Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

Like our new look? Our blog, available at www.erisapracticecenter.com, also has a refreshed design that is easily accessible from your computer, tablet or smartphone.

This month, we look at the implications of the two federal district court cases from California that applied the ban on discretionary clauses typically found in ERISA plans to self-insured plans. The decisions, if adopted elsewhere, have the potential to materially alter the landscape of benefit litigation going forward.

In the Rulings, Filings and Settlements of Interest section, we provide an update on fiduciary rule litigation and review the recently released guidelines under the IRS's Employee Plans Compliance Resolution System, the Eighth Circuit's enforcement of an ERISA plan's forum selection clause, and a decision upholding a wellness program while at the same time signaling that the EEOC's regulations on wells plans may be enforceable going forward.

Self-Funded ERISA Plans Subject to California Law Barring Discretionary Clauses[1]

By Tulio Chirinos

For nearly three decades, ERISA plans have routinely included a provision that grants plan fiduciaries unfettered discretion to interpret and rule on issues concerning plan interpretation. These so-called "discretionary clauses" have been subjected to a firestorm of criticism by many states, which argue that the discretionary clauses lead to inequitable results for the plan participants. As a result, many states have enacted laws banning discretionary clauses in insurance policies. For insured plans, these laws have generally withstood ERISA preemption attacks. Two federal district courts in California have gone a step further and concluded that the California Insurance Code provision that bars discretionary clauses also applies to self-funded ERISA short-term disability plans.

Discretionary Clauses

The U.S. Supreme Court long ago held that reviewing courts should apply a de novo standard of review to plan fiduciaries' decisions unless the benefit plan provides the fiduciary with discretionary authority to determine eligibility for benefits or construe the terms of the plan – a "discretionary clause" – in which case the decision should be reviewed for an abuse of discretion, *i.e.*, under an arbitrary and capricious standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Since *Firestone*, states and plan sponsors and fiduciaries have offered competing views of the benefits associated with plan provisions that allow for an abuse of discretion review. Supporters of the use of discretionary clauses contend that such clauses keep costs manageable, and the failure to control litigation costs will discourage employers from offering employee benefit programs in the first place. Supporters of bans on discretionary clauses argue that such bans help to eliminate unfairness and misleading policy language, and also minimize the conflicts of interest that exist when the claims adjudicator also pays the benefit.

State Bars to Discretionary Clauses

Many states ban or restrict discretionary clauses in ERISA insured plans and insurance policies. Plan sponsors and fiduciaries have challenged the enforceability of these state laws on the ground that they were preempted pursuant to ERISA § 514, which expressly preempts all state laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The states have argued that the clauses were insulated from preemption pursuant to ERISA's "savings clause," which provides that ERISA "shall [not] be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). A state law regulates insurance within the meaning of section 514(b)(2)(A) of ERISA if it: (i) is "specifically directed toward entities engaged in insurance," and (ii) "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003).

The circuit courts have generally concluded that state bans on discretionary clauses regulate insurance and thus are saved from ERISA preemption. *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009); *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009). The Tenth Circuit concluded that Utah's limited state ban on discretionary clauses did not regulate insurance, and thus was preempted. The Court determined that the rule related to the form, and not the substance, of ERISA plans. *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009). On that basis, the Tenth Circuit distinguished Utah's rule from the state bans on discretionary clauses in *Ross* and *Standard Insurance* and suggested that a blanket prohibition on the use of discretion-granting clauses would have altered the court's analysis.

As noted, these lawsuits involved fully insured ERISA plans, not self-funded plans. The distinction is important, since, under ERISA's "deemer clause," self-funded plans are deemed to not be "engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies." 29 U.S.C. § 1144(b)(2)(B). Some courts have thus concluded that these plans are immune from state law bans on discretionary clauses. *Guest-Marcotte v. Life Ins. Co. of N. Am.*, 2016 U.S. Dist. LEXIS 33815, at *21-23 (E.D. Mich. Feb. 17, 2016), *adopted by*, *Guest-Marcotte v. Life Ins. Co. of N. Am.*, No. 15-CV-10738, ECF No. 42 (E.D. Mich. Mar. 15, 2016).

Application of Discretionary Bans to Self-Funded Plans

In what appear to be cases of first impression, two federal district courts in California have held that California's ban on discretionary clauses applied to ERISA self-funded plans. *Williby v. Aetna Life Ins. Co.*, 2015 U.S. Dist. LEXIS 116442 (C.D. Cal. Aug. 31, 2015); *Thomas v. Aetna Life Ins. Co.*, 2016 U.S. Dist. LEXIS 107815 (E.D. Cal. Aug. 15, 2016).

In *Williby*, the court concluded that a plain reading of the state ban – which applies to any insurance policy, certificate or agreement – indicated that the law applied to self-insured plans because "an ERISA plan is a contract." The court stated that its reading of the ban was supported by the legislative history of the state ban, wherein the California Insurance Commissioner's counsel noted that ERISA "employer-sponsored disability contracts" with discretionary clauses deprive insureds of the benefits for which they bargained. The *Williby* court did not conduct any preemption analysis in reaching its conclusion. Because the court found the discretionary clause void and unenforceable, it reviewed Aetna's denial of benefits de novo.

More recently, in *Thomas*, the court followed *Williby* and explained that the California Insurance Code's prohibition against discretionary clauses applies, not only to insurance policies, but also to contracts in general, including self-funded ERISA plans. The court never reached the question of whether the state law was saved from preemption because it concluded that the state law did not relate to an ERISA plan, *i.e.*, it did not have an "impermissible connection" with an ERISA plan. In so ruling, the court rejected Aetna's reliance on *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) in arguing that the ban was preempted because it impermissibly interfered with a key facet of ERISA plan administration by voiding discretionary clauses that allow for the uniform administration of plans and save administrators from having to master the laws of all 50 states. In *Gobeille*, the Supreme Court determined that a Vermont law, that required self-funded plans to report data related to payments for healthcare claims or pay a fine, was expressly preempted by ERISA. The Thomas court distinguished the California state law ban from the Vermont law *Gobeille* found to be preempted because the Vermont law added new requirements, including additional reporting for administrators of ERISA benefits plans, and thus created a new cause of action. The court further explained that since the California ban only enforced the default standard of review under ERISA, *i.e.*, the de novo standard of review, it did not provide an alternative enforcement mechanism outside of ERISA's civil enforcement provisions. The court acknowledged Aetna's arguments that *Williby* was incorrectly decided but stated that absent further direction from the Ninth Circuit it was "reluctant to forge a new path" when all previous cases addressing the California ban – all of which involved fully insured plans, except for *Williby* – have concluded that it is not preempted by ERISA.

Proskauer's View

The rulings in California appear to be clearly at odds with precedent deeming self-funded plans to be outside the purview of ERISA's "savings clause," and thus insulated from state law regulation. They are an indication that, in some jurisdictions, the desire to regulate plan provisions that are deemed to be unfair may cause courts to circumvent these legal constraints. Although these decisions are not binding precedent, plan sponsors and fiduciaries should be mindful of them and watch for further developments, particularly those who may find themselves subject to the California ban on discretionary clauses.

Rulings, Filings, and Settlements of Interest

Update on Lawsuits Challenging the U.S. Department of Labor's Fiduciary Rule

By Russell Hirschhorn and Benjamin Saper

In this update on the litigation challenging the U.S. Department of Labor's new fiduciary rule, we note that there has been a sixth lawsuit filed and oral arguments in two other cases. (Our previous reports are available here, and our client alert on the new rule is available here.)

Thrivent Financial for Lutherans, a Christian fraternal benefit society that provides insurance and financial services to its members, filed a sixth lawsuit challenging the fiduciary rule on September 29, 2016 in the U.S. District Court for the District of Minnesota (captioned *Thrivent Financial for Lutherans v. Perez et al.*, Case No. 0:16-cv-03289). The *Thrivent* suit challenges the rule's "best interest contract exemption" ("BICE"), which requires the resolution of disputes in federal court rather than allowing for alternative dispute resolution methods. Thrivent takes issue with this requirement because it believes that its arbitration system is essential to the fraternal nature of the relationship between Thrivent and its members. Thrivent claims that the DOL has exceeded its statutory authority under the Administrative Procedures Act because nothing in ERISA indicates Congress intended to require an exclusive judicial remedy, and Congress has supported arbitration agreements as a preferred means of resolving disputes through the Federal Arbitration Act.

In the litigation pending in the U.S. District Court for the District of Columbia, *The National Association for Fixed Annuities v. Thomas E. Perez et al.*, Case No. 16-cv-1035, the court held a hearing on August 25, 2016 to address the National Association for Fixed Annuities' motion for a preliminary injunction and for summary judgment, and the DOL's cross-motion for summary judgment. Much of the argument was devoted to the new rule's creation of a private right of action for violations of the BICE. Judge Moss has not yet issued a ruling on those motions. A summary of the parties' arguments from their briefs appears here.

In the litigation pending in the U.S. District of Kansas, *Market Synergy Group, Inc. v. U.S. Dept. of Labor, et al.*, Case No. 16-cv-4083, the court held oral argument on September 2, 2016. Market Synergy argued that the DOL failed to prove the current state-based regulation of fixed-indexed annuities ("FIAs") was broken, and that the judge should "hit the pause" button on including them in the DOL's rule. Following the hearing, the parties filed supplementary briefs focused on the DOL's failure to give notice and receive public comments on the inclusion of FIAs in the BICE. Market Synergy wrote that "[b]ecause the Department never indicated that it might view [fixed indexed annuities] as dissimilar from other fixed annuities or discussed [fixed indexed annuities] in its notice, *nobody* submitted a comment on that issue." The DOL argued that any oversight in its rulemaking was "harmless error" because the DOL considered all public comments and the public was not prejudiced by the notice failure. The court has not yet rendered a decision.

Oral argument is scheduled for November 17, 2016 in lawsuits filed in the Northern District of Texas and consolidated under *Chamber of Commerce of the U.S., et al., v. Perez, et al.*, Case No. 16-cv-1476-M. As previously reported here, the Chamber of Commerce and its co-plaintiffs argue that the new rule unlawfully creates a private right of action, that the rule violates the First Amendment as applied to truthful commercial speech, and that the DOL exceeded its statutory authority and acted arbitrarily and capriciously in imposing fiduciary obligations on non-fiduciary speech and disfavoring annuities. They also argue that the rulemaking process was inadequate.

IRS Issues New EPCRS Guidelines to Coordinate with Limited Determination Letter Program

By Damian A. Myers

On September 29, 2016, the IRS released new guidelines under its Employee Plans Compliance Resolution System (EPCRS). EPCRS consists of three programs by which plan sponsors can correct plan documentation or operational errors – the Self-Correction Program, the Voluntary Correction Program and the Audit Closing Agreement Program. Rev. Proc. 2016-51 supersedes the older guidelines (Rev. Proc. 2013-12) and incorporates certain more recent developments affecting qualified plan corrections. Below are the key changes that plan sponsors should be aware of:

1. Coordination with Determination Letter Program. As set forth in Proc. 2016-37, the IRS has curtailed its determination letter program with respect to individually-designed plans. Rev. Proc. 2016-37 formalized what the IRS had for months said was coming – the remedial amendment cycle program, which permitted individually-designed plans to file for a determination letter every five years, is ending effective January 1, 2017. Beginning on that date, plan sponsors may request a determination letter for an individually-designed plan only if the plan has never received a letter (such as a new plan) or the plan is terminating. Note that the final cycle, Cycle A, does not end until January 31, 2017, so Cycle A filers are permitted to submit determination letter applications until that date.

   The new limited determination letter program created uncertainty under existing EPCRS guidance because applications for correction under EPCRS often required contemporaneous submission of a determination letter application. Additionally, to use the self-correction procedures under EPCRS for significant errors, a plan needed to have a current determination letter. Rev. Proc. 2016-51 modifies the EPCRS guidance to clarify that (i) determination letter applications are no longer required when applying for correction under EPCRS (including correction by a plan amendment) and (ii) self-correction for significant errors is available as long as the plan has a determination letter (whether or not “current”).

2. Incorporation of Rev. Procs. 2015-27 and 2015-28. In 2015, the IRS modified EPCRS guidelines to provide alternative correction options for certain overpayments (Proc. 2015-27) and to relax correction requirements for certain elective deferral errors (Rev. Proc. 2015-28). Prior blog posts summarizing these modifications can be found here and here. The new EPCRS guidelines incorporate these modifications and supersede the 2015 Revenue Procedures.

3. Fees. The new EPCRS guidelines no longer set forth the filing fees owed for use of the correction program. Instead, fees will published annually by the IRS.

4. Audit CAP Program. The new guidelines modify the IRS method of determining sanctions under the Audit Closing Agreement Program (Audit CAP). Under this program, if significant plan errors are uncovered during audit or examination (i.e., the plan sponsor does not voluntarily seek correction before the IRS finds the error(s) on audit), the plan sponsor is entitled to use the Audit CAP. Prior to Rev. Proc. 2016-51, sanctions under Audit CAP were a negotiated percentage of the maximum payment amount, which is based on the potential tax liability that would be incurred in open tax years if the plan was actually disqualified. Under the new EPCRS guidelines sanctions are no longer solely determined based on the maximum payment amount. Instead, the maximum payment amount will be one of many facts and circumstances that the IRS will take into account when determining the sanction.

5. Anonymous VCP Fees. Under the Voluntary Correction Program (VCP), plan sponsors are able to submit a plan to the IRS anonymously and get conditional approval of a proposed correction prior to identifying the plan and plan sponsor. If approval cannot be obtained, a plan sponsor can withdraw the application. The current guidelines provide that the IRS will refund 50% of the VCP filing fee if the anonymous application is withdrawn. Effective January 1, 2017, however, the IRS will no longer refund any portion of the user fee if an anonymous VCP application is withdrawn.

Rev. Proc. 2016-51 provides a necessary update of the EPCRS guidelines because of the changes to the determination letter program. The new EPCRS guidelines are technically effective beginning January 1, 2017, but many of the changes reflect prior guidance (such as Rev. Procs. 2015-27 and 2015-28) that has been effective for quite some time. Additionally, the IRS has informally indicated that although plan sponsors can submit determination letter applications along with VCP submissions for the remainder of 2016 (in accordance with Rev. Proc. 2013-12, as modified), the IRS will not require them to do so.

Eighth Circuit Affirms Enforcement of ERISA Plan Forum Selection Clause

By J. Robert Sheppard III

The Eighth Circuit enforced an ERISA plan's forum selection clause and denied plaintiff's appeal to have her lawsuit for disability benefits transferred back to the District of Arizona. Plaintiff Lorna Clause, who lives in Arizona, is a participant of the Ascension Long-Term Disability Plan. Her application for disability benefits was denied. After exhausting her administrative remedies, Clause filed suit against Defendants in the District of Arizona. Defendants moved to transfer the case to the Eastern District of Missouri based on the Plan's forum selection clause. The Arizona court granted the motion, reasoning that Clause had notice of the forum selection clause from the summary plan description, there was no bad faith or overreaching on the part of defendants, and any information sought from defendants in the litigation would likely be located in Missouri. Interestingly, the Arizona court did not address the issue taken on by many courts to have considered the enforceability of forum selection clauses in ERISA plans, i.e., whether a forum selection clause is consistent with ERISA's policy to provide litigants "ready access to the Federal courts." See our blog post here for more discussion on that point. Once transferred to federal court in Missouri, Clause moved to transfer the case back to Arizona, but the court in Missouri denied the motion. The court rejected Clause's contention that ERISA's venue selection clause does not permit modification because ERISA does not expressly prohibit the use of such clauses, and denied the motion based on a wealth of decisions enforcing forum selection clauses in ERISA plans. Clause then filed a writ of mandamus before the Eighth Circuit, which the Circuit denied in a one-line order. The case is *In re Lorna Clause*, No. 16-2607 (8th Cir. Sept. 27, 2016).

District Court Decision Upholds Employer's Wellness Program But Signals Support for EEOC Positions Going Forward

By Seth Safra and Sunghee Sohn

In*EEOC v. Orion Energy Systems, Inc.*, the Eastern District of Wisconsin rejected the EEOC's claims that Orion Energy's wellness program violated the Americans with Disabilities Act ("ADA"). Although the court upheld the employer's past practice, the court signaled that the EEOC's recent regulations on wellness plans (discussed here and here), which limit the incentive that an employer can provide to encourage participation in a wellness program, will be enforceable going forward. Although it has limited precedential value, the *Orion* decision suggests that employers should continue to take the new regulations into account for 2017 and beyond.

Orion's Wellness Program

Orion's wellness program included three incentives for health behavior:

1. Orion would cover the full cost of medical coverage (ranging from $413 per month for single coverage to $1,130 per month for family coverage) for any employee who completed a health risk assessment ("HRA"). The HRA included a health history questionnaire, biometric screening, and a blood draw. Any employee who declined to participate in the HRA would have to pay the full cost of coverage.

2. Orion charged an extra $50 per month to any employee who did not exercise at least 16 times per month on a machine in Orion's fitness center.

3. Orion charged an extra $80 per month to any employee who smoked.

The Law on Wellness Programs

As discussed in our earlier posts, wellness programs raise issues under the Health Insurance Portability and Accountability Act (HIPAA), which prohibits discrimination in group health plans on the basis of adverse health factors; the ADA, which generally prohibits employers from making disability-related inquiries to employees or requiring employees to take medical examinations; and the Genetic Information Nondiscrimination Act (GINA), which generally prohibits requesting genetic information from employees and their spouses. The HIPAA requirements are enforced by the Department of Health and Human Services (HHS); the ADA and GINA requirements are enforced by the EEOC. The *Orion* case involved only the ADA requirements.

The EEOC's position on wellness programs under ADA and GINA is reflected in final regulations issued in May 2016 (discussed here and here). Those regulations state two rules that are relevant to this case:

1. An ADA safe harbor that allows bona fide plans "based on underwriting risks, classifying risks, or administering . . . risks" (42 U.S.C. § 12201(c)(2), which we call the "underwriting safe harbor") does not apply for wellness programs. Consequently, disability-related inquiries and medical examinations are permitted only if they are voluntary.

2. A program will not be considered voluntary if the incentive for participation exceeds 30% of the cost of self-only coverage (50% for certain tobacco-related

incentives).

The EEOC brought its case against Orion before it published its wellness plan regulations—and before promulgating its 30% rule. Nevertheless, the EEOC asserted that the cost of not participating in Orion's HRA (i.e., having to pay 100% of the premium instead of 0%) was so great as to make the program involuntary.

The Court's Holding

The court deferred to the EEOC's position that the ADA's safe harbor does not apply to wellness programs, but concluded that Orion's program was voluntary—and therefore did not violate the ADA. The court held that "even a strong incentive is still no more than an incentive." According to the court, the fact that the cost of not participating in the HRA was high (having to pay 100% of the premium) was not enough to make the program involuntary: "This choice may have been difficult, but is a choice nonetheless."

At the same time, however, the court noted that Orion's HRA would violate the requirements of the EEOC's May 2016 regulation, had the regulation been in effect—signaling that Orion's victory probably will have only limited significance for future cases.

Where Do We Go From Here?

The *Orion* decision endorses the EEOC's position on wellness programs for 2017 and future years. At the same time, it is only one case in a federal district court. The *Orion* court was not authorized to overturn the Eleventh Circuit's decision in *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012), that the ADA's underwriting safe harbor can apply for wellness programs; and the same issue is currently on appeal to the Seventh Circuit in *EEOC v. Flambeau, Inc.*

Although the issues have not yet been fully resolved by the courts, the path of least resistance is to follow the EEOC's new regulations for 2017 and future years. The new regulations will require some changes to popular programs, as well as new notice requirement; but the combination of regulations from the EEOC and HHS appear to provide a workable roadmap for wellness programs going forward.

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