Proskauer

ERISA Newsletter

Second Quarter 2018

Editor's Overview

As we head into the thick of summer, all eyes are on President Trump's nomination to the U.S. Supreme Court to replace retiring Justice Anthony Kennedy and the impact the new Justice will have on shaping the law for generations to come. We think it's a good bet that not everyone is as focused on a recent benefits decision from Seventh Circuit involving slayers, pension benefits, beneficiaries, and the ultimate question of who gets the money! Nevertheless, for ERISA practitioners and plan administrators, the Seventh Circuit's decision is interesting and should be taken note of. It is a good reminder that, while clear plan language and properly executed beneficiary designations can help minimize the risk of litigation involving competing beneficiaries, it is not foolproof because there are some public policy concerns that may override even the best-written plan terms. In *Laborers' Pension Fund v. Miscevic*, 880 F.3d 927 (7th Cir. 2018), a federal Court of Appeals for the first time considered whether an individual who was the designated beneficiary of a plan participant she killed was precluded from receiving the decedent's pension benefit. As the article below discusses, the Court concluded that ERISA does not preempt a state slayer statute that prohibits killers from benefitting from their crimes.

The balance of our Newsletter reviews a number of developments over the second quarter, including updates on the DOL fiduciary rule, Mental Health Parity Act, IRS announcements, defined contribution plan investment litigation, pharmacy benefit managers, delinquent contributions, and a variety of fiduciary breach issues.

Clear ERISA Plan Beneficiary Designations Go A Long Way, But They Don't Protect Slayers

By Russell L. Hirschhorn and Paul M. Hamburger

Plan administrators are often called upon to identify the proper beneficiary of a deceased participant's ERISA plan benefits. Clear plan language and properly executed beneficiary designations can help minimize the risk of litigation by competing beneficiaries or the need for the plan administrator to file an interpleader action to avoid the risk of having to pay the benefits twice. There are nonetheless occasions where clear plan terms may not alone resolve the question of who the proper beneficiary is. One such occasion, which occurs more frequently than one may think (but thankfully not too frequently), is when the beneficiary under the terms of the plan is responsible for the participant's death.

Most, if not all, states have so-called "slayer statutes"—statutes that prohibit killers from being beneficiaries of their victims' pension benefits, by providing that the killer is deemed to have predeceased the victim. The existence of these statutes can pose a dilemma for plan administrators, who must determine whether to follow a properly executed beneficiary designation, which would require payment to the beneficiary-killer, or the state slayer statute, in which case a contingent beneficiary must be identified.

But which law applies: ERISA or the state slayer statute? The U.S. Court of Appeals for the Seventh Circuit recently became the first circuit court to decide the issue. Relying on dicta from a nearly two-decade old Supreme Court decision, the Seventh Circuit held that that ERISA does not preempt the Illinois slayer statute and that the statute precluded the killer from being the beneficiary of the decedent's ERISA pension benefits. Below, we briefly review ERISA preemption principles, review the Seventh Circuit's decision in *Laborers' Pension Fund v. Miscevic*, 880 F.3d 927 (7th Cir. 2018), and then conclude with implications of the Court's decision for plan administrators and offer some considerations to think about concerning beneficiary designations.

ERISA Preemption Principles

A state slayer statute, like any state law affecting the payment of pension benefits, can be enforced only if it is not found to be preempted by ERISA. The principle of ERISA preemption—the reservation to federal authority of the sole power to regulate the field of employee benefits—has been called ERISA's "crowning achievement." Congress enacted ERISA preemption to simplify the regulatory environment by ensuring that there be a uniform system of benefit plan regulation on a nationwide basis. This, in turn, eliminates the possibility of plans having to reconcile inconsistent state and local regulation. The only exception is that traditional police powers of the States are not preempted absent express congressional intent to the contrary.

A determination that ERISA preempts state law or does not preempt state law, as the case may be, could have significant implications. For instance, if ERISA preemption applies, the claim is more likely than not going to be litigated in federal, not state, court. That is because the federal courts have exclusive jurisdiction over fiduciary breach claims; and benefit claims, even if commenced in state court, can be removed by the defendant to federal court. A determination that ERISA preempts also limits a plaintiff to remedies enumerated under ERISA's civil enforcement scheme rather than potentially more expansive state or common law remedies.

ERISA preemption is codified in Section 514(a) of ERISA, which provides that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. A law "relates to" an employee benefit plan if it has "a connection with or reference to such a plan." *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85 (1983). (ERISA provides for certain exceptions pertaining to the regulation of insurance, banking and securities, and exceptions to that exception, *see* ERISA §§ 514(b)-(d), but those are beyond the scope of this article.)

Over the past several decades, the Supreme Court has issued many decisions on ERISA preemption and, in particular, opined on the breadth of what it means to "relate to" an employee benefit plan for purposes of ERISA preemption. Several relevant principles have emerged from those cases. To begin with, ERISA's preemption provision is "clearly expansive." *N.Y. St. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). At the same time, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. In addition, where the state law is a "traditional area of state regulation," a party seeking a determination that a claim in preempted must overcome "the starting presumption that Congress does not intend to supplant state law." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141 (2001).

Seventh Circuit Concludes ERISA Does Not Preempt Illinois Slayer Statute

The ruling in *Laborers' Pension Fund v. Miscevic* provides a good illustration of the application of ERISA preemption principles, albeit in unique circumstances. The underlying facts are relatively straightforward: Anka Miscevic killed her husband Zeljiko Miscevic and was found by the state court to have intended to kill him without legal justification. However, Anka was determined not guilty by reason of insanity. The question presented, therefore, was whether under these circumstances Anka was entitled to be a beneficiary of her husband's pension benefits.

Following the state criminal proceedings, the Laborers' Pension Fund initiated an interpleader action in federal court to determine the proper beneficiary of Zeljiko's pension benefits. Not surprisingly, the Fund's documents did not address directly whether a claimant who killed a Fund participant can receive a benefit from the Fund as a participant's beneficiary, but there was no question that Anka would otherwise be the proper beneficiary under the terms of the plan. The child of Anka and Zeljiko argued that Anka was barred from receiving the benefits pursuant to the Illinois slayer statute, which provides that a "person who intentionally and unjustifiably causes the death of another shall not receive any property, benefit or other interest by reason of death." The child argued that application of the slayer statute required that the benefits pass as if the person causing the death died before the decedent. Anka claimed she was entitled to the benefits because she was the participant's surviving spouse and that ERISA's spousal beneficiary protections preempt the Illinois slayer statute. Alternatively, Anka argued that the slayer statute should not apply because she was found not guilty by reason of insanity.

The Seventh Circuit reviewed the ERISA preemption principles discussed above and concluded that ERISA does not preempt the Illinois slayer statute. In so ruling, the Court was guided by the Supreme Court's decision in *Egelhoff*. There, the Supreme Court held that ERISA preempted a Washington state statute that provided that a dissolved or invalidated marriage would revoke an earlier beneficiary designation to the former spouse. The Court reached that conclusion upon finding that the state statute "directly conflict[ed] with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents" and also "interfere[d] with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 148-150. Importantly, the Court rejected an argument that if ERISA preemption applied in that case then it also must preempt state slayer statutes. Although slayer statutes were not at issue in *Egelhoff*, the Court commented that the statutes have a long historical pedigree predating ERISA, they have been adopted by nearly every state, and, because the statutes are more or less uniform nationwide, "their interference with the aims of ERISA is at least debatable."

The Seventh Circuit observed that a handful of courts—before and after *Egelhoff*—have expressly held that ERISA does not preempt the slayer statute at issue. For instance, in *Hartford Life & Accident Ins. Co. v. Rogers*, No. 3:13–cv–101, 2014 WL 5847548 (D.N.D. Nov. 12, 2014), the district court ruled that given the well-established principle against permitting slayers to benefit financially from the intentional or felonious killing of another, "it would contradict federal common law and the congressional intent for ERISA to allow" a murderer to recover ERISA benefits. *See also Union Sec. Life Ins. Co. of N.Y. v. JJG-1994*, No. 1:10–CV–00369, 2011 WL 3737277, at *2 (N.D.N.Y. Aug. 24, 2011) (citing *Mendez-Bellido v. Bd. of Trs. Of Div. 1181, A.T.U. N.Y. Emps. Pension Fund & Plan*, 709 F. Supp. 329 (E.D.N.Y. 1989)); *New Orleans Elec. Pension Fund v. Newman*, 784 F. Supp. 1233 (E.D. La. 1992).

Agreeing with those courts, the Seventh Circuit held that ERISA does not preempt the Illinois slayer statute. The Court determined that slayer statutes are an aspect of family law, which is a traditional area of state regulation, and that Anka could not meet the "considerable burden" of overcoming the starting presumption that Congress did not intend to supplant this traditional area of state regulation. The Seventh Circuit then determined that the Illinois slayer statute applies even where the plan participant was killed by an individual found not guilty by reason of insanity. The Court explained that an individual may not appreciate that her conduct amounted to a crime, but she still may have intentionally or unjustifiably caused a death.

Proskauer's Perspective

The ruling in the *Laborers' Pension Fund* came about because the plan administrator was uncertain who the proper beneficiary was and—to remove the risk of paying the wrong beneficiary and possibly having to pay twice—elected to engage in the time consuming and expensive process of initiating an interpleader action. If a consensus develops and the circuits agree that ERISA does not preempt state slayer statutes, plans may more confidently determine not to pay benefits to slayers without resorting to filing an interpleader action. But until then they should proceed with caution.

More broadly, plan administrators should take note that although in this instance, the state statute trumped plan provisions that might otherwise have been properly construed to require payment to the slayer, this represents the exception and not the rule and thus should not deter plan sponsors from carefully delineating plan beneficiary rules and thereby avoiding any ambiguity. Indeed, the Supreme Court has made quite clear that the plan documents rule when it comes to processing claims and disbursing benefits. *Kennedy v. Plan Adm'r for DuPont Savings & Inv. Plan*, 555 U.S. 285 (2009).

Giving advance thought to these issues and proactively addressing areas where there may be ambiguity ought to help minimize the risk of litigation to identify the proper beneficiary of a decedent's benefits. Some questions for plan administrators to consider include the following:

- ???Is the plan language on beneficiary designations clear and complete?
- ???Are beneficiary designation forms (written or electronic) clear as to how to designate multiple beneficiaries and/or contingent beneficiaries?
- ???Are there procedures in place to identify deficiencies/inconsistencies in beneficiary designations so they can be corrected before they are accepted by the plan administrator?
- ???Does the plan provide periodic (perhaps annual) reminders to participants to review and update beneficiary designations?
- ???For pension and 401(k) plans, are the spousal protection provisions clear and up-to-date? Do the plan terms address what happens to beneficiary designations when a participant is married or when a married participant is divorced (or the spouse dies)?
- ???Are existing beneficiary designation records reasonably accessible, either in hard copy or electronically?
- ???If there was a plan merger, are records of the transferor plan's beneficiary designations maintained in good order?

Are there clear default beneficiary designations in case a purported designation is invalid, inaccurate, or incomplete?

Highlights from the Employee Benefits & Executive Compensation Blog

DOL Fiduciary Rule

New DOL FAB Further Delays Enforcement of Fiduciary Rule, But Does Not Undo The Rule In Its Entirety

By Seth Safra, Russell Hirschhorn and Steven A. Sutro

On May 7, 2018, the DOL issued a Field Assistance Bulletin ("FAB") addressing the Department's enforcement policy on the fiduciary rule that was recently vacated by the Fifth Circuit. Although the DOL has elected not to continue defending the rule before the Fifth Circuit, the FAB leaves the rule's status in a holding pattern.

Rather than scrapping the rule in toto, the FAB continues a temporary "no enforcement" policy until the DOL issues new regulations or guidance. This posture has two key consequences:

1. DOL will not enforce the fiduciary rule's test for determining whether a service provider is a fiduciary by reason of providing investment advice for a fee. This means that fiduciary status by reason of providing investment advice for a fee will be determined based on the five-part test from DOL's 1975 regulation.
2. The Best Interest Contract and Principal Transaction exemptions are not dead. Investment advice fiduciaries may continue to rely on those exemptions if they work diligently and in good faith to comply with the impartial conduct standards set forth in those exemptions.

IRS

IRS Announces HSA and HDHP Limitations for 2019

By Damian A. Myers

On May 10, 2018, the IRS released Revenue Procedure 2018-30 setting dollar limitations for health savings accounts (HSAs) and high-deductible health plans (HDHPs) for 2019. HSAs are subject to annual aggregate contribution limits (i.e., employee and dependent contributions plus employer contributions). HSA participants age 55 or older can contribute additional catch-up contributions. Additionally, in order for an individual to contribute to an HSA, he or she must be enrolled in an HDHP meeting minimum deductible and maximum out-of-pocket thresholds. The contribution, deductible and out-of-pocket limitations for 2019 are shown in the table below (2018 limits are included for reference).

HSA/HDHP Limitations

	2018	2019
Maximum HSA Contribution (Employee + Employer)	Self-Only: $3,450 Family: $6,900	Self-Only: $3,5000 Family: $7,000
Catch-Up Contribution Limit	$1,000	$1,000
Minimum HDHP Deductible	Self-Only: $1,350 Family: $2,700	Self-Only: $1,350 Family: $2,700
HDHP Out-of-Pocket Max	Self-Only: $6,650 Family: $13,300	Self-Only: $6,750 Family: $13,500

Note that the Affordable Care Act (ACA) also applies an out-of-pocket maximum on expenditures for essential health benefits. However, employers should keep in mind that the HDHP and ACA out-of-pocket maximums differ in a couple of respects. First, ACA out-of-pocket maximums are higher than the maximums for HDHPs. As explained in our May 9, 2014 blog entry, the ACA's out-of-pocket maximum was identical to the HDHP maximum initially, but the Department of Health and Human Services (which sets the ACA limits) is required to use a different methodology than the IRS (which sets the HSA/HDHP limits) to determine annual inflation increases. That methodology has resulted in a higher out-of-pocket maximum under the ACA. The ACA out-of-pocket limitations for 2019 were announced in the 2019 Notice of Benefit and Payment Parameters and are shown in the table below (2018 limits are included for reference).

ACA Out-of-Pocket Limitations

	2018	2019
Self-Only	$7,350	$7,900
Family	$14,700	$15,800

Second, the ACA requires that the family out-of-pocket maximum include "embedded" self-only maximums on essential health benefits. For example, if an employee is enrolled in family coverage and one member of the family reaches the self-only out-of-pocket maximum on essential health benefits ($7,900 in 2019), that family member cannot incur additional cost-sharing expenses on essential health benefits, even if the family has not collectively reached the family maximum ($15,800 in 2019).

The HDHP rules do not have a similar rule, and therefore, one family member could incur expenses above the HDHP self-only out-of-pocket maximum ($6,750 in 2019). As an example, suppose that one family member incurs expenses of $10,000, $7,900 of which relate to essential health benefits, and no other family member has incurred expenses. That family member has not reached the HDHP maximum ($15,800 in 2019), which applies to all benefits, but has met the self-only embedded ACA maximum ($7,900 in 2019), which applies only to essential health benefits. Therefore, the family member cannot incur additional out-of-pocket expenses related to essential health benefits, but can incur out-of-pocket expenses on non-essential health benefits up to the HDHP family maximum (factoring in expenses incurred by other family members).

Employers should consider these limitations when planning for the 2019 benefit plan year and should review plan communications to ensure that the appropriate limits are reflected.

IRS Transition Relief Reinstates $6,900 Family Limit for 2018 HSAs

By Damian A. Myers

On April 26th, the IRS released Rev. Proc. 2018-27, effectively reinstating a $6,900 limit on 2018 health savings account ("HSA") contributions for family coverage. This is welcome relief for individuals who planned on contributing the maximum permitted HSA contributions for 2018 as well as employers who offer plans that facilitate these contributions.

Background

In our March 7, 2018 blog entry, we described the IRS's retroactive downward adjustment (from $6,900 to $6,850) of the HSA contribution limit for individuals enrolled in family coverage (see Rev. Proc. 2018-18). This adjustment was based on a change in the method by which inflation adjusted limits were to be determined. At that time, the IRS did not provide any transition relief for those individuals who had already contributed up to the limit or who made elections under cafeteria plans to contribute up to the limit. Since the release of Rev. Proc. 2018-18, numerous employers, trade groups, and other stakeholders have asked the IRS to reconsider its retroactive limit adjustment and allow the $6,900 limit announced in 2017 to remain applicable.

Rev. Proc. 2018-27

On April 26th, the IRS relented and released Rev. Proc. 2018-27, stating that it "would be in the best interest of sound and efficient tax administration" to apply the originally announced contribution limit. Therefore, for 2018, the HSA contribution limit for those enrolled in family coverage is $6,900.

Rev. Proc. 2018-27 also contains guidance for individuals who contributed the full $6,900 and then received a distribution of excess contributions and earnings based on Rev. Proc. 2018-18. These individuals may repay the excess contributions and earnings and treat the distribution as a "mistake of fact" (as described in IRS Notice 2004-50). Mistaken distributions that are repaid are not included in gross income or subject to either the 20% tax on non-medical expense distributions or the 6% excise tax on excess contributions.

If an individual has already received a distribution of an excess contributions and earnings based on Rev. Proc. 2018-18 and does not repay as described above (either because he or she chooses not to or the HSA trustee or custodian refuses to accept repayment), the distribution will still be treated as the return of an excess contribution prior to the due date of the individuals 2018 tax return. As such, the distribution would not be included in income or be subject to the 20% additional tax on non-medical expense distributions.

The tax treatment described above does not apply to employer contributions (including employee contributions through a cafeteria plan) made on behalf of employees on a pre-tax basis based on the $6,900 annual limitation. In that case, the normal restrictions and taxes applied to non-medical expense distributions will apply.

The IRS's decision to return to the originally announced HSA limit is welcome news for employers and individuals. Employers that did not reduce the contribution limit and adjust employee elections may continue to operate their HSA contribution programs without regard to Rev. Proc. 2018-18. Employers that did take corrective action and automatically reduce employee's contribution elections should consider whether to again adjust employee contributions to be consistent with their original elections.

Mental Health Parity Act

Proposed Mental Health Parity Guidance Focuses on Nonquantitative Treatment Limitations

By Damian A. Myers and Steven A. Sutro

On April 23, 2018, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (together, the "Agencies") released proposed frequently asked questions ("FAQs") related to nonquantitative treatment limitations ("NQTLs") under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The Agencies also provided guidance on new disclosure requirements (which were described in our May 15, 2018 blog entry) and released a self-compliance tool.

Perhaps one of the more difficult aspects of mental health parity compliance is applying the parity rules to NQTLs. There is a dearth of concrete guidance on what constitutes a NQTL and how the parity rules apply to NQTLs. The Agencies' most recent proposed guidance, FAQs about Mental Health and Substance Abuse Disorder Parity Implementation and the 21st Century Cures Act, Part 39 ("FAQs Part 39"), expands on prior NQTL-related guidance by explaining how the parity rules would apply in various hypothetical situations involving NQTLs.

By way of background, the MHPAEA requires that group health plans provide mental health and substance abuse benefits in parity with medical and surgical benefits. Although the requirements are complex (a summary can be found here), the basic structure of the law is that both quantitative limitations (e.g., dollar and visit limits) and NQTLs (e.g., medical management techniques) applied to mental health and substance abuse benefits must be in parity with the predominant limitations applied to substantially all medical and surgical benefits. This "predominant/substantially all" requirement applies on a classification-by-classification basis, based on six classifications of benefits: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs.

As explained in FAQs Part 39, a plan cannot impose a NQTL with respect to mental health or substance abuse benefits "unless, under the terms of the plan…as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to [mental health and substance abuse] in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification." A summary of the key aspects of the Agencies' guidance on NQTLs is provided below.

- **Blanket Coverage Exclusions.** The MHPAEA does not require that a group health plan provide coverage for any particular mental health or substance abuse condition. However, once a plan covers a mental health or substance abuse condition, any quantitative limitations or NQTLs applied to the condition must be in parity with medical/surgical benefits. For example, a group health plan could exclude all services and treatments related to bipolar disorder without violating the MHPAEA. However, if some services or treatments for bipolar disorder are covered, then any limitation applied to that coverage must meet the MHPAEA requirement that coverage for bipolar disorders be in parity with medical/surgical benefits within the relevant classification.

Even though the MHPAEA is not a coverage mandate, plan sponsors of fully-insured plans should be aware that state law coverage mandates might require coverage of particular mental health and substance abuse disorders.

- **Experimental/Investigational Exclusions.** An exclusion based on the experimental or investigational nature of a service or treatment is a NQTL. Therefore, the method by which a service or treatment is determined to be

experimental or investigational cannot be applied more stringently to mental health and substance abuse benefits than it is to medical/surgical benefits. For example, suppose a plan provides that any treatment (whether mental health/substance abuse or medical/surgical) will be denied as experimental when no professionally recognized treatment guidelines define clinically appropriate standards of care and fewer than two randomized controlled trials support the treatment's use for a particular condition. Despite the plan language, the plan is administered such that it covers treatment for a medical/surgical condition with only one supporting randomized trial, but it still requires two supporting randomized trials before covering treatment for a mental health/substance abuse condition in the same MHPAEA classification. Because the plan's experimental/ investigational exclusion is applied more stringently to mental health/substance abuse benefits, a MHPAEA violation would have occurred.

That experimental/investigational exclusions are NQTLs is not particularly surprising, as these types of exclusions are one way in which plans can manage medical costs. Nevertheless, the description of this NQTL in the FAQs is noteworthy because the example used involves "applied behavioral analysis" ("ABA") for treatment of autism spectrum disorder. Many insurers and plans have excluded ABA on the basis that the treatment is experimental or investigational and this has spawned numerous lawsuits alleging violations of state and federal mental health parity laws. Plans that do cover ABA but apply age or other treatment limitations on ABA might also face litigation if the limits are not in parity with limits applied to medical/surgical benefits.

Plans that cover treatment for autism spectrum disorder but deny coverage for ABA therapy under an experimental/investigational exclusion should be mindful of ABA's growing acceptance as a standard treatment. Continued application of this type of exclusion to ABA may become more difficult to justify over time.

- **Other NQTLs.** The Agencies also identified and provided examples for the following NQTLs: prescription drug dosage limitations, step therapy programs, healthcare facility restrictions, and provider network administration (such as network access standard and network adequacy measurements). The message is clear – if any of these limitations are applied to mental health and substance abuse benefits, the method by which a plan determines whether to apply the NQTL and the method to determine the scope of the NQTL cannot be applied more stringently to mental health and substance abuse benefits than it is applied to medical and surgical benefits.

Monitoring compliance with the MHPAEA's requirements for NQTLs is extremely complicated. In our next blog on mental health parity, we will provide practical steps that plan sponsors and administrators can take to review and monitor compliance. This includes using the new self-compliance tool provided by the Agencies.

Proposed Mental Health Parity Guidance Would Impose Burdensome Disclosure Requirements

By Damian A. Myers

On April 23, 2018, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (together, the "Agencies") released proposed frequently asked questions ("FAQs") related to required disclosures and nonquantitative treatment limitations ("NQTLs") under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The Agencies also released a self-compliance tool to help plans, plan administrators and plan sponsors assess their compliance with the MHPAEA.

The new guidance contains too much information to cover in a single blog, so this is the first of three blogs covering the guidance. In this entry, we highlight the Agencies' proposed rule that would require plan administrators to distribute hard copy health care provider lists when the ERISA electronic disclosure standards cannot be met. This proposed requirement deviates from the standard practice of directing plan participants to network administrator websites for provider lists and would be sure to significantly increase administration costs.

Background

The MHPAEA requires that group health plans provide mental health and substance abuse benefits in parity with medical and surgical benefits. Although the requirements are complex (a summary can be found here), the basic structure of the law is that both quantitative limitations (e.g., dollar and visit limits) and nonquantitative limitations (e.g., medical management techniques) applied to mental health and substance abuse benefits must be the same or better than the predominant limitations applied to substantially all medical and surgical benefits. This "predominant/substantially all" requirement applies on a classification-by-classification basis, based on six classifications of benefits: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs.

The 21st Century Cures Act enacted in 2016 mandated that the Agencies issue guidance with respect to disclosures related to NQTLs and application of the NQTL parity requirements. The first set of Agency guidance under this direction was released in June 2017 as FAQs about Mental Health and Substance Abuse Disorder Parity Implementation and the 21st Century Cures Act, Part 38. Those FAQs addressed parity requirements related to eating disorders and included a draft model form request for disclosure of treatment limitations. The Agencies' most recent proposed guidance, Proposed FAQs about FAQs about Mental Health and Substance Abuse Disorder Parity Implementation and the 21st Century Cures Act, Part 39 ("FAQs Part 39"), builds upon prior mental health parity guidance.

Disclosure Obligations

Prior agency guidance has made clear that plans must disclose information related to NQTLs when that information is requested by participants, and FAQs Part 39 updates the model request form for participants. Perhaps the most surprising aspect of FAQs Part 39 was the proposed guidance regarding disclosure of the healthcare provider network in a plan's summary plan description ("SPD"). The question related to availability of a psychiatrist within a network, but the implications of the Agencies' proposed response goes beyond mental health services.

As a general matter, the DOL regulations setting forth the content requirements for SPDs state that the SPD must contain a description of the "composition of the provider network." Changes to the provider network would also require a summary of material modifications describing the changes within 210 days following the year in which the changes occurred.

The DOL regulations also state that the list of in-network providers can be provided in a separate document as long as the SPD contains a general description of the provider network and a statement that the list of the network providers is automatically provided in a separate document. Although separate hard copy network provider books once existed, for years, insurance carriers and network administrators have given participants access to the provider lists through the carrier's or administrator's website. SPDs now often give a general description of the network and provide a URL address for the provider list website.

FAQs Part 39 contains guidance that is generally consistent with that described above with one major exception. Proposed Q&A 12 states that SPDs are permitted to direct participants to the network administrator's website only if the DOL's electronic disclosure safe harbor requirements are met. In general, the DOL's electronic disclosure rule provides that ERISA-required notices can be sent electronically only if the recipients have access to the internet as part of their day-to-day job functions. This means that employees in many industries, such as retail, hospitality, manufacturing, and transportation, would have to receive hard copy network provider books unless they affirmatively consent to receive electronic disclosures. Terminated employees and retirees who have group health coverage would also have to be provided hard copy provider lists unless they consent to receive electronic disclosures.

The inability of plans and plan sponsors to rely on network administrator websites to communicate network provider lists presents a number of problems. For instance, plans and plan sponsors generally have no control over the network structure, and network administrators are not in the practice of regularly communicating provider changes to participating plans. Providers join and leave various networks on a frequent basis, so hard copy provider lists (which could be dozens of pages long) would need to be updated and distributed, at a minimum, on an annual basis. Thus, plans and sponsors would likely face significant costs if hard copy provider lists were required.

Note that the guidance in FAQs Part 39 is proposed, and the Agencies have solicited comments (deadline is June 22nd).

Anthem Settles Mental Health Parity Litigation Involving Autism Treatment

By Steven A. Sutro

A federal district court in Indiana recently granted preliminary approval of a settlement between Anthem and a class seeking coverage of Applied Behavior Analysis ("ABA") treatment for autism disorders. The three-year old litigation involved claims that Anthem violated the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") by limiting the hours of ABA therapy that would be covered for children ages seven and older. As part of the settlement, Anthem will pay $1.625 million to a common fund for the benefit of approximately 200 class members; the amount per person will vary based on individual claims for ABA therapy that were denied. Anthem also agreed to stop using guidelines that limited ABA coverage based solely on an individual's age. Anthem will further require employees who review treatment plans to participate in periodic external continuing education relating to autism and/or ABA therapy.

As we have discussed previously, MHPAEA claims related to ABA treatment have become more common, but courts have yet to issue many substantive decisions on the lawfulness of plans' ABA restrictions. Plan sponsors and fiduciaries should expect scrutiny of ABA restrictions to continue.

The case is *W.P. v. Anthem Ins. Cos.*, No. 1:15-cv-00562 (S.D. Indiana).

Fee Litigation

First Round of Robo-Advisor Fee Litigation Goes to Record-Keepers

By Lindsey Chopin

Since 2016, record keepers for large 401(k) plans have been defending litigation over investment advice provided by the Financial Engines investment advice algorithm. (This kind of arrangement is commonly referred to as "robo-advice.") The lawsuits claim, in essence, that fees collected by record keepers for investment advice were unreasonably high, because the fees exceeded the amount actually paid to Financial Engines. The suits claimed that the record keepers did not provide services of sufficient value to justify retaining the spread between the amount charged and the amount actually paid to Financial Engines.

In March, two federal courts dismissed claims against the record keepers, bringing the total to four similar cases that all have been dismissed. The courts ruled that the record keepers were not acting as fiduciaries in setting fees at a level that allowed them to retain an amount in excess of what was paid to Financial Engines and thus plaintiffs could not proceed with claims that the record keepers breached fiduciary duties or engaged in prohibited self-dealing.

Despite the record keepers' success in this first round of litigation, the courts have not completely foreclosed plaintiffs' claims. In three of the four cases, the courts gave the plaintiffs a chance to replead their claims. In addition, the courts noted the responsibility of plan sponsors or their designees to review fee arrangements for investment advice (as well as other services) to ensure that the total amount paid is reasonable. That said, the courts have not accepted the plaintiffs' premise that the fees in any case were unreasonable.

The cases are: *Patrico v. Voya Financial, Inc.*, No. 16-7070, 2018 WL 1319028 (S.D.N.Y. Mar. 13, 2018) (denying leave to amend); *Scott v. Aon Hewitt Financial Advisors*, *LLC, et al.,* No. 17 C 679, 2018 WL 1384300 (N.D. Ill. Mar. 19, 2018); *Chendes v. Xerox HR Solutions, LLC*, 2017 WL 4698970 (E.D. Mich. Oct. 19, 2017); and *Fleming v. Fid. Mgmt. Tr. Co.,* No. 16-CV-10918-ADB, 2017 WL 4225624 (D. Mass. Sept. 22, 2017).

403(b) Plans

The Budget Act Relaxes Hardship Withdrawal Rules, But Some Changes May Not Apply to 403(b) Plans

By Steven Einhorn

On Feb. 9, 2018, Congress passed, and the president signed, the Bipartisan Budget Act of 2018 (the "Budget Act"). As we previously discussed here, the Budget Act contains a number of provisions that affect qualified retirement plans. These changes include expanding the type of funds that can be distributed under Code Section 401(k) in the event of a hardship withdrawal, beginning with plan years commencing after December 31, 2018, to include not only a participant's elective deferral contributions, but also qualified nonelective contributions, qualified matching contributions, and earnings on each of those three contribution sources. While this change applies to 401(k) plans, there is uncertainty whether it will apply to 403(b) plans.

The regulations under Code Section 403(b) provide that a hardship withdrawal under Code Section 403(b) has the same meaning, and is subject to the same rules and restrictions, as a hardship distribution under the regulations governing 401(k) plans. This would indicate that if the rules and restrictions applicable to hardship withdrawals for 401(k) plans change, the rules and restrictions applicable to hardship withdrawals for 403(b) plans would change as well. However, the regulations under Code Section 403(b) also state, "In addition, a hardship distribution is limited to the aggregate dollar amount of the participant's section 403(b) elective deferrals under the contract (and may not include any income thereon)..." (Treas. Reg. Section 1.403(b)-6(d)(2)). Furthermore, Code Section 403(b)(11) provides that an annuity contract under a 403(b) plan cannot provide for distributions of any income attributable to a participant's elective deferral contributions.

Reading these provisions together, it appears that while the intent may have been to allow 403(b) plans to take advantage of these relaxed rules regarding the types of funds that can be distributed in the event of a hardship withdrawal, Code Section 403(b) and the regulations governing Section 403(b) appears to limit the ability of a 403(b) plan to do so. Sponsors of 403(b) plans should watch for guidance on this issue.

Breach of Fiduciary Duty

ERISA's Duty To Inform – Distinguishing Between Existing and Possible Benefits

By Benjamin Flaxenburg

A recent ERISA opinion gives us occasion to point out the important distinction under ERISA concerning fiduciary duties as they pertain to existing benefits and possible benefits. In this case, the plaintiff alleged that defendants misrepresented to her that her retirement benefit plan would not change or would only change to her advantage after the residency program that she participated in was terminated, and that she relied on that misrepresentation in suspending her search for a new job. On reconsideration of its prior ruling, the district court realized that it had misapplied Third Circuit precedent as it pertains to the duty to inform. It thus reversed course and ruled that while plan fiduciaries have an affirmative duty to ensure that participants inquiring about *existing* benefits receive relevant information, they do not have a duty to inform participants inquiring about *future* benefits of possible changes to the plan unless they are under serious consideration at the time of the inquiry. Because there was no evidence that plaintiff was misinformed about *existing* benefits at any time, or that changes to future benefits were under serious consideration at the time the inquiries were made, they were not material misrepresentations, and the court granted summary judgment dismissing the case. The case is *Kovarikova v. Wellspan Good Samaritan Hospital*, No. 1:15-CV-2218, 2018 WL 2095700 (M.D. Pa. May 7, 2018).

ERISA Plans

No Ongoing Administration, No ERISA Plan

By Lindsey Chopin

Participants in a voluntary separation program filed suit for breach of fiduciary duty under ERISA seeking additional benefits after learning that greater benefits were provided to individuals who did not participate in the program but were later part of an involuntary reduction-in-force. The Third Circuit concluded that the program was not an ERISA plan because there was no ongoing administration. More specifically, the Court determined that the program was only available for approximately two months and only required the employer to make an initial, discretionary determination of applicants' eligibility for the program, calculate certain one-time payments, and, in some cases, determine whether the applicant was eligible to work part-time for a defined period or subsequently be re-hired. As such, the Court affirmed the lower court's ruling dismissing the case. The case is Girardot v. The Chemours Company, No. 17-1894, 2018 WL 2017914 (3rd Cir. Apr. 30, 2018).

Pharmacy Benefit Managers

Clawbacks: Recent Litigation Targeting Insurers and Pharmacy Benefit Managers

By Neal Schelberg and Randall Bunnell

While the term "co-pay" might suggest a sharing of costs between patients and their health plans, a recent study by the University of Southern California Schaeffer Center found that almost a quarter of patients are paying *more* than the full price for their prescription drugs under their insurance plans due to "clawbacks." A prescription drug clawback occurs when patients purchasing drugs from pharmacies make co-payments required under their insurance plans that exceed the price of the prescriptions and then the insurers and/or pharmacy benefit managers ("PBMs") clawback from the pharmacies the excess amounts paid.

There have been frequent media reports on the practice of prescription drug clawbacks and federal lawsuits have been filed against insurance companies and PBMs, such as UnitedHealth, Cigna, Humana, and Optum Rx. The theories of liability being asserted include breach of fiduciary duty under the Employee Retirement Income Security Act ("ERISA"), violations of the Racketeer Influenced and Corrupt Organizations Act, as well as under various state laws. These actions are all in their early stages, with none having been decided on the merits.

With respect to the ERISA claims, plan participants and beneficiaries have argued that the insurers and PBMs are liable as ERISA plan fiduciaries. In two recent cases, the courts have concluded that the fiduciary duty analysis turns on whether the defendants exercised any discretionary authority or control in creating and implementing the alleged clawbacks and acted in accordance with the terms of the plans. *See Negron v. Cigna Health & Life Ins.*, No. 16-cv-1904, 2018 WL 1258837 (D. Conn. Mar. 12, 2018); *In re UnitedHealth Grp. PBM Litig.*, No. 16-cv-3352, 2017 WL 6512222 (D. Minn. Dec. 19, 2017).

In *In re UnitedHealth*, the court dismissed plaintiffs' ERISA fiduciary argument because the plaintiffs failed to allege facts sufficient to demonstrate that the defendants exercised any discretion and thus UnitedHealth and its PBM, Optum Rx, were not acting as ERISA plan fiduciaries. In so ruling, the court determined that the defendants' performance of "instantaneous calculations" in accordance with the terms of the plan was insufficient to show that their conduct was "anything more than ministerial claims processing." More recently, in *Negron*, plaintiffs' claim survived a motion to dismiss. The court found plaintiffs alleged facts sufficient to assert a plausible claim of fiduciary status based on the argument that Cigna's conduct was in violation of plan terms and thus necessarily required the exercise of discretion.

In light of the *Negron* decision, and armed with a new academic study establishing the overpayment of a large portion of prescription drug claims, we may see an increase in actions involving health insurers and PBMs targeting clawbacks. As the existing cases continue to be litigated and decisions on the merits are rendered, the impact of this trend will become more apparent. In the interim, plan fiduciaries should consider: (i) reaching out to their health insurer and/or PBM to determine whether or not participants are being advised when the co-pay under the plan exceeds the cost of the prescription; and (ii) advising plan participants who fill prescription drugs to ask the pharmacy whether the cash price for that prescription is less than the co-pay required under the plan.

Delinquent Contributions

Ninth Circuit Deepens Circuit Split Over Whether Delinquent Contributions Are Plan Assets

By Neil V. Shah

The Ninth Circuit held that employer contributions due to a Taft Hartley fund are not plan assets until they are actually paid to the fund, irrespective of whether the plan document defines plan assets to include unpaid employer contributions. As a result, a fund could not hold a contributing employer's owner and treasurer personally liable for breach of fiduciary duty for failure to pay the contributions. (The employer was found liable for delinquent contributions under ERISA § 515.) The Ninth Circuit's decision deepens a split between, on the one hand, the Sixth and Tenth Circuits, which have similarly rejected such claims, and, on the other hand, the Second and Eleventh Circuits, which have recognized that unpaid contributions may be plan assets where the plan document defines plan assets as including unpaid employer contributions. The case is *Glazing Health and Welfare Fund v. Lamek*, No. 16-16155, 2018 WL 1403579 (9th Cir. Mar. 21, 2018).

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