Proskauer

newsletter

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in this issue

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A report to clients and friends of the firm

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Editor's Overview

As the summer draws to a close, this month's Newsletter previews three cases that the U.S. Supreme Court already has agreed to hear that ought to be of particular interest to ERISA plan sponsors and fiduciaries. Two of the cases involve claims under ERISA – one case involves a plan's ability to recoup medical expenses paid on behalf of a participant injured by a third party; the other case involves a claim of preemption concerning a state law creating a health claims database to facilitate healthcare and payment policy. The third case is a non-ERISA case with potentially significant consequences under ERISA. The Court will decide whether a plaintiff needs to have suffered individualized injury in order to assert a claim for statutory and regulatory violations.

As always, please be sure to review the Ruling, Filings, and Settlements of Interest where we review decisions involving ERISA section 510, ERISA stock-drop claims, damages, and disclosure claims. We also review 2016 open enrollment issues, SBC requirements, health coverage tax credit, and provide an ACA reporting update.

A Look Ahead at the Supreme Court's October 2015 Term and Petitions of Interest to ERISA Practitioners*

By Neil V. Shah

In its upcoming October term, the U.S. Supreme Court will hear three cases of particular interest to ERISA plan sponsors and fiduciaries. First, the Court will hear yet another case involving a plan's ability to recoup medical expenses paid on behalf of a participant injured by a third party. Second, the Court will decide whether a state law creating a health claims database to facilitate healthcare and payment policy is preempted by ERISA. Third, in a non-ERISA case with potentially significant consequences under ERISA, the Court will decide whether a plaintiff needs to have suffered individualized injury in order to assert a claim for statutory and regulatory violations.

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Subrogation & Reimbursement Claims

In an effort to conserve plan assets, health and welfare plans often contain reimbursement and/or subrogation provisions that allow them to recoup medical expenses paid on behalf of plan participants. These provisions typically come into play when the participant obtains a monetary judgment from a collateral source. Over a decade ago, in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), the Supreme Court held that because ERISA § 502(a)(3) only allowed "categories of relief that were typically available in equity," a plan reimbursement provision could not be enforced against a defendant who did not have possession or control of the disputed funds, as that would amount to imposing personal liability for legal relief. The Court subsequently clarified, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), that a plan document can create an enforceable equitable lien if it identifies a particular fund distinct from an individual's general assets and the corresponding share to which the plan is entitled. Because the defendant in *Sereboff* had deposited the disputed funds in escrow, the Court's decision left unresolved the issue of whether, under ERISA § 502(a)(3), an ERISA plan may recover pursuant to equitable lien payments made to a plan participant that are not traceable to an identifiable fund within a participant's possession and control.

The Supreme Court agreed to hear arguments on this issue in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, No. 14-723. In *Montanile*, an ERISA plan paid medical bills arising out of an automobile accident in which Robert Montanile, a participant in the plan, sustained injuries. Montanile settled with the other driver for $500,000, and the plan sought repayment of $121,000 in expenses it had paid on his behalf. Montanile claimed that he had already spent the proceeds, using more than half for his legal expenses in the personal injury action, and the remainder for his own personal care. In his motion for summary judgment, Mr. Montanile argued that because the funds were no longer in his possession or control, the plan's claim to enforce an equitable lien did not seek "appropriate equitable relief" under the Supreme Court's decision in *Knudson*.

Citing *Sereboff,* the district court rejected plaintiff's argument and held that "a beneficiary's dissipation of assets is immaterial when a fiduciary asserts an equitable lien by agreement." *Bd. of Trs. of the Nat'l Elevator Indus. Health Ben. Plan v. Montanile*, No. 12-80746, 2014 WL 8514011, at *10 (S.D. Fla. Apr. 18, 2014). In so holding, the court stated that a contrary decision would make ERISA's civil enforcement mechanism to "enforce plan terms" an "empty promise," and "would also open the door to the type of 'outrageous' conduct recently censured by the Seventh Circuit, to wit, dissipation of settlement proceeds by a lawyer and client in knowing and willful ignorance of an ERISA plan's lien against the settlement proceeds."

The Eleventh Circuit affirmed. Siding with a majority of circuits to have considered the issue (including the First, Second, Third, Sixth, and Seventh Circuits), the Eleventh Circuit held that "where a plan provision's unambiguous terms gave the plan a first-priority claim to all payments made by a third party," an equitable lien immediately attached to the settlement funds, and the plan's right to equitable relief could not be defeated simply because Montanile had spent the funds after the lien had attached.

The Eleventh Circuit's decision is in conflict with the Ninth and Eighth Circuits. The Ninth Circuit held that where "the 'particular fund' identified by the Plan has been dissipated, the Plan's only choice is to seek recovery from the participant's 'assets generally,'" and "such a recovery would be legal, not equitable, and thus unavailable under ERISA Section 502(a)(3)." *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1094 (9th Cir. 2012). The Eighth Circuit reached a similar conclusion. *See Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (8th Cir. 2012) (holding that plan's subrogation action against participant sought legal, not equitable, relief because the participant no longer possessed the subject settlement funds).

The Department of Labor filed an amicus brief in support of Montanile. It argued that the plan sought relief that was legal, and not equitable in nature, and that the Supreme Court's decision in *Sereboff* requires that the funds be traced to the participant at the time suit is filed. The AARP also filed an amicus brief in support of Montanile. It argued that plan beneficiaries are "ill-equipped to have to pay back a portion of already received funds" and should be permitted to assert laches, changed circumstances, and other equitable defenses in response to reimbursement claims.

ERISA Preemption

Since 2003, a growing number of states have undertaken efforts to create "all-payer claims" databases, *i.e.*, databases that contain information on all medical services paid for by third-parties, to study and improve the cost, quality, and utilization of medical care in their jurisdictions. These states require private and public payers to systematically provide information regarding patient demographics, the services being provided and the cost, and patient responsibility for care (*e.g.*, copayments, deductibles, and coinsurance). However, some institutions have questioned whether such requirements as applied to self-funded plans are preempted by ERISA.

On appeal from the Second Circuit, the issue presented in *Gobeille v. Liberty Mutual Insurance Company*, No. 14-181, is whether ERISA preempts Vermont's law requiring the third-party administrator of a self-funded ERISA plan to file reports with the State containing this claims data. Vermont maintains a unified database that allows it to determine the efficacy of the State's existing healthcare resources and the effectiveness of various treatment approaches. In order to populate the database, the state promulgated regulations requiring health insurers to report various categories of claims data relating to healthcare provided to Vermont residents and by Vermont healthcare providers. The third-party administrator of a self-funded ERISA plan challenged the requirement, arguing that it was preempted by ERISA § 514 because it had a "connection with" or "reference to" an ERISA plan.

The district court agreed with the State of Vermont. After noting that healthcare-related statutes "receive the benefit of the presumption against preemption," the court held that Vermont's statute did not "make reference" to an ERISA plan because it did "not act immediately and exclusively upon ERISA plans, nor [was] the existence of ERISA plans essential to their operation." *Liberty Mut. Ins. Co. v. Kimbell*, No. 11-204, 2012 WL 5471225, at *9 (D. Vt. Nov. 9, 2012). It also determined that the statute did not have a "connection with" an ERISA plan, as it did "not seek to regulate the administration of Liberty Mutual's Plan, or its allocation of benefits," and any "administrative burden" resulting from the mandate was "peripheral" to "core ERISA functions and relationships."

The Second Circuit reversed. In finding the Vermont law preempted by ERISA, the Court observed that the Supreme Court has repeatedly held that "'reporting' and 'disclosure' are core ERISA functions subject to a uniform federal standard." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 505 (2d Cir. 2009).

Following Vermont's filing of a petition for writ of certiorari, the Supreme Court invited the Solicitor General to file a brief expressing the views of the United States. The Solicitor General sided with the State and took the view that the reporting statute was not preempted. It reasoned that ERISA's reporting requirements were intended to secure plan funds, but that the Vermont statute had "an entirely different focus," *i.e.*, to "populate a database that is designed as a tool to assess and improve healthcare outcomes for Vermont residents." The Solicitor General nevertheless urged the Court to deny the petition on the ground that the Court would benefit from other circuits first opining on the issue.

Article III Standing

Despite being a Fair Credit Reporting Act case, a decision by the Supreme Court in *Spokeo, Inc. v. Robins*, No. 13-1339, may impact whether ERISA plan participants have Article III standing to bring claims based on a statutory violation of ERISA. On appeal from the Ninth Circuit, the issue presented in *Spokeo* is whether a statutory violation – without more – is sufficient to confer Article III standing on a person who the underlying statute expressly authorizes to file suit for such violations. Thomas Robins sued Spokeo, a website that aggregates publicly available information about individuals. He alleged that the website published a variety of false information about him, including that he was employed, wealthy, and held a graduate degree, and that these falsities impeded his job search and prolonged his joblessness. Mr. Robins alleged that Spokeo had violated various provisions of the Fair Credit Reporting Act, which he sought to enforce through the statute's private right of action.

Spokeo moved to dismiss, arguing that the alleged statutory violations did not constitute the types of injuries necessary to confer Article III standing, and that Mr. Robins failed to allege actual harm that he personally suffered. The district court agreed, but the Ninth Circuit reversed. It held that Congress had created a private right of action to redress statutory violations, and that Mr. Robins had sufficiently alleged injury to himself (as opposed to others) as a result of these violations. The Ninth Circuit further determined that this was not a case where Congress manufactured Article III standing by elevating undifferentiated, collective injuries into statutory rights. Instead, Mr. Robins alleged that Spokeo had violated his statutory rights (as opposed to the rights of others) by publishing false information about him, and that the statutory rights protected interests that were "sufficiently concrete and particularized" for Article III purposes.

The Solicitor General and the Consumer Financial Protection Bureau had urged the Supreme Court to deny the petition, arguing that the publication of inaccurate information about the plaintiff was clearly sufficient to constitute actual harm for Article III purposes. A number of social media and technology companies also filed amicus curiae urging the court to overturn the Ninth Circuit. They argued that the Ninth Circuit's ruling "allows plaintiff to bring suits in federal court based on nothing more than an allegation of a bare statutory violation without any requirement of actual harm" that "renders technology companies . . . uniquely vulnerable to baseless and abusive litigation."

Proskauer's Perspective

The Supreme Court appears poised to render rulings that could have a significant impact on ERISA litigation in the coming years. First, a decision in *Montanile* could serve to further clarify the requirements for ERISA plans to seek equitable relief from participants pursuant to reimbursement and subrogation provisions. Depending on the outcome, the Court's ruling could bolster recovery actions by insurers who issue, underwrite, and/or administer ERISA health and welfare plans.

Second, a decision by the Supreme Court in *Gobeille* is likely to have immediate implications for at least 19 other states that are implementing a comparable reporting requirement. Beyond determining the legality of these statutes, the case may also affect the ability of private and public payers and healthcare providers to study the efficacy of pilot programs established pursuant to the Patient Protection and Affordable Care Act and other state initiatives.

Third, *Spokeo* may have a significant impact on the ability of plan participants to seek relief from plan fiduciaries for statutory and regulatory violations on both a class-wide and individual basis. ERISA authorizes plan participants to commence actions for violating the statute. A ruling by the Supreme Court in *Spokeo* that an individual must allege personal injury resulting from the statutory violation in order to establish Article III standing may significantly curtail a participant's ability to seek relief for these types of violations.

Rulings, Filings, and Settlements of Interest

Ninth Circuit Affirms Dismissal of ERISA Section 510 Claim

By Madeline Chimento Rea

> The Ninth Circuit affirmed the dismissal on summary judgment of Plaintiff Rosemarie Cole's claim that her employer, Permanente Medical Group, interfered with her receipt of pension benefits in violation of ERISA § 510. In so ruling, the Court explained that even if Cole established a prima facie case of discrimination under § 510 – by showing that Permanente terminated her employment eighteen months before she would have been entitled to additional pension benefits — her claim still failed because Permanente stated that it terminated Cole's employment because she knowingly violated Permanente's confidentiality policy, and Cole offered no evidence that Permanente actually had a discriminatory motive or that the person who made the decision to fire her was aware that the termination would negatively affect her benefits. The case is *Cole v. Permanente Medical Group, Inc.*, No. 13 Civ. 15952, 2015 WL 3982534 (9th Cir. July 1, 2015).

Eleventh Circuit Again Affirms Dismissal of Stock Drop Claim Against Delta Air Lines

By Joseph Clark

> The Eleventh Circuit affirmed dismissal of ERISA breach of fiduciary claims against Delta Air Lines and other alleged plan fiduciaries in connection with a defined contribution plan's investments in Delta Air Lines stock. In so ruling, the Court joined a growing number of decisions following *Dudenhoeffer* that have dismissed claims based on public information.

Plaintiff Dennis Smith was a participant in the Delta Family-Care Savings Plan, which offered Delta stock as an investment option. His plan account value declined when the price of Delta stock dropped between 2000 and 2004. He sued Delta and plan fiduciaries in 2005, alleging, among other things, that they imprudently continued to permit participants to invest in Delta stock despite the company's poor financial performance and questions about its ability to survive.

The district court originally dismissed the Complaint for failure to state a claim, and the Eleventh Circuit affirmed. After the Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*, Smith filed a petition for writ of certiorari with the U.S. Supreme Court. The Supreme Court vacated and remanded for further consideration in light of *Dudenhoeffer*.

On remand, the district court again dismissed the claims and the Eleventh Circuit again affirmed. In so ruling, the Eleventh Circuit cited to *Dudenhoeffer*'s finding that "allegations based on 'over- or undervaluing the stock are implausible as a general rule, at least in the absence of special circumstances.'" The Court concluded that the prudence claim before it was just the type of claim that the Supreme Court would deem "implausible," particularly since plaintiff did not allege that the fiduciaries "had material inside information about Delta's financial condition that was not disclosed to the market" or the existence of a special circumstance, such as fraud or other improper conduct, that would render reliance on the market price imprudent.

> The case is *Smith v. Delta Air Lines*, 2015 U.S. App. LEXIS 13165 (11th Cir. July 29, 2015) (unpublished).

District Court Rules Privately-Held Stock Plan Fiduciary May Have Affirmative Duty to Disclose

By Neil Shah

> A federal district court in Georgia held that plan fiduciaries of a closely-held company's single stock ERISA fund may have a duty to disclose material, non-public information concerning the value of the company's shares when the information could have a potentially extreme negative effect on a plan participant. The plaintiffs were participants in defendant Stiefel Laboratories, Inc.'s (SLI's) defined contribution stock plan. The plan terms permitted plaintiffs, under certain circumstances, to require SLI to purchase their shares at the price set forth in the most recent stock appraisal. Plaintiffs alleged that SLI encouraged them to sell their shares in SLI's single stock ERISA fund for one-fifth of the amount they would have received as part of GlaxoSmithKline's subsequent purchase of SLI. Plaintiffs argued that SLI and the plan fiduciaries had a fiduciary duty to disclose the impending acquisition, and that had they been so informed, they would not have exercised their rights to put the shares to SLI.

The court denied defendants' motion for summary judgment on plaintiffs' nondisclosure claim. In so ruling, the court relied on earlier decisions recognizing an affirmative duty to disclose under "special circumstances with a potentially extreme impact on a plan as a whole, or where participants generally could be materially and negatively affected." The court distinguished recent Eleventh Circuit authority that plan fiduciaries do not have a duty to disclose material, nonpublic information to plan participants as being limited to publicly traded stock where the value is set in the

open market and where a contrary rule would conflict with prohibitions on insider trading. According to the court, it was up to the factfinder to decide whether SLI's "plans of going public" constituted "special circumstances" requiring disclosure. Central to the court's decision was the fact that the plan participant was "in a vulnerable position" because he did not receive any warning that "investment in a non-diversified single stock fund was risky" and because he did not "have the benefit of the open market determining the value of his SLI stock." Under these circumstances, the plan participant "did not receive the slightest hint that his shares would not be purchased at a fair market value." To the contrary, the court pointed to evidence that the defendants communicated false information to him regarding the actual value of SLI stock and management's plans about the future of the company, either of which the court held could have been actionable as affirmative misrepresentations. The case is *Wagner v. Stiefel Laboratories, Inc.*, No. 12 Civ. 3234, 2015 U.S. Dist. LEXIS 81464 (N.D. Ga. June 18, 2014).

No Damages Awarded for ERISA Plan Fund Mapping Claims

By Neil Shah

> Mapping in a 401(k) plan occurs when an investment option is removed and the participant's investment in that option is transferred to a different investment option (absent direction from the participant). On remand from the Eighth Circuit, the district court in *Tussey v. ABB Inc.*, No. 2:06-cv-04305 (W.D. Mo. July 9, 2015), held that plan fiduciaries abused their discretion when they mapped participants' investments from a balanced fund to the plan trustee's managed allocation fund. In so ruling, the court found that the trustee and plan sponsor had entered into an improper cross-subsidization agreement whereby the trustee was paid above-market rates for providing services to the plan in exchange for providing various administrative services to the plan sponsor at a loss. As a result of this conflict, the court held that the plan's decision to map funds was "motivated in large part" to benefit the trustee and the plan sponsor, rather than the plan participants. Despite this finding, the court declined to award plaintiffs damages. The court held that because the plan's investment policy statement contemplated the addition of a managed allocation fund to the plan's investment options, the proper measure of damages was the "difference between the performance of the [balanced fund] and the minimum return of the subset of managed allocation funds the ABB fiduciaries could have chosen without breaching their fiduciary obligations." Although the court on remand allowed discovery on this damages calculation, neither party presented evidence regarding the performance of any alternative managed allocation fund. As a result, the court held that the plaintiffs had failed to satisfy their burden of proof on the issue of damages.

Reminder: Non-Grandfathered Plans Must Implement Embedded Out-of-Pocket Maximums

By Robert Projansky and Lisa Schlesinger

> As employers and plans prepare for 2016 open enrollment, they must be sure to address in their benefit design and with their third party vendors the new embedded out-of-pocket maximum limitations on individuals that were announced at the end of

May by the U.S. Departments of Labor ("DOL"), Health and Human Services ("HHS") and the Treasury (collectively, the "Departments").

The Affordable Care Act ("ACA") requires that non-grandfathered group health plans place limits on the maximum annual cost sharing imposed on plan enrollees for out-of-pocket costs associated with essential health benefits. For plan and policy years beginning in 2016, the maximum out-of-pocket cost for self-only coverage is $6,850, while the maximum out-of-pocket cost for coverage that is not self-only coverage is $13,700.

On February 27, 2015, HHS issued the HHS Notice of Benefit and Payment Parameters for 2016 (the "2016 HHS Notice"), which explained that the self-only maximum annual limitation on out-of-pocket costs applies to *each individual*, irrespective of whether that individual is enrolled in self-only coverage or coverage that is not self-only coverage. Initially, this appeared to apply only to small group and individual coverage.

However, on May 26, 2015, the Departments issued DOL FAQs Part XXVII, which clarify that the Departments intended to expand this rule to all non-grandfathered health plans, including non-grandfathered group health plans, large and small, insured and self-insured. Thus, non-grandfathered large group health plans must apply this $6,850 annual maximum cost sharing cap to each individual, regardless of the type of coverage in which the individual is enrolled.

Therefore, if a participant has family coverage, his or her family members must have a combined out-of-pocket limit of no more than $13,700, such that when some combination of them reaches that amount, there is no further cost sharing. However, even in this family coverage, there is an embedded individual out-of-pocket limit that cannot exceed $6,850, meaning that if any one of the family members reaches $6,850, there is no further cost sharing for that individual.

What Next?

Although some plans already use an embedded out-of-pocket limit, there are many that do not. Accordingly, as employers plan for 2016 open enrollment, they must ensure that their benefit structures are consistent with this new rule. This includes updating their summary plan descriptions and contacting their vendors to ensure that the administration is consistent with this rule.

Particular attention must be paid to non-grandfathered high deductible health plans ("HDHPs"), to which this new rule also applies. High deductible plans often have no embedded limit, applying the family out-of-pocket maximum to all family members in the case of family coverage.

Implementation of the new rule in HDHPs may be particularly confusing to participants because the ACA maximum out-of-pocket limit differs from the IRS maximum out-of-pocket limit used to determine whether the HDHP can be coordinated with a health savings account ("HSA"). Specifically, in 2016, for HDHP purposes, the lower IRS dollar limits are $6,550 for self-only coverage and $13,100 for family coverage with no embedded limit rule applicable (as compared to the ACA limit of $6,850 for self-only coverage and $13,700 for other than self-only coverage with an embedded limit rule). What this means, effectively, is that for an HDHP that is

intended to coordinate with an HSA, the maximum out-of-pocket limit for a particular individual will be $6,550 for a person with self-only coverage and $6,850 for a person with family coverage (subject to an earlier limit if the individual's family hits the $13,100 family coverage limit).

Agencies Issue Final Regulations on the Summary of Benefits and Coverage (SBC) Requirements

By Katrina McCann and Ahuva Warburg

> As promised in the FAQ issued on March 30, 2015, the U.S. Departments of the Treasury, Labor and Health and Human Services (the Departments) have issued final regulations regarding the summary of benefits and coverage (SBC) and uniform glossary for group health plans and health insurance coverage in group and individual markets under the Patient Protection and Affordable Care Act (ACA). These regulations finalize, with very few changes, the proposed regulations issued on December 30, 2014. The final regulations state that the Departments anticipate a new SBC template and associated documents will be issued by January 2016 and will apply to coverage that begins or is renewed after January 1, 2017.

These final regulations make changes to the initial SBC regulations, issued on February 14, 2012, and codify certain guidance previously set forth in the FAQs about Affordable Care Act Implementation.

The changes and clarifications are summarized as follows:

- If an SBC was provided to an individual or entity prior to the individual or entity submitting an application for coverage, then unless any of the information has changed in the interim, there is no obligation to provide the SBC upon application. The regulations set forth the timing requirements for providing a new SBC if the information has changed.
- If an entity contracts with a third party to provide SBCs, the contracting entity must monitor the third party. As soon as the contracting entity becomes aware of any non-compliance, it must take certain steps to correct the non-compliance and avoid future violations.
- If a plan uses a combination of products from separate issuers (or self-insures certain benefits), individual issuers might not have all of the information required to provide a complete SBC. Accordingly, in such circumstances the group health plan administrator is the only entity responsible for providing complete SBCs to participants and beneficiaries, and in certain cases multiple SBCs may be provided with respect to one plan.
- If an individual with individual market coverage is automatically re-enrolled in a different plan or product than he or she was previously enrolled in, the issuer must provide an SBC with respect to the new coverage, consistent with the timing requirements that apply when a policy is renewed or reissued.
- Until the new template SBC is released, plans and issuers can continue to use the Minimum Essential Coverage and Minimum Value language set forth in the 2013 template, which may be provided in a cover letter if the SBC cannot be modified to include such language.

- Qualified Health Plans sold through individual market Exchanges must disclose on the SBC (or, until the new template is issued, in a cover letter) whether abortion services are covered or excluded, and whether coverage is limited to services for which federal funding is allowed.
- All plans and issuers must include in the SBC contact information for the consumer to call with questions.
- Individual coverage policies and group certificates of coverage must be posted to an Internet address easily available to individuals, plan sponsors, participants and beneficiaries prior to their submitting an application. For the group market, if the terms have not yet been finalized by the plan sponsor and issuer, then posting samples for each applicable product is sufficient, with the actual certificate of coverage to be made available after it is executed.
- SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage, and to participants and beneficiaries who request an SBC online. Paper copies must be made available upon request.
- SBCs provided by a self-insured non-Federal government plan may be provided in paper form, or may be provided electronically if the plan conforms to the electronic disclosure requirements for either ERISA plans or individual health insurance coverage.
- Willful failure to provide the required information is subject to a fine. The DOL and IRS set forth the processes and procedures to be used for enforcement.
- Group health plan benefit packages providing Medicare Advantage benefits are exempt from the SBC requirements.
- The SBC requirements will not be enforced with respect to insurance products that are no longer offered for purchase if they have not been actively marketed since before September 23, 2012, and if the health insurance issuer has never provided an SBC with respect to the product.

The final regulations are effective as follows:

- For disclosures to participants and beneficiaries enrolling or re-enrolling in group coverage, on the first day of the first open enrollment period beginning on or after September 1, 2015 (or the first day of the first plan year beginning on or after September 1, 2015 for those not enrolling through an open enrollment period).
- For disclosures to plans, on September 1, 2015.
- For disclosures to individuals and dependents in the individual market, on January 1, 2016.

Trade Act Reinstates Expired Health Coverage Tax Credit (HCTC)

By Paul M. Hamburger and Justin Alex

> On July 6, 2015, President Obama signed the Trade Preferences Extension Act of 2015. Among other things, the Trade Act retroactively reinstated the Health Coverage Tax Credit (HCTC), which had previously expired on January 1, 2014, and extended its availability through December 31, 2019. As discussed below, the reinstated HCTC

may require employers to update COBRA notices and summary plan descriptions. In addition, it may present a strategic planning opportunity in certain bankruptcy situations.

What is the HCTC?
The HCTC is a refundable federal tax credit that was first made available in 2002 to subsidize the cost of qualified health insurance coverage for certain individuals and their qualifying family members (generally an individual's spouse and dependent children). The HCTC's subsidy level varied over time, but it currently covers 72.5% of the premium for qualifying coverage. The HCTC is generally available to an individual who satisfies each of the following conditions: 1) the individual meets the general eligibility requirements described below; 2) the individual pays 50% or more of the cost of coverage for qualified health insurance; 3) the individual does not have other specified coverage; and 4) the individual is not incarcerated or claimed as a dependent by another person.

What are the general eligibility requirements for the HCTC?
An individual is generally eligible for the HCTC if the individual meets any of the following criteria:

- the individual receives a Trade Readjustment Allowance under the Trade Adjustment Assistance (TAA) program, or is eligible for the allowance, but not yet receiving it because the individual has not yet exhausted his or her state unemployment benefits;
- the individual receives Reemployment Trade Adjustment Assistance benefits;
- the individual is at least 55 years old and receives payments from the Pension Benefit Guaranty Corporation (PBGC); or
- the individual is the spouse or dependent of an individual who satisfies any of foregoing criteria.

The trade assistance described above is generally for individuals in certain industries whose jobs are lost or threatened due to foreign-trade related circumstances, as determined by the DOL through a specified process. The PBGC pays benefits to participants in terminated, underfunded pension plans.

What is qualified health insurance coverage for the HCTC?
The following forms of health insurance coverage are included in the list of qualified health insurance coverage for the HCTC:

- coverage under COBRA;
- coverage under a group health plan available through a spouse's employer;
- coverage under individual health insurance if the eligible individual was covered by the insurance for the entire 30-day period ending on the date the individual became separated from employment that qualified the individual for the benefits described above and, for tax years beginning after December 31, 2015, the insurance was not obtained from an exchange established under the Affordable Care Act (ACA);
- coverage under a voluntary employees' beneficiary association (VEBA); and

- certain state-qualified health plans, such as state-based continuation coverage or covered offered through a state high-risk pool.

What is disqualifying coverage for the HCTC?
An individual may not claim the HCTC if enrolled in any of the following health plans:

- Medicare Part B;
- the Federal Employees Health Benefits Program;
- Medicaid; or
- the State Children's Health Insurance Program.

In addition, an individual may not claim the HCTC if *eligible* for Medicare Part A or coverage through the U.S. military health system (*i.e.*, TRICARE). As a practical matter, the Medicare Part A rule essentially limits eligibility for the HCTC to individuals under age 65.

How do individuals claim the HCTC?
To claim the HCTC, an individual must elect to receive it for an eligible coverage month. This election must be made no later than the due date (including extensions) for the tax return for the taxable year that includes the eligible coverage month and the individual will then receive the HCTC in the form of a refundable credit. Once the election is made, it is irrevocable and will apply for all subsequent eligible coverage months in the taxable year. The Trade Act provides transition relief to make elections for eligible coverage months in taxable years beginning after December 31, 2013 and before July 6, 2015.

In addition, the Trade Act requires the Secretary of Treasury to implement a mechanism to provide for advance payments of the HCTC within one year of the Trade Act's enactment. Prior to the HCTC's expiration, individuals could register with the HCTC Program's Customer Contact Center to receive advance payments of the HCTC. In this case, an individual needed to pay his or her share of the monthly insurance premium (*i.e.*, 27.5% of the premium) to the HCTC Program and the U.S. Treasury would then send payment for 100% of the premium to the individual's health insurance plan. Presumably, the IRS and Treasury will reinstate the HCTC Program mechanism that was in place before 2014 in order to implement the revived HCTC Program.

How does the HCTC work with the ACA?
As noted above, beginning in 2016, individuals are not eligible to receive the HCTC in connection with insurance purchased through an exchange created under the ACA. In addition, any eligible coverage month for which an individual makes an election for the HCTC is not treated as a coverage month for the premium tax credits provided under the ACA. The reinstated HCTC also includes an adjustment/offset provision if an individual receives the HCTC and an ACA premium tax credit for the same tax year.

What does the HCTC mean for employers?
Prior to its expiration, the HCTC was not widely used – it is estimated that less than 30,000 people per year took advantage of the HCTC. However, employers still need to keep the HCTC in mind going forward. Specifically, employers should consider adding information about the HCTC back to COBRA notices (particularly for terminations of

employment that are related to international trade) and descriptions of COBRA in summary plan descriptions and other communications with employees. In addition, employers should bear in mind that COBRA provides a TAA-eligible individual (but not PBGC-eligible individuals) who did not initially elect COBRA coverage with a second chance to make the election during the 60-day period that begins on the first day of the month in which the individuals becomes TAA-eligible if the election is made within six months after the date of the TAA-related loss of coverage. Before 2014, the DOL model COBRA notice included specific information concerning the HCTC. It is likely that the DOL will re-issue COBRA notices with similar model language for employers and plan administrators to use. In the meantime, employers and administrators could consider using that model language to update notices for the reinstatement of the HCTC.

Finally, the HCTC presents a strategic opportunity in certain bankruptcy situations where the debtor sponsors a PBGC-covered pension plan that will terminate through the bankruptcy and the debtor seeks to modify or terminate its retiree medical coverage. In this type of bankruptcy situation, the HCTC may allow the debtor to soften the impact of such changes on its retirees. However, under current law, the HCTC will again expire on December 31, 2019, so it may only assist retirees for a limited period.

Employers should review their COBRA notices, group health plan documents and summary plan descriptions and decide what administrative and document changes are needed to conform to the reinstated HCTC Program.

Third Circuit Rules That Actual Harm Needed for Monetary Equitable Remedy

By Madeline Chimento Rea

> The Third Circuit recently held that a plaintiff was not entitled to a monetary, equitable remedy under ERISA § 502(a)(3) where he failed to prove actual harm. *Perelman v. Perelman*, Nos. 14–1663, 14–2742, 2015 WL 4174537 (3d Cir. 2015). Appellant Jeffrey Perelman ("Perelman"), a participant in the defined benefit plan ("Plan") of Appellee General Refractories Company ("GRC"), brought suit in his individual capacity and on behalf of the Plan against his father, brother, GRC, and a former Plan administrator claiming his father, as trustee of the Plan, breached his fiduciary duties by investing Plan assets in companies owned and controlled by Perelman's brother. Perelman claimed these transactions were not properly reported, reduced Plan assets, and increased the risk of default. Plaintiff sought injunctive relief, attorney's fees and costs, and monetary relief under ERISA § 502(a)(3) in the form of restitution and disgorgement. The district court held that Perelman lacked constitutional standing to pursue his restitution and disgorgement claims because he did not demonstrate actual injury to himself. The district court dismissed all claims and denied Perelman's request for attorney's fees and costs. Perelman appealed seeking monetary relief and attorney's fees claiming he was entitled to restitution or surcharge because, as a result of his father's actions, the Plan suffered a diminution in assets, increasing its risk of default. The Third Circuit affirmed the dismissal of Perelman's monetary equitable relief claims, noting that "[c]laims demanding a monetary equitable remedy . . . require the plaintiff to allege an individualized financial harm traceable to the defendant's alleged ERISA violations." First, it held that a diminution in Plan assets was insufficient for standing purposes absent individualized harm, which Perelman could not show because he had received all

required distributions. As a result he suffered no financial harm traceable to the alleged ERISA violation. The Court also addressed Perelman's allegations regarding the risk of default and noted that since the "[P]lan's assets exceed[ed] its liabilities under a statutorily accepted accounting method, it passe[d] muster as a matter of law" even though the Plan was underfunded according to a different accounting method used by Perelman. Second, the Third Circuit also rejected his disgorgement claim because Perelman failed to show he had a right to any defendant's profit. Finally, the Court dismissed as unsupported Perelman's argument that he did not need to prove an individualized injury insofar as he sought monetary equitable remedies on behalf of the Plan. It also affirmed the denial of attorney's fees because, although Perelman's suit pressured defendants into significant concessions, an award of fees was not appropriate.

ACA Reporting Update: New Forms, Higher Penalties & Other Guidance

By Damian A. Myers

> With the impending deadline early next year, most applicable large employers are (or should be) in the process of gearing up for what is perhaps the biggest Affordable Care Act ("ACA") compliance challenge this year — the information reporting requirements found in Sections 6055 and 6056 of the Internal Revenue Code (the "Code") (details of which can be found here). Many employers are finding that properly programming their systems to track the data necessary to complete the forms is a lengthy, time consuming and complicated process. As they work with their vendors and internal resources to prepare to meet their obligations, employers should be aware that over the last few months, the stakes have been raised by new legislation and there has been some additional guidance as to completion of the forms.

A brief description of recent developments related to ACA reporting is provided below:

1. **IRS Releases New Draft Forms.** Despite releasing "final" forms and instructions in February 2015, the IRS released new draft forms in June 2015. The changes were, for the most part, minimal. For example, the new draft Form 1095-B now has an additional page so that more covered individuals can be listed. The new draft Form 1094-C has been renumbered so that Item 19 is now in Part I of the form. Form 1095-C has been revised to include a box for the employer to indicate the first month of the plan year. Completing this new box, which is optional for 2015 reporting, will assist employers sponsoring plans with non-calendar plan years. Finally, the IRS indicated that for 2016 reporting, new indicator codes will be established to require employers to report conditional offers to spouses. A conditional offer is one that is subject to a reasonable, objective condition, such as offering coverage upon certification that the spouse does not have group health coverage available from another employer. Currently, the instructions to Form 1095-C provide that a conditional offer such as this should be treated as an offer for reporting purposes only. However, the new indicator codes are needed so that the IRS can determine whether the spouse should be eligible for a premium tax credit.

2. **Trade Legislation Increases Reporting Penalties.** In July 2015, Congress passed, and the President signed, the Trade Preferences Extension Act of 2015. Among other things, the new law increased the statutory penalties for failing to file information reporting forms with the IRS or failing to provide copies of these forms to employees. The ACA reporting forms are subject to these penalties. The chart below reflects the increased penalties.

Reason for Penalty	Standard Penalty	Maximum Penalty
Forms filed or provided late, but within 30 days	$50 per report (previously $30 per report)	$500,000 (previously $250,000)
Forms filed or provided late, but by August 1	$100 per report (previously $60 per report)	$1,500,000 (previously $500,000)
Forms filed or provided late, but after August 1, or not filed at all	$250 per report (previously $100 per report)	$3,000,000 (previously $1,500,000)

If necessary, employers can request a 30-day extension to file the forms. Otherwise, penalty relief for late reports is subject to a reasonable cause standard. Also, for 2015, the IRS will not assess a penalty for an incorrect report as long as the report is timely filed and the employer attempted in good faith to complete the report correctly. In future years, incorrect filings will be subject to a reasonable cause standard.

3. **IRS Q&As Provide Special Rules for COBRA Offers**. In May 2015, the IRS released Questions & Answers ("Q&As") providing additional guidance on Form 1095-C, the form on which employers will use indicator codes to report offers of, and enrollment in, coverage. Among other things, the Q&As provided special rules relating to the coding for offers of COBRA coverage. When an offer of COBRA coverage is made to a former employee as the result of a termination from employment, the employer should indicate on Form 1095-C that an offer of coverage was made only if the former employee actually elects to enroll in the coverage. The reason for this is that the IRS does not want to disqualify a terminated employee from a premium subsidy based on an offer of COBRA coverage that was not accepted. However, when an offer of COBRA coverage is made to an employee due to a reduction in hours, the employer should indicate on Form 1095-C that an offer of coverage was made whether or not the employee elects to enroll in the coverage. In this situation, the cost used to determine affordability should be the employee's self-only COBRA premium or contribution. Employers should be aware that a loss of coverage due to a reduction in hours could trigger a penalty under Code Section 4980H(b). This would happen if the affected employee was determined to be full-time based on the look-back measurement method and the reduction in hours occurred during the applicable stability period. In most circumstances, employees are required to

pay a COBRA premium or contribution equal to 102% of the cost of coverage, which would usually exceed the affordability threshold for purposes of Code Section 4980H. Although the offer of COBRA coverage would prevent a penalty under Code Section 4980H(a), the employee could reject the COBRA coverage and obtain a premium subsidy when Marketplace coverage is purchased. This would trigger the penalty under Code Section 4980H(b).

Over the next few months, it is anticipated that the IRS will issue additional guidance related to these reporting requirements. As this additional guidance is released, employers should consider whether any adjustments are needed to their programming. Of course, given the complexities involved with these requirements, employers should seek the assistance of counsel to make sure the forms are properly completed.

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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