Proskauer

ERISA Newsletter

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Editor's Overview

As we have observed on other occasions, the ERISA class action plaintiffs' bar has, for several years now, honed in on 401(k) plan fiduciaries and their decisions to select and retain investment options that they allege, in hindsight, underperformed and/or were too expensive. More recently, they have done the same for 403(b) plans sponsored by non-profit institutions. Our featured article this quarter reviews current developments in these lawsuits and urges, as a means to stem this tide and the associated costs, judicial enforcement of heightened pleading standards established by the U.S. Supreme Court.

We also cover developments concerning the DOL fiduciary rule, disaster relief, wellness programs, disability benefits retiree benefits, exhaustion of administrative remedies, and health care reform.

401(k) and 403(b) Plan Investment Litigation—Dividing the Plausible Sheep From the Meritless Goats

By Russell Hirschhorn

Over the past decade, there have been scores of lawsuits filed against ERISA plan fiduciaries charging them with breaches of fiduciary duty and prohibited transactions in connection with their selection and retention of the investment options made available to previous hit401(knext hit) and 403(b) plan participants. Plaintiffs have advanced several theories against these plan fiduciaries, including that the available investment funds underperformed alleged comparable investments, charged excessive fees, and/or were unsuitable investments for plan participants. They also have argued that plan fiduciaries engaged in self-dealing by selecting and maintaining affiliated funds (also referred to as proprietary funds or in-house funds) as plan investment options. Litigation also has expanded to include challenges to fee arrangements with service providers. Most recently, plaintiffs have launched attacks on 403(b) plans sponsored by universities, which, in an interesting twist, include allegations that plan fiduciaries offered participants too many investment options.

Depending on one's point of view, the proliferation of these lawsuits may be seen as a sincere effort to insure that ERISA plan fiduciaries act prudently and loyally in fulfilling their obligations to the plan, or simply the product of entrepreneurial ingenuity on the part of a growing and opportunistic ERISA plaintiffs' bar, which is well aware that these lawsuits can generate handsome settlements and concomitant attorneys' fees awards. A recent survey revealed that there may be cause for the more skeptical approach: from 2009 through 2016, ERISA plan sponsors and fiduciaries paid nearly $700 million in fines, penalties and settlements in connection with breach of fiduciary duty lawsuits, while plaintiffs' counsel collected more than $200 million and the average plan participant award was $116. *See* Tom Kmak, *Fiduciary Benchmarks: Protect Yourself at All Times*, DC DIMENSIONS (Summer 2016).

The most logical remedy for these alarming developments is judicial enforcement of heightened pleading standards. In this article, we review the standards established by the U.S. Supreme Court that plan participants must meet in order for their complaints to survive a motion to dismiss. We then survey some of the recent case law to illustrate how courts have, with less than complete consistency, applied these pleading standards to previous hit401(knext hit) and 403(b) plan investment challenges. Lastly, we comment on the going-forward implications for plan sponsors and fiduciaries.

Requirements for Pleading ERISA Fiduciary Breach Claims

The Federal Rules of Civil Procedure govern (with some exception) the procedure in all civil actions and proceedings in the United States district courts. Rule 8(a)(2) requires that, to state a claim for relief, a plaintiff file a pleading that contains a "short and plain statement of the claim showing that the pleader is entitled to relief."

For decades, this Rule had been broadly construed to require only "notice pleading" such that a plaintiff's allegations were presumed to be true, facts were construed in a manner most favorable to a plaintiff, and, importantly, a court could not dismiss a complaint unless a plaintiff could prove "no set of facts" in support of his or her claim for relief. *Conley v. Gibson*, 355 U.S. 41 (1957). In 2007, however, the U.S. Supreme Court changed the existing interpretation of Rule 8(a)(2). In *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), the Court adopted a more strict, "plausibility" standard. In *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), the Supreme Court provided guidance as to how lower courts should apply the *Twombly*test: "First, the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions…Second, only a complaint that states a plausible claim for relief survives a motion to dismiss. Determining whether a complaint states a plausible claim for relief will…be a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679 (citations omitted).

The Second Circuit translated this standard into a heightened one for participants advancing ERISA fiduciary breach claims based on investment losses. The court required participants to either: (i) allege facts referring directly to a fiduciary's deficient investigation of the investment in question; or (ii) if the complaint relies on inferences from circumstantial factual allegations to show a breach, "allege facts, accepted as true, showing that a prudent fiduciary in like circumstances would have acted differently." *Pension Benefit Guar. Corp. v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 718-20 (2d Cir. 2013). While the court did not specify what facts would suffice to meet this standard—since each case is "context-specific"—it explained that neither poor performance of an investment nor the availability of "better investment opportunities" would show that a prudent fiduciary would have made different choices. *Id.* at 718. The court also stated that the cost of defending fiduciary breach claims in discovery, and the risk that these prospective costs will be used to extort settlements, require that participants include in their complaints "a factual predicate concrete enough to warrant further proceedings." *Id.* at 719 (quotation omitted).

The Supreme Court subsequently endorsed that view in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), when it devised a rigorous pleading standard for fiduciary breach claims, and stated that a motion to dismiss is an "important mechanism for weeding out meritless" ERISA claims—or, as the Court expressed it, to "divide the plausible sheep from the meritless goats." *Id.* at 2470. That standard also furthers ERISA's twin policies of (i) defraying litigation expenses that might otherwise discourage employers from offering benefit plans in the first place; and (ii) affording deference to the decision-making of plan fiduciaries, and not transforming courts into *de facto* plan administrators.

Application of Pleading Standards to Defined Contribution Plan Investment Litigation

The plaintiffs' bar has, for many years now, launched a multi-prong attack on plan fiduciaries' decisions to select and maintain various investment options in 401(k) plans and, more recently, in 403(b) plans. These lawsuits generally fall into one of the following categories:

Underperformance and Excessive Fees. Plan participants claim that the investment options charge higher fees than alleged comparables. A corollary claim is that it was imprudent to offer actively managed funds because these funds have not outperformed index funds that charge lower fees. Often times, these claims are combined with the assertion that the performance of the challenged funds, net of the fees charged, trails the net performance of the comparable investments alleged in the complaint. Although scores of lawsuits have been filed, to date, there are but a few bright lines that have evolved in evaluating whether plaintiffs' claims should be permitted to proceed into discovery. For example, courts have held that an investment's poor performance, standing alone, does not create an inference that a prudent fiduciary would have chosen different investment products because investments cannot be evaluated based on hindsight and periods of underperformance are not uncommon. *White v. Chevron Corp.*, No. 16-cv-0793-PJH (N.D. Cal. Aug. 29, 2016). And, the fact that an investment option may charge higher fees than other investments does not create an inference of imprudence because "nothing in ERISA requires every fiduciary to scour the market to find and offer the cheapest possible fund." *Hecker v. Deere & Co.*, 556 F.3d 575, 586 (7th Cir. 2009).

Affiliated Funds. In recent years, the claims for underperformance and/or excessive fees have increasingly targeted affiliated funds. Plaintiffs' argument is that the plan fiduciaries breached their duty of prudence and loyalty by offering these funds, in lieu of supposedly superior funds, to generate profits for the plan sponsor or to "seed" these funds with investment money that will make them more attractive to other investors. Because of the added disloyalty allegations, these cases have generally been more successful in withstanding motions to dismiss. *See Cryer v. Franklin Templeton Res.*, No. C 16-4265 CW (N.D. Cal. Jan. 17, 2017); *Urakhchin v. Allianz Asset Mgmt. of Am., L.P.*, No. SACV 15-1614-JLS (JCGx) (C.D. Cal. Aug. 5, 2016). The reasoning of these rulings seemingly ignores the fact that both Congress and the U.S. Department of Labor have created exemptions to permit the use of affiliated funds as investment options in a 401(k) plan. See, e.g., 29 U.S.C. § 1108(b)(8); 42 Fed. Reg. 18,734 (Mar. 31, 1977). Thus, one can argue that a claim that is otherwise implausible does not become plausible just because an affiliated fund is involved. After all, zero plus zero still equals zero.

Alternative Investments. Plan participants also have targeted alternative investments, such as hedge funds, as being unsuitable for 401(k) plans, either as stand-alone investment options or as a significant component of an investment vehicle such as a target date fund or default investment vehicle. *See Johnson v. Fujitsu Tech. & Bus. of Am., Inc.*, No. 16-cv-03698 NC (N.D. Cal. Apr. 11, 2017) (denying motion to dismiss complaint challenging a plan's custom target date funds invested in "speculative assets classes" that are allegedly not common and underperformed their benchmarks and other established target date funds).

403(b) Plans. With respect to the more recent spate of lawsuits against the fiduciaries of university sponsored 403(b) plans, the few courts that have issued opinions evaluating motions to dismiss have permitted many of the claims to proceed to discovery. They generally have reasoned that the complaints pled specific enough allegations about better performing or cheaper alleged comparables to create issues of fact that should not be resolved on a motion to dismiss. For example, plaintiffs survived dismissal in a case challenging a 403(b) plan's decision to offer: (i) the retail share class version of many of the plan's investment options, which allegedly charged excessive fees and performed poorly when compared to identical, lower-cost share classes of the same funds; and (ii) actively managed funds when passively managed funds in the same investment style were available with lower fees and better performance.

Proskauer's Perspective

The results thus far on motions to dismiss have been mixed at best. Notwithstanding the Supreme Court's endorsement of stricter pleading requirements, many complaints have withstood motions to dismiss, particularly—but not exclusively—those challenging the use of affiliated funds. The courts' failure to apply these standards consistently is significant for plan sponsors and fiduciaries: Plaintiffs who survive a motion to dismiss are permitted to engage in costly class action discovery, which often causes plan fiduciaries to think about settlement despite the fact that the claims, if taken to summary judgment or trial, would be successfully refuted. According to a recent study, defending a breach of fiduciary duty lawsuit through the motion to dismiss stage can cost up to $750,000 and discovery can cost affected companies between $2.5 million and $5 million. *See* LOCKTON COMPANIES, *Fiduciary Liability Claim Trends* (February 2017). Moreover, as discussed above, these lawsuits rarely inure to the benefit of plan participants in any meaningful way.

Given the high stakes associated with the outcome of the motion to dismiss, and the obstacles they face to prevailing using the heightened pleading standards, it is important to think "outside-the-box" when devising a motion to dismiss strategy. For example, conventional arguments about the insufficiency of the pleadings may be coupled with attacks on the plaintiff's standing to bring suit or timeliness of the complaint. It also may be appropriate to consider the prospects of an immediate motion for summary judgment if the court will need to consider documents not embraced by the complaint in order to conclude that the complaint is insufficient.

Although it is always difficult to predict the future, we remain optimistic that the courts will eventually apply the rigorous pleading standards with greater consistency, and thus will separate the plausible sheep from the meritless goats and preclude the plaintiffs' bar from extracting multi-million dollar settlements merely on the threat of costly, class action discovery. Any other result would be harmful to the individual plans targeted and, more broadly, the private retirement system.

Highlights from the Employee Benefits & Executive Compensation Blog

DOL Fiduciary Rule

Department of Labor Officially Proposes Delaying Fiduciary Rule's Exemptions for 18 Months

By Russell Hirschhorn, Seth Safra and James Huffman

On August 30, 2017, the Department of Labor ("DOL") officially proposed delaying the applicability date of exemptions to its fiduciary rule until July 1, 2019. The proposal was expected after DOL stated in a court filing earlier this month that a delay proposal was under review by the Office of Management and Budget.

This proposal would further delay applicability of the most onerous conditions for the Best Interest Contract Exemption as well as the Principal Transaction Exemption and Prohibited Transaction Exemption 84-24 (which provides an exemption for certain advice related to insurance and annuity contracts). For example, the proposal would delay applicability of the following conditions for the Best Interest Contract Exemption:

- The requirement to enter into written contracts that create a private right of action (and restrict arbitration provisions) for breach of fiduciary duty with respect to an IRA or other non-ERISA arrangement;

- The requirement to adopt policies and procedures for mitigating conflicts (although policies and procedures might still be appropriate for implementing the impartial conduct standard that is currently in effect); and

- Disclosure requirements.

In proposing the extension, DOL stated that it has not completed its review of the fiduciary rule that was ordered by the President on February 3, 2017. DOL indicated that it intends to coordinate with the SEC and to make changes before the requirements become applicable. In particular, DOL stated that it expects to propose a "new and more streamlined class exemption built in large part on recent innovations in the financial services industry."

In the meantime, as discussed in this post, the fiduciary rule's "impartial conduct standards" remain in effect. Until January 1, 2018, a good faith standard applies for enforcement actions—meaning that DOL and IRS "will not pursue claims against investment advice fiduciaries who are working diligently and in good faith to comply with their fiduciary duties and to meet the conditions of the [prohibited transaction exemptions]." DOL has requested comments on whether to extend this temporary enforcement policy past January 1, 2018.

Relatedly, DOL also released Field Assistance Bulletin No. 2017-03, in which it announced that it will not pursue claims against fiduciaries for failure to comply with the "Arbitration Limitation" in the Best Interest Contract Exemption and the Principal Transaction Exemption. This is consistent with the position taken by the Acting Solicitor General in pending litigations. The "Arbitration Limitation" would make the Best Interest Contraction Exemption and the Principal Transaction Exemption unavailable if a fiduciary's contract with a retirement investor includes a waiver of the investor's right to bring or participate in a class action.

We are continuing to monitor developments.

Department of Labor Requests Additional 18-Month Delay of Certain Fiduciary Rule Requirements

By Russell Hirschhorn, Seth Safra and James Huffman

On August 9, 2017, the Department of Labor ("DOL") stated in a court filing that the Office of Management and Budget ("OMB") is reviewing a proposal to extend the applicability date for certain requirements under DOL's fiduciary rule until July 1, 2019. As discussed here and here the fiduciary rule's "impartial conduct standards" have been in effect since June 9, 2017; but other requirements, including the written contract required under the Best Interest Contract exemption and certain disclosure requirements, have been delayed pending DOL's review of the rule. DOL's request suggests that DOL will need significantly more time to complete its review of the rule.

The delay will not be official unless and until it is approved by OMB—a process that can take as long as 90 days. In the meantime, the fiduciary rule's "impartial conduct standards" remain in effect. This means that investment advice (defined under the new regulation's broad definition) is subject to the following standards:

- Any recommendation (defined under the new broad definition) must be in the best interest of the investor, meaning that it must be based on the investor's investment objectives, risk tolerance, and financial circumstances (and not financial considerations of the fiduciary);

- A fiduciary must not make misleading statements about investment transactions, compensation, or conflicts of interest; and

- A fiduciary may not charge more than a reasonable amount for services.

The most recent period for submitting comments on the fiduciary rule ended on August 7, 2017. DOL received over 500 comments, available here. In addition to addressing the delay, the comments addressed a number of substantive issues under the regulation and exemptions. DOL will be reviewing the comments to decide what changes, if any, should be made to the final rule and exemptions.

Disaster Relief

DOL and IRS Issue Guidance for Employee Benefit Plans Impacted by Hurricane Harvey

By Damian Myers and Cristopher Jones

In the wake of massive floods caused by Hurricane Harvey, the Department of Labor (DOL), Internal Revenue Service (IRS), and Pension Benefit Guaranty Corporation (PBGC) have issued initial employee benefit plan guidance. The temporary relief provided in the guidance relates to such things as hardship distributions, plan loans, filing deadlines, plan deposits, and notice requirements. Plan sponsors and administrators with participants or beneficiaries who live or work in the disaster zone should consider whether to implement this temporary relief. A summary of the guidance is provided below.

Qualified Plan Loan, Hardship, and Other Distribution Procedures

IRS Announcement 2017-11 allows for relaxed rules concerning hardship distributions, plan loans, and other plan distributions made on or after August 23, 2017 through January 31, 2018. Key components of this relief include the following:

- Hurricane Harvey relief is available to participants who work or live in the designated disaster area. Additionally, relief is available for participants with relatives (spouses, children, parents, grandparents and other dependents) who work or live in the designated disaster area.

- Plans must be amended before the end of the first plan year beginning after December 31, 2017 (by December 31, 2018 for calendar year plans) to allow Hurricane Harvey hardship distributions or, if the plan document does not currently permit plan loans, to allow plan loans.

- Hardship Distributions:

    - A qualified retirement plan (such as a 401(k) plan) may make a hardship distribution based on an affected participant's representation that the distribution is needed due to Hurricane Harvey. Hurricane Harvey hardship distributions are not limited to the events listed in IRS regulations. This means that affected participants can access their plan accounts to pay for such things as temporary lodging, replacement clothing, and food.

    - If a participant takes a Hurricane Harvey hardship distribution, the plan will not be required to impose a six-month suspension of elective deferrals, as would otherwise be required under IRS regulations.

- Plan Loans and Other Distributions

    - A retirement plan may disregard procedural requirements for plan loans and other distributions made to participants and beneficiaries affected by Hurricane Harvey, so long as the plan administrator takes reasonable steps to obtain required documentation as soon as practicable. This does not mean that such things as the spousal consent requirement are waived. It does mean, however, that a plan may temporarily disregard the need to follow plan loan or distribution procedural requirements or delay getting required documentation from an affected participant or beneficiary until it is practicable to obtain the required documentation.

Form 5500 Filing Relief

Hurricane Harvey disaster relief includes a delay in the filing deadline for Form 5500s that were or are required to be filed on or after August 23, 2017 and before January 31, 2018. Plan administrators who are unable to obtain on a timely basis the information they need to complete Form 5500s because of the disaster caused by Hurricane Harvey will have until January 31, 2018 to file their Form 5500s.

Deposit of Participant Contributions and Plan Loan Repayments

Under DOL regulations, participant contributions and plan loan repayments must be forwarded to the plan as soon as possible after they are received, but no later than the fifteenth business day of the following month. As part of its Hurricane Harvey disaster relief, DOL has said that it will not pursue claims under Title I of ERISA with respect to temporary delays in forwarding contributions and plan loan repayments that are caused by Hurricane Harvey. Employers and service providers should forward these contributions and plan loan repayments as soon as possible, as the relief applies only to the extent that affected employers and service providers act reasonably, prudently, and in the interests of participants to comply "as soon as practical under the circumstances."

Blackout Notices

DOL also provided relief with respect to plan blackout notices. Normally, a plan administrator must provide 30 days' advance written notice when participants' or beneficiaries' rights to direct investments or obtain loans or other distributions from a plan will be temporarily suspended or restricted by a blackout period. However, blackout notices are not required when a plan fiduciary determines in writing that advance notice cannot be made due to events beyond the plan administrator's control. Because hurricanes are beyond the control of a plan administrator, DOL will not allege a violation of the blackout notice requirement solely because a plan fiduciary did not make a written determination that notices cannot be provided.

PBGC Hurricane Harvey Relief

PBGC's Hurricane Harvey relief waives certain penalties and deadlines applicable to single-employer and multiemployer defined benefit pension plan administrators and others who are responsible for meeting PBGC deadlines. The relief applies to these parties if they are located in the disaster zone or if they cannot get required information from service providers located in the disaster zone.

PBGC's relief extends to January 31, 2018 the deadline for the following if their deadlines were on or after August 23, 2017 and before January 31, 2018:

- Filing reportable event post-event notices with the PBGC;
- Requesting reconsideration or appeal of a PBGC determination;

- Paying PBGC premiums (late payment penalties are waived, but not applicable interest charges);
- Filing a standard termination notice (Form 500) or distressed termination notice (Form 601);
- Completing the distribution of plan assets in a standard termination and filing the post-distribution certification (Form 501);
- Filing a distress termination notice (Form 601); and
- Making multiemployer plan PBGC filings and notices to persons other than PBGC.

In addition, the PBGC will grant other relief to pension plans on a case-by-case basis.

The full text of the DOL's and the IRS's Hurricane Harvey guidance is available on EBSA's disaster relief website, and PBGC's guidance is available on its website. The DOL has also prepared a set of "FAQs for Participants and Beneficiaries Following Hurricane Harvey."

We anticipate the release of additional guidance concerning benefit plan relief in the coming weeks and months.

Wellness Programs

Court Throws Monkey Wrench Into Wellness Programs

By Seth Safra and Laura Fant

The U.S. District Court for the District of Columbia has ordered the EEOC to reconsider its final regulations 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 court, however, declined to vacate the regulations; the status quo therefore remains in effect pending the EEOC's review.

The decision is an unexpected twist to a regulatory tale that started before passage of the Affordable Care Act and seemed to have finally been resolved in May 2016. At issue is whether offering incentives to provide employee medical information or family medical history (such as a health risk assessment) makes participation in a wellness program involuntary—and therefore in violation of the ADA and GINA. After years of uncertainty, the EEOC published final regulations that provide a clear standard for how valuable an incentive can be before crossing the voluntariness line. Under the regulations, an incentive is permissible if the value does not exceed 30% of the cost of self-only health insurance. This standard is similar, but not identical, to what is permitted under HIPAA non-discrimination rules that were adjusted by the Affordable Care Act.

A few months after the EEOC finalized its rules, AARP sued to block implementation. AARP argued that, although the EEOC borrowed from HIPAA regulations and the Affordable Care Act, it impermissibly "depart[ed] 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." In other words, AARP seemed to take the position that no meaningful incentive is permissible, because an employee's forgoing of an incentive amounts to a penalty that effectively makes participation involuntary.

In December 2016, the district court denied AARP's request for a preliminary injunction blocking the implementation of the final rules. At that time, the court found that AARP had failed to demonstrate that its members would suffer irreparable harm if the rules went into effect, and that the evidence in the record did not support a finding that AARP was likely to succeed on the merits of its arguments.

Following review of the full administrative record, however, the court found that the EEOC failed to explain the reasoning behind its decision that an incentive of up to 30% of the cost of self-only coverage would not make participation involuntary. Although the court recognized that it must defer to the agency's decision "if the agency has offered a reasoned explanation," the court concluded that it "could find nothing in the administrative record that explains the agency's conclusion that the 30% incentive level is the appropriate measure for voluntariness."

The court rejected the EEOC's argument that it was appropriate to harmonize the incentive level with the 30% rule under HIPAA and the Affordable Care Act. The court found that the HIPAA/ACA 30% incentive figure was selected to prevent insurance discrimination and was "not intended to serve as a proxy for or interpretation of the term 'voluntary'" under the ADA and GINA. The court also noted that the EEOC's standard does not match perfectly with the HIPAA/ACA standard. The court cited differences in both: (i) the basis for calculating the 30% incentive cap (the EEOC regulations base the 30% on the cost of self-only coverage while the HIPAA regulations use the cost of either family or self-only coverage, depending on the circumstances), and (ii) the types of wellness programs to which the cap is applied (HIPAA's 30% incentive cap applies only to health-contingent wellness programs that require participants to satisfy particular health standards, while the EEOC's regulations extend the cap also to participatory wellness programs—that is, programs that do not condition receipt of an incentive on satisfaction of a health factor).

Additionally, the court found that the EEOC failed to address adequately comments submitted during the rulemaking process regarding the potentially significant financial burden imposed on employees. The court faulted the EEOC for defining voluntariness in financial terms (*i.e.*, saying that a penalty of up to 30% of the health premium would not make participation involuntary), without "appear[ing] to have considered any factors relevant to the financial and economic impact the rule is likely to have on individuals who will be affected by the rule."

As noted above, the court has allowed the EEOC's final rules to remain in effect pending the EEOC's review. We will continue to monitor this case and report on further developments.

Disability Benefits

Disability Claims Procedures Should be Updated for New Regulations

By Seth Safra and Laura Fant

As open enrollment approaches for many benefit plans, employers and plans sponsors should check to make sure their claims procedures for disability claims are consistent with regulations that become effective for plan years beginning on and after January 1, 2018. These regulations apply to ERISA-covered short-term and long-term disability plans, as well as retirement plans that provide disability benefits that require disability determinations by the plan administrator (as opposed to relying on a Social Security Administration determination or long-term disability plan determination). The new disability claims procedures are largely meant to track, with some differences, the enhanced disclosure and claims procedures established for medical claims by the Affordable Care Act. Below are the key components that employers and plan administrators should consider.

1. Claims and appeals to be determined with impartiality. The new regulations emphasize independence and impartiality on the part of those making disability benefit determinations. This means that plan administrators cannot base their hiring, compensation, termination, or promotion decisions based on the likelihood that a claims adjudicator will deny a disability claim. The same is true for similar decisions made with respect to retaining medical or vocational experts.

2. More information in benefit denial notices. If a disability benefit claim is denied, plans must now include with such denial a detailed explanation for the denial. More specifically, the denial should include an explanation for disagreeing with or not following the views of health care professionals treating the claimant, the views of medical or vocational experts obtained on behalf of the plan, and a disability determination made by the Social Security Administration. This explanation is also required with respect to health care professionals and experts that the plan retained on its own. Additionally, if the denial is based on an exclusion or limit, such as medical necessity or experimental treatment, the plan must explain the scientific judgment for such determination, or at least state that such an explanation is available free of charge. Internal rules, guidelines, and protocols relied on in the denial must also be disclosed. Finally, claimants must receive timely notice of their right to receive copies of their files and other documents and records relevant to their disability claim determination.

3. Right to know about new evidence or new rationale on appeal. If the claims administrator relies on new information in determining the appeal of a disability benefit determination, the claims administrator must disclose this information to the claimant and afford the claimant the opportunity to respond. The regulations do not provide insight as to what type of information is considered "new" for this purpose, but claims administrators should err on the side of disclosure.

4. Deemed exhaustion. The new regulations provide for deemed exhaustion of administrative remedies (which would allow claimants to go directly to court rather than complete the internal claims and appeals procedures) when a claims administrator fails to adhere to the regulation's requirements. Exceptions to this general rule apply when the violation is de minimis, non-prejudicial, attributable to good cause or to matters beyond the plan's control, or in the context of a good-faith exchange of information and not be reflective of a pattern or practice of non-compliance.

5. Extension to rescission of disability coverage. As with medical claims, a rescission of disability coverage is treated as an "adverse benefit determination," which triggers application of the new claims and appeals procedures.

6. Culturally and linguistically appropriate notices. The new regulations require that notices of adverse benefit determinations be provided in a "culturally and linguistically appropriate manner." Similar to ACA requirements, if a claimant's address is located in an area in which 10% or more residents are literate only in the same non-English language, claim or appeal denial letters must include a statement in the applicable non-English language regarding the availability of language assistance.

7. Contractual Limitations Periods. Many plans include contractual time limitations for when a claimant can sue under ERISA Section 502 following exhaustion of internal claims procedures. The proposed disability regulations requested comments on whether such limitations should be permitted. During the comment period, the United States Supreme Court ruled that contractual limitation periods are permissible. However, the new regulations provide a few guidelines. First, the contractual limitations period cannot end before the internal claims procedures are exhausted. Second, claimants must receive adequate disclosure of the contractual limitations period.

The new disability claim procedures will undoubtedly complicate disability claims administration. Nevertheless, these new procedures largely track the enhanced disclosure requirements under the Affordable Care Act. Therefore, plan administrators familiar with the ACA requirements should be well-equipped to apply the requirements to disability benefit determinations.

Retiree Benefits

Third Circuit Rules That Johnson Controls Did Not Promise Lifetime Health Benefits

By Madeline Chimento Rea

The Third Circuit rejected a claim for lifetime health insurance benefits filed by retired employees of Johnson Controls, finding that the clear and unambiguous language of the CBAs and group insurance booklets did not guarantee lifetime health insurance benefits. The suit was filed after the group insurance booklets, which were incorporated into and subject to the CBAs, were modified to add lifetime caps. The Court held that, prior to the change, health insurance benefits for the two groups of retirees at issue were promised only for the duration of the relevant CBAs. For the first group of retirees, the insurance booklets provided that benefits would continue in retirement, but the booklets were incorporated into CBAs that contained durational clauses. The Court also stated that such contractual obligations would ordinarily end in any event upon termination of the bargaining agreement. The insurance booklets for the second group of retirees provided that their benefits would continue until death, but the Court held that, when considered in conjunction with the booklets' reservation of rights provisions and the durational language in the CBAs, this language provided coverage for eligible retirees only for the term of the CBA, and thus were not a guarantee of lifetime benefits. The case is *Grove v. Johnson Controls, Inc.*, No. 16-2178, 2017 WL 2590762 (3d Cir. June 15, 2017).

Exhaustion of Administrative Remedies

Exhaustion of Plan Administrative Remedies: Important Considerations Following Hitchcock v. Cumberland

By Neal Schelberg and Lisa Schlesinger

Recently, the Sixth Circuit ruled in *Hitchcock v. Cumberland University 403(b) Plan* that pension plan participants are not required to exhaust their plan's administrative remedies before pursuing claims alleging statutory violations of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").[i] In so deciding, the Sixth Circuit joined the majority of circuit courts in holding that claims alleging statutory violations of ERISA do not impose the same administrative exhaustion requirements that are applicable to claims seeking to enforce contractual rights under the terms of a plan. By deepening the current split on this issue among the circuit courts, the ruling could have a significant impact on future ERISA litigations.

The Historical and Procedural Background of *Cumberland*

In *Cumberland*, the plaintiffs were employees of Cumberland University ("University") who participated in the University's defined contribution pension plan (the "Plan"). Since 2009, the Plan document provided that the University would match employee contributions of up to five percent of an employee's salary. In 2014, the University amended the Plan, replacing the five percent match with a discretionary match, retroactively applicable to 2013. Thereafter, the University announced through email that the discretionary match would be zero percent for both the 2013-2014 and 2014-2015 years.[ii]

In November 2015, the plaintiffs filed a class action against the University and the Plan, alleging, among other claims, that the retroactive adoption of the 2014 Plan amendment constituted a breach of fiduciary duty and a violation of ERISA's anti-cutback provision. In June 2016, the district court dismissed the case without prejudice so that the plaintiffs "may administratively exhaust their claims" before proceeding. The plaintiffs appealed. [iii]

On appeal, the Sixth Circuit concluded that the district court erred in requiring the plaintiffs to exhaust their administrative remedies before filing suit.[iv] Specifically, the Sixth Circuit stated that, while administrative exhaustion serves an important policy purpose when dealing with plan interpretation questions – such as disputes involving benefits claims – such purpose is not served when the claims allege statutory violations of ERISA. According to the Sixth Circuit, it is the courts, not plan administrators, who are best suited to settle disputes "directed to the *legality* of a plan", not to a mere *interpretation* of it." Since the plaintiffs in *Cumberland* conceded that their benefits were properly calculated under the terms of the Plan as written, the Sixth Circuit concluded that it would be futile to force them to pursue the administrative process simply to confirm such undisputed calculation.[v] The court reasoned that, when plaintiffs challenge the legality of a plan's provision, they should not face the same administrative exhaustion requirement as those making claims for benefits. The key question, the Sixth Circuit noted, is whether the plaintiffs' claims properly assert statutory violations or instead are "plan-based claims artfully dressed in statutory clothing." And if the latter, then the claims would require administrative exhaustion before the plaintiffs could file suit.[vi]

Sixth Circuit Sides with the Majority of Circuits

In analyzing the nature of a claim, the Sixth Circuit stated that "[t]he relevant inquiry is what forms the basis of [Plaintiffs'] right to relief: the contractual terms of the pension plan or the provisions of ERISA and its regulations." In *Cumberland*, the Sixth Circuit noted that because the alleged anti-cutback violation was based on "the right to receive accrued benefits which have not been decreased by an illegal amendment," and because the breach of fiduciary duty claim was based on "the right to have a fiduciary discharge his or her duties in accordance with the statute," the plaintiffs' claims were statutory rights granted to them by ERISA.[vii] In contrast, the court stated that if the plaintiff's claims challenged the administrator's interpretations of the contractual terms of the pension plan, then the claim would require administrative exhaustion. Based on its determination that plaintiffs asserted ERISA statutory claims, the Sixth Circuit held that administrative exhaustion was not required before the plaintiffs could proceed with their lawsuit.[viii]

While the precise impact of the *Cumberland* decision is unclear, the overall trend is clear. The Sixth Circuit has now joined the majority of circuit courts holding that administrative exhaustion is not required for plaintiffs asserting statutory rights under ERISA. These circuits include the Third, Fourth, Fifth, Ninth, Tenth, and D.C. Circuits. Only two circuits – the Seventh and Eleventh Circuits – have held otherwise, requiring plaintiffs to exhaust their claims internally with the plan, even when asserting statutory violations. These latter circuit courts emphasize that administrative exhaustion serves the important function of reducing the number of frivolous ERISA lawsuits. And if the claims eventually are litigated, it aids the litigation process with a more complete factual record compiled by a plan fiduciary.[ix] After the Sixth Circuit's ruling in *Cumberland*, the Seventh and Eleventh Circuits have now become an even smaller minority than before. And there is little indication that this trend will not continue. Further, it is important to note that the Seventh and Eleventh Circuit decisions were rendered in 1996 and 1985, respectively. It will be informative to see if these circuit courts revisit their position if they are asked to address this issue again. It is also possible that the U.S. Supreme Court will choose to resolve the current split among the circuit courts.

Key Take-Aways for Plan Fiduciaries

The trend in the cases is clear. The majority of circuit courts have held that plaintiffs alleging statutory ERISA claims, as opposed to challenges to the plan administrator's interpretations of the plan, will not be required to exhaust their administrative remedies. However, plan fiduciaries should be aware that some plaintiffs, who are ostensibly subject to the exhaustion requirement, may attempt to circumvent administrative exhaustion prior to filing their lawsuit by framing their ERISA claims as statutory violations rather than as claims of plan interpretation.

To address this concern, plan fiduciaries should consider taking several steps, including: (1) reviewing their claims and appeals procedures to establish guidelines distinguishing ERISA statutory claims from plan interpretive claims; (2) consulting with legal counsel before making benefit decisions; and (3) carefully and thoughtfully articulating in the denial letter the basis for the benefit denial. Of course, while these steps cannot entirely eliminate the possibility that a participant will attempt to circumvent the exhaustion requirement by asserting that he is vindicating an ERISA statutory right and not pursuing a contractual claim under the plan, by adopting and following plan guidelines, the plan fiduciaries may stand a better chance of convincing a court that the action should be dismissed for failing to exhaust administrative remedies.

Health Care Reform

Health Care Reform Roundup – Issue 9

By Damian Myers

After health care reform efforts failed in late-Spring/early-Summer, things have been quiet. However, Congress returned to DC this week. Although legislative focus now appears to be on general tax reform, we expect some health care reform legislation (whether stand-alone or as part of tax reform) during the new session. Recent developments are provided below.

Senator Hatch Introduces Bills to Repeal Individual/Employer Mandates. Senator Orrin Hatch has introduced two bills that would separately repeal the Affordable Care Act's (ACA) individual and employer mandates. The American Liberty Restoration Act would eliminate the individual mandate effective after December 31, 2016. The American Jobs Protection Act would eliminate the employer mandate effective after December 31, 2016. These bills would also eliminate the ACA reporting requirements set forth in Internal Revenue Code §§ 6055 and 6056 (i.e., Forms 1094/5-B and C).

Draft 2017 ACA Reporting Forms and Instructions Released. Unless Senator Hatch's legislation (or other health care reform legislation) is enacted, employers will be required to comply with the ACA reporting requirements for 2017. The IRS recently released draft ACA reporting forms and instructions for 2017. Although not much has changed, below are key changes.

- References to transition relief have been removed now that all relief (except the multiemployer interim guidance) has ended.

- Errors in the dollar amount in Line 15 (i.e., the cost of coverage) will not result in penalties or the need to correct if the difference between the correct amount and the entered amount is $100 or less.

- The IRS clarified that there is no separate Line 16 code if an employee is offered coverage but declines. Instead, employers should enter the applicable affordability safe harbor code, or if none applies, leave Line 16 blank.

- Importantly, the good faith compliance standard made available for 2015 and 2016 no longer applies. ACA reporting errors and late filings are now subject to the generally applicable reasonable cause standard.

ACA Preventive Care Recommendations. The United States Preventive Services Task Force ("USPSTF") recently issued a new recommendation regarding preventive coverage services. Under the ACA, non-grandfathered group health plans must cover in-network preventive services without cost-sharing. Among the various definitions of preventive services are those that the USPSTF recommends with an "A" or "B" rating. On September 5, 2017, the USPSTF gave a "B" rating to vision screening for amblyopia (sometimes referred to as "lazy eye") or its risk factors in children aged 3 to 5. This recommendation would require non-grandfathered plans to cover without cost-sharing this vision screening for plan years beginning on or after September 5, 2018.

Health Care Reform Roundup – Issue 8

By Damian Myers

Below is a summary of significant health care reform developments over the past two weeks.

- **GOP Repeal and Replace Efforts Stalled.** After releasing a revised version of the Better Care Reconciliation Act (BCRA) on July 13, 2017, Senate Republican leadership pushed strongly for its passage. After the BCRA failed to get sufficient support, the Senate GOP turned its efforts to a "skinny" bill that would have repealed the individual and employer mandates, plus a few ACA-related taxes. The purpose of the skinny bill was to get a piece of legislation passed so that the Senate could conference with the House of Representatives and amend the legislation to

include additional ACA repeal and replacement provisions. However, in the early morning hours of July 27th, the skinny bill failed to pass. Therefore, GOP efforts to repeal and replace the ACA have stalled. Employers should continue administering their health plans in compliance with the ACA.

- **Bipartisan Reform May be Coming.** In the wake of the GOP's failure to repeal and replace the ACA, a bipartisan group of House members has announced a preliminary framework for bipartisan reform designed to stabilize the individual insurance market. The "Problem Solvers Caucus," consisting of 43 House Republicans and Democrats, proposed a variety of reforms, including Congressional oversight of cost-sharing reduction payments, a stability fund available to states to help reduce premiums, increasing the full-time employee threshold for applicable large employer status (currently 50) to 500, and repeal of the medical device tax.

- **IRS Reaffirms Individual Mandate.** On June 30, 2017, the IRS Office of Chief Counsel issued an information letter reaffirming the requirement to maintain minimum essential coverage and that the IRS intends to enforce the individual mandate. Additionally, the IRS addressed the impact of President Trump's Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal (issued January 20, 2017). The IRS noted that although this Executive order directed regulatory agencies to exercise discretion to reduce ACA-related burdens, it did not change the legislative provisions of the ACA (such as the requirement to have minimum essential coverage or make a shared responsibility payment).

Health Care Reform Roundup – Issue 7

By Damian Myers

All eyes are on the Senate at the moment as efforts to round-up support for the Better Care Reconciliation Act (BCRA) continue. Developments over the past week are summarized below.

- On July 13, 2017, the Senate released a revised version of the BCRA in an effort to placate Senators who have been reluctant to support the legislation (summaries prepared by the Senate Budget Committee can be found here and here). From an employer and plan sponsor perspective, the changes to the BCRA are generally immaterial. They include retaining the Medicare tax on investment income, the additional Medicare tax on high earners, and the compensation deduction limit on health insurance executives. Additionally, the revised BCRA would allow health savings accounts to be used to reimburse insurance premiums.

Importantly, the revised BCRA includes the so-called "Cruz Amendment" (proposed by Senator Ted Cruz), which would permit carriers to offer non-ACA compliant health plans in a rating area as long as the ACA Marketplace in that area offers at least one qualified health plan at each of the gold, silver, and premium levels. This revision would generally allow younger, healthier individuals to purchase limited coverage at a lower cost. However, without that population in ACA Marketplace risk-pool, some have argued that the Marketplaces could further destabilize.

See our June 28, 2017 blog entry for a summary of the BCRA provisions relevant to employers and group health plan sponsors. An updated comparison chart of the ACA, American Health Care Act, and BCRA can be found here.

- Senator Lindsey Graham announced on July 13, 2017 that he is working with Senator Bill Cassidy on an alternative ACA replacement that focuses on giving states wide latitude to develop their own health coverage systems. Under this alternative, the individual and employer mandates under the ACA would be repealed. The medical device tax would be repealed, but all other ACA-related taxed would continue. Although the alternative proposed by Senator Graham states that the ACA's prohibition of preexisting condition exclusions would remain, there is no indication how this proposal would treat other ACA market reforms.

Health Care Reform Roundup – Issue 6

By Damian Myers

With the exception of the Senate's Better Care Reconciliation Act ("BCRA"), things are relatively quiet on the health care reform front. Below are a few developments from the week of June 26th.

- **Senate's BCRA Updated.** The big news over the past few weeks has been the Senate's release of the BCRA, which serves as an alternative to the House of Representatives' American Health Care Act. See our June 28, 2017 blog entry for a detailed description of key provisions of the BCRA (including the update released on June 26th), as well as a chart comparing the BCRA, AHCA, and the Affordable Care Act.

- **CBO Scores the BCRA.** The Congressional Budget Office (CBO) released its cost estimate on the BCRA on June 26, 2017. The CBO estimated that the BCRA would reduce the federal deficit by $321 billion by 2026, $202 billion more than the AHCA. However, the BCRA would increase the number of uninsured individuals by 22 million in 2026, a slight decrease from the AHCA estimate.

- **Draft Executive Order Seeks to Expand Pre-Deductible Coverage under High-Deductible Health Plans.** Currently, in order to contribute to a health savings account, an individual must be enrolled in a high-deductible health plan that covers services only after a relatively high deductible is satisfied. An exception to the deductible requirement applies to preventive care. The White House has released a draft executive order that would expand this exception to health care received for the purpose of managing chronic conditions.

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