Proskauer

ERISA Newsletter

Fourth Quarter 2017
Editor's Overview

For over two decades, federal law has required covered health plans and insurers to ensure that certain mental health benefits are in parity with offered medical/surgical benefits. The meaning of "parity," however, has expanded over time, most significantly with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("the MHPAEA") and the regulations that followed. With the final regulations having gone into effect for plan years starting on July 1, 2014, we are observing a noticeable uptick in enforcement activity and decisions from the courts. Our featured article this quarter reviews the statutory and regulatory scheme and case law developments under the MHPAEA, and offers some practical considerations for plan sponsors and fiduciaries moving forward.

We also cover developments concerning tax reform, the DOL fiduciary rule, health care reform, disability benefits, standing, statute of limitations and attorney fees.

Recent Developments in Federal Mental Health Parity Act Enforcement and Litigation*

By Russell Hirschhorn, Seth Safra and Steven Sutro

For over two decades, federal law has required covered health plans and insurers to ensure that certain mental health benefits are in parity with offered medical/surgical benefits. The meaning of "parity," however, has expanded over time, most significantly with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("the MHPAEA") and the regulations that followed. With the final regulations having gone into effect for plan years starting on July 1, 2014, we are observing a noticeable uptick in enforcement activity and decisions from the courts. This article reviews the statutory and regulatory scheme and case law developments under the MHPAEA, and offers some practical considerations for plan sponsors and fiduciaries moving forward.

The Mental Health Parity Act of 1996

The Mental Health Parity Act of 1996 ("MHPA '96") for the first time prohibited imposing annual or lifetime limits on mental health benefits that were more restrictive than the limits on medical/surgical benefits. MHPA '96 had its limitations, however. For example, it did not restrict common cost management techniques, such as step therapy, requiring pre-certification, limiting the number of visits to specialists, or limiting the types of services that would be covered. MHPA '96 also contained three exemptions: (i) businesses that chose not to provide mental health coverage; (ii) businesses with less than fifty employees; and (iii) businesses that documented at least a one percent increase in premiums due to implementation of parity requirements. Given those limitations and exclusions, MHPA '96 had a limited impact on plan sponsors and insurers.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

MHPA '96 was superseded by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which Congress passed as rider legislation on the Troubled Asset Relief Program, signed into law by President Bush in October 2008. The MHPAEA is codified in ERISA § 712, Internal Revenue Code § 9812, and Public Health Services Act § 2705.

The MHPAEA broadened the meaning of parity. It requires parity with respect to "financial requirements" and "treatment limitations" in covered plans—generally, group health plans maintained by employers with more than fifty employees. Specifically, the statute prohibits:

- Imposing *financial requirements* for mental health or substance use disorder benefits that are *more restrictive* than the *predominant financial requirements* applied to *substantially all* medical/surgical benefits covered by the plan, or imposing *separate cost sharing requirements* for mental health or substance use disorder benefits; and

- Imposing *treatment limitations* for mental health or substance use disorder benefits that are *more restrictive* than the *predominant treatment limitations* applied to *substantially all* medical/surgical benefits, or imposing *separate treatment limitations* for mental health or substance use disorder benefits.

The MHPAEA does not mandate that plans provide coverage for any particular type of condition. But if a plan provides coverage for a mental health or substance use condition, the MHPAEA requires that cost sharing arrangements and treatment limits be in line with such limits for analogous medical/surgical conditions. For example, the MHPAEA generally prohibits imposing a higher co-pay for a covered mental health benefit or capping the number of visits or covered days in a hospital for substance abuse, unless comparable caps apply for analogous medical/surgical conditions.

MHPAEA Regulations

The U.S. Departments of Labor, Health and Human Services, and Treasury issued regulations interpreting the requirements of the MHPAEA. The regulations apply for plan years starting on and after July 1, 2014, and provide guidance on how to evaluate parity. See 29 C.F.R. § 2590.712 (DOL); 26 C.F.R. § 54.9812-1 (IRS); 45 C.F.R. § 146.136 (HHS). Highlights from the regulations include the following:

- The regulations state that a type of financial requirement or treatment limitation is considered to apply to "substantially all" medical/surgical benefits in a classification of benefits only if it applies to at least two-thirds of all medical/surgical benefits in that classification. This means that a financial requirement or treatment limitation for a mental health/substance use disorder benefit (*e.g.*, imposing a co-pay or requiring precertification) must also apply for at least two-thirds of medical/surgical benefits in the applicable classification.

- The regulations define the "predominant" level of each permissible financial requirement or treatment limitation within a classification as the level that applies to more than half of the medical/surgical benefits in the classification that are subject to the financial requirement or treatment limitation. For example, a $40 co-pay for visiting an in-network mental health professional is permitted only if: (i) a co-pay is required for at least two-thirds ("substantially all") of outpatient visits with in-network medical/surgical professionals, and (ii) the level of co-pay required for at least half of outpatient visits with in-network medical/surgical professionals (excluding any types of visits for which a co-pay is not required) is at least $40 (the "predominant" level).

- The regulations explain that mental health and substance use disorder benefits must be combined with medical/surgical benefits for purposes of tracking financial requirements (deductibles, co-insurance, etc.) and treatment limits. Separate requirements and limits for particular types of treatment are prohibited.

The final regulations provide numerous examples to illustrate the applicability of these rules.

Enforcement Activity

Since the final regulations became effective, it appears that the Department of Labor (DOL) has stepped up its enforcement activity with respect to the MHPAEA. The DOL issued a Fact Sheet in January 2016 that summarized enforcement activity in the aggregate for 2010 through 2015. It reported 170 violations of the MHPAEA for those years combined. A DOL Enforcement Fact Sheet for 2016 reported 191 reviews for MHPAEA compliance (out of 330 closed health plan investigations) with violations found in 44 cases. The violations in the most recent Fact Sheet included:

- Unlawful non-quantitative limitations, such as imposing pre-certification requirements or step therapy that are not required for at least two-thirds of medical/surgical conditions in the applicable category;
- Unlawful financial limits and quantitative limitations; and
- Other violations, such as unlawful dollar and treatment limits.

Litigation Activity

Among the more significant litigations asserting claims for violation of the MHPAEA are claims for coverage of certain Autism Spectrum Disorder treatments, wilderness therapy, and residential treatment for mental health and substance abuse. In each case, plaintiffs allege impermissible treatment limitations (usually non-quantitative, such as a refusal to cover the particular treatment for an otherwise-covered condition). Below we take a look at a few of these cases.

Autism Treatment

To date, we are aware of only one decision, among the many cases filed, that has reached the merits of a complaint alleging violations of the MHPAEA for failure to provide coverage for Applied Behavior Analysis ("ABA") treatment for Autism Spectrum Disorder ("ASD"). In *A.F. ex rel. Legaard v. Providence Health Plan*, 35 F. Supp. 3d 1298 (D. Or. 2014), the plaintiffs challenged the denial of ABA treatment based on a "Developmental Disability Exclusion" that excluded coverage for services "related to developmental disabilities, developmental delays, or learning disabilities." The plan argued that there was no violation of the MHPAEA because the Act does not require a plan to cover any particular benefit or condition. The plaintiffs argued that, because the plan covered certain treatments for autism, the plan could not exclude expensive treatments for the condition unless a comparable exclusion also applied for substantially all of the medical/surgical benefits in the particular classification. The court agreed with the plaintiffs, concluding that the exclusion violated the MHPAEA because it applied specifically and exclusively to developmental disabilities (a mental health condition), and there was no similar exclusion for medical/surgical conditions.

Another court denied a motion to dismiss where the plaintiff challenged the denial of ABA treatment based on a "Developmental Delay Exclusion," by which a plan excluded coverage for "therapy for learning disability, communication delay, perceptual disorders, sensory deficit, developmental disability and related conditions." The court ruled that it could not determine on a motion to dismiss whether the plan covered ASD at all, and thus whether the exclusion of ABA was a permissible blanket exclusion of a condition or an impermissible treatment limitation for a covered condition. *D.T. v. NECA/IBEW Family Med. Care Plan*, No. 17-civ-4, 2017 WL 5756870 (W.D. Wash. Nov. 27, 2017).

Other decisions involving claims for ABA treatment for ASD generally have addressed class certification or procedural issues, not the merits of the claims. *See Wilson v. Anthem Health Plans of Kentucky, Inc.*, 14-civ-743, 2017 WL 56064 (W.D. Ky. Jan. 4, 2017) (certifying a class in a lawsuit claiming that a plan covering ABA treatment impermissibly imposed more restrictive time and dollar limitations for ABA treatment than for analogous medical/surgical benefits); *Whitley v. Dr. Pepper Snapple Grp., Inc.*, 17-civ-0047, 2017 WL 4155257 (E.D. Tex. Sept. 19, 2017) (granting motion to dismiss for failure to exhaust the plan's claims procedures); *Coleman v. Alcatel-Lucent USA, Inc.*, 16-civ-00108 (N.D. Ala. Sept. 1, 2017) (denying motion to dismiss for failure to exhaust the plan's claims procedures); *W.P. v. Anthem Ins. Companies Inc.*, No. 15-civ-562, 2017 WL 605079 (S.D. Ind. Feb. 15, 2017) (concluding that plaintiffs could not pursue their claim under ERISA § 502(a)(3) for equitable relief when they also asserted a claim for benefits).

Wilderness Therapy

A number of lawsuits have challenged the denial of wilderness therapy to treat certain mental health or substance use disorders. There do not appear to be any publicly available decisions on the merits of these claims. In one case, a plaintiff sought coverage for a wilderness therapy program in Utah to treat depression, low self-esteem, and suicidal thoughts. The case was dismissed for failure to show a comparison between the limitation imposed on the mental health condition and those on medical/surgical analogues, but the plaintiff has since filed an amended complaint. *Welp v. Cigna Health & Life Ins. Co.*, No. 17-civ-80237, 2017 WL 3263138 (S.D. Fla. July 20, 2017). In another case, a court denied defendants' statute of limitations defense. The court has not yet reached the merits. *William G. v. United Healthcare*, No. 16-civ-144, 2017 WL 2414607 (D. Utah June 2, 2017).

Residential Treatment

There have been a number of lawsuits challenging exclusions of residential treatment for mental health and substance use disorders. In one case, a plan participant was denied coverage for treatment at a residential treatment center for her anorexia nervosa, general anxiety disorder, and major depressive disorder. The district court denied the motion to dismiss because the plaintiff sufficiently alleged that the conditions were covered and that the plan categorically excluded residential treatment for mental health without imposing a comparable limit on long-term inpatient (non-hospital) treatment for medical/surgical conditions. *Natalie V. v. Health Care Serv. Corp.*, No. 15-civ-09174, 2016 WL 4765709 (N.D. Ill. Sept. 13, 2016). In so ruling, the court cautioned that the plan could prevail after discovery, if it could show that the denial of plaintiff's coverage used the "same non-quantitative treatment limitation standard—that is, it used the same processes, strategies, evidentiary standards, or other factors when applying treatment limitations to all inpatient benefits—when deciding whether it could categorically exclude coverage for residential treatment centers." The parties ultimately settled the case on undisclosed terms.

In another case, the plaintiff prevailed on summary judgment because she established that a residential treatment exclusion was aimed only at mental health conditions like her depression, despite the plan's argument that residential treatment services were excluded for all disorders, whether mental health, medical, or surgical. *Joseph F. v. Sinclair Servs. Co.*, 158 F. Supp. 3d 1239 (D. Utah 2016). Another court found that "[t]he practical effect of the [residential treatment exclusion] is that [plaintiff] receives fewer hours (or days) of coverage for medically necessary nursing care than, for example, an elderly person would receive to rehabilitate a broken hip." *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 749 (N.D. Ill. 2015). The court subsequently issued an order granting preliminary approval of a $5.25 million settlement.

In contrast to the cases above, Aetna recently prevailed on summary judgment in a case concerning residential treatment for mental, behavioral, and emotional disorders. As in the other cases, the plaintiffs alleged that the plan's conditions for coverage in the residential treatment facility were more stringent than the plan's conditions for physical rehabilitation facilities and skilled nursing facilities. The court rejected plaintiffs' argument because there was no evidence that the plan's denial of coverage was not properly based on clinically appropriate standards—even though application of those standards resulted in fewer visits or days covered for mental health than for a particular medical/surgical condition. The court held that MHPAEA compliance should be tested by comparing evidentiary standards for mental health conditions to evidentiary standards for medical/surgical conditions, rather than by looking at the resulting level of coverage that is approved. *Michael P. v. Aetna Life Ins. Co.*, No. 16-civ-439, 2017 WL 4011153 (D. Utah Sept. 11, 2017).

Proskauer's Perspective

The DOL's published enforcement statistics suggest that the DOL is continuing to investigate compliance with the MHPAEA, and our own experience assisting clients with DOL audits suggests the same. The experience in litigation thus far suggests a fairly low burden to state a claim under the MHPAEA that survives a motion to dismiss. But the case law in this area is still developing and there are still ways to manage the costs of treatment. Plan sponsors should review cost management techniques with counsel to ensure they are designed to mitigate risk in this area.

Highlights from the Employee Benefits & Executive Compensation Blog

Tax Reform

Tax Reform Act Denies Deductions for Some Sexual Harassment Settlements

By Tony Oncidi

In a little-noticed provision buried deep inside the new Tax Cuts and Jobs Act (signed into law on Dec. 22) is the following "denial of deduction":

"**Payments related to sexual harassment and sexual abuse** – No deduction shall be allowed under this chapter for –

- any settlement or payment related to sexual harassment or sexual abuse if such settlement or payment is subject to a nondisclosure agreement; or

- attorney's fees related to such a settlement or payment."

The statute adds a new Section 162(q) to the Internal Revenue Code, effective for amounts paid or incurred after December 22, 2017. Where applicable, it may require taxpayers to choose between non-deductibility of the payment and non-disclosure of the settlement.

The Conference Report accompanying the statute does not include any guidance as to the scope of the key statutory text: "related to sexual harassment or sexual abuse." Because many cases involve multiple claims, only some of which may be "related to sexual harassment or sexual abuse," careful planning and drafting of settlement and other agreements may be necessary to minimize the impact of this broad proscription. Where factually supportable, litigants may want to allocate settlement payments to claims other than sexual harassment or sexual abuse, possibly creating opportunities to deduct at least portions of settlement payments to claimants with multiple claims. Such allocations also may allow the deductibility of at least a portion of the attorney's fees incurred in connection with the claims.

Also of interest is that the deductibility of attorney's fees is not limited to fees incurred by defendants. Read literally, new Section 162(q)(2) would deny a deduction for all attorney's fees related to "such a settlement or payment," which presumably would include the fees paid by a plaintiff/settlement recipient as well, which may further complicate settlement negotiations. However, until and unless a statutory change is made (for example, in a technical corrections bill) or the Treasury or IRS releases interpretive guidance otherwise, litigants should carefully consider the effect of the statute's plain text in their planning.

Tax Reform Contemplates Changes to Employee Benefits

By Damian Myers and Justin Alex

The House Committee on Ways and Means publicly released a working draft of the Tax Cuts and Jobs Act for the first time on Thursday. In the weeks leading up to the release of the draft, speculation has swirled as to whether it would eliminate or otherwise limit the ability to make pre-tax employee deferrals into 401(k) plans. The current draft of the bill would *not* impact 401(k) deferrals, but would bring other changes to employee benefit plans and programs beginning in 2018, as described below. However, the bill is still a working draft and has not yet become law. The bill would also make significant changes with respect to executive compensation, which we will address in a separate blog post.

Elimination of Certain Income Tax Exclusions

The bill would eliminate the income tax exclusions currently available for the following types of benefits:

1. Employer-provided dependent care assistance programs (currently tax-free up to $5,000 per year or $2,500 per year in the case of married individuals who file separate tax returns);

2. Employer-provided adoption assistance programs (currently tax-free up to $13,570 per child);

3. Moving expense reimbursements by employers;

4. Tuition reimbursements provided by employers through qualified educational assistance programs (currently tax-free up to $5,250 per year); and

5. Qualified tuition reductions provided by educational institutions to employees and their spouses and dependents (currently tax-free for undergraduate tuition and, in the case of teaching and research assistants, graduate tuition).

Employees that receive such benefits or reimbursements would therefore need to include the value of the benefits or reimbursements in their gross income for tax purposes.

Loosen Restrictions on Hardship Distributions from 401(k) Plans

The bill would eliminate two restrictions that currently apply to hardship distributions from 401(k) plans. First, IRS regulations currently require 401(k) plans to prohibit participants who receive certain hardship distributions from making plan contributions for six months after the hardship distribution. The bill would force the IRS to eliminate this requirement. Second, under current law, hardship distributions from 401(k) plans cannot include qualified nonelective employer contributions (QNECs), qualified matching employer contributions (QMACs), or earnings on elective deferrals. The bill would allow employers to make such amounts available for hardship distributions. Finally, for purposes of determining a participant's eligibility to receive a hardship distribution, the bill would clarify that the participant is *not* required to take the maximum available loan available from the 401(k) plan to receive a hardship distribution.

Reduction in Minimum Age for In-Service Distributions from 457(b) Plans and Pension Plans

The bill would make in-service distributions available from 457(b) plans (deferred compensation plans available for employees of state and local governments and certain tax-exempt organizations) and tax-qualified pension plans beginning at age 59½. Under current law, in-service distributions are only available from 457(b) plans in the case of eligible hardships or the attainment of age 70½ and from tax-qualified pension plans beginning at age 62.

Extended Rollover Period for Plan Loan Offset Amounts

The bill would provide certain defined contribution plan participants with more time to roll over "plan loan offset amounts" to individual retirement account (IRA) or other eligible retirement plan. Specifically, if a participant would have a deemed distribution for failing to repay an outstanding plan loan following a termination of the plan or the participant's employment, the participant could avoid the deemed distribution by contributing the outstanding loan balance to an IRA or other eligible retirement plan no later than the due date (with extensions) for filing the participant's tax return for the year of the potential deemed distribution. This change is intended to help participants avoid having their outstanding loan balances treated as deemed distributions, which are subject to taxation (and the additional 10% penalty on early withdrawals if applicable) in the year of the deemed distribution. Currently, participants only have 60 days to do this from the date on which the participant receives a distribution of the participant's outstanding account balance.

Modified Nondiscrimination Testing Rules for Frozen Legacy Plans

The bill would make technical changes to the nondiscrimination testing rules for tax-qualified pension plans and defined contribution plans sponsored by employers that close or freeze their pension plans for certain classes of participants (which is an increasingly common occurrence).

In particular, such pension plans will be deemed not to discriminate in favor of highly compensated employees solely due to the composition of the closed class of participants or the benefits, rights, or other features provided to the closed class if certain requirements are met, including that the plan is not discriminatory in the year of the plan closure and the following two plan years. Such pension plans could also be aggregated with certain defined contribution plans on a benefits basis for nondiscrimination testing and minimum coverage testing. For this purpose, testing could include the portion of the defined contribution plan(s) that provides matching contributions, 403(b) annuity contracts purchased with matching contributions or nonelective contributions, or that consists of an employee stock ownership plan.

The bill would also make similar changes with respect to nondiscrimination and minimum coverage testing for defined contribution plans that provide "make-whole" nonelective employer contributions that are intended to replace some or all of the retirement benefits a participant would have otherwise earned under a pension plan or other qualified cash or deferred arrangement if the change had not been made.

Additional Limitations on Archer Medical Savings Accounts (Archer MSAs)

The bill would limit the continued use of Archer MSAs by eliminating the deduction for employee contributions to Archer MSAs and the income tax exclusion for employer contributions to Archer MSAs. However, individuals could continue to roll over their Archer MSAs to HSAs on a tax-free basis. This change is expected to have a limited impact because Archer MSAs have largely been replaced by health savings accounts (HSAs) and new Archer MSAs could not be established after 2007 (although individuals who already had Archer MSAs are currently allowed to continue contributions to their Archer MSAs).

As noted above, the bill is still a working draft and has not become law. The Administration has indicated that it hopes to complete tax reform by the end of 2017, but it is too early to tell whether that will happen. In any event, we expect additional modifications to the bill as it is further reviewed by the House and introduced in the Senate.

For a summary of the other significant changes proposed in the bill, please see our Tax Talks blog post.

IRS Issues Limited Section 409A Relief to Pay Income Taxes on Pre-2009 Section 457A Deferrals

By Adam Scoll, Ira Bogner and Amanda Nussbaum

The Internal Revenue Service (the "IRS") has issued Notice 2017-75 (the "Notice"), which provides certain limited relief from the strict requirements of Section 409A of the Internal Revenue Code of 1986, as amended (the "Code"), in order to pay income taxes on deferrals attributable to services performed before 2009 that are required to be included in gross income under Section 457A.

For a summary of the Notice, please see our Tax Talks blog post.

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

By Robert Projansky and Damian Myers

Following the old "better late than never" axiom, the IRS recently announced (see Notice 2018-06) that once again it would be extending 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, 2018	March 2, 2018
Deadline to File with the IRS	Feb. 28, 2018 (paper) April 2, 2018 (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 2018-06 provides that, as was the case last year, 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.

Perhaps more significantly to many, the IRS carried over from last year a second valuable measure of relief. Specifically, the IRS continued the interim good faith compliance standard under which the IRS will not assess a penalty for incomplete or incorrect information on the reporting forms if a filer can show that it completed the forms in good faith. As was the case last year, this relief only applies if the forms were filed on time. Thus, filers would be wise to distribute and file forms, even imperfect ones, timely and should document their good faith efforts.

Those that do not file by the new deadlines have a more uphill battle to avoid penalties under Code Sections 6721 and 6722. The IRS stated in Notice 2018-06 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.

Annual IRS Revenue Procedure Includes Surprising Change to User Fees

By Seth Safra and Randall Bunnell

On January 2, 2018, the IRS published its annual bulletin that updates procedures for requesting rulings, determinations, and other guidance from the IRS. As in past years, the bulletin includes new user fees for determination requests and submissions under the Voluntary Correction Program ("VCP"). But this year's update includes a significant surprise for the VCP program; and while changes in past years typically went into effect about a month after they were announced, this year's changes are effective immediately.

For many VCP filings, the new fees are significantly lower than in the past. Instead of fees based on the number of participants and capped at $15,000, the new fee schedule is based on plan assets and caps out at $3,500 (for a plan with over $10 million in assets). While this is certainly a welcome change, the IRS has eliminated the availability of reduced fees for streamlined filings. For example, in 2017 plan sponsors could correct minor plan loan and minimum required distribution errors for as little as $300; these streamlined options are no longer available.

Under the new fee schedule, the user fee for a VCP filing is the same for any type of error and there is no limit on the number of errors that can be included in a submission. Plan sponsors considering the pros and cons of self-correction vs. VCP should consider the new fee schedule.

In addition to the VCP change, the user fee for a Form 5310 filing (a determination letter application for a terminating plan) has increased from $2,300 to $3,000.

DOL Fiduciary Rule

Department of Labor Finalizes 18-Month Delay of Fiduciary Rule Exemptions

By Russell Hirschhorn, Seth Safra and Ruthanne Minoru

On November 27, 2017, the Department of Labor ("DOL") finalized the delay of the applicability date for certain conditions for exemptions to the fiduciary rule until July 1, 2019. This delay was initially proposed in late August as described here.

Although certain requirements have been delayed, the fiduciary rule's broad definition of "fiduciary" and the "impartial conduct standards" continue in effect, subject to a good faith compliance standard. (Those requirements have been in effect since June 9, 2017.) Consequently, financial institutions and advisers continue to be subject to requirements to give prudent advice that is in the retirement investor's best interest, charge no more than reasonable compensation, and avoid misleading statements. But other requirements, including the written contract required by BIC Exemption and certain disclosure requirements, have been delayed pending DOL's review of the rule.

DOL's stated reason for the delay is that it has not yet completed its reexamination of the fiduciary rule and exemptions, as directed by the President in his February 3, 2017 memorandum, including its review of hundreds of comments that it received from stakeholders. In addition, DOL stated that it intends to use the additional time to consult further with other regulators, including the National Association of Insurance Commissioners and the SEC.

By continuing the status quo during the review period, DOL appears to be allowing the rule's core principles to grow roots. At the same time, however, DOL has suggested that it intends to make significant changes to the compliance details. First, DOL has stated that it anticipates proposing a new streamlined class exemption in the near future. Second, DOL has made clear that it does not want stakeholders to incur additional costs to comply with conditions that DOL might revise, repeal, or replace.

Health Care Reform

ACA Employer Mandate Assessments Coming

By Damian Myers

Within the past few weeks, IRS officials have informally indicated that the IRS would begin assessing tax penalties under the Affordable Care Act's (ACA) employer shared responsibility. The IRS has now updated its Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act (see Q&As 55-58) and has issued a form preliminary tax notification letter (Letter 226J). The first round of letters is expected before the end of the year and will relate to the 2015 tax year. Background information and steps employers should take if they receive Letter 226J are provided below.

Background

A key component of the ACA is the employer shared responsibility mandate, which requires applicable large employers (generally those with 50 or more full-time employees and equivalents, determined on a controlled group basis) ("ALEs") to offer minimum essential coverage (MEC) to 95% of their full-time employees. This coverage must also be affordable, based on various affordability safe harbors, and have minimum value. For plan years beginning in 2015, ALEs with 50-99 full-time employees were exempt from the requirement to offer MEC to 95% of their full-time employees, but the MEC offered to full-time employees still had to be affordable and have minimum value. ALEs with 100 or more full-time employees would be deemed to satisfy the employer shared responsibility mandate in 2015 if MEC was offered to 70% of their full-time employees, and that coverage was affordable and had minimum value. All ALEs became subject to the full 95% threshold in plan years beginning in 2016.

Over the past few years, ALEs and other coverage providers have been required to submit information reporting forms to give the IRS the information necessary to determine compliance with the individual and employer shared responsibility mandates. ALEs generally file Forms 1094-C and 1095-C containing information regarding offers of MEC, including whether that MEC was affordable and had minimum value.

Penalties for failure to satisfy the employer shared responsibility mandate can be severe. Under Internal Revenue Code Section 4980H(a), an ALE that fails to offer coverage to 95% of its full-time employees could be assessed a penalty equal to $166.67 (for 2014 and later indexed for inflation, as described below) per full-time employee (less 30 full-time employees) per month if any full-time employee obtains coverage on the Marketplace and receives a premium credit. Under Internal Revenue Code ("Code") Section 4980H(b), an ALE that fails to offer affordable coverage or coverage that has minimum value to any full-time employee could be assessed a penalty equal to $250 (for 2014 and later indexed for inflation, as described below) per month for any full-time employee that obtains coverage on the Marketplace and receives a premium credit. The penalty amounts under the employer shared responsibility mandates are indexed for inflation:

Year	**4980H(a)**	**4980H(b)**
2014 (non-enforcement year)	$166.67/month	$250/month
2015 (transition relief)	$173.33/month	$260/month
2016	$180/month	$270/month
2017	$188.33/month	$280/month
2018	$193.33/month	$290/month

Preliminary Penalty Notice

Based on statements from the IRS, notices of preliminary penalty determinations will be sent before the end of 2017. ALEs who could be assessed a penalty will receive a Letter 226J which will include general information regarding the employer shared responsibility mandate and assessable penalties, a tabular summary of the penalties being assessed (shown on a monthly basis), an employee list showing each full-time employee triggering a penalty and the Form 1095-C indicator codes attributable to that employee, an employer response form (Form 14764, which as of the date of this blog entry, has not been released), and a description of steps to take if the employer disagrees with the IRS.

An employer will respond using Form 14764 to either agree or disagree with the proposed penalty amount. If an employer indicates its disagreement, the IRS will respond with a Letter 227 (not yet released) describing further actions the employer must take. The Letter 227 will likely explain that an employer must follow the steps set forth in Publication 5 and may request a pre-assessment conference within 30 days of the employer's receipt of the Letter 227. If an employer fails to respond to either Letter 226J or Letter 227, the IRS will formally assess the penalty and issue a notice of demand for payment (Notice CP 220J).

Employer Steps if Penalty Notice Received

Given the severity of penalties that could be assessed under the employer shared responsibility mandate, employers take action immediately upon receiving a Letter 226J. Below are recommended steps to take upon being assessed a penalty:

1. Utilize counsel experienced with the ACA's employer shared responsibility mandate.

2. Compile the Form 1095-Cs for each assessable full-time employee listed by the IRS in Letter 226J.

3. Closely compare the information contained in Letter 226J with the Form 1095-Cs for each assessable full-time employee.

4. Review other relevant payroll and benefit enrollment as necessary to determine whether each assessable full-time employee listed by the IRS was, in fact, full-time and did not actually receive an offer or MEC or the MEC offered was not affordable or did not have minimum value.

5. Work with counsel to determine how to respond to the IRS. If the employer disagrees with the assessment, Form 14764 should be submitted explaining the disagreement. Once Letter 227 is received by the employer, a pre-assessment conference should be scheduled to formally appeal the potential assessment.

6. Prepare all relevant materials and supporting documentation in advance of the pre-assessment conference.

7. Attend the pre-assessment conference with counsel and await the IRS's determination.

Because transition relief during the 2015 plan year exempted employers with less than 100 full-time employees from the penalty in Code Section 4980H(a) and reduced the penalty threshold to 70% for larger employers, we anticipate that assessments this year will primarily be based on the smaller, individualized penalty set forth in Code Section 4980(b).

Health Care Reform Roundup – Issue 10

By Damian Myers

After months of failed attempts to pass any health care reform legislation, it appears efforts to pass a bipartisan bill to improve the Affordable Care Act (ACA) are picking up steam. Below is a summary of regent health care reform developments.

- ??? **White House Directive.s** On October 12, 2017, President Trump released his "Executive Order Promoting Healthcare Choice and Competition Across the United States." In this Executive Order, the President directed agencies to take action to (1) expand access to association health plans, (2) permit short-term, limited-duration insurance policies to cover 12 months (instead of the current limit of 3 months), and (3) expand access to health reimbursement accounts (presumably to allow their use to purchase individual market insurance). We can expect regulations on each of these items in the coming months.

Shortly after releasing the Executive Order, President Trump also announced that the Administration would stop funding cost-sharing reductions available on the ACA Health Insurance Marketplaces. These cost-sharing reductions have been controversial and subject to litigation on the basis that Congress never appropriated funds to pay for the reductions. Critics of the President's directive to end the reductions argue that it would destabilize the Marketplace and cause premiums to drastically increase. The Congressional Budget Office issued a report in August stating that ending the cost-sharing reductions would actually increase the federal deficit by $194 billion by 2026. This increase is attributable to the fact that the increase in premiums would cause a corresponding increase in premium subsidies funded by the federal government.

An attempt to enjoin the President from ending the cost-sharing reduction program failed in a California district court. Thus, it is likely that the only available path to continuing the program is through the bipartisan legislation described below.

- **Legislative Efforts.** Following the failure to pass a full-scale repeal and replacement of the ACA, Congress is currently focusing on bipartisan ACA stabilization legislation. It appears at the moment that the leading piece of legislation is that being sponsored by Senators Lamar Alexander and Patty Murray. Under the Alexander-Murray bill, cost-sharing reductions would be available to individuals with incomes within 100-250% of the federal poverty limit when purchasing coverage on the Marketplace. The bill would also fund ACA assistance and enrollment programs, which have been faced with budgets cuts. Additionally, catastrophic health plans would be available to everyone (i.e., not just those less than age 30 or with a financial hardship). Finally, the bill would relax state ACA waiver programs under ACA Section 1332. This component of the ACA is intended to incentivize states to create innovative ways to improve health care, though opponents of relaxed waiver rules argue that states would be able to curtail many of the ACA's market reforms.

A possible second bill has been announced by Senator Hatch and Representative Brady. The parameters of this legislation are not yet clear. However, it appears that it would also continue funding for cost-sharing reductions (but only for a few years and only for policies that do not cover abortion-related services), provide limited relief from the individual and employer shared responsibility mandates, and increase the contribution limits on health savings accounts.

- **Contraceptive Coverage Mandate Relaxed.** The Departments of the Treasury, Labor and Health and Human Services released proposed regulations greatly expanding the ability to opt-out of the ACA's contraceptive coverage mandate. The ACA requires that health plans cover designated preventive services without cost-sharing and contraceptives are designated as a preventive service for this purpose. Previously, religious organizations and closely-held companies with religious objections to the mandate could opt-out of the ACA's requirement to cover contraceptives. The new proposed regulations provide that all entities can now claim an exemption from the ACA contraceptive coverage mandate for religious reasons. Additionally, group health plan sponsors (other than publicly-traded companies) are able to claim an exemption from this mandate based on "sincerely held moral convictions."

- **ACA Reporting Forms and Instructions Finalized.** ACA reporting forms of the 2017 filing season have been finalized. For a summary of the changes to the forms, please see Roundup Issue 9.

Disability Benefits

Department of Labor Finalizes 90 Day Delay on New Disability Claims Procedures

By Damian Myers and James Huffman

On November 24, 2017, the Department of Labor ("DOL") released regulations finalizing a 90-day delay on the application of new claims procedures for disability claims. The Obama-era regulations providing for the new claims procedures were set to become effective for disability claims filed on or after January 1, 2018. In the absence of additional regulatory changes, the new claims procedures will apply to disability claims filed on or after April 1, 2018.

The 60-day public comment period for the final disability claims procedures regulations remains open (ending on December 11, 2017), although the DOL did not extend that period. Because the DOL is still accepting comments on the final regulations relating to their possible rescission, modification or retention, the ultimate fate of the final regulations remains uncertain.

Despite the uncertain climate, because of the time needed to adopt and implement new procedures, plans may still wish to continue working toward being in compliance with the final regulations on April 1, 2018 until more information and guidance is available. We will continue monitoring for developments. For more information on the new disability claims procedures and the 90-day delay, see our August 1, 2017 and October 12, 2017 blog entries.

District Court Applies Texas Ban on Discretionary Clauses in Insurance Contracts

By Madeline Chimento Rea

A federal district court in Louisiana upheld a Texas state law prohibiting insurers from granting themselves discretion to interpret benefit plans when deciding benefit claims. These so-called "discretionary clauses" are routinely found in plans governed by ERISA and generally result in courts deferring to the plan administrator's decisions. As a practical matter, the current ruling means that, at least in this court's view, an insurer's denial of a claim for benefits may receive a higher level of judicial scrutiny than the abuse of discretion standard it would have received if discretionary clauses were permitted and the plan contained such a clause. The court held that the Commissioner of Insurance had broad authority to adopt rules governing insurers and did not exceed his statutory authority in enacting the regulations at issue. The case is *Jacob v. Unum Life Insurance Company*, No. 16-17666, 2017 WL 4764357 (E.D. La.).

Standing

Plaintiffs Lack Standing to Bring ERISA Fee Litigation Case

By Tulio D. Chirinos

A federal district court in Georgia dismissed claims by participants in Delta Air Lines, Inc.'s 401(k) plan who alleged that Delta breached its ERISA fiduciary duties by allowing the plan to invest in funds that allegedly charged excessive fees and unperformed against comparable funds. Consistent with rulings in other jurisdictions, the court held that plaintiffs lacked Article III standing because they failed to allege that they were invested in the challenged funds or that they paid excessive fees. In so holding, the court explained that personal injury is a prerequisite to standing even when plaintiffs purport to bring their claims on behalf of a 401(k) plan. The court also rejected plaintiffs' argument that the mere fact that defendants allegedly violated ERISA rights creates an injury to them. The case is *Johnson v. Delta Air Lines, Inc.*, No. 1:17-cv-02608, ECF No. 53 (N.D. Ga. Dec. 12, 2017).

No Standing To Pursue Fiduciary-Breach Claim Where Plan Became Overfunded During Litigation

By Steven Sutro

The Eighth Circuit held that defined benefit pension plan participants who alleged breach of fiduciary duty and prohibited transaction claims under ERISA lacked standing to assert their claims because, during the course of the litigation, the plan became overfunded. Plaintiffs brought suit after the plan lost $1.1 billion, which plaintiffs claimed arose from imprudent investments and caused the plan to go from being significantly overfunded to being 84% funded. During the course of the litigation, the plan recovered from the losses and returned to an overfunded status. Defendants moved to dismiss on the ground that plaintiffs had suffered no harm. The Eighth Circuit agreed and held that "when a plan is overfunded, a participant in a defined benefit plan no longer falls within the class of plaintiffs authorized under [ERISA] to bring suit claiming liability . . . for alleged breaches of fiduciary duties." The case is *Thole v. U.S. Bank, Nat'l Ass'n*, No. 16-1928, 2017 WL 4544953 (8th Cir. Oct. 12, 2017).

Statute of Limitations

Fifth Circuit Borrows One-Year Statute of Limitations for Section 502(c)(1) Claim

By Benjamin Flaxenburg

The Fifth Circuit held that the statute of limitations for an ERISA § 502(c)(1) claim—a claim for penalties for failure to provide certain documents within thirty days of a written request—was subject to a one-year statute of limitations. In so holding, the Court borrowed the statute of limitations from the Louisiana Civil Code for claims alleging a violation of a general duty owed, and rejected plaintiff's argument in favor of the ten-year breach of contract statute of limitations. Accordingly, the Court ruled that the claim expired one year and thirty days from the date of the request for documents. The case is *Babin v. Quality Energy Servs.*, Inc., No. 17-civ-30059, 2017 WL 6374738 (5th Cir. Dec. 14, 2017).

ERISA's Six-Year Statute of Repose for Fiduciary-Breach Claims Can Be Tolled

By Tulio D. Chirinos

The Eleventh Circuit ruled that ERISA's six-year statute of repose can be tolled by the parties even though it is a statute of repose. During pre-litigation negotiations between the U.S. Department of Labor and a trustee of an employee stock ownership plan, the parties signed a series of tolling agreements, which delayed the filing of any action in exchange for the trustee agreeing not to raise a timeliness defense if the DOL later sued. Ultimately, the negotiations failed and the DOL sued the trustee for breach of fiduciary duty and prohibited self-dealing. The trustee moved to dismiss the complaint, arguing that the claims were untimely and that the tolling agreements were invalid because ERISA's six-year statute of repose is jurisdictional and therefore cannot be waived. Even if not jurisdictional, the trustee argued, a statute of repose is per se immune from waiver. The Eleventh Circuit held that ERISA's six-year statute of repose is not jurisdictional because ERISA does not contain the clear textual indication required to characterize the limitation as such. The Court also explained that, contrary to the trustee's argument, there is well-established precedent holding that statutes of repose are subject to express waiver, particularly when the statute setting forth the limitation period does not contain a categorical rule prohibiting waiver. The case is *Sec'y, United States DOL v. Preston*, No. 17-10833, 2017 U.S. App. LEXIS 19926 (11th Cir. Oct. 12, 2017).

Attorney Fees

Ninth Circuit Considers Pre-Appeal Conduct in Plan's Request for Appellate Attorney's Fees

By Benjamin Flaxenburg

The Ninth Circuit ruled that a district court erred by failing to consider the entire course of the litigation when analyzing a request for attorney's fees under ERISA and remanded the case for a calculation of fees. A plan participant filed suit against a plan and insurer seeking disability benefits. The plan, in turn, filed a cross-claim against the insurer seeking reimbursement of costs it would be required to expend in the lawsuit. The plan ultimately received an award for attorneys' fees from the insurer in connection with the plan's work in the case. The insurer appealed the award of attorney's fees and lost. The plan then sought to recover its attorney's fees associated with the appeal. The Ninth Circuit concluded that the insurer's actions in the underlying benefits claim litigation were relevant to a determination of whether to award attorney's fees to the plan in connection with the appeal, and held that the district court erred when it failed to consider them. The case is *Micha v. Sun Life Assurance of Canada, Inc.*, No. 16-55053, 2017 WL 4896481 (9th Cir. Oct. 31, 2017).

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???Russell L. Hirschhorn
Partner