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ERISA Newsletter

Fourth Quarter 2019

Editor's Overview

Happy New Year. We wrap-up 2019 with an article that reflects on significant developments in ERISA litigation during 2019, and takes a look at what's on the horizon for 2020. The courts (at all levels) were quite busy in 2019 attending to ERISA issues and all indications are that they will be in 2020 as well. Most notably, the Supreme Court has agreed to consider a number of ERISA cases. Our article discusses a trilogy of cases that the Supreme Court will consider—company stock fund litigation, statute of limitations, and standing. And, as we go to print, the Supreme Court agreed to hear a fourth ERISA case dealing with issues of preemption. More to come on that case on our blog. But, the Supreme Court has declined (again) to consider issues bearing on who has the burden of proof in proving losses resulting from a fiduciary breach—a significant issue as to which there is a deep split among the circuit courts.

Also of note in this Newsletter is a reproduction of a ten-part blog series on best practices in benefit claim administration. Our blog posts often discuss many complex, and sometimes esoteric, substantive and procedural ERISA issues, as well as related agency guidance and case law. In this ten-part blog series, however, we take a step away from the complex and esoteric in order to review some of the fundamentals of benefit claim administration.

As always, the balance of our Newsletter presents highlights from our blog and addresses a variety of topics, including the Affordable Care Act, arbitration, attorneys' Fees, disclosure, health plan compliance, HRAs, multiemployer funds, plan qualification, venue, and vested health care benefits.

A Reflection on ERISA Litigation in the Year Gone By

By: Russell L. Hirschhorn and James Barnett

As we head into the New Year, we take time to reflect on some of the highlights in ERISA litigation, the effects of which are likely to have an impact in 2020 and beyond. For the first time in several years, the U.S. Supreme Court has agreed to consider multiple ERISA cases and, depending on how the Supreme Court rules in each of these cases, we may see a substantial uptick in the filing of ERISA class actions and/or the trial courts being less inclined to dismiss cases prior to discovery taking place. The circuit courts also have been quite busy. One of the most notable ERISA litigation decisions of the year came from the Ninth Circuit where it concluded that, not only are ERISA claims arbitral, but that a plan can prohibit a participant from pursuing anything but individual relief in arbitration. Finally, the district courts have been addressing all sorts of ERISA claims from challenges under the Mental Health Parity Act to novel claims asserting violations of ERISA's anti-cutback rules. We review each of these areas below.

The U.S. Supreme Court's ERISA Trilogy

This term's Supreme Court docket takes on three important issues dealing with the litigation of ERISA claims that, regardless of their ultimate rulings, are likely to shape the future of ERISA litigation on multiple fronts.

Company Stock Fund Cases. On November 6, 2019, the Justices heard oral argument in *Retirement Plans Committee of IBM v. Jander*. In this case, the Supreme Court will determine whether the Second Circuit incorrectly applied the pleading standard for claims challenging the prudence of 401(k) plan participant investments in company stock funds. The Second Circuit concluded that, consistent with the pleadings standard previously set by the Supreme Court, plaintiff's allegation that the IBM defendants could have publicly disclosed that IBM's microelectronics business was impaired plausibly pled an alternative action the plan fiduciaries could have taken that would not have caused more harm than good to the plan. *See Jander v. Ret. Plans Comm. of IBM*, 910 F.3d 620 (2d Cir. 2018). (A more in-depth discussion of the Second Circuit's opinion is available here.) The Second Circuit's decision was significant because it was the first (and remains the only) circuit court decision to permit fiduciary breach claims in connection with investment in a company stock fund to survive a motion to dismiss and proceed into discovery since the Supreme Court re-defined the pleading standard for such claims in 2014. Depending on the scope of the Court's ruling, this could be the final nail in the coffin for these types of claims; alternatively, it could once again open the floodgates to these types of claims being brought every time there is a downtick in a company stock's price.

Statute of Limitations. On December 4, 2019, the Justices heard oral argument in *Intel Corporation Investment Policy Committee v. Sulyma*. The Supreme Court agreed to consider whether the Ninth Circuit erred when it split from the Sixth Circuit and found that, to have the "actual knowledge" needed to trigger ERISA § 413(2)'s three-year limitations period, a plaintiff must read and understand plan information provided to him by the ERISA plan. If the Supreme Court adopts the Ninth Circuit's interpretation, it may be more difficult in some cases to obtain dismissal of a case based on the three-year limitations period. But, at the same time, the need for individualized inquiries into what each participant actually knew may make class certification quite difficult to obtain in many cases.

Statutory Standing. The Supreme Court agreed to consider whether pension plan participants have Article III and ERISA standing to bring fiduciary breach claims without first demonstrating actual or imminent injury to their financial interests. The Eighth Circuit held that a participant in a fully-funded defined benefit plan lacked standing under ERISA to assert breach of fiduciary duty claims based on the failure to diversify investments because the participants had not suffered any individual financial harm. *See Thole v. U.S. Bank*, 873 F.3d 617 (8th Cir. 2017). (A more in-depth discussion of the Eighth Circuit's opinion is available here.) The Second, Third, and Sixth Circuits had reached the opposite conclusion, holding that no individual financial loss is necessary, and a violation of the participants' rights under ERISA is enough to establish standing. The Supreme Court is scheduled to hear oral argument on January 13, 2020. The Court's decision could have a significant impact on who can bring ERISA claims against pension plans. With respect to defined benefit plans, participants are generally not at risk of losing their benefits when the plan loses money—though the investment losses may make future benefit enhancements less likely—and thus 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. With respect to defined contribution plans, a pro-defendant 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.

Loss Causation (maybe). It remains to be seen whether the Court will agree to consider a petition submitted by Putnam Investments concerning a case in which the First Circuit concluded that once a plaintiff asserting an ERISA fiduciary breach claim establishes a breach and loss to the plan, the burden of disproving that the breach caused the loss shifts to the defendant. *See Brotherston v. Putnam Investments, LLC*, 907 F.3d 17 (1st Cir. 2018) (A more in-depth discussion of the First Circuit's opinion is available here.) Interestingly, the district court previously found the opposite and dismissed the case in the middle of trial. The First Circuit aligned itself with the Fourth, Fifth, and Eighth Circuits, and departed from the Second, Sixth, Seventh, Ninth, Tenth, and Eleventh Circuits. Acknowledging that plaintiffs typically bear the burden of proving all elements of their claim, the First Circuit explained that, in its view, the default rule has exceptions where, as here, the facts are "peculiarly within the knowledge of" the defendant. Though the issue is seemingly "procedural," who bears the burden of proof can be outcome-determinative, and a ruling from the Supreme Court (regardless of its outcome) would likely have a broad impact on ERISA fiduciary litigation. While the deep circuit split on the issue may lead some to believe that the case is a good candidate for Supreme Court review, the government recommended against review because, in its view, the case is a "poor vehicle" to resolve the circuit split, given the mid-trial disposition of the case.

The Ninth Circuit Tackles Arbitration of ERISA Claims

More ERISA claims may be headed to arbitration after the Ninth Circuit ruled that ERISA class action claims brought on behalf of an ERISA plan are subject to individual arbitration. In *Dorman v. Charles Schwab Corp.*, 934 F.3d 1107 (9th Cir. 2019), participants in the company's 401(k) plan filed ERISA fiduciary breach and prohibited transaction claims against the Schwab 401(k) plan's fiduciaries. The Ninth Circuit held that claims under ERISA, like any other federal statute, are subject to arbitration under the Federal Arbitration Act. The Ninth Circuit also upheld the plan's class action waiver, and thus became the first federal circuit court of appeal to hold that class action ERISA claims brought on behalf of an entire ERISA plan can be subject to individual arbitration with relief limited to the individual plaintiff's claims. (A more in-depth discussion of the Ninth Circuit's opinion is available here.)

The District Courts Allow Wilderness Therapy Claims To Proceed Into Discovery

Health plan coverage for wilderness therapy—a combination of wilderness experiences and more traditional mental health care—has been the subject of many court decisions over the past year. In particular, courts are typically asked to address whether the denial of coverage for wilderness therapy violates the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act"). As explained in more detail here, group health plans and insurers are not required to provide coverage for mental health and substance abuse (MHSA) disorders, but if MHSA coverage is provided, the Parity Act requires that such coverage be "in parity" with coverage for medical/surgical benefits. For the most part, courts have rejected complaints that merely alleged that the plan or insurer did not cover wilderness therapy (but provided coverage for medical/surgical benefits in equivalent treatment settings). Some courts, however, have concluded that discovery is required before dismissing the complaint in order to evaluate whether there is a disparity between the availability of treatments for mental health and substance abuse disorders and treatment for medical/surgical conditions. *See Michael W. v. United Behavioral Health*, 2019 BL 367207 (D. Utah Sept. 27, 2019).

The District Courts Offer Mixed Rulings On Challenges To The Use of Pension Plan's Mortality Assumptions

It has been just over a year since the first claim alleging that the use of older mortality tables in connection with the calculation of alternative forms of benefits in defined benefit plans violated ERISA's anti-cutback rule. To date, nine cases have been filed and all of the defendants have moved to dismiss the claims on various grounds. One court granted the motion to dismiss because the plaintiffs failed to plead that ERISA's "anti-forfeiture provision" applied to individuals who had elected early retirement. *See DuBuske v. PepsiCo, Inc.*, 2019 BL 360470 (S.D.N.Y. Sept. 24, 2019). Two courts denied the motions to dismiss and concluded that discovery was necessary before ruling on the merits of the claims. *See Smith v. U.S. Bancorp*, 2019 BL 238928 (D. Minn. Jun. 26, 2019); *Torres v. American Airlines*, No. 18-cv-983, Dkt. 31 (N.D. Tex. Aug. 7, 2019). There are six other motions to dismiss pending throughout several district courts. We remain hopeful that these courts will recognize that the claims are legally deficient and should be dismissed.

Proskauer's Perspective

Employee benefits issues continued to be actively litigated in 2019. With the Supreme Court set to rule in three cases (and maybe more) addressing a wide-range of procedural and substantive issues, and other significant issues pending before district courts throughout the country, 2020 promises to be an interesting, if not exciting, year for ERISA litigation. Plan sponsors and fiduciaries are well advised to continue to monitor developments at the Supreme Court and elsewhere.

Highlights from the Employee Benefits & Executive Compensation Blog

Affordable Care Act

New Jersey Individual Mandate Requires State Filings in March 2020

By: Damian Myers and Annie (Chenxiaoyang) Zhang

The Affordable Care Act's individual mandate (i.e., the requirement that most individuals obtain adequate health insurance or pay a penalty) is dead. A side effect of the ACA mandate's demise is that states are beginning to step-in and pass their own versions of the individual mandate. Massachusetts, of course, has long had an individual mandate in place for its residents. Since the ACA mandate's repeal, California, the District of Columbia, New Jersey, Rhode Island, and Vermont have passed individual mandates. Several other states are also considering enacting individual mandates. As these state laws become more prevalent, employers and plan sponsors need to consider whether these states have reporting requirements similar to the ACA's requirements under Sections 6055 and 6056 of the Internal Revenue Code. This blog highlights the filing requirement in New Jersey, under which forms must be filed with the state by March 31, 2020.

Similar to the repealed ACA individual mandate, New Jersey requires its residents to obtain minimum essential health coverage (subject to various exemptions) or pay a penalty. To assist the state in verifying enrollment information provided by taxpayers, employers and plan sponsors (whether or not domiciled in New Jersey) providing coverage to New Jersey residents will need to submit to the state the same forms required under Sections 6055 of 6056 of the Internal Revenue Code (i.e., Forms 1094/5-B and 1094/5-C). The forms must be submitted electronically through the Division of Revenue and Enterprise Services' MFT SecureTransport service, which is the same system for processing W-2 forms.

Currently, the existing IRS Forms 1094/5-B and 1094/5-C contain the information New Jersey needs to verify enrollment, and therefore, New Jersey is willing to accept those forms. However, New Jersey notes that if the IRS changes the forms, it is possible that the state will develop its own forms. This is an important point, because as of the date of this blog, the IRS has not issued draft Forms 1094/5-B or 1094/5-C for 2019. Given that 2019 is the first year without the ACA's individual mandate, it is possible that the IRS is developing significantly revised forms (and, hence, the delay).

Employers and plan sponsors providing coverage to New Jersey residents should consider contacting their reporting vendors to ensure that the vendors have the capability to submit forms to the state. Employers and plan sponsors that handle reporting on their own should start working now to make sure current file submission programming is compatible with New Jersey's filing system. In a more perfect world, the IRS forms will continue to request enrollment information so that states with individual mandates can "piggy-back" on those forms. If that is not the case, the rising tide of state individual mandates could because an administrative headache for employers and plan sponsors.

IRS Extends ACA Reporting Deadline and Issues Transition Relief

By: Damian Myers

The IRS has not yet finalized the ACA reporting forms (i.e., the 1094-B/C and 1095-B/C) for the 2019 tax year, so it is no surprise that the IRS issued guidance this week extending the deadline to furnish the forms to employees and covered individuals (see Notice 2019-63). In addition to extending the deadline to furnish the forms, the IRS also issued transition relief for "B Form" filers that would waive penalties for failure to furnish the B Forms if certain conditions are met.

As a quick background, the ACA reporting requirements are set forth in Sections 6055 and 6056 of the Internal Revenue Code (the "Code"). Under Code Section 6055, health coverage providers are required to file with the IRS, and distribute to covered individuals, forms showing the months in which the individuals were covered by "minimum essential coverage." Under Code Section 6056, applicable large employers (generally, those with 50 or more full-time employees and equivalents) are required to file with the IRS, and distribute to employees, forms containing detailed information regarding offers of, and enrollment in, health coverage. In most cases, employers and coverage providers will use Forms 1094-B and 1095-B and/or Forms 1094-C and 1095-C. Highlights of the IRS's recent guidance are provided below.

Section 6055 Transition Relief

When enacted, Section 6055 served two primary purposes: (1) to allow covered individuals to substantiate compliance with the individual mandate, and (2) to provide the IRS with information necessary to determine whether covered individuals were eligible for premium tax credits on the ACA Marketplace. Now that the individual mandate has been repealed, covered individuals no longer need documentation showing that they were enrolled in minimum essential coverage.

The IRS explained that it is evaluating whether and how the Section 6055 reporting requirements should change given the individual mandate's repeal. In the meantime, the IRS issued transition relief for the 2019 tax year such that no penalties will be assessed against a B Form filer for failing to furnish the forms to covered individuals if two requirements are met. First, the coverage provider must post a notice on its website stating that an individual's B Form is available and can be requested at any time. This notice must include an email address and physical address where the request can be sent and a phone number where individuals can get additional information. Second, the coverage provider must provide any requested form within 30 days of the request.

This transition relief will primarily benefit insurance companies providing coverage in the group market, non-applicable large employers, and non-employer group coverage providers (such as multiemployer plans). Applicable large employers sponsoring self-insured plans are generally required to use the C Forms, which combine the reporting obligations under Sections 6055 and 6056. The IRS explains that the transition relief does not apply to forms to be furnished to full-time employees of applicable large employers.

Importantly, the transition relief applies only the requirement to furnish the forms to covered individuals. The B Forms still must be submitted to the IRS by the deadline noted below.

Deadline Extended

As it has in the past when necessary, the IRS extended the deadline to furnish the ACA reporting forms to employees and covered individuals. The deadline to file with the IRS, however, was not extended.

	Old Deadline	New Deadline

Deadline to Distribute Forms to Employees and Covered Individuals	Jan. 31, 2020	March 2, 2020

Deadline to File with the IRS	Feb. 28, 2020 (paper) March 31, 2020 (electronic)	**NO CHANGE**

The regulations issued under Code Section 6055 and 6056 allow for an automatic 30-day extension to distribute and file the forms if good cause exists. An additional 30-day is extension is available upon application to the IRS. Consistent with prior extensions, Notice 2019-63 provides that these extensions do not apply to the extended due date for the distribution of the forms, but they do apply to the unchanged deadline to file the forms with the IRS.

Good Faith Compliance Standard Renewed

The IRS also continued the interim good faith compliance standard under which the IRS will not assess a penalty for incomplete or incorrect information on the reporting forms if a filer can show that it completed the forms in good faith. As in prior years, this relief only applies if the forms were filed on time. Thus, filers would be wise to distribute and file forms, even imperfect ones, timely and should document their good faith efforts.

Those that do not file by the new deadlines have a more uphill battle to avoid penalties under Code Sections 6721 and 6722. In that case, the IRS would apply a reasonable cause analysis when determining the penalty amount for a late filer. As noted by the IRS in prior guidance, this analysis will take into account such things as whether reasonable efforts were made to prepare for filing (e.g., gathering and transmitting data to an agent or testing its own ability to transmit information to the IRS) and the extent to which the filer is taking steps to ensure that it can comply with the reporting requirements for 2019.

"Cadillac Tax" on High-Cost Group Health Plans Repealed

By: Damian Myers

On December 20, 2019, the President signed into law the "Further Consolidated Appropriations Act, 2020" (the "Act"). Among many other things, the Act repeals the Affordable Care Act's controversial 40% excise tax on high-cost health care (commonly referred to as the "Cadillac Tax"). From an economic perspective, the Cadillac Tax was intended to generate tax revenue and drive down utilization of unnecessary health care services. Originally scheduled to become effective in 2018, two separate legislative acts pushed the effective date to 2022. Given the Cadillac Tax's unpopularity on both sides of the aisle, it seemed that it was only a matter of time before the tax was repealed.

The Act also repealed two other healthcare-related taxes established by the Affordable Care Act – the medical device tax and the tax on health insurance providers. Both of these taxes were also delayed or paused in prior legislation.

The Saga Continues – Fifth Circuit Affirms ACA Individual Mandate's Unconstitutionality; Remands for Further Consideration

By: Damian Myers

Roughly a year ago, we reported on a district court judge's determination that the Affordable Care Act's ("ACA") individual mandate was unconstitutional and that, therefore, the entire ACA was invalid. A detailed summary of the district court's decision can be found in our December 17, 2018 post. Not surprisingly, this ruling was appealed to the 5th Circuit Court of Appeals.

On December 18, 2019, the 5th Circuit issued its ruling affirming the district court's determination that the individual mandate was unconstitutional. In 2012, the United States Supreme Court upheld the individual mandate as a constitutional application of Congress' taxing power. The 5th Circuit agreed with the district court that the individual mandate can no longer stand as a tax given that penalties under the individual mandate were reduced to zero in 2017.

The 5th Circuit, however, was not willing to go as far as the district court and declare the entire ACA unconstitutional. Instead, the 5th Circuit remanded the litigation back to the district court for a detailed analysis on which other provisions of the ACA are severable from the individual mandate and can therefore remain intact. A district court determination that the individual mandate cannot be severed from the rest of the ACA will undoubtedly be appealed to the 5th Circuit and, perhaps, the United States Supreme Court.

Although this litigation will not likely be resolved within the next year or two, it nevertheless creates uncertainty regarding which of the ACA's other provisions will be invalidated along with the individual mandate. For the time being, what is left of the ACA beyond the individual mandate is still the law, so employers and plan sponsors should continue to comply with the ACA's coverage mandates and, if applicable, the employer shared responsibility mandate.

Arbitration

Arbitrator To Decide Whether ERISA Fiduciary Claims Should Be Arbitrated

By: Benjamin Flaxenburg

A federal district court in Texas referred to arbitration a 401(k) plan participant's ERISA breach of fiduciary duty action based on allegations that certain plan investment options charged excessive fees. In a two-page order, the court instructed the arbitrator to determine whether the arbitrator or a court should determine whether the class action waiver provision in the participant's arbitration agreement waived her right to bring a representative action under ERISA § 502(a)(2). The case is *Torres v. Greystar Mgmt. Servs., L.P.*, No. 5:19-cv-00510 (W.D. Tex. Oct. 25, 2019).

Attorneys' Fees

Fifth Circuit: Procedural Win Is Not Grounds for Attorney's Fees

By: Lindsey Chopin

The Fifth Circuit concluded that a plan participant was not entitled to recover attorneys' fees for obtaining a remand order requiring the district court to apply a *de novo*, rather than abuse of discretion, standard of review to the administrative determination of her benefit claim. In so ruling, the Court applied the principles enunciated by the U.S. Supreme Court in *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242 (2010), which held that a plan participant must have "achieved some degree of success on the merits" in order to receive a fee award under ERISA. The Supreme Court held that, although the participant need not qualify as a "prevailing party," she must obtain more than "trivial success on the merits or a purely procedural victory." The Fifth Circuit applied the "some success on the merits" standard and observed that the remand order here included no comment on the strength of the remanded claim. The case is *Ariana M. v. Humana Health Plan of Texas, Inc.*, No. 18-cv-20700, 2019 WL 5866677 (5th Cir. Nov. 8, 2019).

Benefit Claims

Best Practices in Administering Benefit Claims #1 – Know (and Read) Your Plan Document

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

Our ERISA Practice Center blog posts often discuss many complex, and sometimes esoteric, substantive and procedural ERISA issues, as well as related agency guidance and case law. In this new ten-part blog series, however, we take a step away from the complex and esoteric in order to review some of the fundamentals of benefit claim administration. To that end, we want to share with you our top ten best practices for benefit claim administration. Let's dive right into our first best practice: *Know (and read) your plan document*.

Know your plan document? Read your plan document? Seems simple enough. Sometimes, however, some of the simplest things can prove to be the most difficult. ERISA requires every employee benefit plan to be in writing. The plan document is at the core of ERISA and provides the foundation for the benefits to which participants and beneficiaries are (and are not) entitled. Plan sponsors and fiduciaries are well-advised to review their plan documents periodically. Make sure the plan terms are consistent with the plan sponsor's and plan administrator's understanding. This is particularly true when it comes to plan amendments and restatements. Given the number of hands potentially involved in the adoption and implementation of plan amendments and restatements, it is important to make sure nothing has "slipped through the cracks." In addition, a periodic review of the plan document can help you find those plan terms that may be ambiguous or have unintended consequences. Use this review as an opportunity to clarify ambiguous terms to help mitigate risks of litigation. In short, a relatively small amount of effort now to know and read your plan document may save an enormous amount of effort (and money) later.

Come see us again next week where we'll take a look at the importance of other plan-related documents.

Best Practices in Administering Benefit Claims #2 – Know (and Read) Your SPD

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

Last week, we kicked off our blog series on the fundamentals of benefit claim administration with an explanation of how important it is to know and read your plan document. The plan document is the legally binding contract that describes each participant's rights and benefits under the plan. It also guides the legal obligations and protections for the plan administrator and other plan fiduciaries responsible for plan administration. This week, in part two, we review the importance of the summary plan description.

Many plan documents are accompanied by a separate summary plan description. Under ERISA, a summary plan description is precisely what it sounds like—an easy to understand summary of the plan document. Applicable ERISA regulations explain the specific types of information that must be included in the summary plan description, depending on the type of plan in question. Case law also has, from time to time, imposed requirements to include additional information. Separately, based on years of experience, we, as practitioners, have developed recommended language or SPD terms that help clarify plan terms and provide protection against misrepresentations or misunderstandings. Plan sponsors and fiduciaries are well-advised to periodically read their summary plan descriptions to ensure that they comply with all available guidance, are consistent with the plan documents, and have not inadvertently omitted required information. Although the plan document, not the summary description, is supposed to "rule" in court, inconsistencies and inadvertent omissions have given rise to costly, unnecessary litigation. A little bit of effort now, may avoid a large, costly headache later on.

Is it possible that a plan and summary plan description can be one and the same document? Yes. This is found particularly in the context of health plans or other "welfare benefit plans" under ERISA. Practitioners regularly discuss with clients questions of format and presentation as part of an overall compliance review.

Finally, remember, a good summary plan description doesn't do anyone any good if it is not timely and appropriately distributed to plan participants. There are various ways to distribute a summary plan description, including through electronic means. ERISA regulations should be considered carefully in deciding how to proceed.

Stop by next week when we discuss authorized representatives and assignments.

Best Practices in Administering Benefit Claims #3 – Dealing with Benefit Assignments

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

Our blog series on best practices in administering benefit claims has thus far stressed the importance of knowing and reading the plan document and summary plan description. This week, we take a look at a plan term that has been the subject of frequent dispute in health and welfare benefits claim litigation—interpretation of plan provisions prohibiting a participant's right to assign benefits to healthcare providers.

Out-of-network medical providers commonly require patients to sign documents that purport to assign their rights to plan benefits to the provider. If this assignment works (if it's valid), it would allow the medical provider to "step into the shoes" of the patient and challenge the amount a plan pays to the provider. This would give the provider direct rights against the plan, including through a plan administrative claim and, if necessary, litigation.

Under ERISA, group health plans are allowed to prohibit benefit assignments and, for a variety of reasons, many plans do so. With a valid anti-assignment provision, plans have successfully defeated claims brought by out-of-network providers seeking additional plan reimbursements.

Anti-assignment provisions must be drafted carefully and clearly so they will accurately reflect the plan sponsor's intentions. Some of the issues to consider include: Will the plan prohibit all benefit assignments? Will it prohibit only the assignment of payment of benefits? Will it only prohibit the provider from commencing action in court? Will it require that providers and participants get the plan administrator's consent before the assignment is valid? Plan sponsors generally have wide latitude to limit, or prohibit altogether, the assignment of benefits.

In considering anti-assignment provisions, there are two other points to remember:

First, ERISA allows participants to designate authorized representatives to act on their behalf through the claims process. This could mean that a provider, an attorney, or any other individual could be appointed to act on behalf of the participant. Unlike a properly designated assignee, however, an authorized representative does *not* step into the shoes of the participant and does not acquire rights independent of the participant. A plan may provide for reasonable procedures that participants must follow in designating authorized representatives, which may facilitate benefit claim administration.

Second, many health plans will have "direct payment" provisions whereby the plan will pay out-of-network benefits directly to a provider as a convenience to the participant. A properly drafted anti-assignment clause will distinguish between a permissible direct payment arrangement from a prohibited assignment of benefits. This is an important and difficult provision to draft, and counsel should be consulted on this point.

Next week, we'll discuss the importance of knowing and understanding the applicable law and regulations on benefit claim and appeal procedures.

Best Practices in Administering Benefit Claims #4 – Know (and Understand) the Law: Full and Fair Review

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

This week in our blog series on best practices in administering benefit claims, we discuss the importance of knowing and, importantly, understanding the laws governing benefit claim administration.

Section 503 of ERISA sets forth the general guidelines for a plan's claims and appeal procedures. It requires that a plan provide adequate written notice of the denial of a claim by a participant or beneficiary (or authorized representative). The notice has to set forth the specific reasons for the denial and be "written in a manner calculated to be understood by the participant." ERISA also requires that a plan provide a participant whose claim has been denied the opportunity for a "full and fair review by the appropriate named fiduciary." The U.S. Department of Labor's implementing regulations elaborate on the ERISA claims procedures requirements in much more detail and, in particular, concern the time, notification, and content requirements for each phase of the claims process.

- *What is the timing for an initial claim decision?* The regulations provide specific timing requirements for deciding an initial claim; generally speaking, a decision regarding a claim must be rendered within 90 days of receipt of the claim regardless of whether the claim was complete. That period can be extended in the case of "special circumstances" provided the claimant is notified of the extension before the expiration of the initial period. In some cases (, urgent care, pre-service, and post-service claims under a group health plan), the period may be shorter than 90 days.

- *What information must an adverse claim decision include?* If the claims fiduciary determines that the claim should be denied (in whole or in part), that adverse determination has to include the specific reasons for determination, information needed to perfect the claim, references to relevant plan provisions, a statement of the claimant's right to relevant documents, a description of the plan's appeal procedures and time limits, and a statement of the claimant's right to bring suit under ERISA following an adverse benefit determination on appeal. Additional information may be required when dealing with a group health plan or a plan providing disability benefits.

- *What is the timing for decision on appeal?* A claimant should be given at least 60 days (or 180 days for group health plans) to appeal following receipt of an adverse benefit determination notice. In connection with their appeals, claimants should be given the opportunity to submit comments and other documentation related to the claim, and to request any documents, records, and information relevant to the claim.

- *Who decides the appeal and what information must an adverse appeal decision include?* The same person or group may generally decide the claim and appeal other than for group health plans where the decision-maker on the appeal must be different from the decision-maker on the claim. In all cases, the fiduciary responsible for the decision on appeal may not give deference to the initial claim decision and should take into account everything submitted in connection with appeal to make its own decision. If there is an adverse benefit determination on appeal, the notice must contain much of the same information as the initial adverse claim decision.

- *Special rules for group health plans.* There are a number of special rules for group health plans, including those noted above and, in certain instances, an external review requirement. These requirements go well-beyond the scope of this blog.

ERISA's claims regulations weave a complex web of rules for a plan's claims and appeal procedures. Care should be taken to (1) review and understand the regulations, and (2) properly document the claims procedures in the plan document and summary plan description.

Next week, we'll discuss the importance of a good claims process and a participant's obligation to exhaust the claims procedures before commencing an action for benefits.

Best Practices in Administering Benefit Claims #5 – Establishing (and Following) a Good Claims Process

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

This week we discuss the importance of establishing good claims procedures and the benefits of following those procedures.

A plan's claims procedures should be spelled out clearly in both the plan document and the summary plan description (where the two documents are not one in the same). In addition to setting all of the applicable deadlines for submitting claims and appeals (as we discussed last week), the procedures should inform claimants of: optional levels of appeal or review (if any); procedures for designating an authorized representative; the requirement to exhaust the plan's claims procedures before commencing an action; and their right to review documents relevant to the claim decision. Good claims procedures also will confer final, decision-making authority on one or more people, or a committee. Importantly, the claims procedures must be made known to all participants because, of course, without knowledge of what the claims procedures are, a participant cannot reasonably be expected to utilize them.

The claims process, contrary to what may be intuitive to many, is not generally viewed by the courts to be an adversarial process—at least not at the beginning stages. That is because plan fiduciaries—such as those responsible for deciding claims and appeals—owe a fiduciary duty of loyalty to participants. Now, that is certainly not to say that claims decisions must always be in the participant's favor. It does mean, however, that participants must be given an opportunity to present their position on why they believe they are entitled to benefits and that the plan fiduciary should consider and evaluate all of their arguments at the claim and appeal stages. The fiduciary should give careful consideration to the evaluation of a participant's claims and arguments, particularly since the participant is generally entitled to all documents that are considered by the claims fiduciary in making its decision—even if the documents are not relied upon in reaching the decision.

There are many benefits to making sure the claims fiduciary follows the plan's claims procedures. For instance, a court (or arbitrator) will require a claimant to first exhaust the plan's administrative process before s/he brings an action for benefits under ERISA section 502(a). And, if after exhausting the claims procedures, the participant pursues a claim for benefits in court (or arbitration), the judge (or arbitrator) is required to defer to the claims fiduciary's decision unless it was arbitrary and capricious. Unlike giving the claim a fresh review, the arbitrary and capricious standard of review is highly deferential to the plan fiduciary's decision. Furthermore, the participant generally will not be entitled to discovery in litigation (or arbitration) outside of the administrative record. This has the added benefit of reducing litigation (or arbitration) costs.

Next week, we'll discuss the mechanics of benefit claim administration, including dealing with the fiduciary exception to attorney-client privilege.

Best Practices in Administering Benefit Claims #6 – Distinguishing an Inquiry from a Claim

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

It's Week #6, and we have turned the corner in our Top 10 Best Practices in Administering Benefit Claims. In case you missed any (or all) of the first five best practices, links to each of them appear below. This week we discuss how to distinguish an inquiry from a claim for benefits.

The claims and appeals procedures only apply insofar as there has been a "claim for benefits" under the plan. In general, a "claim for benefits" is a request for benefits made by a claimant in accordance with the plan's reasonable procedures for filing such claims. Ideally, a participant or beneficiary would specify in their communications that s/he is making a "claim for benefits" or otherwise asserting that s/he is entitled to some benefits under the plan. Unfortunately, participants and beneficiaries (and even their authorized representatives) are often less than clear about what it is they are seeking.

The U.S. Department of Labor is of the view that mere casual inquiries about benefits or when benefits might be paid do not qualify as formal "claims for benefits." Similarly, an individual's question concerning his/her eligibility for coverage and the administrator's subsequent eligibility determination is *not* subject to the claims and appeals procedures. On the other hand, if an individual files a claim for benefits and the administrator denies that claim on the basis of ineligibility, then the claims and appeals procedures are triggered even though the denial is based on an eligibility issue.

Careful consideration should be given to whether a participant's (or beneficiary's) communication triggers the plan's claims process. For instance, does the plan require claims to be in writing, or are telephonic claims accepted? Has the participant or beneficiary submitted all required documentation with the claim? Should an inquiry, although not technically a claim, be processed through the plan's claims procedures? When is it appropriate to do so? Are there strategic reasons to do so in the particular situation? There is no one-size-fits-all answer to many of these considerations and each inquiry and claim should be evaluated on its own facts, while ensuring that there is consistency in the way inquiries and claims are managed.

In our next best practice, we'll discuss the "fiduciary exception" to the attorney-client privilege.

Best Practices in Administering Benefit Claims #7 – Understanding Attorney-Client Privilege in the Benefits Claims Process

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

When a plan administrator is attending to a benefit claim and thinks it is time to call in an attorney, are those discussions privileged and protected from disclosure to claimants? In this week's blog, we take a look at some of those communications between attorneys and plan administrators and examine whether or not they are privileged. To the surprise of many, communications between a plan administrator and the plan's attorney may not be protected from disclosure by the attorney-client privilege.

Let's start with the basics: The attorney-client privilege generally protects communications (and the substance of those communications) between an attorney and a client that are made in confidence for the purpose of obtaining or providing legal assistance to the client. In the ordinary course, those communications are privileged and not discoverable by anyone in litigation (or in other proceedings). This privilege exists to ensure the free flow of information between the attorney and client.

When addressing a claim for plan benefits, however, communications between the plan administrator and the plan's attorney may not benefit from that privilege. As the courts have explained, a plan fiduciary must act solely in the interests of participants and beneficiaries. Therefore, when a plan fiduciary speaks with a lawyer about matters relating to plan administration, the "real client" vis-à-vis the plan attorney is the participant or beneficiary who is impacted by the issue and not the plan fiduciary. This is often referred to as the "fiduciary exception" to the attorney-client privilege.

In the benefit claim context, the so-called fiduciary exception may require the production of communications between a plan administrator and plan counsel concerning plan administration. For example, an email or memorandum from the plan's lawyer to the plan administrator addressing whether or not a participant is entitled to benefits under a plan may be discoverable by the participant as part of the administrative record. The fact that the email or memorandum was written by a lawyer may not necessarily shield it from production.

At the same time, the fiduciary exception is not without its limits. For instance, once the interests of the parties are clearly adverse (they diverge), a plan administrator may engage counsel and the attorney-client privilege should protect from disclosure communications about a participant's claim. As a practical matter, some courts have concluded that the interests sufficiently diverge once a participant's appeal (not claim) for benefits is finally denied. In addition, communications between a plan attorney and a plan fiduciary about a plan fiduciary's personal liability also are not discoverable by a participant or beneficiary.

There are many nuances to the fiduciary exception, and it is important to be mindful of its application during the administration of claims for benefits and appeals.

For further discussion of the attorney-client privilege and fiduciary exception, you can check out our Benefits Brief Podcast.

On the blog next week, we'll discuss managing litigation of a benefits claim.

Best Practices in Administering Benefit Claims #8 – Facing Litigation of Benefit Claims

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

Up to now, our blog series has focused on best practices for implementing a plan's claims and appeals procedure. We shift gears this week to see how following these best practices pays dividends if a participant's (or beneficiary's) claim is denied and the participant decides to pursue the claim for benefits in court (or, if required, arbitration).

After a participant exhausts a plan's claims procedures, ERISA Section 502(a)(1)(B) authorizes the participant to seek benefits due under the terms of the plan, enforce his or her rights under the terms of the plan, or clarify his or her rights to future benefits under the terms of the plan.

With the plan's claims process exhausted, the plan administrator defending the benefit claim should be armed with a full administrative record that supports the reasonableness of the decision for denial of benefits. Participants are entitled under ERISA to request and receive a copy of the administrative record prior to commencing litigation, and participants often make such a request. Even where a participant does not request the administrative record, consideration should be given to producing the record to the participant.

Strategically, of course, the plan administrator's goal is to find the quickest means to get the case dismissed. And, putting the administrative record in the hands of the participant prior to the participant commencing an action often helps put the plan administrator in a better position to try to get the case dismissed on an immediate "motion to dismiss" or "motion for summary judgment." As we have explained in prior blog entries, in ERISA benefit claim litigation, discovery typically is limited to the administrative record, and courts are required to defer to the plan administrator's decision unless it was arbitrary and capricious. The bottom line—a good administrative record is key to setting up the possibility of an early resolution of a benefit claim dispute.

That said, sometimes a participant will try to avoid early dismissal of his or her case based on the administrative record by claiming that he or she needs discovery because the plan administrator had a conflict of interest in reaching the decision to deny benefits. For instance, a participant may claim that because the company was responsible for paying severance benefits and the plan administrator (*i.e.*, the decision-maker) worked for the company, the plan administrator suffered from a conflict of interest—by denying the claim the plan administrator was trying to benefit the very company that he or she worked for. This, so the argument goes, makes the decision to deny benefits arbitrary and capricious and necessitates discovery beyond the administrative record to get more information about that conflict. But, a structural conflict such as that just described does not in and of itself warrant additional discovery. A participant must allege more. He or she must plausibly allege—in more than a conclusory fashion—that the conflict infected the decision-making process in order to possibly be entitled to discovery on the conflict outside of the administrative record.

In short, with a well-documented administrative record, and application of the highly deferential arbitrary and capricious standard of review, the plan administrator should be well-positioned to minimize costs and obtain immediate dismissal of the action.

Next week, we'll discuss other techniques for controlling and minimizing the costs of litigation of benefit claims, including contractual limitations clauses and venue selection clauses.

Best Practices in Administering Benefit Claims #9 – Managing Litigation

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

As we shifted focus last week from a plan's administrative claims procedures to defending against a claim for benefits in court, we explained how a well-documented administrative record can enhance the chances of getting a case dismissed at the outset without the need for protracted litigation. This week, we offer three opportunities to further manage litigation by adding one or more of the following provisions to plans: a contractual limitations period, a forum selection clause, and/or a mandatory arbitration provision.

- *Contractual Limitations Periods.* ERISA does not specify a statute of limitations for claims for benefits under Section 502(a)(1)(B). Thus, courts borrow the state statute of limitations for the state claim that is most analogous to a claim for benefits, which, in most cases, is a breach of contract claim. In New York, for example, a claim for benefits is generally subject to a six-year statute of limitations. In other jurisdictions, the statute of limitations has been determined to be as many as fifteen years. There is a separate issue of when the statute of limitations begins to accrue, which is typically governed by the federal discovery rule, *e.*, when a participant knew or should have known that he or she was not entitled to benefits. In light of the length of these limitations periods, plan sponsors often include a contractual limitations period in the plan document and summary plan description that considerably shortens the statute of limitations and also specifies when the period begins to run. Depending on the type of plan, we have seen limitations periods in plan documents that range from a couple of years to as few as a couple of months. Although there is little, if any, dispute that contractual limitations periods are enforceable, it is important that they be reasonable, be published in the summary plan description, and be included in all benefit denial letters. By drafting clear contractual limitations periods that also specify precisely when the period is triggered, plan sponsors can limit the ability of participants and beneficiaries to bring suits based on events that occurred many years earlier.
- *Forum Selection Clauses.* ERISA contains a venue provision, which provides that a claim under ERISA "may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found."

ERISA § 502(e)(2). ERISA's broad venue provision can make it costly to defend a case, particularly if a participant with a claim works in or retires to a location that is far from where the plan is administered. Most courts have concluded that ERISA's venue provision is permissive, not mandatory. As such, plan sponsors are free to draft a plan provision that requires all ERISA claims to be commenced in particular state and/or court. By dictating where the plan will be required to defend against ERISA claims (of any kind), plan sponsors can help reduce the costs and burdens of the plan being involved in litigation.

- *Mandatory Arbitration Provisions.* It is well-established that plan sponsors and plan fiduciaries may require claims for benefits, after the claim is processed through the plan's administrative claims procedures, to be arbitrated rather than litigated in court. Because arbitration is generally viewed to be less costly than litigation, plan sponsors may wish to consider the relative pros and cons of arbitration. When doing so, there are a multitude of factors to consider, including the following: Which arbitration forum should be used—AAA, JAMS or something else? Should the plan create its own arbitration procedures? Where should the arbitration be commenced? How many arbitrators should there be—one or a panel of three? Who should pay for the arbitration? Should class-wide arbitration be prohibited? What appellate rights should be provided following arbitration? There are many answers to these questions, and there is not necessarily a one-size-fits-all answer to them. The answers may very well differ depending on, among other things, the type of ERISA claim. The answers to these questions are well beyond the scope of this blog, but the important thing to recognize here is that arbitration is available and that there are many important questions that must answered besides the most fundamental one—does the plan and/or plan sponsor want to arbitrate ERISA claims?

A decision by the plan sponsor and/or plan fiduciary to include some or all of these provisions in the plan (and summary plan description) can serve to help avoid and/or minimize the costs and burdens of ERISA litigation. Careful consideration should be given to determining whether any of these provisions are a good choice for your plan.

Next week, we wrap-up with some final thoughts on best practices in benefit claim administration.

Best Practices in Administering Benefit Claims #10 – The Three C's

By: Paul Hamburger, Russell Hirschhorn and Malerie Bulot

We conclude our blog series on best practices in administering benefit claims with the three C's: *be clear, be consistent, and communicate*. The key to effective benefit claim administration ultimately boils down to drafting and maintaining clear plan documents, implementing and enforcing plan terms consistently, and communicating clearly with plan participants and beneficiaries.

First, all documents, from the plan document and summary plan description to the claims procedures, should be drafted as clearly as possible. That seems obvious and simple enough, but it is not always accomplished. When the documents are clear in their meanings, plan fiduciaries and administrators, as well as plan participants and beneficiaries, can rest easier knowing that the plan is being properly administered in accordance with its terms.

Second, plan terms should be implemented and enforced consistently. This is particularly true when fiduciaries have to interpret the plan terms. Given the importance of consistent plan interpretation, fiduciaries should consider appropriate documentation of their decisions. This can help minimize the risk of future, unintended inconsistent interpretations.

Third, the importance of clear communications with plan participants and beneficiaries cannot be overstated. Clear communications can go a long way in providing comfort to participants and beneficiaries that they have an accurate understanding of the benefits provided under the plan (and those that are not).

Keeping in mind the three C's should help reduce the risk of participant claims and/or litigation about whether the participant is receiving the benefits due under the plan. If, however, litigation arises, plan sponsors and fiduciaries will be able to take comfort in the fact that they have clear plan documents, that have been consistently enforced, and that have been clearly communicated to participants, all of which will aid in the defense of the litigation.

Disclosure

Guide to DOL's New "Notice and Access" Proposal for Electronic Delivery

By: Seth Safra and Jennifer Rigterink

On October 23, 2019, the Department of Labor published a new proposed regulation that paves the way for "notice and access" electronic delivery of certain disclosures for retirement plans. The proposal is welcome news for plan sponsors and administrators who have been frustrated by the existing "opt-in" regime for electronic disclosure. But the proposal is limited in scope—it covers only notices related to retirement plans, leaving health and welfare plans for another day—and it imposes significant obligations for sponsors and administrators who wish to have safe harbor protection under the proposed regulation.

DOL has requested comments on the proposal and additional issues related to required disclosures. ***Comments are due by November 22, 2019.*** The following are important points about the proposal:

- ***Limited scope: the proposal covers only retirement ("pension") plans, not health or other welfare plans.*** The safe harbor does not apply to health or other welfare benefit plan disclosures. DOL indicated in the preamble that it is considering whether to expand the proposed safe harbor to include welfare plans.
- ***Opt-out regime: the proposal includes a safe harbor for plan sponsors and administrators to furnish notices on a website, unless participants affirmatively request paper disclosure.*** To take advantage of the safe harbor, two notices will be required. First, the proposal requires that an initial paper notice be sent to each person intended to be covered by the safe harbor; the paper notice must explain the documents that will be furnished electronically, the right to request paper copies free of charge, and how to opt out of electronic delivery (either for certain documents or globally). After the initial paper notice is furnished, participants would have to be notified electronically each time a document is posted on the website (unless the document falls under the "consolidated" notice rule, explained below). The proposal requires that the electronic notice include a website address directing participants to the posted document.
- ***Consolidated notice: exception to requirement to send a separate electronic notice for each document posted online.*** Although the safe harbor generally requires a separate electronic notice be sent each time a document is posted, the proposed regulation permits one "consolidated" notice covering all of the following documents: summary plan description (SPD), summary of material modifications (SMM), summary annual report (SAR), annual funding notice, section 404a-5 investment-related disclosure, notice about default investment alternatives (QDIA notice), and pension benefit statement. The consolidated electronic notice must be furnished annually.

- ***Retention required: documents posted on the website must remain posted until they are updated, changed, or become obsolete.*** Documents posted under the proposed safe harbor would have to be maintained on the website until superseded. In addition, documents posted on the website would have to be searchable electronically.
- ***Existing safe harbor not affected: the proposal is to have a new safe harbor that is in addition to (not a replacement for) the existing safe harbor for participants who opt in and employees who have computers at their desks.*** There is a general obligation to furnish ERISA-required documents by a method "reasonably calculated to ensure actual receipt." An existing DOL safe harbor provides that this obligation may be satisfied by electronic delivery only if the participant has work-related computer access (such as a computer at their desk) or the participant affirmatively consents to receive notices electronically; that safe harbor has detailed requirements for the consent to be valid. The proposed regulation offers an additional safe harbor for delivery of ERISA-required notices, but it does not replace or supersede the existing DOL safe harbor.
- ***Comments requested: DOL requests comments on the proposal and an assortment of questions about disclosure more generally.*** In addition to its general request for comments in response to the proposed regulation, DOL asked for feedback on 21 separate topics related to disclosure, such as:
  - Whether any ERISA-required disclosures have become obsolete (due to the passage of time or technology);
  - Whether more personalized disclosures would enhance participant engagement;
  - Whether cybersecurity risk assessments and security measures related to plan disclosures should be incorporated into the regulation; and
  - Whether and to what extent plans should share the "substantial" cost savings from electronic distribution of documents with participants.

Employers who have struggled with seemingly endless disclosure obligations that are not widely read should welcome the opportunity to submit comments.

* * *

The proposed regulation will become effective 60 days after the final rule is published in the *Federal Register*, with no option to rely on the proposed regulation before it is finalized.

Health Plan Compliance

New IRS Guidance for Tax-Exempt Entities Funding Employee Benefits

By: Paul Hamburger and Jennifer Rigterink

The IRS recently released a final regulation clarifying how voluntary employees' beneficiary associations (VEBAs) and supplemental unemployment benefit trusts (SUBs) should calculate unrelated business taxable income. VEBAs and SUBs are tax-exempt entities that are used to fund employee benefit programs. Read below for background, details of the final regulation, and the applicability date.

Background

Although VEBAs and SUBs are tax-exempt entities, they are subject to tax on their unrelated business taxable income. However, under an exception to this general rule, collectively-bargained VEBAs and SUBs are ***not*** subject to tax on their unrelated business income. The analysis below applies to non-collectively bargained VEBAs and SUBs.

For VEBAs and SUBs, unrelated business taxable income is defined to include all gross income earned during the year, but excluding member contributions and excluding amounts set aside to pay benefits and related costs up to the IRC section 419A account limit for the year (which, generally speaking, is the amount necessary to pay incurred but unpaid benefit claims at year-end). Amounts set aside to pay benefits in excess of the IRC section 419A account limit are included in unrelated business taxable income and subject to tax.

Against this backdrop, some taxpayers had taken the position that VEBA or SUB investment income earned during the year but spent on benefits was not included in unrelated business taxable income for the year. The U.S. Court of Appeals for the Sixth Circuit endorsed this interpretation in *Sherwin-Williams Co. Employee Health Plan Trust v. Commissioner* (6th Cir. 2003), and concluded that a VEBA's investment income spent on administrative costs was not included in unrelated business taxable income for that year.

Final regulation and applicability date

The final regulation clarifies that, for VEBAs and SUBs, investment income earned during the year is subject to unrelated business income tax to the extent it exceeds the IRC section 419A account limit for the year. This rule applies regardless of whether the investment income is spent on benefits during the year. Recognizing that VEBAs and SUBs under the Sixth Circuit's jurisdiction may have been operating in good faith reliance on the Sixth Circuit's decision in *Sherwin-Williams*, the IRS provided a delayed applicability date for the final regulation. The final regulation will apply to taxable years ***beginning*** on or after the date of publication of the final regulation (December 10, 2019).

* * *

Plan sponsors should carefully review the current treatment of non-collectively bargained VEBA and SUB investment income to confirm that their approach complies with the final regulation.

HRA

New HRA Regulations Part 5 – More on the Employer Shared Responsibility Mandate

By: Damian Myers, Kaitlin Hulbert, and Malerie Bulot

On September 30th, the IRS issued proposed regulations that establish safe harbors for compliance with the employer mandate in the context of individual coverage health reimbursement arrangements (or "ICHRAs"). These proposed regulations are important for employers that choose to offer ICHRAs and want to be sure they comply with the employer shared responsibility mandate requirements under the Affordable Care Act ("ACA").

The issues being clarified in the proposed regulations stem from prior guidance that we explained in our blog series on the final health reimbursement arrangement (HRA) regulations issued by the Departments of Labor, Health and Human Services, and Treasury (the "Departments") in June 2019. That guidance established basic parameters for how the new ICHRAs would interact with the ACA employer shared responsibility mandate. However, that earlier guidance needed to be fleshed out based on industry feedback and experience. The September 30th proposed regulations (which also cover nondiscrimination issues that will be summarized in a subsequent blog) provide that additional guidance.

The key stumbling block to ACA compliance in this area is in determining whether the ICHRA coverage provided is "affordable" for ACA purposes. This is an extraordinarily complex undertaking. To help solve that problem, therefore, the proposed regulations include several safe harbor methods of compliance, such as a location-based safe harbor, a lookback safe harbor and a general affordability safe harbor. Before we explain these safe harbor rules, let's step back and understand why affordability matters for ACA purposes.

ACA Employer Mandate: Why Affordability Matters

The ACA's employer mandate, codified under Section 4980H of the Internal Revenue Code ("Section 4980H") generally requires (subject to stiff penalties) that applicable large employers ("ALEs," generally employers that employ more than 50 full-time employees on a controlled-group basis) offer eligible employer-sponsored health coverage to at least 95% of their full-time employees and their dependent children. Even if an employer satisfies the 95% requirement, though, a smaller penalty under Section 4980H(b) could still be assessed if the coverage offered is either not "affordable" or does not have minimum value. So it is important to know whether coverage is "affordable" in order to mitigate or avoid ACA penalties.

Here's where it gets complicated. Affordability for purposes of the employer mandate is tied to the same formula used for determining an individual's premium tax credit eligibility on the ACA Marketplace. In that context, affordability is determined based on whether the cost of the second lowest cost silver plan available to the individual on the ACA Marketplace is less than 9.5% (adjusted for inflation) of his or her household income. In the *group* health plan context, the relevant comparator is the employee portion of the self-only premium for the lowest cost minimum value coverage option offered by the employer to the employee.

Determining the coverage option to use for affordability purposes is easy enough in the group health plan environment, but using household income as a measure of affordability is a problem because employers typically do not have that information. Therefore, in prior ACA guidance, the IRS established three affordability safe harbors for employers—the W-2 safe harbor, the rate of pay safe harbor, and the federal poverty line safe harbor.

The problem is that these general safe harbors alone cannot solve the affordability conundrum related to ICHRAs. With IRS Notice 2018-88, the IRS began laying the groundwork for future regulations by outlining some basic parameters for compliance with the ACA mandate. For example, Notice 2018-88 provided that ICHRAs are minimum essential coverage and an affordable ICHRA will be deemed to have minimum value. But even with those basic rules, affordability was viewed as a real challenge and additional guidance was necessary.

Applying Affordability to ICHRAs

The proposed regulations reiterate the position in IRS Notice 2018-88 and state that affordability for purposes of Section 4980H(b) involves a similar methodology to that used for calculating premium tax credit eligibility. For an ICHRA to be affordable in a given month, an "employee's required HRA contribution" (or the difference the monthly HRA contribution for self-only coverage and the lowest cost silver-level plan available on the Marketplace) must not exceed 1/12 of (a) the employee's household income for the taxable year multiplied by (b) the "required contribution percentage" (currently set at 9.86%).

For employers, particularly those with a large, national workforce, applying this formula would be extremely difficult. That is because the "required HRA contribution" is based in part on the lowest cost silver-level plan available on the Marketplace within the relevant rating area. That cost varies on an individual-basis depending on age and place of residence. To help employers apply these rules, the proposed regulations propose the following safe harbors for affordability purposes:

- ??Location Safe Harbor. Under the location safe harbor for determining affordability, the proposed regulations would allow ALEs to measure affordability against the lowest cost silver-level plan available in the area where an employee's primary site of employment is located. For purposes of this safe harbor, an employee's primary site of employment is the location at which the employer reasonably expects the employee to perform services on the first day of the plan year (or, on the first day the ICHRA takes effect). In some cases (, when an employee works remotely and cannot be required to report to a particular worksite), the ALE will be required to consider an employee's place of residence. Employers with multiple worksite locations would still be required to determine affordability for Section 4980H purposes separately for each area.
- ??Lookback Safe Harbor. Employers typically determine the employee cost-share for coverage in the fall of each year (i.e., the open enrollment period for calendar year plans). However, at that time, the premiums for individual market coverage in the following year are typically not yet available. As such, for measuring affordability, the proposed regulations offer a safe harbor through which ALEs with a calendar plan year may use the monthly premium for the lowest cost silver plan in January of the prior calendar year. A similar safe harbor is also available to ALEs with non-calendar plan years; however, the applicable lookback date is the January of the current calendar year, as opposed to the January of the prior year.
- ??General Affordability Safe Harbors. As discussed above, whether an ICHRA is considered affordable is partially based on the relationship between the employee's required HRA contribution and the employee's household income for the taxable year. Because an employer offering an ICHRA will generally not know an employee's household income, the proposed regulations provide that ALEs offering ICHRAs are permitted to use the three general affordability safe harbors established previously by the IRS (, the W-2 safe harbor, the rate of pay safe harbor, and the federal poverty line safe harbor).

What about other safe harbors?

The Treasury Department declined to provide an age-based safe harbor, noting that it was limited in its ability to materially deviate from the premium tax credit rules. Nevertheless, the proposed regulations did offer some simplifications to help employers through this problem. First, although affordability is determined on a monthly basis, an employee's age at the start of the plan year (or the date on which the employee becomes eligible to participate) can be used for the duration of the plan year. Second, if within an age band, there is variation among the lowest cost silver plan for different ages in that band, the lowest cost silver plan for that entire age band can be used for all ages in the age band. Employers would still need to make adjustments based on location, however. Finally, the Treasury Department noted that employers could always simplify the process by using the premium applicable to the lowest cost silver plan available to the oldest employee for all employees within the applicable location. This simplification, however, would generally require a higher benefits spend than necessary.

* * *

These proposed regulations make an effort to ease the burden on employers with respect to the affordability calculus for ICHRAs. To some degree, the proposed safe harbors will be helpful for ICHRA sponsors. Even with these safe harbors, though, the administrative burden in determining affordability may be significant, particularly for employers with a widespread employee base. ALEs that are considering adopting ICHRAs should consult with benefit advisors and counsel when designing the plan and assessing affordability.

Multiemployer Funds

Proskauer to Speak at the 65th Annual International Foundation's Annual Employee Benefits Conference

By: Robert Projansky, Neal Schelberg and Anthony Cacace

Proskauer's Employee Benefits and Executive Compensation Group will be attending and speaking at the 65th Annual Employee Benefits Conference hosted by the International Foundation of Employee Benefit Plans. Robert Projansky, Neal Schelberg and Anthony Cacace will be leading conversations around hot topics in the industry. We welcome you to join any of our presentations, we look forward to seeing you!

When: Sunday, October 20th – Wednesday October 23rd, pre-conference beginning on Saturday, October 19

Where: The San Diego Convention Center, 111 W Harbor Drive, San Diego, CA 92101

Saturday, October 19 – Pre-conference

Time	Topic	Presenter

8:00 am – 12:00 pm	Trustee Responsibility and Legal Environment	Robert Projansky

Monday, October 21

Time	Topic	Presenter

9:15 – 10:30 am	Fiduciary Refresher	Neal Schelberg

1:15 – 2:30 pm	Fiduciary Dilemmas	Robert Projansky

1:15 – 2:30 pm	Tensions in the Boardroom: Issues Confronting Trustees Who Are in Disagreement	Anthony Cacace

2:45 – 4:00 pm	Working With Your A-Team (for Trustees)	Robert Projansky

Tuesday, October 22

Time	Topic	Presenter

7:30 – 8:45 am	Working With Your A-Team (for Trustees)	Robert Projansky

1:15 – 2:30 pm	Fiduciary Dilemmas	Robert Projansky

1:15 – 2:30 pm	Tensions in the Boardroom: Issues Confronting Trustees Who Are in Disagreement	Anthony Cacace

Plan Qualification

IRS Reiterates Requirement to Sign Plan Documents and Amendments

By: Paul Hamburger and James Huffman

At the heart of tax qualified retirement plan compliance is a requirement to timely adopt plans and plan amendments. Failure to adopt plan amendments when required can result in plan disqualification. Accordingly, it is very important for plan sponsors to prove that amendments were properly executed in a timely manner. In a General Legal Advice Memorandum from the IRS's Office of Chief Counsel dated December 13, 2019, the IRS provided a reminder of this important qualification requirement and the ramifications of noncompliance.

(The issue of *when* plan amendments must be made is a technical issue and will vary based on a number of factors, including whether the amendment is a legally-required amendment, an optional/design amendment, or an amendment required as a condition of obtaining a favorable IRS determination letter for the plan. This blog addresses the separate technical requirement to prove that a plan amendment was properly adopted.)

The question of how to prove timely adoption of plan amendments arose following the Tax Court's decision in *Val Lanes Recreation Center v. Commissioner, TC Memo 2018-92*. The taxpayer in *Val Lanes* was an employer sponsoring an employee stock ownership plan (ESOP) that was under examination by the IRS. The IRS proposed to disqualify the ESOP for several reasons, one of which was that the employer could not prove timely adoption of a plan amendment. All that was in the record was an unsigned amendment that the employer agreed to adopt upon receipt of its favorable determination letter; but the employer could not later produce a signed version of the amendment. The problem was that the employer's records were destroyed when bad weather caused extensive damage to the business premises and the employer thought the signed plan amendment might have been destroyed. However, the employer could credibly show that it had a practice of always signing plan documents sent by its tax advisor. After considering all the facts, the Tax Court agreed with the employer and determined that the plan amendment in question was indeed validly executed by the employer in a timely fashion.

In the General Legal Advice Memorandum, the IRS emphasized that employers should not try to rely on the arguments presented in *Val Lanes* because they were highly fact-specific. The burden of proof to show timely adoption, according to the IRS, is on the plan sponsor. The IRS emphasized that it would be unlikely for a plan sponsor to meet its burden of proof that a plan amendment had been executed without providing an actual signed plan amendment. Therefore, the IRS concluded by stating that "it is appropriate for IRS exam agents and others to pursue plan disqualification if a signed plan document cannot be produced by the taxpayer."

As this IRS memorandum emphasizes, plan sponsors should make sure that all plan amendments are properly and timely adopted. Sometimes plan sponsors might simply rely on board resolutions or committee resolutions as proof of adoption without a corresponding signed document. In light of the IRS emphasis on relying on *signed* documentation, plan sponsors should consider how best to document proper and timely adoption. For example, a contemporaneous signed certificate of the corporate secretary might corroborate the timing of unsigned board resolutions. It would also help plan sponsors to keep clear records (perhaps in a plan amendment tracking chart like this sample chart identifying plan amendments and when they were adopted.

The bottom line is that the IRS General Legal Advice Memorandum serves as a reminder that this is an issue the IRS will be looking for on examination and that plan qualification could hang in the balance.

Venue

District Court Enforces Forum Selection Clause in Employer's Benefits Plan

By: James Barnett

A federal district court in North Carolina enforced a forum selection clause in a short-term disability plan and on that basis transferred the case to Wisconsin federal court. In so ruling, the court explained that ERISA's venue provision is permissive, not mandatory, and thus rejected the plaintiff's argument that ERISA's venue provision guaranteed her a right to litigate in her choice of one of the three designated venues in ERISA § 502(e), *i.e.*, where the action "may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." The court also found it irrelevant whether the plaintiff was made aware of the forum selection clause when her claim for benefits was denied by the plan fiduciary. The case is *Manuel-Clark v. ManpowerGroup Short-Term Disability Plan*, No. 19-cv-147, 2019 WL 5558406 (E.D.N.C. Oct. 28, 2019).

Vested Health Care Benefits

Seventh Circuit: Agreement for Retiree Healthcare Benefits Survives Agreement's Termination

By: James Barnett

The Seventh Circuit held that retirees and their families were entitled to lifetime healthcare benefits because, although the healthcare agreement that had been negotiated by their union had expired, it provided that covered individuals "shall not have such coverage terminated or reduced . . . notwithstanding the expiration of this Agreement, except as the Company and the Union may agree otherwise." The Seventh Circuit applied ordinary contract law interpretation principles and concluded that the agreement "unambiguously" provided the retirees with vested healthcare benefits. And, even if the agreement was viewed to be ambiguous, the Court determined that the parties' behavior provided enough extrinsic evidence to support the conclusion that retiree benefits had vested. The case is *Stone v. Signode Indus. Grp. LLC*, No. 19-1601 (7th Cir. 2019).

Withdrawal Liability

Sun Capital Update: First Circuit Reverses District Court's "Partnership-in-Fact" Holding and Finds Private Equity Funds Not Part of Controlled Group and Not Liable for Portfolio Company's Pension Liabilities

By Ira Bogner, Ira Golub, Justin Alex, Adam Scoll and Jennifer Rigterink

Last Friday, the U.S. Court of Appeals for the First Circuit ruled that two co-investing Sun Capital private equity funds (the Sun Funds)[1] had not created an implied "partnership-in-fact" for purposes of determining whether the Sun Funds were under "common control" with their portfolio company, Scott Brass, Inc. (SBI) – resulting in a ruling that the Sun Funds were not under "common control" with SBI or a part of SBI's "controlled group" and, therefore, that the Sun Funds could not be held liable for SBI's multiemployer pension fund withdrawal liability. This ruling marks the end (for now) to the seven-year Sun Capital dispute (see our prior client alert here). Read below for a high-level summary of the First Circuit's ruling, as well as key takeaways for private investment funds and multiemployer pension funds. A forthcoming client alert will include more detailed analysis of the First Circuit's decision, the history of the *Sun Capital* saga, and the implications for private investment funds and multiemployer pension funds. Check back here for the link to the alert.

Factual and Procedural Background

As a refresher, in *Sun Capital*, the Sun Funds acquired 100% of SBI through SBI's ultimate parent, Sun Scott Brass, LLC (SSB). Sun Fund III owned 30% of SSB while Sun Fund IV owned 70% of SSB. SBI eventually filed for bankruptcy and withdrew from a multiemployer pension fund. As a result, the pension fund asserted withdrawal liability against the Sun Funds on the theory that the Sun Funds were both (i) under "common control" with SBI (which, in relevant part, generally requires an 80% or greater ownership interest), and (ii) engaged in a "trade or business" and, therefore, in SBI's "controlled group" (which, if true, meant the Sun Funds would be jointly and severally liable for SBI's withdrawal liability).

Following an initial round of rulings, in 2016, the U.S. District Court for the District of Massachusetts determined that the Sun Funds had formed a "partnership-in-fact" that was part of SBI's "controlled group" because the implied "partnership-in-fact" was deemed to own 100% of SSB (and, therefore, SBI) and was engaged in a "trade or business"; and, that the Sun Funds could therefore be held liable for SBI's withdrawal liability as partners in the implied "partnership-in-fact".

First Circuit Decision

On appeal of the District Court's decision, the First Circuit limited its analysis to a single issue: whether the record demonstrated that the Sun Funds had formed a "partnership-in-fact" under the U.S. Tax Court's eight-factor *Luna* test.

The First Circuit noted that several facts in the record supported finding a partnership-in-fact between the Sun Funds. For example, the Sun Funds, through their manager Sun Capital Advisors, Inc. (SCAI), developed restructuring and operating plans for target portfolio companies before actually acquiring them through limited liability companies; the two individuals in control of the general partners of the Sun Funds "essentially ran things" for the Sun Funds and SBI, including placing SCAI employees in two out of three director positions at SBI, allowing SCAI to "control" SBI; the Sun Funds had leveraged SCAI's resources and expertise to not only identify, acquire, and manage portfolio companies, and structure their acquisitions, but also to provide management consulting and employees to the portfolio companies; and the record did not show a single disagreement between the Sun Funds regarding the operation of SSB.

However, on balance, the First Circuit concluded that more factors weighed in favor of finding that a partnership-in-fact ***did not*** exist, pointing to the following facts: the Sun Funds did not intend to form a partnership beyond their coordination within SSB and expressly disclaimed any sort of partnership; most of the limited partners in Sun Fund IV were not limited partners in Sun Fund III; the Sun Funds filed separate tax returns, kept separate books and maintained separate bank accounts; the Sun Funds did not invest in parallel in the same companies at a fixed or even variable ratio – which the First Circuit observed showed "some independence in activity and structure"; and the creation of a limited liability company (i.e., SSB) by the Sun Funds showed an "intent" not to form a partnership, and prevented them from conducting their business in their joint names and limited the manner in which they could exercise mutual control over and assume mutual responsibilities for managing SBI.

Having determined that the record pointed away from concluding that the Sun Funds had created an implied "partnership-in-fact" in connection with their investment in SBI – meaning their ownership interests could not be aggregated for purposes of determining whether they were under "common control" with SBI – the First Circuit held that the Sun Funds could not be held liable for SBI's multiemployer pension fund withdrawal liability. The First Circuit expressly declined to reach the other legal issues in the case – including whether the Sun Funds were engaged in a "trade or business." The First Circuit remanded the case to the District Court for entry of summary judgment in favor of the Sun Funds.

Key Takeaways

In light of the First Circuit's decision, here are a few key points for private investment funds and multiemployer pension plans to consider:

- The First Circuit did not rule on the "trade or business" issue, so the existing *Sun Capital* "trade or business" analysis remains intact. Further, there is still the possibility of two or more co-investing private investment funds being deemed to be engaged in a "trade or business" and under "common control" with a portfolio company under a "partnership-in-fact" analysis. While the First Circuit found that such a "partnership-in-fact" did not exist here under the facts, different facts could lead to a different holding in the future.
- Accordingly, this ruling should not preclude, but it may hamper, the efforts of multiemployer pension plans and the PBGC to collect plan termination and withdrawal liability from private investment funds (and their other portfolio companies) based on a "partnership-in-fact" analysis.
- In any event, as we have previously noted, private equity fund sponsors should be aware that (i) acquiring an 80% (or more) interest in a portfolio company, whether within one private equity fund or pursuant to a "joint venture" between related (and maybe even unrelated) funds, may trigger joint and several liability for the portfolio company's underfunded pension or withdrawal liabilities, and (ii) even a smaller ownership interest percentage could possibly trigger the ERISA "controlled group" rules based on complicated "common control" determinations.

* * *

As noted above, a forthcoming client alert will include more detailed analysis of the First Circuit's decision and the implications for private investment funds and multiemployer pension funds. Check back here for the link to the alert.

[1] Although the First Circuit referred to "two" co-investing funds, there were actually three separate funds –Sun Capital III, LP, Sun Capital III QP, LP and Sun Capital IV, LP (Sun Fund IV). The First Circuit treated the two Sun Capital III funds (i.e., Sun Capital III, LP and Sun Capital III QP, LP) (Sun Fund III) as one fund because they are parallel funds run by the same general partner and generally make the same investments in the same proportions. Accordingly, the remainder of this blog generally follows the First Circuit's analysis as though there were only two funds, Sun Fund III and Sun Fund IV.

PBGC Adopts AAA's Amended Withdrawal Liability Arbitration Rules

By Anthony Cacace, Justin Alex and Benjamin Flaxenburg

Beginning January 1, 2020, the American Arbitration Association (AAA) will: (i) reduce filing fees charged to parties initiating arbitrations of withdrawal liability disputes; (ii) change how costs of arbitrations are allocated among the parties to the disputes; and (iii) amend the process for resolving arbitrator selection disputes.

The new filing fees are modest in comparison to the fee schedule proposed to the Pension Benefit Guaranty Corporation (PBGC) by the AAA in 2013—which imposed a flexible and final fee schedule that in some cases could result in filing fees that were higher by tens of thousands of dollars than the AAA's original 1986 filing fees.

Although the PBGC had not approved the AAA's 2013 request to increase fees, the AAA has been applying the 2013 fee schedule to this point. After the PBGC received commentary that was critical of the AAA's 2013 fee schedule, the AAA submitted a *revised* proposal containing a filing fee schedule (removing the flexible and final fees contained in the AAA 2013 fee schedule). On December 10, 2019, the PBGC adopted the revised proposal (the "2019 Rules").

2019 Rules: New Filing Fee Schedule:

Disputes below $1 million.....$2,500 filing fee
Disputes equal to $1 million but less than $5 million.....$3,750 filing fee
Disputes equal to $5 million or more.....$5,000 filing fee

In addition to AAA's initial filing fee, parties that proceed to arbitration will still have to pay other costs associated with the arbitration, such as the arbitrator's fees. While an employer that initiates arbitration will be required to cover the upfront filing fee, the 2019 Rules provide, subject to the arbitrator's discretion, that arbitration costs will be borne equally between the parties.

The 2019 Rules will also allow the parties to seek appointment of an arbitrator by a federal district court in the event they are unable to agree on an arbitrator through the AAA mutual selection process. Under the old rules, the AAA resolved such disputes by appointing an arbitrator if one was not mutually selected.

Also, after the parties receive post-appointment disclosures from an arbitrator who they have mutually selected, either party has 10 days to seek automatic removal of the appointed arbitrator. In the event of an automatic removal, the AAA will select a new arbitrator using the initial AAA mutual selection process.

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