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Editor's Overview

This month we review a recent Second Circuit decision addressing ERISA plan status as a class member in a securities shareholder class action. As discussed in the article, the decision exposes a potential conflict among the circuits as to whether plans will be permitted to participate as class members in a securities settlement, although the conflict can be altogether averted through careful drafting of the class definition.

In the Rulings, Filings, and Settlements of Interest section, we review the IRS's extension of the distribution deadline for ACA reporting and the continuation of the good faith compliance standard that was in effect for the first year of ACA reporting; the first ruling denying a challenge to the DOL's conflict of interest rule and related exemptions; the impact of the election on the ACA; an Oregon state court's treatment of the federal slayer rule; and the AARP's suit to block the EEOC's final rules on employee wellness programs.

Second Circuit Addresses ERISA Plan Participation in Securities Lawsuit Settlements*

By Tulio Chirinos

In many class action securities litigations, the company's own pension plans are significant shareholders, by virtue of the plans' investment in company stock. Most frequently the plan at issue is a 401(k) plan that offers company stock as an investment option, but defined benefit and other plans could be shareholders as well. It is important to consider whether and, if so, how the plans participate in settlements of securities lawsuits.

As the legal record-holder of the stock, the plan, as opposed to the plan participants, is the most likely candidate to be the class member in the lawsuit. Plaintiffs' counsel, however, may seek to exclude the plan from participation in the lawsuit's settlement as part of a general exclusion of any persons or entities associated with the corporate defendant. Furthermore, when a plan does participate in the settlement, there are sometimes disputes about how to calculate its recovery because plans often offset purchases and sales requests of their participants before engaging in transactions on the open market. A claim that is submitted based on a plan's net purchases may not yield the same recovery as a claim that is submitted based on individual participant elections.

In the AIG securities class action, *In re Am. Int'l Grp., Inc. Sec. Litig.*,14-4067, 2016 WL 5075939 (2d Cir. Sept. 20, 2016), the Second Circuit addressed the first of these issues, but not the second. The Court was asked to determine whether AIG's ERISA plans – three 401(k) plans and one defined benefit plan (the "Plans") – were properly excluded from the class of shareholders participating in the settlement because they were deemed "affiliates" of AIG. The Second Circuit concluded that the Plans were not affiliates and thus could participate in the settlement. But it left for another day the issue of whether the Plans could submit their claims on a plan-wide level or on a participant-by-participant basis.

Background

AIG was sued for violations of the federal securities laws. The lawsuit ultimately settled pursuant to an agreement which by its terms excluded from the settlement class "any parent, subsidiary, affiliate, officer, or director of AIG." The settlement agreement did not define "affiliate."

After the district court granted final approval to the settlement, the Plans moved the district court to direct the claims administrator to approve their settlement claims. The claims administrator determined that that the Plans were ineligible to participate in the settlement for two reasons. First, the claims administrator concluded that the Plans were "affiliates" of AIG, and thus excluded from the class. Second, the claims administrator concluded that the Plans failed to identify any purchases of publicly traded AIG securities because their claims were based on participant-level purchase requests, and the participants were not the legal title holders of the stock.

The district court declined the Plans' request to approve their claims. After consulting Black's Law Dictionary and securities law regulations, the district court concluded that the Plans were affiliates of AIG because of the control AIG exhibited over them – specifically, through the power to direct the management and policies of the Plans. Among other things, the court observed that the Plans are sponsored by AIG or a subsidiary, the individuals comprising the Plans' administrator (consisting of AIG employees) were appointed by AIG, and AIG could disband the Plans without reason. In so ruling, the court relied on *In re Motorola Sec. Litig.* 644 F. 3d 511 (7th Cir. 2011), where the Seventh Circuit held, under substantially similar circumstances, that an ERISA plan was an affiliate of Motorola.

The Plans thereafter moved to intervene in the underlying class action for the purpose of appealing the district court's order. The court denied the motion and the Plans appealed.

The Second Circuit's Decision

The Second Circuit reversed and remanded, concluding that the Plans were eligible to collect a "slice of the settlement pie" because they were not affiliates of AIG.

Like the district court, the Second Circuit looked first to Black's Law Dictionary and to the securities law regulations and found that they each conditioned affiliate status on the level of control exercised by the parent entity on the purported affiliate. Unlike the district court, however, the Second Circuit found that sponsorship of the Plans by AIG or an affiliate was "too slender a reed upon which to predicate a finding of control." First, the Court observed that ERISA presumes that the interests of the employer and the employer-sponsored plans are adverse and requires that ERISA plans be managed solely in the interest of the plan's participants and beneficiaries. Second, the Court concluded that AIG's ability to select the plan administrator was not equal to the power to shape the Plans' management and policies because the plan administrator must wear different "hats" when it acts for AIG and when it act for the Plans, and may only wear one hat at a time. Third, the Court rejected the district court's finding that AIG's authority to disband the Plans without reason gave it sufficient "control" to be deemed an affiliate because ERISA's fiduciary duties prohibit the Plans from being influenced by AIG threatening to disband them for lack of cooperation.

The Second Circuit declined to follow the Seventh Circuit's ruling that Motorola had control over the plans (and thus that the plans were affiliates) because, in its view, the Seventh Circuit did not consider the role of ERISA in shaping the limits of an employer's control over a sponsored plan. In particular, the Second Circuit observed that the U.S. Department of Labor has stated that many of ERISA's provisions are premised on the concept of an employee benefit plan being independent of the employer plan sponsor. Furthermore, ERISA § 403 provides that ERISA plan assets "shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries."

Finally, the Second Circuit concluded that AIG was not an affiliate because it was not within the category of entities that the parties would have intended to exclude from the class. The Court explained that exclusions like this are generally drafted to ensure that those who perpetrated, or otherwise profited from, the alleged wrong would not benefit from the settlement. Here, that purpose would not be fostered because there was no dispute that the Plans' participants and beneficiaries were not those that perpetrated the alleged securities violations that gave rise to the class actions.

The Second Circuit declined to rule on the issue of whether the claims administrator erred when denying the claims by the three defined contribution plans on the grounds that the claims were submitted on a participant-level, rather than on a plan-level. The issue was significant because the participant-level "recognized loss," was $200.6 million collectively across the Plans, whereas the plan-based "recognized loss," which took into account the Plan's net purchases and sales on the open market, was only $80.5 million collectively across the Plans. Because the district court did not reach this issue, the Second Circuit remanded the question to the district court to consider it in the first instance.

Proskauer's Perspective

The Second Circuit's decision exposes a potential conflict among circuits as to whether plans will be permitted to participate as class members in a securities settlement. The potential conflict can be averted, however, through careful drafting of the class definition, whether in the initial class certification motion or the class settlement agreement. As the Second Circuit noted, "if drafters *do* want to exclude employer-sponsored plans, they can simply say so." The case law does not resolve the related issue of whether, if the plan is excluded, participants can file their own individual claims, notwithstanding the fact that they do not own legal title to the shares held on their behalf by the plan.

Assuming participation in the settlement by the ERISA plan, it remains to be seen how the plans will be able submit its claim to the settlement administrator, *i.e.*, on a participant-level or a plan-level. As the *AIG* litigation illustrates, the outcome of this issue can have a material impact on the amount of a plan's recovery.

Rulings, Filings, and Settlements of Interest

IRS Extends Distribution (Not Filing) Deadline for ACA Reporting and Continues Good Faith Standard

By Damian A. Myers

Today, the IRS announced (see Notice 2016-70) an extension to the distribution (but not filing) deadline for the Affordable Care Act (ACA) reporting requirements set forth in Sections 6055 and 6056 of the Internal Revenue Code (the "Code"). Under Code Section 6055, health coverage providers are required to file with the IRS, and distribute to covered individuals, forms showing the months in which the individuals were covered by "minimum essential coverage." Under Code Section 6056, applicable large employers (generally, those with 50 or more full-time employees and equivalents) are required to file with the IRS, and distribute to employees, forms containing detailed information regarding offers of, and enrollment in, health coverage. In most cases, employers and coverage providers will use Forms 1094-B and 1095-B and/or Forms 1094-C and 1095-C. The chart below shows the new deadline for distributing the forms.

	Old Deadline	**New Deadline**

Deadline to Distribute Forms to Employees and Covered Individuals	Jan. 31, 2017	March 2, 2017
Deadline to File with the IRS	Feb. 28, 2017 (paper) March 31, 2017 (electronic)	**NO CHANGE**

The regulations issued under Code Section 6055 and 6056 allow for an automatic 30-day extension to distribute and file the forms if good cause exists. An additional 30-day is extension is available upon application to the IRS. Notice 2016-70 provides that these extensions do not apply to the extended due date for the distribution of the forms, but they do apply to the unchanged deadline to file the forms with the IRS.

In addition to extending the distribution deadline, the IRS continued the interim good faith compliance standard that was in effect for the first year of ACA reporting (for the 2015 year). Under this standard, the IRS will not assess a penalty for incomplete or incorrect information on the reporting forms as long as the forms were filed on time and the filer can show that it completed the forms in good faith. Thus, it is important to distribute and file the forms on time.

Those that do not file by the new deadlines will be subject to penalties under Code Sections 6721 and 6722. The IRS stated in Notice 2016-70 that it would apply a reasonable cause analysis when determining the penalty amount for a late filer. According to the IRS, this analysis will take into account such things as whether reasonable efforts were made to prepare for filing (e.g., gathering and transmitting data to an agent or testing its own ability to transmit information to the IRS) and the extent to which the filer is taking steps to ensure that it can comply with the reporting requirements for 2017.

DOL Prevails In First Challenge to the Conflict of Interest Rule and Related Exemptions

By Russell Hirschhorn and Benjamin Saper

On November 4, 2016, Judge Moss in the U.S. District Court for the District of Columbia granted the U.S. Department of Labor's motion for summary judgment and dismissed claims brought by the National Association for Fixed Annuities ("NAFA") challenging the Department's conflict of interest rule and related exemptions. *Nat'l Ass'n for Fixed Annuities v. Perez*, No. CV 16-1035 (RDM), 2016 WL 6573480 (D.D.C. Nov. 4, 2016). The decision is the first to be issued among the four pending cases asserting similar challenges. (Our earlier blog posts on the cases are available here.)

NAFA asserted claims under the Administrative Procedures Act, the Regulatory Flexibility Act and the Due Process Clause of the Fifth Amendment, challenging: (i) the Department's decision to replace the five-part test set forth in the 1975 regulation and, in particular, its decision to eliminate the requirement that advice be offered "on a regular basis;" (ii) the Department's decision to apply the rules to IRAs and other plans that are not subject to Title I of ERISA; (iii) the written contract requirement contained in the Best Interest Contract ("BIC") Exemption on the ground that it impermissibly creates a private right of action; (iv) the BIC Exemption on the ground that the "reasonable compensation" condition is vague; (v) the Department's decision to move fixed indexed annuities ("FIAs") from PTE 84-24 to the BIC Exemption; and (vi) the effectiveness of the rule for want of a regulatory impact analysis.

First, the court rejected NAFA's argument that the Department exceeded its statutory authority by abandoning its decades-old five-part test under which an individual was an investment advice "fiduciary" only if they rendered investment advice for a fee "on a regular basis." The new rule establishes a broader definition of "investment advice," which includes advice even if not given "on a regular basis." In ruling against NAFA, the court held that the Department was entitled to *Chevron* deference in its interpretation of the term "investment advice," and that nothing in the statutory text foreclosed the Department's new interpretation. In fact, the court concluded that the Department's new interpretation better comports with the text and purpose of ERISA than the old rule.

Second, the court rejected NAFA's argument that the Department exceeded its statutory authority by extending fiduciary duties found only in Title I of ERISA to individuals who advise IRAs and other non-Title I plans. The court determined that the Department had the authority to condition prohibited transactions exemptions on compliance with ERISA's duties of loyalty and prudence.

Third, the court rejected NAFA's argument that the new rules impermissibly created a private right of action for violations of the BIC Exemption. The court concluded that the Department was extending rights that already existed under state law and that any action brought to enforce the terms of the written contract would be brought under state law.

Fourth, the court rejected NAFA's argument that the "reasonable compensation" requirement of the BIC Exemption was void for vagueness because the concept of "reasonable compensation" is a common one that appears throughout the U.S. Code, including in ERISA. The court determined that "a reasonably prudent person, familiar with the conditions the BIC Exemption is meant to address and the objectives the exemption and conditions are meant to achieve, would have fair warning of what the regulations require."

Fifth, the court rejected NAFA's argument that the Department failed to give fair warning or an opportunity to comment on the Department's decision to make FIAs ineligible for PTE 84-24. Although the decision to subject FIAs to the more onerous BIC Exemption is different than the proposed rule, the court held that the Department had satisfied the notice requirements because the final rule was a "logical outgrowth of the notice."

Lastly, the court rejected NAFA's argument that the Department failed to accompany the final rule with a "final regulatory flexibility analysis." According to the court, the final regulatory flexibility analysis is only a procedural requirement, and it is not for the court to analyze whether the agency's analysis was correct. Rather, the only question for the court was whether the Department put forth a reasonable good-faith effort to comply with the procedural steps laid out in the statute. The court concluded that the Department's 382-page final analysis satisfied the requirement.

Proskauer's Perspective

Although the Department scored an early victory in the *NAFA* litigation, it will certainly not be the last word on the Department's conflict of interest rule and related exemptions. NAFA already has filed an appeal to the D.C. Circuit and that appeal, along with the three other cases, remain to be decided.

In the lawsuit filed by Market Synergy Group, the U.S. District Court in Kansas heard oral argument on September 21, 2016. In the consolidated case led by the U.S. Chamber of Commerce, the U.S. District Court for the Northern District of Texas heard oral argument on November 17, 2016. In the case filed by Thrivent Financial, the U.S. District Court in Minnesota is scheduled to hear oral argument on March 3, 2017. Unlike the cases filed by Market Synergy and the Chamber, Thrivent Financial challenges the rule on the ground that it impermissibly requires the resolution of disputes in federal court rather than allowing for alternative dispute resolution methods.

It also remains to be seen what action, if any, the Trump administration will take. President-elect Trump has expressed a desire to reduce regulation and the Republican-controlled Congress previously passed legislation that would have undone the regulation (but was vetoed by President Obama). Although nothing is certain – and there has been no announcement – the April 10, 2017 applicability date very well may be delayed.

Election Results Likely to Result in the End of the ACA as We Know It, But Employers and Plan Sponsors Should Stay the Course for Now

By Robert Projansky, Steven Weinstein and Damian A. Myers

Over the past five years or so, Republican Congressmen have repeatedly taken steps to repeal President Obama's landmark legislative effort – the Patient Protection and Affordable Care Act (the "ACA"). However, those efforts either failed to advance in Congress or were vetoed by President Obama. Tuesday's Presidential and Congressional election, in which Donald Trump was elected President and Republicans maintained a Congressional majority in both houses, puts the future of the ACA in jeopardy. Indeed, President-elect Trump and Congressional leaders have already confirmed that repeal of the ACA is a top priority.

Although the ACA is certainly in the crosshairs, the path to outright repeal is not so clear. Republicans have majority control in both chambers of Congress, but they do not have a filibuster-proof supermajority in the Senate. This means that unless Congress changes procedural rules, Democratic Senators can effectively block though filibuster any blanket repeal of the ACA.

So what other options do Congress and President-elect Trump have? First, Congress could invalidate many of the ACA's revenue-related provisions through budget recollection legislation. This is not a novel approach to effect healthcare legislation – the ACA itself was a product of budget reconciliation legislation passed after Democrats lost their Senate supermajority in 2010. Budget reconciliation legislation cannot be held-up by filibuster, but the subject of the legislation must be related to revenue. Non-revenue related provisions can be struck from this type of legislation.

In 2015, the Republican-controlled Congress passed budget reconciliation legislation to invalidate many of the ACA's revenue-related provisions. Although that legislation was vetoed by President Obama, it might be used as a template for new legislation once President-elect Trump takes office. Here are some key parts of the 2015 legislation:

- The individual and employer mandates (and associated reporting requirements) would be repealed.
- Expansion of Medicaid to electing States would be repealed.
- The availability of premium and cost-sharing subsidies on the public insurance Marketplace would be repealed.
- Taxes, such as the "Cadillac Tax", medical device tax and increased Medicare taxes on high-earners would all be repealed.

Other ACA market reforms, such as first-dollar coverage of preventive healthcare, prohibition on preexisting condition exclusions, prohibition of annual and lifetime limits on certain benefits, and required coverage of dependents through age 26, are generally not related to revenue and probably cannot be included in budget reconciliation legislation.

Second, President-elect Trump could take immediate action to impact agency enforcement of various aspects of the ACA. For example, President-elect Trump could issue a directive to agencies to stop all enforcement of regulations currently in effect under the ACA. In addition, incoming Presidents often take immediate action to stop regulatory efforts in process. This means that proposed and pending regulations would never become effective. At the moment, regulations related to expatriate healthcare coverage and opt-out payments are currently proposed and regulations related to the Cadillac Tax are being drafted. In addition, recently proposed regulations would expand Form 5500 filing requirements to include attestations regarding compliance with the ACA. Presumably, those regulatory efforts would end.

Moreover, a significant part of the ACA's enforcement infrastructure is found in sub-regulatory guidance – there are 34 interpretive FAQs alone – meaning that there are opportunities for the new administration to take action without significant procedural hurdles. One could surmise that the days of expansive interpretations of the ACA in sub-regulatory guidance are over and, in some cases, prior sub-regulatory guidance would be reversed.

To the extent that the ACA is limited or eliminated by these actions, there is then the question of what stands in its place. Throughout his campaign, President-elect Trump has made clear that he intends not just to repeal the ACA, but also replace it with something new. Concrete details are lacking at the moment, but the following are possible components of his replacement plan:

- A cap on the employer deduction for health coverage provided to employees.
- Individuals without employer-provided health coverage would receive a tax credit against the cost of coverage purchased on the individual market. The tax credit would not be an advanced premium credit, but would instead be taken in full when filing income tax returns.
- Expansion of health savings accounts, including increased contribution limits, and improved price transparency from healthcare providers.
- Insurance companies would be able to sell policies across state lines.
- Provide block grants to states for Medicaid.
- Allow consumer access to imported drugs meeting safety standards.

Ultimately, it is far too early to know exactly what President-elect Trump and the Republican-controlled Congress will do with respect to the repeal of the ACA and the enactment of new health care reform or what the impact of any of those changes will be. Even if the ACA is ultimately repealed in full or in part, it is unlikely to happen on "day one." Therefore, at least for the time being, employers and plan sponsors should continue operating their health plans in compliance with the ACA.

Oregon State Court of Appeals Recognizes Federal Slayer Law

By Lindsey Chopin

Oregon, like many states, has on its books a "slayer statute," which generally prohibits a slayer or abuser of a decedent from obtaining benefits by virtue of the death of the decedent. The parents of Julianne Herinckx sought to enforce the Oregon slayer statute and preclude their daughter's murderers from receiving life insurance benefits payable from a policy held through her former employer. The Oregon state trial and appellate courts determined that Oregon's slayer statute was preempted by ERISA because it impermissibly governed the payment of benefits and interfered with ERISA's intended national uniformity in the administration of benefits. However, the appellate court also concluded that the decedent's parents should have been permitted to amend their complaint to assert a claim for benefits as a matter of federal common law, which includes a slayer law. The case was thus remanded to the district court for further proceedings. The case is *Herinckx v. Sanelle*, 2016 WL 6246921 (Or. Ct. App. Oct. 26, 2016).

AARP Files Suit to Block the EEOC's Final Rules on Employee Wellness Programs

By Seth Safra and Laura Fant

As we have previously discussed in detail in several blogs (New EEOC Regulations Provide Roadmap for Wellness Programs; EEOC Issues Final Rules On Employer-Sponsored Wellness Program Compliance Under the ADA and GINA; and District Court Decision Upholds Employer's Wellness Program But Signals Support for EEOC Positions Going Forward), the EEOC issued final rules in May 2016 on the extent to which an employer may offer incentives to participate in a wellness program without violating the Americans with Disabilities Act (ADA) or the Genetic Information Nondiscrimination Act (GINA). The final rules were intended to put to rest uncertainty as to the line between a permissible *incentive* to participate in a wellness program and an impermissible *penalty* for not participating in the program. The line that the EEOC drew appeared to be consistent with an authorization for wellness programs under the Affordable Care Act.

AARP has now sued the EEOC to block the May final rules. In its complaint, AARP asserts that the EEOC's final rules did not go far enough to avoid compelling participation. AARP asserts that the incentives permitted by the final rules "enable employers to pressure employees to divulge their own confidential health information and the confidential genetic information of their spouses as part of an employee 'wellness' program." AARP argues that the final rules "depart starkly from the EEOC's longstanding position" that "employee wellness programs implicating confidential medical information are voluntary only if employers neither require participation nor penalize employees who choose to keep their medical and genetic information private." The complaint alleges that the final rules are contrary with Congressional intent and that the EEOC did not adequately justify the standard for voluntariness in its final rule.

AARP is seeking a preliminary injunction that would keep the final regulations from going into effect on January 1. If AARP is successful, common wellness programs will again be called into question—for example, premium discounts and prizes for participating in health risk assessments and screenings.

We will continue to monitor this case and report on further developments.

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