Proskauer

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A report to clients and friends of the firm

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Editor's Overview

In this month's Newsletter, Robert Rachal discusses recent "church plan" rulings where some federal judges have declined to give deference to long-standing, consistent guidance from the Internal Revenue Service on the scope of the "church plan" exemption. Robert argues that this lack of deference is defeating ERISA's twin-goals of uniformity and predictability, making it difficult for plan sponsors to offer and administer pension plans.

Please be sure to see this month's Rulings, Filings, and Settlements of Interest section where we review new HHS regulations as well as decisions pertaining to the potential fiduciary status of delinquent contributing employers to multiemployer funds, equitable relief, and the possibility of a fiduciary breach claim based on an oral representation.

Pension Plan Administration and Court Deference to the IRS: The "Church Plan" Cases as a Case Study on the Significance of Agency Deference to Plan Administration*

By Robert Rachal

ERISA, as the Supreme Court has often noted, reflects a "careful balancing" between the interests of plan sponsors and plan participants.[1] Uniformity and predictability are critical protections that ERISA affords plan sponsors, and these goals have been used to justify important aspects of ERISA, such as the need for judicial deference to plan administrators. *See Conkright v. Frommert*, 130 S. Ct. 1640, 1649-51 (2010). This need for uniformity and predictability applies with added force to pension plan administration, in which the IRS plays a critical role in determining whether these plans are tax-qualified, and thus eligible for the tax benefits (*e.g.*, deferral of income for participants until received) that justify their existence. Indeed, the need for predictability has been deemed so important to pension plan administration that the Supreme Court has protected plans

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[1] *Conkright v. Frommert*, 130 S. Ct. 1640, 1649 (2010) (*quoting Aetna Health Inc. v. Davila*, 542 U.S. 200 215 (2004)).

and plan sponsors from retroactive liability caused by any "marked departure from past practice."[2]

In light of this need for uniformity and predictability, deference to the IRS's guidance on pension law should be uncontroversial, at least when it is long-standing and consistent guidance. Yet, as the recent rulings in the "church plan" cases aptly illustrate, federal judges have sometimes become quick to second-guess the IRS and to develop their own unique pension rules, even when these new rules are a "marked departure from past practice."[3] Given the complexity of ERISA and the large number of federal judges (*e.g.*, 677 district judges are currently authorized[4]) this lack of judicial deference can, unfortunately, create balkanized and unexpected legal rules, defeating some of the very protections ERISA is supposed to provide plan sponsors.

Background on the "Church Plan" Exemption

The "church plan" cases arise out of Congress's expansion of the "church plan" exemption in 1980. As originally enacted in 1974 with ERISA, the "church plan" exemption only exempted from ERISA plans established by "churches" for the church and a church agency. The IRS applied this original exemption narrowly, focusing on whether the activity of the organization seeking the exemption was, in the IRS's view, sufficiently "religious" to deem that organization to be part of a "church." Thus, the IRS concluded a Catholic religious order was not part of the church, as the order's operation of health facilities was not, per the IRS, deemed sufficiently "religious," that is, focused on worshipful or sacerdotal functions.[5]

This and other aspects of the original exemption led to complaints from churches that this exemption as originally enacted was too narrow. The churches proposed to Congress an expansion that would, among other things, include within the "church plan" exemption the churches' "good works" ministries, such as their schools, hospitals and charitable organizations.[6] Notably, Treasury objected to this very expansion, but was overruled by the Senate Finance Committee.[7]

As amended and reenacted, subsection (A) of the "church plan" exemption remains unchanged substantively from its original enactment. Subsection (A) provides that a "church plan" is a plan established and maintained by a church. Subsection (C), however, was added by the 1980 amendment, and extends "church plan" status to include plans administered by organizations controlled by or associated with a church: "A [church plan] ***includes*** a plan maintained by an organization . . . if such organization is controlled by or associated with a church or a convention or association of churches." ERISA § 3(33)(C)(i)

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[2] *City of Los Angeles Dept. of Water & Power v. Manhart*, 435 U.S. 702, 722 (1978) (refusing to impose retroactive liability based on Court's ruling that sex-based pension contribution tables violated Title VII).

[3] *Manhart*, 435 U.S. at 722.

[4] See http://www.uscourts.gov/JudgesAndJudgeships/FederalJudgeships.aspx (last visited April 1, 2015).

[5] *See* I.R.S. Gen. Couns. Mem. 37,266, 1977 WL 46200, *5 (Sept. 22, 1977). The IRS noted that its rule defining religious mission applied even when it was contrary to the religious doctrine of the applicable church. *Id.*

[6] *See* 125 Cong. Rec. 10,054-58 (1979) (Sen. Talmadge, publishing letters of the religious organizations).

[7] *See* Exec. Sess. of S. Comm. on Fin., 96th Cong. 41-42 (June 12, 1980).

(emphasis added). Congress also deemed the church to be the employer of the employees of these church-affiliated organizations. ERISA § 3(33)(C)(ii)(II), (C)(iii).

Treasury, which had participated in this legislative process, and its bureau the IRS, revisited its guidance in *I.R.S. General Counsel Memo* 39,007, 1983 WL 197946 (Nov. 2, 1982). The IRS examined in detail the text of the expanded "church plan" exemption and reversed its earlier ruling, concluding that plans of organizations controlled by or associated with churches, in this instance plans for employees of hospitals run by religious orders, could be "church plans." *Id.* at *2-6. The IRS based its contemporaneous guidance on the newly added exemption in subsection (C)(i), which "includes" within the definition of "church plan," plans of church-affiliated organizations that are administered by an organization with a principal purpose to administer or fund the plan.[8]

Since the IRS issued its guidance, for the last thirty-plus years there has been a settled understanding among the federal agencies (the IRS, DOL and PBGC), the federal courts, and religiously affiliated plan sponsors that this expanded exemption included plans established by the "good works" ministries of churches, such as their religiously-affiliated schools and hospitals.[9] As part of this settled understanding, the IRS and DOL have issued over 500 rulings to church-affiliated organizations exempting their plans from ERISA. Also, after the IRS issued its guidance, Congress has repeatedly expanded the "church plan" exemption to exempt these "church plans" from various health care, insurance, and securities laws.[10]

The "Church Plan" Cases

In the last two years, twelve class actions have been filed across the country against religiously-affiliated healthcare institutions (principally Catholic institutions), challenging whether their pension plans are exempt "church plans."[11] Although there are some variations in the complaints, a core issue common to all is whether the "church plan" exemption includes plans established by church-affiliated organizations (the prior settled understanding), or instead should be limited to only plans established by "churches" – presumably as previously construed by the IRS to be institutions focused on worshipful activities, instead of "good works" ministries. This later approach would resurrect the troubling constitutional issues engendered by the original exemption, since many religious faiths and traditions include good works as part of ***how*** they practice their faith. In any event, the statutory construction issue can be distilled to whether "include" in

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[8] *Id.* at *3. The IRS also cited Senator Javits' floor statement to note that, as amended, the "church plan" exemption is no longer limited to plans of churches. *Id.* at *6, n.1.

[9] *See, e.g.*, *Lown v. Continental Cas. Co.*, 238 F.3d 543, 547 (4th Cir. 2001) ("church plans" include plans established by church-affiliated organizations); *Hall v. USAble Life*, 774 F. Supp. 2d 953, 958-61 (E.D. Ark. 2011) (rejecting argument that "church plan" exemption could not extend to a hospital).

[10] For some examples, (i) in 1988 Congress excluded "church plans" from the requirement to provide health continuation coverage under Code § 4980B. *See* 26 U.S.C. § 4980B(d)(3); (ii) in 1996 Congress added § 3(c)(14) to the Investment Company Act of 1940 to exclude "church plans" from the definition of "investment companies" under that Act. *See* 15 U.S.C. § 80a-3(c)(14); and (iii) in 2000 Congress enacted the "Church Plan Parity and Entanglement Prevention Act" to amend ERISA to preempt certain state insurance requirements from applying to "church plans." *See* 29 U.S.C. § 1144(a).

[11] See Jacklyn Willie, Firms File 12th Church Plan Lawsuit; Illinois-Based Presence Health Targeted, BNA Pension & Benefits Daily (April 6, 2015).

ERISA § 3(33)(C) is read as illustrative or additive – does it only illustrate a "subset" of the "plans established by churches" set forth in subsection (A) of the exemption, or does it add a category of plans, *i.e.*, of plans maintained by church-affiliated organizations, to the exemption?

There are powerful arguments why "include" should be read in its normal sense to add something to a group or category, including that this is how "include" is used throughout ERISA's "governmental plan" and "church plan" exemptions.[12] There are also thirty-plus years of settled understandings between the federal agencies, courts and plan sponsors that this is what the exemption meant. Nonetheless, recently three district court judges have held that only "churches" can establish "church plans." To do so, each district judge concluded that no deference was due the IRS, reasoning that only his construction of the statute made sense.

Thus, in *Rollins v. Dignity Health*, 19 F. Supp. 2d 909, 913 (N.D. Cal. 2013), the district judge focused on only a part of IRS's post-amendment guidance and held he "declines to defer to the IRS's interpretation"; instead, he would conduct his own "independent analysis" of the statute. In *Kaplan v. Saint Peter's Healthcare System*, 2014 WL `284854 at *5 & 9-10 (D.N.J. March 31, 2014), the district judge at least noted that deference may be due the IRS if the statute were ambiguous, but then concluded that the exemption could be read in only one way, as making "include" illustrative since subsection (A) is, in his view, the "gatekeeper" for the exemption. Finally, in *Stapleton v. Advocate*, 2014 WL 7525481 at *4 & 8 (N.D. Ill. Dec. 31, 2014), the district judge noted that deference would be due the IRS if its guidance were persuasive, but again the judge found the exemption could be read in only one way, as making "include" illustrative since subsection (C)(i) was, in his view, a "subset" of the category protected by subsection (A).

Unless the district judges properly found the statute to be unambiguous, their dismissal of the IRS guidance is doctrinally questionable. But "gatekeeper" and "subset" are nowhere in the statutory text, and instead are interpretative glosses added by these respective judges. And although each of these judges concluded that the exemption was unambiguous (and thus that reasonable minds could read the statute in only one way) each one also certified this same question for appeal pursuant to 28 U.S.C. § 1292(b) – and each case has been accepted for appeal by the respective circuit, the Ninth, Third, and Seventh Circuits. But 1292(b) certification requires that "there is a substantial ground for difference of opinion" over the question at issue. In sum, the "unambiguous" conclusion does not appear to withstand rigorous scrutiny.

Other courts have not been so dismissive of the IRS. Thus, in *Thorkelson v. Publ'g House of Evangelical Lutheran Church of Am.*, 764 F. Supp. 2d 1119, 1126-29 (D. Minn. 2011), the district court considered prior court decisions and agency guidance to conclude they supported reading the "church plan" exemption inclusively, to include plans established by church-affiliated organizations. And in *Overall v. Ascension Health*, 23 F. Supp. 3d 816, 826 (E.D. Mich. 2014), the district judge went further, noting:

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[12] *See, e.g.,* ERISA § 3(32) ("including" plans of Indian tribes, international organizations, and railroads within "governmental plan" exemption); § 3(33)(C)(ii)(II) ("including" as employees of a church the employees of church-affiliated organizations).

> Also important is that the "church plan" exemption is codified in parallel form in the Internal Revenue Code ("IRC") at § 414(e), 26 U.S.C. § 414(e). The IRS construed and applied the "church plan" exemption shortly after the 1980 revision. In IRS General Counsel Memo 39007, 1983 WL 197946 (July 1, 1983), the IRS recognized that its "worshipful activity" requirement had been legislatively overruled and that the "church plan" exemption now includes plans sponsored by non-profit organizations that are "controlled by or associated with a church," which the IRS memorandum applied to include hospitals operated by Roman Catholic religious orders. *Id.* at *4 to *6.
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> The IRS has followed this rule for more than 30 years.

The district judge thus accorded the IRS's rulings deference in concluding the "church plan" exemption should be read according to the prior settled understanding, *i.e.*, inclusively to include plans established by church-affiliated organizations. *Id.* at 827-29. The IRS's involvement in the legislative process, and its long-standing consistent construction of the exemption, amply support this deference.[13]

Proskauer's Perspective. It is no surprise that ERISA and the Internal Revenue Code provisions applicable to pension plans are often dense and complex. In the instant area, the "church plan" exemption is a bit of a Frankenstein, cobbled together from Congressional enactments occurring years apart – part (A) from 1974; part (C) from 1980. Clever arguments can be made to find and exploit potential latent ambiguities lurking in complex statutory language, such as the different meanings that can be attributed, *post hoc,* to the word "include" used in the "church plan" exemption. Yet ERISA cannot offer plan sponsors promised uniformity and predictability if each federal judge decides these issues anew.

In these circumstances there are sound grounds to defer to the IRS, which (other than the Supreme Court or Congress) is the only entity that can provide uniform and predictable rules in this area. This should not be a blank check, and courts must review IRS guidance for consistency with the statutory language. But ignoring long-settled, consistent IRS and court' construction, by effectively deeming them all to be unreasonable, is not a sound way to administer pension law, and defeats the uniformity and predictability necessary for plan sponsors to offer and administer pension plans.

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[13] For example, the IRS's General Counsel Memo 39,007 (subsequently followed by the DOL and PBGC) reflects its contemporaneous analysis of the amended exemption in light of that institutional knowledge. *Compare United States v. Cleveland Indians Baseball Co.*, 532 U.S. 200, 220 (2001) (noting IRS ruling reflecting agency's longstanding interpretation that is reasonable "attracts substantial judicial deference"). Congress' expanding the "church plan" exemption to other contexts after this agency guidance was published provides further grounds for deference. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978).

Rulings, Filings, and Settlements of Interest

New HHS Regulations "Clarify" that Health Plans Covering Families Must Have "Embedded" Individual Cost-Sharing Limits

By Stacy Barrow and Damian A. Myers

> On February 27, 2015, the Department of Health and Human Services (HHS) released its final HHS Notice of Benefit and Payment Parameters for 2016. The lengthy regulation covers a wide range of topics affecting group health plans, including minimum value, determination of the transitional reinsurance fee, and qualified health plan rates and other market reforms applicable to the group and individual insurance markets.

Within the portion of the regulation's Preamble explaining insurance issuer standards under the Affordable Care Act ("ACA"), HHS formally adopted a "clarification" to the application of annual cost sharing limitations. By way of background, the ACA requires that all non-grandfathered group health plans adopt an annual cost sharing limit for covered, in-network essential health benefits for self-only coverage ($6,600 in 2015 and $6,850 in 2016) and other than self-only coverage ($13,200 in 2015 and $13,700 in 2016). Until HHS's clarification, many group health plan administrators applied a single limitation depending on whether the employee enrolled in self-only or other than self-only coverage (e.g., "family" coverage). That is, if an employee enrolled in family coverage, the higher limit applied to the family as a whole, regardless of the amount applied to any single covered individual.

HHS, however, now requires group health plans to embed an individual cost sharing limit within the family limit. For example, suppose an employee and his or her spouse enroll in family coverage with an annual cost sharing limit of $13,000, and during the 2016 plan year, $10,000 of cost sharing payments are attributable to the spouse and $3,000 of cost sharing payments are attributable to the employee. Prior to the HHS's clarification, the full $13,000 would be payable by the covered individuals because the $13,000 plan limit had not been reached on an aggregate basis. However, with the new embedded self-only limitation, the cost sharing payments attributable to the spouse must be capped at the self-only limit of $6,850, with the remaining $3,150 being covered 100% by the group health plan. The employee would still be subject to cost sharing, however, until the $13,000 plan limit is reached.

The HHS clarification is not effective until plan years beginning on or after January 1, 2016. It is important to note that, at the moment, it is unclear whether the HHS clarification is intended to apply to self-insured plans. The 2016 Benefit and Payment Parameters are rules related to the group and individual insured market, including the Marketplace, and the Preamble section under which the clarification is found is titled "Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges." Additionally, all previous cost sharing guidance applicable to self-insured plans have been issued jointly by the HHS, Department of Treasury and Department of Labor. As of the date of this blog entry, the Departments of Treasury and Labor have not issued a similar clarification. Nevertheless, although the HHS clarification is potentially unenforceable with respect to self-insured plans, employers and plans sponsors with self-insured plans should be prepared to adopt an embedded cost sharing limit should the other two agencies follow suit.

Delinquent Contributing Employer May Be Fiduciary

By Anthony Cacace

> The Second Circuit held that the owner of a contributing employer to multiemployer benefit plans breached his fiduciary duties by failing to make required contributions and was thus personally liable for the delinquencies, interest, and attorneys' fees. In so holding, the Court determined that the owner was a plan fiduciary because: (a) the plan's trust document designated required contributions as plan assets, (b) the owner was responsible for determining the order in which the company's creditors would be paid, and (c) the owner had authority and control over management of the contributing employer. As a fiduciary wrongly in possession of plan assets, the Court held that the owner was "personally liable to make good to such plan any losses to the plan." Notably, the Court also ruled that the owner was not obligated to pay liquidated damages because the owner was liable under a fiduciary breach claim, not a claim for delinquent contributions. The case is *Bricklayers & Allied Craftworkers Local 2, Albany, N.Y. Pension Fund v. Moulton Masonry & Const., LLC*, No. 14-295, 2015 WL 795290 (2d Cir. Feb. 26, 2015).

Breaching Fiduciary Cannot Seek Equitable Indemnity from Another Fiduciary

By Aaron Feuer

> A California federal district court dismissed a plan fiduciary's equitable indemnity claim because such claims are not available to a breaching fiduciary under ERISA. Plaintiff William Brown commenced a putative class action for long-term disability benefits. He alleged that the plan administrator breached its fiduciary duties by failing to inform him that, when his union switch LTD coverage to another provider, he needed to continue paying premiums (which had previously been deducted from his paycheck) in order to remain eligible for disability benefits.
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> The plan administrator, in turn, filed a third-party complaint against the participant's union, seeking an order that, in the event it was held liable to the class, it should be indemnified by the union since the union allegedly prevented the plan administrator from successfully providing the participant correct information. The plan administrator argued that it tried to inform Brown of the risk of losing his benefits if he did not enroll in the individual plan, but the union prevented it from giving correct information. In dismissing the third-party complaint, the court first held that the union was not a fiduciary by virtue of having made representations to participants that they would keep their LTD benefits. Second, the court held that even if the union was a fiduciary, ERISA does not provide breaching fiduciaries the right to seek relief from other fiduciaries. The case is *Brown v. Cal. Law Enforcement Ass'n,* No. 3:14-cv-03559-JCS (N.D. Cal., March 2, 2015).

Fifth Circuit: Hospital Enjoys Standing to Seek ERISA Benefits

By Lindsey Chopin

> The Fifth Circuit ruled that an out-of-network medical provider that was assigned a patient's rights to health insurance benefits has standing to sue a health plan that underpays its portion of the benefits due even if the plan participant portion is paid in full. *North Cypress Medical Ctr. Operating Co., et al. v. Cigna Healthcare, et al.*, No. 12-20695 (5th Cir. Mar. 10, 2015).

CIGNA and the CIGNA plan participants share the cost of out-of-network care, and to facilitate payment, many patients expressly assign their right to benefits under the CIGNA plan to North Cypress Medical Center. For purposes of calculating the amount owed by participants, the hospital discounted the rate charged to participants. The hospital did not discount the amount charged to the plan. When CIGNA learned of the hospital's practice, it started making its proportional payments to the hospital based on the discounted rates.

The hospital filed suit against CIGNA under ERISA for recovery of the balance. The district court granted summary judgment in favor of CIGNA. In its view, the hospital lacked standing because participants who assigned their rights to the hospital did not incur any out-of-pocket expenses since the hospital did not bill its patients for the amounts CIGNA did not pay.

The Fifth Circuit vacated the district court's ruling. It reasoned that participants have the right to be reimbursed by CIGNA for medical costs incurred at an out-of-network provider, and the fact that participants assigned that right to the hospital "does not cause [the right] to disappear." As an express assignee of the patients' rights, the hospital had standing to sue for underpayment of benefits. According to the Court, any argument that the hospital's billing and discounting practices reduces or eliminates CIGNA's payment obligations under the terms of the plans is a merits-based contention that does not affect the hospital's standing to sue. The Fifth Circuit instructed the district court to consider that issue on remand.

Fiduciary Breach Claim Based On Oral Representation Can Proceed

By Madeline Chimento Rea

> A federal district court in New Jersey held that oral misrepresentations may support a breach of fiduciary duty claim under ERISA. Plaintiff Richard Lees was hired by American Re–Insurance Company, although he was paid by another entity called SMS. When American sought to transfer Lees to its payroll, Lees allegedly agreed to the transfer only if he would be treated as if he had been on American's payroll the entire time for the purpose of his pension benefits. According to Lees, he was promised these benefits instead of receiving a sign-on bonus. Lees alleged that over a decade after his transfer, the successor to American, Munich, informed him that he would not receive pension credit for the time he was on SMS's payroll. According to the district court, nothing in Third Circuit precedent precludes oral misrepresentations from supporting a breach of fiduciary duty claim under ERISA. The court added that even if the oral representations could not support Lees' breach of fiduciary duty claim under ERISA, Lees had alleged sufficient facts on which to base his claim and further discovery into his employee file could reveal written materials to support the claim. The court thus denied defendant's motion to dismiss. The case is *Lees v. Munich Reinsurance Am., Inc.*, No. 14–2532, 2015 WL 1021299 (D.N.J. Mar. 9, 2015).

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits, Executive Compensation & ERISA Litigation Practice Center. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

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