Proskauer

ERISA Newsletter

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Editor's Overview

We often talk about the importance of evaluating whether there are any procedural obstacles to plaintiffs pursuing their ERISA claims, particularly in complex, class actions where it may not be possible to challenge the viability of the claim on the merits. If, by virtue of one of these procedural devices, defendants can prevail on a motion to dismiss, they can avert expensive, timing-consuming discovery, including all of its electronic components, that are a necessary predicate to prevailing on a motion for summary judgment or trial directed to the merits of the case. It is with those considerations in mind that we take a look this month at a pending petition for certiorari to the U.S. Supreme Court in the case of *Thole v. US Bancorp*. That case, coming from the Eighth Circuit, addresses the issue of standing and, in particular, whether participants have standing under ERISA and/or Article III of the U.S. Constitution to commence an ERISA breach of fiduciary duty action where they have not suffered any individual harm. As our colleague discusses, Supreme Court review of *Thole* could have a significant bearing on the future conduct of ERISA litigation on several fronts.

The balance of the Newsletter addresses a variety of regulatory guidance from the IRS and PBGC, as well as court decisions addressing appellate deadlines, recoupment of benefit overpayments, defined contribution plan investments, jury trials, statute of limitations, ERISA 510, fiduciary status and benefit claim standard of review.

U.S. Supreme Court Weighs Whether To Consider ERISA Participants' Standing To Sue*

By: Tulio D. Chirinos

The issue of whether a plan participant must have suffered individual financial harm in order to assert claims for breach of fiduciary duty under ERISA Sections 502(a)(2) and (3), and whether that is an issue of Article III constitutional standing or ERISA statutory standing, has been the subject of considerable debate. These issues were addressed by the Eighth Circuit in *Thole v. U.S. Bank*, 873 F.3d 617 (8th Cir. 2017), wherein the Court concluded that plan participants did not have statutory standing to assert breach of fiduciary duty claims against defined benefit plan fiduciaries based on their failure to diversify investments because the participants had not suffered any individual financial harm. In so ruling, the Eighth Circuit explained that its earlier decision in *Harley v. Minn. Mining & Mfg. Co.*, 284 F.3d 901 (8th Cir. 2002) resolved the statutory standing issue—not the Article III standing issue—as it pertains to Section 502(a)(2) claims, and then reached the same conclusion with respect to Section 502(a)(3) claims for injunctive relief.

This article reviews the Eighth Circuit's decision and the issues presented by the plaintiffs' petition for certiorari to the Supreme Court. The petition has garnered significant attention in part due to the Supreme Court's request that the Solicitor General submit a brief expressing the views of the United States.

The District Court's Opinions

In *Thole*, two participants in U.S. Bank's defined benefit pension plan commenced a putative class action alleging that defendants breached their fiduciary duties and violated ERISA's prohibited transaction rules by failing to diversify the plan's investments, *i.e.*, by investing the entire plan's portfolio in equities managed by entities affiliated with U.S. Bank. According to the complaint, the investments substantially underperformed, resulting in plan losses of $1.1 billion and causing the plan to become underfunded.

The plaintiffs sought to recover plan losses, disgorgement of profits, injunctive relief, and other remedial relief under ERISA §§ 502(a)(2) and (a)(3). Section 502(a)(2) provides that a plan participant may commence a civil action for appropriate relief under Section 409 of ERISA, which, in turn, provides that plan fiduciaries are personally liable to the plan for any losses to the plan resulting from fiduciary breaches, must restore to the plan any profits generated by such breaches, and are subject to other equitable or remedial relief, including removal as a plan fiduciary. Section 502(a)(3) is a catchall provision that provides that a plan participant may commence a civil action to enjoin any violation of ERISA or to obtain other appropriate equitable relief that Section 502 does not elsewhere adequately remedy.

U.S. Bank initially moved to dismiss the complaint on a number of grounds, including that plaintiffs lacked Article III constitutional standing—a prerequisite to commencing any action in federal court. To establish Article III standing, a plaintiff must show an injury-in-fact, a causal connection between the injury and the ERISA misconduct, and a likelihood that the injury will be redressed by a favorable decision in the plaintiff's favor. Injury-in-fact exists when (i) there is "an invasion of a legally protected interest," (ii) that is "concrete and particularized," and (iii) is "actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). The district court denied the motion to dismiss because, as alleged, defendants' actions increased the risk that participants will not receive the level of benefits that had been promised them under the plan due to the plan being underfunded.

U.S. Bank subsequently renewed its motion to dismiss, arguing that the plaintiffs did not suffer an injury-in-fact because the plan became overfunded as a result of several voluntary contributions to the plan made by U.S. Bank. The district court concluded that the issue raised was not one of constitutional standing, but one of mootness, and determined that plaintiffs no longer had a concrete interest in the monetary and equitable relief sought to remedy the alleged injury, i.e., the increased risk that in the future plan beneficiaries would not receive the level of benefits promised. It accordingly dismissed the complaint.

The Eighth Circuit's Opinion

On appeal, plaintiffs argued that the plan was underfunded at the time they filed the lawsuit and thus they had satisfied the Article III standing requirement. In plaintiffs' view, that was all that was required by the Eighth Circuit's prior decision in *Harley* (discussed below). Plaintiffs also argued that, notwithstanding their inability to receive the monetary relief they originally sought when the plan was underfunded, their case was not moot because they were capable of receiving the other forms of relief sought in the complaint and authorized by ERISA, including an injunction barring the defendants from continuing to act as plan fiduciaries.

The Eighth Circuit began by reviewing its decision in *Harley*, which it stated was decided under principles of statutory standing, not under Article III standing principles. According to the Court, *Harley* held that when a plan is overfunded, a participant in a defined benefit plan no longer falls within the class of plaintiffs authorized under Section 502(a)(2) to bring suit because the investment loss does not cause actual injury to the plaintiffs' interest in the plan. Therefore, ERISA's primary purpose of protecting individual pension rights is not furthered, and allowing costly litigation by parties who have suffered no injury would run

counter to ERISA's purpose. The Court also observed that the *Harley* Court also explained that a contrary construction of Section 502(a)(2) would raise serious Article III concerns, given that the limits of judicial power imposed by Article III counsel against permitting participants who have suffered no injury-in-fact from suing to enforce ERISA's fiduciary duties. With that said, the Court made it clear that it was making clear that Harley was not decided on Article III grounds.

Because the U.S. Bank plan was overfunded, the Court held that *Harley* was applicable and the *Thole* plaintiffs no longer fell within the class of plaintiffs authorized to bring suit. Although the district court had dismissed the case on mootness grounds, the Eighth Circuit determined that dismissal of the Section 502(a)(2) claim was warranted for lack of statutory standing. (The Court could affirm dismissal of the action for any reason supported by the record.)

The Court then concluded that the analysis it applied under Section 502(a)(2) applied equally to plaintiffs' claim under Section 502(a)(3): plaintiffs were required to establish actual injury and, given that the plan was overfunded, there was no actual or imminent injury to the plan that caused injury to the plaintiffs' interests in the plan. In so ruling, the Court relied on a similar conclusion reached by the Sixth Circuit that had been decided on Article III grounds. And, while the Court recognized that other circuits had concluded that a plan participant may seek injunctive relief under Section 502(a)(3) even when a plan is overfunded, the Court was unpersuaded by those cases.

In a separate opinion, Judge Kelly dissented from the Court's opinion as it pertained to plaintiffs' Section 502(a)(3) claim. In Judge Kelly's view, the allegations showed actual or imminent injury because some of the plan fiduciaries continued to serve and remain in positions to resume their alleged ERISA violations notwithstanding the plan's current funding status. Accordingly, Judge Kelly believed that plaintiffs were authorized to sue for injunctive relief under Section 502(a)(3).

Plaintiffs' Petition for Certiorari

Plaintiffs petitioned the Supreme Court for review, asking the Court to resolve two questions:

1. May an ERISA plan participant or beneficiary seek injunctive relief against fiduciary misconduct under Section 502(a)(3) without demonstrating individual financial loss or the imminent risk thereof?
2. May an ERISA plan participant or beneficiary seek restoration of plan losses caused by fiduciary breach under Section 502(a)(2) without demonstrating individual financial loss or the imminent risk therefore?

In their petition, Plaintiffs argued that the Eighth Circuit created a circuit split with the Second, Third and Sixth Circuits in holding that participants cannot seek injunctive relief under Section 502(a)(3) absent individual financial injury. *See Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 607–10 (6th Cir. 2007); *Cent. States Se. & Sw. Areas Health & Welfare Fund v. Merck-Medco Managed Care LLC*, 433 F.3d 181, 199 (2d Cir. 2005); *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 455–56 (3d Cir. 2003). Those courts, according to plaintiffs, held that no individual financial loss is necessary and that violation of plaintiffs' rights under ERISA is enough to establish statutory standing under Section 502(a)(3).

Plaintiffs also argued that this case provides an opportunity for the Court to resolve confusion over whether a plan participant has standing to sue to restore plan losses under Section 502(a)(2) without alleging individual financial harm. Plaintiffs explained that the U.S. Department of Labor had taken the view for decades that a participant has standing in these circumstances, and that, while the courts had historically disagreed with the

Department of Labor, the Second Circuit recently adopted the Department of Labor's position in an unpublished decision. *Fletcher v. Convergex Grp., LLC*, 679 F. App'x 19 (2d Cir. 2017) (unpublished), *cert. denied* 138 S. Ct. 644 (Jan. 8, 2018). The Court's intervention also was necessary, according to plaintiffs, because the Eighth Circuit had inappropriately dismissed their claim for want of statutory standing, as opposed to constitutional standing, in an effort to bypass the Article III analysis altogether.

Defendants submitted a brief in opposition to the petition, which argued that review was unwarranted because plaintiffs' benefits are fixed under the defined benefit plan, the purported plan losses will have no effect on the plaintiffs themselves, and there was no reasonable possibility that the challenged investment decisions will reoccur. In defendants' view, the Eighth Circuit's Section 502(a)(2) ruling was based on a straightforward statutory standing interpretation. The defendants argued that there likewise was no circuit split concerning the Section 502(a)(3) claim because no circuit court has held that an uninjured plan participant has standing under Section 502(a)(3) to seek to enjoin all breaches of fiduciary duty. Rather, the Second, Third, and Sixth Circuits have addressed only questions of Article III standing.

Following briefing on the petition, the Supreme Court asked the Solicitor General to file a brief expressing the views of the United States. That brief has not yet been submitted.

Proskauer's Perspective

Supreme Court review of *Thole* could have a significant bearing on the future conduct of ERISA litigation on several fronts. To begin with, the case appears to present an opportunity for the Supreme Court to rule on whether an ERISA participant or beneficiary who has not experienced individual harm lacks Article III standing to pursue his or her claim and/or lacks a plausible claim for relief under ERISA Sections 502(a)(2) and (3)—which the Eighth Circuit treated as a lack of ERISA statutory standing. Because in most instances defined benefit plan participants are not at risk of losing their benefits when the plan loses money—though the investment losses may make future benefit enhancements less likely—a requirement of individual harm, whether for statutory or constitutional standing purposes, could effectively preclude participants of these plans from pursuing recovery of plan losses. Second, if the Supreme Court were to rule that individual harm is required as a condition for having statutory standing under Section 502(a)(2) or (3), the ruling could increase the likelihood for mounting an effective argument in defined contribution litigation that plaintiffs lack standing to sue to recover for investment losses in funds in which they did not invest—an argument that has not faired very well when asserted under Article III grounds.

Highlights from the Employee Benefits & Executive Compensation Blog

Appeals

Supreme Court Says that Equitable Tolling Cannot Extend Rule 23(f) Deadline

By: Elise M. Bloom, Mark W. Batten and Noa Baddish

The First Circuit held that a plaintiff failed to timely exhaust her administrative remedies under a long-term disability plan because the plan's 180-day time limit for submitting appeals commenced on the date the plaintiff received notice of the decision that it was going to terminate her long-term disability benefits, not the actual date her benefits were terminated. In so ruling, the Court rejected plaintiff's argument that the doctrine of substantial compliance and the state's notice-prejudice rule somehow excused her late-filed appeal. The Court first concluded that the doctrine of substantial compliance, which is sometimes used by a plan administrator to excuse a failure to comply perfectly with ERISA's notice requirements, could not be used by the plaintiff to excuse her late filing because such an expansion of the doctrine would render it "effectively impossible" for plan administrators to enforce administrative deadlines. The Court also concluded that the plaintiff could not invoke the state's common law notice-prejudice rule, which requires an insurer to show that it was prejudiced by an untimely notice of appeal in order to deny certain types of claims, because doing so would undercut the policy purposes behind the exhaustion requirement. The case is *Fortier v. Hartford Life & Accident Ins. Co.*, No. 18-1752, 2019 WL 697989 (1st Cir. Feb. 20, 2019).

IRS

IRS Expands Rules for Returning Mistaken HSA Contributions

By: Steven Weinstein

In Notice 2008-59, the IRS provided certain limited exceptions to its previously stated general position that employers may not recoup any portion of the employer's contribution to an HSA. Specifically, Notice 2008-59 provided that an employer may recover amounts that it contributes to an HSA account if: (i) the employee for whom the contribution was made was never eligible for an HSA contribution, provided the contribution is returned by the end of the tax year for which it was contributed, or (ii) the employer contributed an amount to the employee's HSA in excess of the maximum amount permitted under the Internal Revenue Code due to an error. The IRS has stated that employers generally cannot recover amounts from an HSA other than for the two reasons described in Notice 2008-59.

In response to a request for additional guidance relating to the ability of employer's to recover mistaken contributions to HSAs, the IRS recently released Information Letter 2018-0033.[1] The Information Letter clarifies that Notice 2008-59 was not meant to provide an exhaustive list of situations in which employers could recover contributions to an HSA that were made as a result of the employer's (or its provider's) administrative errors. Rather, if there is "clear documentary evidence" that demonstrates an administrative error, the employer may request a return of contributions under other circumstances to the extent necessary to correct the error.

In the Information Letter, the IRS provided the following examples of errors that may be corrected under this standard:

- An amount is withheld and deposited in an employee's HSA for a pay period that exceeds the amount shown on the employee's HSA salary reduction election.
- An amount received as an employer contribution to an HSA that the employer did not intend to contribute, but was transmitted because an incorrect spreadsheet was accessed or because employees with similar names were confused with each other.
- An amount received as an HSA contribution because it was incorrectly entered by a payroll administrator (whether in-house or third-party) causing the incorrect amount to be withheld and contributed.
- An amount received as a second HSA contribution because duplicate payroll files were transmitted.
- An amount received as an HSA contribution because a change in employee payroll elections was not processed timely so that amounts withheld and contributed were greater than (or less than) the employee elected.
- An amount received because an HSA contribution amount was calculated incorrectly (e.g., where an employee elects a total amount for the year that is allocated by the system over an incorrect number of pay periods).
- An amount received as an HSA contribution because the decimal position was set incorrectly resulting in a contribution greater than intended.
- Because the Information Letter list is intended to provide examples of correctable errors, there are presumably other situations where a return of contributions from an employee's HSA may be warranted if an administrative error can be clearly demonstrated. In any case, where a corrective action is to be taken, an employer should make sure to maintain documentation to support its conclusion that a mistaken contribution has occurred as the result of an administrative error.

[1] An "information letter" is used by the IRS to provide a general statement of well-defined law without applying it to a specific set of facts and is given in response to requests for general information by taxpayers or by Congress.

IRS Reopens Opportunity to Cash Out Retirees in Pay Status—At Least For Now

By: Seth Safra and Malerie Bulot

One de-risking tool for employers with defined benefit pension liabilities is to allow participants to receive lump-sum distributions. Although lump sums result in a short-term cash drain, they reduce the plan's long-term liability—reducing the sponsor's exposure to contribution volatility.

Over the last several years, there has been a question whether lump-sum cashouts may be offered to retirees who are already receiving annuities. Ironically, the concern was based on the IRS's minimum required distribution rules. Although the purpose of minimum required distributions is to force participants to take their money, the rules prohibit an increase to the payment amount after payments start, subject to limited exceptions. The concern is that a lump-sum cashout could be a prohibited increase to the payment amount.

In 2012, the IRS issued two Private Letter Rulings that said a cashout would not be prohibited if (1) cashouts are available only during a limited window and (2) annuitants did not previously have a right to cash out annuities in pay status. The IRS reasoned that, under those circumstances, the increase to the payment amount is caused by an amendment to increase benefits, which is one of the limited circumstances when an increase to the payment amount is permitted. The IRS's conclusion was consistent with the underlying policy of minimum required distributions: if the annuity in place will pay out fast enough, cashing out must be okay because it results in payment being made even faster.

Following those rulings, many employers looked into offering cashout windows to retirees in pay status. Seeing the interest, IRS officials stated informally that it considered the analysis in the Private Letter Rulings to be settled law, and the IRS issued favorable determination letters for plans that allowed cashout windows.

But the IRS changed course in 2015. In Notice 2015-49, the IRS recanted its 2012 analysis. Instead, the IRS said it intended to amend its minimum required distribution regulation to state that cashing out annuities in pay status would be a prohibited acceleration; the IRS also said the new regulation would be effective July 9, 2015. With that, the opportunity to cash out annuities in pay status went away.

In the time since, the IRS never issued the intended regulation, and the project was eventually removed from the Treasury Department's Priority Guidance Plan. On March 6, 2019, in [Notice 2019-18] the IRS announced that it no longer intends to amend the minimum required distribution regulation. Until further notice, the IRS will not assert that a window to cash out annuities in pay status violates the minimum required distribution rules.

The IRS cautioned that it will continue to examine the issue, and nothing prohibits the IRS from changing its view. In addition, the IRS cautioned that any cashout window must comply with all of the other requirements for tax-qualification.

For now, the guidance gives plan sponsors another de-risking tool.

Interim Guidance Released on Excise Tax on Executive Compensation Paid by Tax-Exempt Organizations

The Department of the Treasury and the Internal Revenue Service recently released Notice 2019-09 (the "Notice"), which provides interim guidance under Section 4960 of the Internal Revenue Code.

Section 4960 was added to the Internal Revenue Code as part of the tax reform legislation that was enacted on December 22, 2017. Very generally, Section 4960 imposes a 21% excise tax (based upon the current corporate tax rate) on certain tax-exempt entities (and related organizations) that pay remuneration in excess of $1 million to certain highly-paid individuals or that make "excess parachute payments" to this class of highly-paid individuals.

The Notice provides interim guidance on how to interpret and apply Section 4960, including answering questions concerning:

- ??Which tax-exempt organizations does the excise tax apply to?

- ???How does the excise tax apply to related organizations and entities, including for-profit and governmental entities?
- ???How should an organization determine which employees are covered?
- ???How to determine if an employee receives remuneration in excess of $1 million?
- ???What are excess parachute payments that could subject an organization to the excise tax?
- ???How should the excise tax be reported and paid?

We have provided more information regarding the guidance contained in the Notice on our Not for Profit/Exempt Organization Blog, available at the following link: IRS Releases Interim Guidance on New Excise Tax on Executive Compensation Paid by Tax-Exempt Organizations

New Excise Tax For Tax-Exempts Can Ensnare For-Profit Employers: Comment Deadline Fast Approaching

By: Seth Safra, Steven Weinstein and Damian A. Myers

As discussed here, the IRS's initial interpretation of a new excise tax under Section 4960 of the Internal Revenue Code could catch for-profit employers who set up foundations, trusts, PACs, and other tax-exempt entities off guard. The tax is 21% of certain compensation paid to the top five highest paid employees of the tax-exempt entity. Although the tax was designed to apply for compensation to high-paid executives of tax-exempt entities, an aggregation rule in the IRS's initial guidance (Notice 2019-9) picks up compensation paid by related employers, even if they are for-profit companies.

For example, suppose a for-profit company controls more than 50% of the board of a tax-exempt foundation, and the company's treasurer also serves as an officer of the foundation. If the foundation is treated as a common law employer of the treasurer (even if the for-profit company is also a common law employer), the CIO could be a covered employee of the foundation. If the treasurer makes more than $1 million—whether in the current year or in the future—the excise tax can be triggered, even if all of the treasurer's compensation is paid by the for-profit company. A similar issue could arise if the treasurer receives significant separation pay, even if it does not reach the $1 million threshold. The tax would be owed by the for-profit employer and any others who pay the treasurer's compensation.

The deadline for submitting comments to the IRS is April 2nd. Employers who are affected by the rule's broad net should consider submitting comments (and we can help).

PBGC

Let's Talk – PBGC Pilot Mediation Project is Now Permanent

By: Damian A. Myers and Annie (Chenxiaoyang) Zhang

The Pension Benefit Guaranty Corporation (the "PBGC") launched a Pilot Mediation Project in October 2017 to provide plan sponsors an opportunity to negotiate resolutions in Early Warning Program cases and in termination liability cases (see our prior post). Following its trial run, the PBGC announced last month that it would make the Mediation Program permanent, and also expanded its use to include fiduciary breach cases involving terminated plans.

The Mediation Program remains voluntary and available only for certain cases and eligible plan sponsors. Cases are generally ineligible for the program if: (1) the plan sponsor has a minimal ability to pay; (2) there is a pending court proceeding; or (3) there is limited time to act and the plan sponsor has declined to sign a standstill or tolling agreement.

Early Warning Program cases are those where a plan sponsor is involved in a corporate transaction that the PBGC thinks could affect the plan sponsor's ability to continue to support its pension plan. In an eligible case, the PBGC will inform the plan sponsor of the availability of mediation at the onset of negotiations and mediation will begin after the PBGC receives sufficient responses to its information requests. However, the transaction's timing will limit the window for mediation. The parties must complete mediation before the transaction closes and with sufficient time to document the resolution or for PBGC to institute legal action.

Termination liability cases are those that require a determination of the amount that a plan sponsor and its controlled group members must pay to the PBGC when a pension plan is terminated and transferred to the PBGC. Plan sponsors have 120 days after the plan's termination date is established to disclose required information about its controlled group's net worth. The PBGC will then make mediation available within a reasonable time after it reviews the information submitted by the plan sponsor.

Fiduciary breach cases are those that involve situations where fiduciaries of a terminated plan allegedly took actions that violated their fiduciary duties under ERISA. In these cases, the PBGC will include an option to mediate in its demand letters. Importantly, the Mediation Program only applies to fiduciary breach claims asserted by the PBGC with respect to terminated pension plans. It does not cover other fiduciary breach claims.

The Federal Mediation and Conciliation Service will continue to facilitate all mediations, with costs shared by the PBGC and the plan sponsor.

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Although the PBGC stated that it will generally inform plan sponsors when a case is eligible for the Mediation Program, plan sponsors that are particularly interested in using the Program should consider voicing their interest at the start of discussions with the PBGC.

Benefit Overpayments

Eighth Circuit Decision On "Cross-Plan Offsetting" Illustrates Importance Of Careful Plan Drafting

By: Seth Safra and Caroline Cima

The U.S. Court of Appeals for the Eighth Circuit recently weighed in on a practice for recovering health plan overpayments known as "cross-plan offsetting." In addition to shining a light on the controversial (but potentially useful) practice, the decision offers an important lesson in plan drafting that extends beyond the particular case. The case is *Louis J. Peterson, D.C., et al. v. UnitedHealth Group Inc., et al.*, no. 17-1744 (8th Cir. Jan. 15, 2019).

From time to time, group health plans inadvertently pay the wrong amount to doctors, clinics, and other providers. When the amount paid is more than what the plan allows (an "overpayment"), the plan generally must be made whole; to make this happen, administrators typically try to recover the overpayment from the provider. But what happens when the provider refuses to return the overpayment?

Plans often authorize the administrator to recover the overpayment by offsetting it against future payments owed by the same plan to the same provider. This approach works well if another plan participant uses the same provider, but it is not helpful if the plan does not have other bills from the provider from which it can recover. Enter "cross-plan offsetting," where a third-party administrator with multiple clients collects the overpayment by offsetting it against another plan's bills from the same provider. If the amount of the offset is credited back to the first plan, then both plans, the provider, and the affected participants can get back to where they would have been had the error not occurred. But the practice exposes the offsetting plan and its participants to some risk, and it raises questions under ERISA's prohibited transaction and fiduciary rules because assets of one plan are being used to solve a problem for another plan.

In a 2017 amicus brief, the U.S. Department of Labor ("DOL") took the position that cross-plan offsetting violated ERISA's prohibited transaction and fiduciary rules, at least where overpayments from a plan insured by the administrator are recovered from amounts owed by a separate self-insured plan. DOL reasoned that cross-plan offsetting imposed on "innocent participants a financial risk and potential harm in order to recoup an alleged, unrelated overpayment for another plan." DOL concluded that the insurer received an improper benefit, because recoveries out of the self-insured plans' assets flowed back to plans for which the insurer was financially responsible.

In the Peterson decision, the Eighth Circuit stated that cross-plan offsetting was "questionable at the very least," in "tension with the requirements of ERISA," and straddling the "line of what is permissible." But the court did not actually reach the merits on the legal question of cross-plan offsetting. Instead, the court concluded that the practice was not authorized by the plan that was seeking recovery.

The third-party administrator argued that its use of cross-plan offsetting was authorized general language that gave the plan administrator discretion to interpret and implement the plan's terms. The Eighth Circuit held that this language was not specific enough to authorize cross-plan offsetting, reasoning that such an interpretation would be "akin to adopting a rule that anything not forbidden by the plan is permissible."

The Eighth Circuit's holding leaves the legal status of cross-plan offsetting unresolved. The practice might be permissible under certain circumstances but it raises important considerations for plan sponsors and fiduciaries. The immediate lesson is that if a plan sponsor wants cross-plan offsetting to be available as a remedy for overpayments (even if the remedy might rarely be pursued), the plan must expressly authorize the practice.

More generally, plan sponsors and fiduciaries should consult with counsel to consider options for addressing overpayments. Under appropriate circumstances, cross-plan offsetting might be desirable, but it is important to be careful about how and when the practice is used.

In short, the Eighth Circuit's decision offers two important take-aways:

1. Plan language matters. It is important to review and update plan documents to ensure that they authorize the latest approaches for recovering overpayments; and care should be taken in drafting to avoid authorizing non-compliant remedies.
2. Understand how cross-plan offsetting is used. Plan fiduciaries should review their administrative service agreements to understand whether and when cross-plan offsetting might be used. In particular, it is important to review risks to the plan and participants if the third-party administrator refuses to pay legitimate claims in order to recover another plan's overpayments.

Affordable Care Act

Nationwide Injunction Halts Exemptions and Accommodations to the ACA Contraceptive Coverage Mandate

By: Damian A. Myers and Annie (Chenxiaoyang) Zhang

On January 14, 2019, a district court in the Eastern District of Pennsylvania granted a nationwide preliminary injunction halting the application of final regulations governing religious and moral-based exemptions from the Affordable Care Act ("ACA") mandate to cover contraceptives without cost sharing. The final regulations would have dramatically expanded the scope of existing exemptions and accommodations rules related to the contraceptive coverage mandate. The case is *Commonwealth of Pennsylvania v. Trump et al.*, No. 2:17-cv-04540 (E.D. Pa. Jan. 14, 2019).

Interestingly, just one day before the *Commonwealth of Pennsylvania* case, a court in the Northern District of California granted a preliminary injunction against application of the final regulations, but limited its order to the thirteen states and Washington, D.C. that are parties to that case. *See State of California et al. v. Health and Human Services et al.*, No. 4:17-cv-05783 (N.D. Cal. Jan. 13, 2019).

Below, we briefly review the legal landscape leading up to the *Commonwealth of Pennsylvania* court's nationwide injunction, the decision itself, and the potential implications going forward.

Background

The ACA generally requires group health plans and insurance providers to provide preventive care and screenings, including specified contraceptive methods, with no cost sharing. In 2012, the Department of Health and Human Services, the Department of Labor, and the Department of Treasury (collectively "the Agencies") issued a final rule to exempt qualified "religious employers" from this contraceptive coverage mandate. In 2013, the Agencies issued another final rule that (1) expanded the "religious employers" exemption and (2) created an accommodation for "eligible organizations" with religious objections to providing contraceptive coverage.

The contraceptive coverage mandate has been the subject of numerous lawsuits. For example, the Supreme Court has heard issues related to the mandate on three separate occasions: (1) in 2014, the Court held that the application of the contraceptive coverage mandate to closely-held corporations violated the Religious Freedom Restoration Act ("RFRA") (*Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751); (2) in 2014, the Court enjoined the government from enforcing the self-certification requirements on an organization eligible for an accommodation, pending final disposition of the litigation (*Wheaton College v. Burwell*, 134 S. Ct. 2806); and (3) in 2016, the Court remanded a case for the parties to consider an alternative approach that can both accommodate religious exercise and ensure that women receive contraceptive coverage (*Zubik v. Burwell*, 136 S. Ct. 1557).

In 2017, the Agencies issued two interim final rules that, generally speaking, would allow many non-profit and for-profit organizations to seek exemptions and accommodations from the ACA contraceptive coverage mandate based on "sincerely held" religious or moral convictions. In December 2017, a preliminary injunction was granted to block enforcement of the rules on the ground that the rules likely violated the Administrative Procedure Act ("APA").

In 2018, the Agencies issued the final religious and moral exemption regulations which are the subject of the dispute in *Commonwealth of Pennsylvania*.

The *Commonwealth of Pennsylvania* Decision

The Commonwealth of Pennsylvania and the State of New Jersey sued the Trump Administration to enjoin implementation of the final regulations arguing that the final regulations violated the APA and various other constitutional requirements.

The court first noted that the final regulations made only minor revisions to the 2017 interim final rules and explained that the issuance of procedurally flawed interim final rules "fatally taint[s] the issuance of the Final Rules." Furthermore, the court stated that the Agencies did not have authority under the ACA or the RFRA to pass the final regulations. Under the ACA, the court explained, Congress directed that *any* "group health plan" or "health insurance issuer offering group or individual insurance coverage" must provide "preventative care and screenings." Because there is no ambiguity over *who* must abide by the Congressional directive, the Agencies did not have the power to establish exceptions. Additionally, RFRA grants the courts, not the Agencies, the power to determine "whether generally applicable laws violate a person's religious exercise." The court noted that although it was unclear whether the contraceptive coverage mandate violates RFRA, it is clear that the RFRA does not require the final regulations.

Proskauer's Perspective

The court granted the injunction the day the final regulations were scheduled to take effect. Thus, as a practical matter, the ruling maintains the status quo for now. A notice of appeal has been filed, which means that this litigation will continue for the foreseeable future. Should the Trump Administration ultimately prevail, non-profit and for-profit organizations will be able to rely on the regulations to seek exemptions from the ACA's contraceptive coverage mandate.

DC Plan Investment Litigation

Georgetown Prevails In ERISA Fee Litigation Case

By: Kyle Hansen

A federal district court in the District of Columbia dismissed ERISA fiduciary-breach claims by participants in Georgetown's 403(b) retirement plans that were predicated on allegations that the trustees invested in funds that allegedly charged excessive fees and underperformed relative to alleged comparable funds, and that the fund paid excessive recordkeeping fees. To begin with, the court concluded that plaintiffs lacked Article III standing, *i.e.*, they had not experienced any harm, as to three of the challenged funds because they failed to allege that: (i) they were invested in the challenged funds, (ii) the challenged funds outperformed plaintiffs' alleged comparable investment fund, and/or (iii) that they had withdrawn, or planned to withdraw from, one of the funds that charged an allegedly excessive 2.5% early-withdrawal fee in exchange for a lump-sum payout. Next, the court rejected plaintiffs' arguments that the plan's fiduciaries acted imprudently by retaining a fund that allegedly had underperformed because: (i) a fiduciary is not required to select the best performing fund, and (ii) plaintiffs' alleged comparable fund had a different underlying allocation of domestic investments. Lastly, the court rejected plaintiffs' excessive recordkeeping fee claim because plaintiffs did not show that the fees were excessive relative to the services that were being offered. In so ruling, the court stated that since fiduciaries may structure their plans in different ways, the plaintiffs' allegations that the funds could hypothetically be structured to charge a lower fee did not state a viable claim for an imprudent process with respect to the record-keeping fees. The case is *Wilcox v. Georgetown University,* 2019 WL 132281 (D.D.C. Jan. 8, 2019).

Jury Trial

Plaintiffs Not Entitled to Jury Trial for ERISA Breach of Fiduciary Duty Claims

By: Kyle Hansen

Massachusetts Institute of Technology persuaded a federal district court to toss a jury demand in a case alleging that the MIT 401(k) plan fiduciaries breached their duties by charging unreasonable administrative and management fees, engaging in prohibited transactions and failing to monitor those to whom the fiduciaries delegated their responsibilities. In so ruling, the court held that plaintiffs had no Seventh Amendment right to a jury trial because actions under ERISA to remedy alleged violations of fiduciary duties are equitable rather than legal in nature. The court explained that the "great weight of authority" has concluded that claims by plan participants against plan fiduciaries are analogous to claims against trustees typically heard only in a court of equity. The case is *Tracey v. Massachusetts Institute of Technology*, No. 1:16-cv-11620, 2019 WL 1005488 (D. Mass. Feb. 28, 2019).

Statute of Limitations

ERISA Administrative Appeal Barred As Untimely

By: Kyle Hansen

The First Circuit held that a plaintiff failed to timely exhaust her administrative remedies under a long-term disability plan because the plan's 180-day time limit for submitting appeals commenced on the date the plaintiff received notice of the decision that it was going to terminate her long-term disability benefits, not the actual date her benefits were terminated. In so ruling, the Court rejected plaintiff's argument that the doctrine of substantial compliance and the state's notice-prejudice rule somehow excused her late-filed appeal. The Court first concluded that the doctrine of substantial compliance, which is sometimes used by a plan administrator to excuse a failure to comply perfectly with ERISA's notice requirements, could not be used by the plaintiff to excuse her late filing because such an expansion of the doctrine would render it "effectively impossible" for plan administrators to enforce administrative deadlines. The Court also concluded that the plaintiff could not invoke the state's common law notice-prejudice rule, which requires an insurer to show that it was prejudiced by an untimely notice of appeal in order to deny certain types of claims, because doing so would undercut the policy purposes behind the exhaustion requirement. The case is *Fortier v. Hartford Life & Accident Ins. Co.*, No. 18-1752, 2019 WL 697989 (1st Cir. Feb. 20, 2019).

ERISA Section 510

Participants' ERISA Retaliation Claim Dismissed

By: Neil V. Shah

A federal district court in Illinois held that participants in a multiemployer pension plan failed to plausibly allege that plan fiduciaries retaliated against them in violation of ERISA § 510 by refusing to consider their employer's offer to settle its withdrawal liability to the plan. In lieu of paying withdrawal liability, the employer offered to create a new plan that assumed the former plan's obligations. After the plan fiduciaries rejected the proposal, the participants filed suit, alleging that the refusal to negotiate or even consider the employer's proposal constituted a breach of fiduciary duty. The plan fiduciaries then informed the employer that they would "either negotiate or litigate but not both." The participants thereafter amended their complaint to allege that the plan fiduciaries' position violated Section 510, claiming that the plan fiduciaries' position was motivated by the participants' initial decision to file suit. The district court dismissed the participants' claim as implausible, pointing to the participants' admission that the plan fiduciaries refused to consider the employer's proposal both before and after the participants filed suit. The court also expressed skepticism that the participants could assert a viable Section 510 claim against plan fiduciaries for "failing to do something [they] never had any legal obligation to do in the first place"—that is, accept the employer's proposal to settle its withdrawal liability. The case is *Campbell v. Whobrey*, 2019 WL 184056 (N.D. Ill. Jan. 14, 2019).

Fiduciary Status

Ninth Circuit Affirms Dismissal of ERISA Claims Against Health Insurers

By: Kyle Hansen

The Ninth Circuit agreed that the employer-members of Montana's Chamber of Commerce failed to state a claim for breach of fiduciary duty under ERISA § 502(a)(2) and violations of ERISA's prohibited transaction rules under ERISA § 502(a)(3) against health insurers as a result of alleged misrepresentations in the marketing and negotiation of the insurers' fully insured health plans to the Chamber's members. The Court first determined that defendants were not fiduciaries because they did not exercise discretion over plan management or control over plan assets. In so ruling, the Court explained that defendants had no fiduciary relationship to the plans and exercised no discretion over the plans' management because they were merely negotiating at arms-length to set rates and collect premiums prior to any agreement being executed. The Court also found that the allegedly excessive premiums that defendants collected did not qualify as plan assets because the plans were fully insured, i.e., the premiums were not held in trust and they were simply fixed fees paid in exchange for defendants' financial risk of providing the promised benefits.

The Court next dismissed the prohibited transaction claims because the nature of the underlying remedies sought, restitution and disgorgement, were not equitable in nature. The Court held that the remedy of restitution was legal because the premium payments plaintiffs sought to recover had no connection to any particular fund and plaintiffs failed to identify a specific fund to which they were entitled. Similarly, the Court held that disgorgement was not equitable because plaintiff did not identify any particular property from which defendants derived an improper profit or benefit.

Finally, the Court reversed the dismissal of plaintiffs' state law claims alleging fraud and misrepresentation and remanded for further proceedings. The Court held that plaintiffs' state law claims were not preempted by ERISA because they did not have an impermissible connection with an ERISA plan, but rather were connected to negotiations occurring prior to any ERISA-regulated relationship. In this vein, the Court characterized the case as one about fraud and misrepresentation in the sale of health insurance policies, rather than as a case implicating ERISA.

The case is *The Depot Inc. v. Caring for Montanans Inc.*, No. 9:16-cv-00074, 2019 WL 453485 (9th Cir. Feb. 6, 2019).

Benefit Claims

Categorical Conflict of Interest Does Not Alter Standard of Review of Benefit Denials

By: Neil V. Shah

The Second Circuit held that plaintiffs' allegations that the defendant suffered from a "categorical potential conflict of interest"—because it both funded the plan and was the claim's decision-maker—did not affect the application of the arbitrary and capricious standard of review in the absence of a showing by the plaintiffs that the conflict actually affected the plan administrator's decision-making. The dispute involved whether plan participants could "grow into" early retirement eligibility for benefits they accrued before the plan sponsor sold their employer's business. The plan's benefits committee determined that participants could not earn service credit after the sale because they were no longer employed by an entity related to the plan sponsor. Plaintiffs, a group of participants who continued with the business after the sale and eventually reached the required early retirement age, argued that their service after the sale should count because they continued working for the same business. Applying the arbitrary and capricious standard of review, the Second Circuit concluded that it could not overturn the benefits committee's decision denying the claim, even though the Court believed the plaintiffs' reading of the plan language was "more reasonable." To overturn the committee's decision, plaintiffs would have had to show that it was without reason, unsupported by substantial evidence, or erroneous as a matter of law, a standard the plaintiffs were unable to meet.

The decision illustrates the significance that the standard of review can have on the outcome of a benefit denial challenge. Had the standard been de novo (where the court takes a fresh look) or the alleged conflict taken into account in determining whether the plaintiffs' claims were correctly denied, the outcome might have been different. To preserve the deferential standard of review, plan sponsors should ensure that the governing plan document affords the individual or body that resolves benefit claims interpretive discretion, and that the reviewing body adheres to the procedural requirements that apply to administrative claims and appeals. The case is *Kirkendall v. Halliburton, Inc.*, No. 17-3487, 2019 WL 325649 (2d Cir. Jan. 24, 2019).

Related Professionals

???Russell L. Hirschhorn
Partner