects of its premium proposal at a later date, but finalized this particular rule now because the 2014 flat-rate premium due date for calendar-year large plans under the old rule was February 28, 2014. The new rule provides welcome relief for large plan sponsors by simplifying the PBGC premium filing process and providing additional time for large plan sponsors to determine all of the required information for the flat-rate premium filing.

Regions Financial Agrees to Pay $22.5 Million to Settle ERISA Stock-Drop Litigation

By Joseph Clark

> According to a December 18, 2013 motion for preliminary approval, Regions Financial Corp. has agreed to pay $22.5 million to settle an ERISA stock-drop litigation pending in the Western District of Tennessee. Plaintiffs alleged that defendants, which included members of the plan investment committees, among others, imprudently retained Regions Financial stock as an employee retirement plan option despite risky loan practices that utilized subprime mortgages and other "exotic" loan products. *Hamby v. Morgan Asset Management, Inc.*, No. 2:08-cv-02192 (W.D. Tenn.).

District Court Relies on Recent Supreme Court Decision to Uphold Plan Limitations Provision

By Tulio Chirinos

> A federal district court in New Jersey granted summary judgment in favor of New Jersey Bac Health Fund, finding the limitations provision set forth in the Fund's SPD to be reasonable. *Barriero v. NJ Bac Health Fund*, 2013 U.S. Dist. LEXIS 181277 (D.N.J. Dec. 27, 2013). Under the welfare plan limitations provision, participants seeking to file suit pursuant to section 502(a)(1)(B) of ERISA must do so within "3 years after the end of the year in which medical . . . services were provided." Plaintiff underwent surgeries in March and April of 2009 and appealed the total amount paid by the plan. On April 1, 2011, Plaintiff's final appeal was denied. He subsequently filed suit on January 28, 2013, three years and one month after the end of the year he received medical services.
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> Plaintiff argued that the SPD's three-year limitations period was inherently unfair because it began to run prior to the time when a participant could seek judicial review. Plaintiff contended that the deadline for filing the suit should have been April 1, 2014, three years after the exhaustion of all internal administrative appeals. The court, relying on the recent Supreme Court decision in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013),disagreed, holding that effect must be given to a plan's limitations provision unless the provision is determined to be unreasonable. Here, the court found the three-year limitations period reasonable and noted that the plaintiff could have filed suit at any time between April 1, 2011 and December 31, 2012.

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