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A Brief History of Pensions

The past 40 years saw private-sector defined benefit (DB) pension plans gradually replaced by 401(k) and other defined contribution (DC) plans. Yet, most folks would be better off with a lifetime pension and—benefit dollar for benefit dollar—a DB plan is the more cost-effective of the two. A brief history of the DB-to-DC transition may be helpful for politicians, academics, and humans considering the much-needed overhaul of the current mess of the U.S. retirement and savings system.

In the 1980s, most companies offered a DB plan and the big issue was *overfunding*. High-interest rates (which minimize benefit liabilities), a strong stock market, and steady contributions combined to create surplus DB assets. Before the '80s, companies used their relatively modest pension surpluses to take funding "holidays"—saving cash and improving profits while expecting the excess to gradually wear away.

Instead, pension funding continued to improve with favorable financial markets and, by 1980, DB overfunding grew sufficiently large to begin burning a hole in corporate pockets. The first big company to act was the A&P supermarket chain (once the largest retailer in the world). In 1981, A&P terminated its DB plan and captured $200 million in surplus, using the proceeds to finance a companywide restructuring. (It eventually failed, and A&P is no more.)

With the pension gates opened, two questions arose: who owns the excess, and what should be done with it? Employee and retiree advocates argued that the surplus belonged to participants and should be used to protect benefits in the lean years or to increase benefits, say through a cost-of-living adjustment. Businesses argued that since they were on the hook for any DB underfunding, they were also entitled to any surplus.

After several years of ERISA litigation, it became settled law that participants had no rights to the overfunding if their DB document said that employers owned the "actuarial surplus" on plan termination. DB plan termination is a relatively straightforward, if somewhat lengthy, process: all employees become 100-percent vested, and the plan buys an insurance company annuity covering each participant's benefit. Sometimes participants are offered the option of a cash payment in lieu of an annuity.

Typically, after a termination, the DB plan was replaced by a DC plan, usually a new-fangled 401(k). However, some employers wanted to capture the DB funding surplus *and* continue providing employees the security of a pension. What to do? Creative advisors came up with the "spin-off termination," splitting the plan into two plans: the first for current employees with enough money to cover all benefits and

the second for retirees and former employees and all of the remaining assets (including the surplus). The second plan was terminated and the excess assets were paid to the employer. Spin-off terminations were controversial until the Internal Revenue Service ruled that these transactions, with proper safeguards, didn't run afoul of the Tax Code. Given that the excess belonged to the employers, spin-off terminations were a win–win, allowing employees to keep their pensions and employers getting the surplus.

Even companies that wanted to leave their overfunded DB plans untouched became nervous that a corporate raider might use the surplus as "free money" to fund a takeover—hence, the popularity of "pension parachutes" that automatically triggered benefit increases to soak up any DB plan surplus upon a hostile takeover.

An unsavory element of the excess asset recapture emerged when a few companies selected the cheapest annuity they could find to satisfy the plan's benefit obligations, even if the insurance company selling the annuity was financially weak or downright sketchy. Some of these insurers did indeed go broke. Fortunately, litigation, state insurance guaranty funds, and Department of Labor (DOL) rulings combined to protect participants and punish abusers.

Ironically, while companies were capturing pension surpluses, the 1980s also saw employees advocating for DC plans over DBs. Huh? At the time, this seemed logical. Inflation was high, quickly eroding the value of a fixed lifetime pension, and large numbers of employees began job-hopping. A DB plan works best when someone spends his or her entire career at the same company, while DCs are portable. Perhaps the biggest enticement of DCs was a booming stock market; employees wanted a piece of the action. A DC plan where each employee had his or her own account and could benefit from high investment returns seemed the perfect ticket to wealth and security.

Once most employers that wanted to had captured their DB overfunding, Congress—Democrats and Republicans alike—jumped in to "help." Starting in 1986, a series of "reforms" imposed draconian tax penalties on recaptured pension surpluses, punished employers with underfunded plans, and increased Pension Benefit Guaranty Corporation insurance premiums. Several times, Congress also curtailed the amount of benefits that high-paid executives could earn through various limits on benefits and pensionable compensation. The message to employers was clear: you'll be punished for DB plan underfunding but won't be able to capture any overfunding and must limit the pensions of senior executives—the very folks deciding the fate of the DB plan. At the same time, interest rates began declining, making DB plans more expensive and overfunding a relic. DB plans became a lose–lose proposition for management. Companies responded by, first, closing their DB plans to new employees (soft

freeze) and then eliminating all future benefits of grandfathered employees (hard freeze). More recently, companies are "de-risking" by buying annuities to assume some of their pension obligations, thereby transferring responsibility to insurance companies (that, after all, are in the business of paying lifetime benefits). All told, few companies are continuing their DB plans, and no sizable employer has started a new DB plan in decades.

And workers? Today, inflation is quiescent; stock markets are volatile; and most folks have realized that savings, investing, and retirement planning are complicated and time-consuming. It turns out that DB plans can be an efficient and effective way to provide retirement income. Alas, the regulatory and economic winds are blowing in the opposite direction, making private-sector DB plans too dangerous for most employers.

Pension history teaches that a sound retirement system requires long-term thinking and cautions Washington about imposing well-intentioned but ineffective new restrictions. The pension of yesteryear will not return, but we can and should pluck what worked from DB plans and use it to develop a solid system that provides lifetime income for a reasonable cost.

The views set forth herein are the personal views of the author and do not necessarily reflect those of the law firm with which he is associated.

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Benefits Issues Return to U.S. Supreme Court in October 2020 Term

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In October 2020, the U.S. Supreme Court embarked on a term unlike any other. The passing of the 27-year iconic veteran Justice Ruth Bader Ginsburg just before the start of the term instantly left an undeniable mark on the Court. Add to that, the Justices are hearing arguments by phone with a regimented question and answer period—a far cry from the vivacious debate at in-person oral arguments.

One thing remains constant: the Court will consider a number of cases with potentially dramatic impact on employee benefits. The range of issues is diverse, with two "favorite" issues—preemption and the viability of the Affordable Care Act (ACA)—making a reappearance this term. A third is on the procedural issues in the statutory scheme providing benefits for railroad workers. While narrow, the decision in the case could broadly affect a number of beneficiaries.

SCOPE OF ERISA PREEMPTION AND STATE REGULATION OF PHARMACY BENEFIT MANAGERS

In *Rutledge v. Pharmaceutical Care Management Association*,[1] the Court heard argument concerning ERISA's preemptive effect on a state law regulating pharmacy benefit managers' (PBMs) generic drug reimbursement rates. The case considers regulation of PBMs under Arkansas law, but because a majority of states have enacted similar laws, the decision will likely extend beyond Arkansas.[2]

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PBMs, Pharmacies, MAC Lists, and the Laws Regulating Them

PBMs are third party administrators that act as intermediaries between employers that sponsor prescription drug benefit plans and insurers, pharmacies, and other health care providers.[3] PBMs have a number of roles, including creating networks of pharmacies, to negotiate drug reimbursement rates for pharmacies within those networks, and to contract with benefit plans to provide plan beneficiaries with access to those networks.[4] The vast majority of employers that sponsor prescription benefit plans engage a PBM, and the vast majority of pharmacies participate in PBM-created networks.[5]

Pharmacies acquire the drugs that they stock from wholesalers at a cost that is not typically disclosed.[6] When an individual with prescription drug insurance presents a prescription at a pharmacy, the pharmacy verifies coverage with the PBM and charges the individual their share of the cost, which is either a copay or co-insurance fee set by the benefit plan.[7] PBMs reimburse pharmacies for the pharmacies' costs to acquire the drugs it sells to prescription drug plan participants at a contractually set rate.[8] Frequently, reimbursement for generic drugs is controlled by a PBM-created schedule of covered drugs and the maximum rate at which the plan will reimburse the pharmacy for each.[9] Those schedules are known as Maximum Allowable Cost (MAC) lists. PBMs then bill the benefit plan for their services. There are two types of billing methods: one that charges a fixed rate that is higher than the MAC list price, with the PBM retaining the "spread" between the MAC list price and the plan's cost; or one where PBMs simply pass through their actual reimbursement costs and profit through administrative fees.[10]

In an effort to regulate MAC lists,[11] Arkansas passed Act 900 to require MAC lists to (1) allow reimbursements to pharmacies at a rate at least equal to the pharmacy's acquisition cost[12]; (2) be updated within seven days of a 10-percent increase in a pharmacy's acquisition cost from 60 percent of wholesalers[13]; and (3) be disclosed to pharmacies.[14] Act 900 also requires that an appeal procedure be provided for claims by pharmacies challenging MAC-based reimbursements; if the appeal reveals the pharmacy's acquisition cost is higher than its reimbursement under the MAC list, the PBM must adjust the MAC list cost to equal the acquisition cost, unless the PBM can identify a wholesaler that will supply the drug to the pharmacy at the MAC list price.[15] If a pharmacy foregoes an appeal, it can decline to provide the prescribed drug or charge the patient the usual and customary price it would charge out-of-network customers (*i.e.*, cash pay customers).[16]

While *Rutledge* focuses on Act 900, dozens of other states have enacted legislation regulating PBMs[17] that have had mixed success in

the courts.[18] These laws come in different forms with some, like Act 900, protecting pharmacies from excessively low reimbursement rates, and some that focus on protecting consumers from high PBM spread between the acquisition price and retail price.[19]

Does ERISA Preempt Act 900?

A trade association of several PBMs, Pharmaceutical Care Management Association, filed suit against the state of Arkansas claiming Act 900 is preempted by the Employee Retirement Income Security Act (ERISA) and therefore is invalid. The Association prevailed in the district court and in the U.S. Court of Appeals for the Eighth Circuit, and Arkansas sought and obtained Supreme Court review.

According to the parties' briefing, the resolution of this issue turns on whether Act 900 imposes an administrative scheme on ERISA benefit plans, and is thus preempted by ERISA, or whether it is simply rate regulation, which historically has been protected from ERISA preemption.[20]

The Association argues that Act 900 is preempted by ERISA because Act 900 controls administration of prescription drug benefit plans by imposing substantive and procedural rules that must be filed when using a MAC list reimbursement model.[21] This is problematic, according to the Association, because it mandates how ERISA plans are designed and pay benefits, and imposes administrative burdens on PBMs that will be inconsistent across states and that are extraordinarily burdensome (*i.e.*, frequent appeals, reversals, and rebilling, and constant updating of MAC lists when PBMs learn wholesalers' acquisition costs have changed).[22] The Association also argues that ERISA preempts Act 900 because it "refers to" ERISA plans by directly applying to any "plan or program that … provides for pharmacist services to individuals."[23]

Arkansas argues that Act 900 does not regulate plan administration[24]; rather, Act 900 permissibly regulates reimbursement rates and the remaining provisions, such as the appeal provisions, are simply incidental to that primary purpose and not grounds for preemption.[25] The Association calls the "incidental effects" argument novel and entirely unsupported by law.[26]

The U.S. Solicitor General filed a brief supporting Arkansas, arguing against ERISA preemption because Act 900 affects more than just ERISA plans.[27] The Solicitor General alternatively argues that Act 900 has only an incidental economic effect on ERISA plans, which is permissible.[28]

Why Rutledge *Matters?*

Rutledge presents an important substantive issue and also gives the Court opportunity to clarify or further muddle ERISA preemption standards, which have been notoriously difficult to decipher.[29] On the substance of the issues, if the Supreme Court strikes down the Arkansas law, a domino effect of invalidating other state laws could ensue, leaving PBMs unregulated, absent federal legislation. However, state laws that regulate PBMs without placing affirmative burdens on plan administration may escape preemption,[30] making it premature to declare that all state PBM legislation would fall if Act 900 is held to be preempted.

If the Supreme Court upholds the Arkansas law, more state-level regulation of PBMs may result. This could affect generic drug pricing and prescription benefit plans. According to the Association, over-regulation of MAC list pricing by states can cause drug prices to go up or lead to drug shortages and increase benefit administration costs.[31] Additionally, "decline to dispense" provisions like that in Act 900 can cause patients to bear the burden of finding the drug elsewhere or paying the cost out of pocket.[32] Arkansas counters that laws like Act 900 support independent and rural pharmacies, providing access to generic drugs in areas that are typically underserved.[33]

There are also potential effects that would reach past drug benefits to ERISA preemption more generally as the Court has the opportunity to recontour ERISA preemption standards if it is so inclined. For example, respondents point out the Court's perceived frustration with their preemption precedent that requires a state law to have an "impermissible connection with" an ERISA plan to be preempted.[34] Thus, it is possible that the Court could more broadly address its preemption standards rather than simply deciding if the facts in this case meet the standard.

THE ACA'S INDIVIDUAL MANDATE AND MINIMUM-COVERAGE PROVISIONS

This term, the Court returns to a politically charged challenge to the Affordable Care Act (ACA). In the consolidated cases *California v. Texas* and *Texas v. California*, the Court must decide whether a group of states and private individuals have standing to challenge the Act at all. If that procedural hurdle is cleared, the Court then must decide whether the ACA's individual mandate is constitutional and, if it is not, whether that requirement can be severed from the Act or whether the entire ACA must fall.

Background on the Individual Mandate's Challenges

In 2012, the Court held that the ACA's individual mandate was unconstitutional under the Commerce Clause; but because failure to comply with the individual mandate triggered a penalty tax, it could fairly be read as exercising Congress's power to tax.[35] Congress then passed the Tax Cuts and Jobs Act of 2017 (TCJA), which reduced that penalty to zero.[36]

After the passage of the TCJA, two individuals and a block of states (referred to as the "State Respondents")[37] filed suit against the federal government (also respondents) challenging the constitutionality of the individual mandate in light of the TCJA's elimination of the individual shared responsibility tax.[38] In response, the federal government agreed that the individual mandate was unconstitutional and advocated for an order severing the individual mandate and the ACA's preexisting condition provisions.[39] Later, on appeal, the federal government argued that none of the ACA's provisions were severable and therefore supported invalidating the ACA in its entirety.[40] Thus, additional states (referred to as the "petitioner states")[41] intervened at various points in the litigation in the lower courts to defend the ACA.

The district court determined that Congress nullified its revenue-raising potential by reducing the individual shared responsibility penalty amount to zero.[42] Thus, the passage of the TCJA eliminated the only basis on which the Supreme Court upheld the individual mandate's constitutionality in 2012.[43] The district court then determined that the individual mandate is "essential to and inseverable from the remainder of the ACA," thus the entire ACA must be invalidated.[44] The court also rejected the argument that the individuals challenging the ACA lacked standing, finding that the individuals suffered an injury in that they only bought insurance because they felt compelled to under the ACA to do so.[45]

Petitioners and the federal government appealed to the U.S. Court of Appeals for the Fifth Circuit, which affirmed in part the district court's ruling. The majority agreed that the respondents have standing[46] and that the TCJA rendered the individual mandate unconstitutional; however, it found the district court's severability analysis lacking and remanded the case.[47] The dissenting judge disagreed on standing because the TCJA removed all enforcement provisions of the individual mandate and eliminated any possible injury.[48] The dissent also disagreed on the merits, finding that the individual mandate is constitutional and, even if not, it is severable from the remainder of the ACA because had Congress intended to repeal the entire ACA, it would have done so rather than just "declawing" the individual mandate through the TCJA.[49] The Supreme Court accepted both blocks of

states' and the federal governments' petitions for certiorari to review these issues.

Potential Outcomes and Effects

It has been a long road to reach this point, and it may not be over yet. The standing issues presented in this case could give the Justices a way out of the case without rendering a decision on the merits. Assuming the Court reaches the merits, however, the petitioner states' must convince the Court that the lower courts got it wrong: setting the penalty tax at zero and erasing its revenue-raising potential does not make the individual mandate an unconstitutional "command to purchase insurance."[50] Instead, with the tax currently set at zero, Americans can choose whether to purchase insurance or not, with no penalty for the latter.[51] If the Court agrees with the petitioner states, the ACA will stand as is.

If the Court agrees with the lower courts that the individual mandate is now unconstitutional, their decision on severability from the rest of the ACA will have a substantial impact on the future of health care. If the Court severs the individual mandate only, not much will change. As it currently stands, there is no penalty for failing to purchase insurance, so invalidating the toothless individual mandate has little effect, and other key protections in the ACA, such as its guaranteed issue provisions[52] and the community-rating requirements[53] would remain. Affirmation of the district court's finding that the entire ACA must be thrown out with the individual mandate, however, will eliminate the ACA and all of its protections in total.

It is never easy to guess where the Court will land on an issue, especially one as charged as the validity of the ACA. The Supreme Court's past severability decisions indicate that where the statute does not expressly provide direction on severability, as is the case with the ACA, there is a strong presumption that Congress would want the law saved to the extent possible. As Chief Justice John Roberts explained, it is preferable "to use a scalpel rather than a bulldozer" when considering severability of unconstitutional portions of a law.[54] Justice Kavanaugh, too, has stated a strong preference for precision in severing invalid portions of a law.[55] Even Justices Thomas and Gorsuch, who have expressed an increasing discomfort with "rewriting" statutes through the surgical severance principles, would not necessarily toss the entire law but rather would just bar enforcement of the unconstitutional clauses.[56]

Nonetheless, the presumption against severability is not enough to save the ACA if the individual mandate is so intertwined that it cannot be extracted on its own. As the district court recognized,

many, including Congress, have recognized that "the Individual Mandate is essential to the ACA" and its absence from the Act would "undercut [federal] regulation of the health insurance market."[57] Indeed, Justices Sotomayor, Breyer, and Kagan recognized in *NFIB* that "the minimum coverage provision as a key component of the ACA to address an economic and social problem that has plagued the Nation for decades."[58] And Justices Thomas and Alito, who would have held in *NFIB* that the individual mandate was unconstitutional, stated in 2012 that the individual mandate is not severable.[59]

Thus, it remains to be seen if and how the current Court will slice up the ACA.

Judicial Review of Railroad Retirement Board Decisions

Finally, the Court is considering separation of powers and statutory interpretation issues when it decides whether the Railroad Retirement Board's denial of a claimant's request to open a prior benefits decision is reviewable by the courts.

Congress, through the Railroad Retirement Act (RRA) and Railroad Unemployment Insurance Act (RUIA), created a program to provide retirement, disability, sickness, and unemployment benefits to covered railroad workers.[60] The Railroad Retirement Board, an agency of the executive branch, administers the benefits program.[61] As a check on the Board's powers, "any final decision" of the Board is reviewable by a direct appeal in the United States Courts of Appeals.[62]

In *Salinas v. U.S. Railroad Retirement Board*, petitioner requested that the Board reopen his previously denied benefit claims in light of new evidence.[63] That request was denied, and petitioner appealed the denial to the Fifth Circuit.[64] The Fifth Circuit denied the appeal, citing binding precedent that the Board's denial of a request to reopen claims is not reviewable on appeal.[65]

The issue before the Court is a straightforward question of statutory interpretation. Section 355(f) of the RUIA provides that any claimant, certain railway labor organizations, certain of the claimant's employers, "or any other party aggrieved by a final decision under [Section 355(c)]" may obtain a court review of "any final decision of the Board" if they follow the proscribed claims procedures.[66] The Board construes this provision as limiting court review to the types of final decisions listed in Section 355(c) of the RUIA. It argues that the term "other" in the phrase "any other party aggrieved by a final decision under [Section 355(c)]" indicates that the other categories in the list of individuals or entities that can seek review must have also been "aggrieved by a final decision under [Section 355(c)]."[67] Since Section 355(c) does

not encompass decisions regarding reopening claims, there is no right to appeal such a decision.[68] This construction is appropriate, per the Board, because reopening of claims is a matter of "agency grace" not a statutory requirement.[69]

Petitioners disagree, contending that the phrase "any final decision" in Section 355(f) means just that—every decision that is a claimant's "last stop" at the administrative level, including a denial of a request to reopen a claim.[70] Petitioners argue that the government's limited reading of the statute cuts off a claimants' recourse in the courts prematurely, potentially depriving claimants of benefits owed to them but mistakenly denied and violating "bedrock principles of agency accountability."[71]

The issue before the Court is narrow but that should not be mistaken for insignificance. The Board administers billions of dollars of benefits each year for hundreds of thousands of claimants,[72] thus a Supreme Court order limiting the availability of judicial review to a discrete list of decisions, as the Board argues is appropriate, would have a profound impact on RUIA benefit claimants.[73]

NOTES

1. No. 18-540 (U.S. 2020).

2. *See* Brief for Respondent Pharmaceutical Care Management Association (Assoc. Br.) at 27–32, *Rutledge*, No. 18-540 (Mar. 25, 2020) (discussing various state laws regulating PBMs.); Brief for Petitioner (Rutledge Br.) at 9, *Rutledge*, No. 18-540 (Feb. 24, 2020) (over 40 states have passed laws regulating PBMs).

3. Assoc. Br., *supra* n.2, at 6–7; Rutledge Br., *supra* note 2, at 2–3; Amicus Curae Brief by the United States (U.S. Br.) at 3, *Rutledge*, No. 18-540 (Mar. 2, 2020).

4. *Pharm. Care Mgmt. Ass'n v. Rutledge*, 891 F.3d 1109, 1111 (8th Cir. 2018); Assoc. Br., *supra* n.2, at 6–7.

5. Assoc. Br., *supra* n.2, at 6–14 (Mar. 25, 2020); Rutledge Br., *supra* n.2, at 7.

6. Assoc. Br., *supra* n.2, at 5–6, 10–11 (explaining that invoice costs do not reflect negotiated discounts).

7. Rutledge Br., *supra* n.2, at 3–4; Assoc. Br., *supra* n.2, at 8.

8. Assoc. Br., *supra* n.2, at 8; Rutledge Br., *supra* n.2, at 5.

9. Assoc. Br., *supra* n.2, at 11; Rutledge Br., *supra* n.2, at 5.

10. *Id.*

11. S.B. 688, 90th Gen. Assemb., Reg. Sess. (Ark. 2015).

12. Ark. Code Ann. § 17-92-507(a)(6).

13. Ark. Code Ann. § 17-92-507(c)(2).

14. Ark. Code Ann. § 17-92-507(c)(1).

15. Ark. Code Ann. § 17-92-507(c)(4).

16. Ark. Code Ann. § 17-92-507(e); Assoc. Br., *supra* n.2, at 16.

17. *See supra* n.2.

18. *See, e.g.*, *Pharm. Care Mgmt. Ass'n v. Tufte*, 968 F.3d 901 (8th Cir. 2020) (finding similar North Dakota legislation—N.D. Century Code §§ 19-02.1-16.1 and 16.2–preempted); *Pharm. Care Mgmt. Ass'n v. Gerhart,* 852 F.3d 722, 730 (8th Cir. 2017) (same for Iowa legislation); *Pharm. Care Mgmt. Ass'n v. District of Columbia*, 613 F.3d 179, 190 (D.C. Cir. 2010) (finding compulsory provisions of a D.C. law regulating PBMs to be preempted by ERISA);*but see Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1stCir. 2005) (upholding Maine law regulating PBMs); *Pharm. Care Mgmt. Ass'n v. Mulready*, No. 19-cv-977, slip op. at 7–9, ECF No. 48 (W.D. Okla. July 9, 2020) (refusing to enjoin enforcement of Oklahoma legislation regulating PBMs and finding the plaintiffs unlikely to prevail on their argument that ERISA preempted the state law) *appeal voluntarily dismissed*, No. 20-6107 (10th Cir. Aug. 28, 2020).

19. *See* Petition for Writ of Certiorari at 9 & n.4, *Rutledge*, No. 18-540 (Oct. 22, 2018).

20. The parties' briefing focuses on this dichotomy, but the Court may focus on different issues. *See infra*.

21. Assoc. Br., *supra* n.2, at 22–35.

22. *Id.*

23. Assoc. Br., *supra* n.2, at 48 *citing* Ark. Code. Ann. § 17-92-507(a)(9) (alterations in original).

24. Rutledge Br., *supra* n.2, at 30–51.

25. *Id.* at 19–24.

26. Assoc. Br., *supra* n.2, at 40–41.

27. U.S. Br., *supra* n.3, at 12–25.

28. *Id.*

29. The Court has ruled on an ERISA preemption issue at least a dozen times since ERISA was enacted in 1979.

30. *See, e.g.*, *Rowe*, 429 F.3d at 303; *Mulready*, slip op. at 5.

31. *See, e.g.*, Assoc. Br., *supra* n.2, at 11–12; *see also* Transcript of Oral Argument at 15:22–17:1, *Rutledge*, No. 18-540 (Oct. 6, 2020).

32. *See, e.g.*, Assoc. Br., *supra* n.2, at 24.

33. *See, e.g.*, Rutledge Br., *supra* n.2, at 9.

34. *See* Rutledge Br., *supra* n.2, at 18; *see also* Transcript of Oral Argument at 35:6–19, *Rutledge*, No. 18-540 (Oct. 6, 2020) (Justice Kavanaugh noting that "something's gone awry in the jurisprudence" if drug costs are not considered "a central matter of plan administration" because those "costs will directly affect the benefits paid to beneficiaries").

35. *National Federation of Independent Businesses v. Sebelius* (*NFIB*), 567 U.S. 519, 552, 574 (2012).

36. *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092; *see also Texas v. United States* (*Texas I*), 340 F. Supp. 3d 579, 585 (N.D. Tex. 2018).

37. This includes the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi North Dakota, South Dakota, South Carolina, Tennessee, Utah, and West Virginia. *See* Brief for Petitioner States (Petitioner States' Br.) at ii, *California v. Texas*, No. 19-849 (May 6, 2020).

38. *See Texas I*, *supra* n.36.

39. *Texas v. United States* (*Texas II*), Civil Action No. 4:18-cv-00167-O, 2018 U.S. Dist. LEXIS 222345, at *11 (N.D. Tex. Dec. 30, 2018).

40. *Texas v. United States* (*Texas III*), 945 F.3d 355, 374 (5th Cir. 2019).

41. This group includes the States of California, Connecticut, Delaware, Hawaii, Illinois, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, Washington, Kentucky, and the District of Columbia. *See* Petitioner States' Br., *supra* n.37, at ii.

42. *Texas II*, *supra* n.39, at *30–36; *see also Texas I*, *supra* n.36, at 595–605.

43. *Texas II*, *supra* n.39, at 34.

44. *Id*. at 36–39; *see also TexasI*, *supra* n.36, at 605–19.

45. *Texas II*, *supra* n.39, at 19–28.

46. In addition to affirming the district court's determination that the individual plaintiffs had Article III standing, the Fifth Circuit determined that the respondent states also have standing because the individual mandate causes more individuals to buy insurance and thus increases the states, as employers of these individuals, have increased administrative costs associated with tracking and reporting on ACA compliance. *See Texas III*, *supra* n.40, at 384–87.

47. *See Texas III*, *supra* n.40.

48. *Id*. at 405–12.

49. *Id*. at 413–24.

50. Petitioner States' Br., *supra* n.37, at 26–35; *see also Texas II, supra* n.39, at *28 ("the production of revenue at all times is [not] the *sine qua non* of a tax.").

51. Petitioner States' Br., *supra* n.37, at 26–35.

52. These are "requirement[s] that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services." *Glossary*, Healthcare.gov, *https://www.healthcare.gov/glossary/guaranteed-issue/*.

53. Community rating requirements "prevent[] health insurers from varying premiums within a geographic area based on age, gender, health status or other factors."*Glossary*, Healthcare.gov, *https://www.healthcare.gov/glossary/community-rating/*.

54. *Seila Law LLC v. Consumer Fin. Prot. Bureau*, 140 S. Ct. 2183, 2210–11 (2020).

55. *Barr v. Am. Ass'n of Political Consultants*, 140 S. Ct. 2335, 2350 (2020) ("The Court's precedents reflect a decisive preference for surgical severance rather than wholesale destruction, even in the absence of a severability clause.").

56. *See Seila Law*, *supra* n.22, at 2219–20 (Thomas, J. concurring in part, dissenting in part); *Barr, supra* n.23, at 2365–67 (Justices Gorsuch and Thomas concurring in the judgment and dissenting in part).

57. *Texas II*, *supra* n.39, at *36 n.67.

58. *NFIB*, 567 U.S. at 591–603 (joint dissent).

59. *Id.* at 691–707 (joint dissent).

60. Brief for Petitioner (Salinas Br.) at 5–6, *Salinas v. U.S. R.R. Ret. Bd.*, No. 19-999 (Mar. 31, 2020).

61. *Id.* at 6; Brief for Respondent (RRB Br.) at 2–3, *Salinas*, No. 19-999 (June 8, 2020).

62. 45 U.S.C. § 355(f); 45 U.S.C § 231(g); *see also* Salinas Br., *supra* n.58, 8, and 16.

63. Salinas Br., *supra* n.58, at 13.

64. *Id.* at 14.

65. *Id.*

66. 45 U.S.C. § 355(f).

67. RRB Br., *supra* n.59, at 17–20.

68. *Id.*

69. *Id.* at 34–39.

70. Salinas Br., *supra* n.58, at 15.

71. *Id.* at 17.

72. *Id.* at 6 ("In 2017, the Board administered nearly $12.7 billion in retirement, survivor, and disability benefits to some 634,000 beneficiaries, and paid another $93 million in unemployment and sickness benefits to some 25,000 claimants.").

73. *Id.* at 28–29.

Employee Health and Welfare Benefit and Employment Considerations in the Time of COVID-19

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This article sets forth health and welfare and employment pandemic-related guidance, providing a general framework for operating as a compliant employer in these challenging times. We begin by defining the terms furlough and layoff. We then address ACA, COBRA, HIPAA special enrollment, claim procedures, cafeteria plan, and HDHP/HSA compliance in responding to employee benefit issues related to the pandemic. We continue by discussing mandatory coverage of COVID-19 testing, vaccine and preventive care coverage, and special leaves under the FFCRA and the CARES Act, including guidance resulting from the recent U.S. District Court case. We conclude with the pandemic effects on employment practices, including developing a pandemic response plan, providing guidance on disability-related inquires and medical

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exams, the confidentiality of medical information, hiring and onboarding, employee relations, and returning to work.

The rapid spread of COVID-19 has resulted in a stark new world for employers as they make the difficult decision to furlough or terminate employees. The decision is not an easy one and it is further complicated by federal, state, and local laws that present challenging hurdles. Given that employers must review the eligibility and rehire provisions of every employee health and welfare benefit plan and, if applicable, layoff or severance policies, the guidance of internal legal counsel will be of paramount importance. This article is meant to provide a general overview and framework for employers and is not intended to supplant the guidance of legal counsel.

We first consider whether an employer is furloughing or laying off employees, and then look at application of federal law and plan design to benefits during that period. Employers will need to engage legal counsel to determine the effect of applicable laws and, in particular, state and local laws that are not discussed herein.

TEMPORARY CHANGE IN EMPLOYMENT STATUS

In using terms like "furlough," "layoff" or similar language to describe what an employer intends to be a temporary change in an employee's employment status, the employer must determine what that term means with regard to employment status. Is the employee continuing in employment or is employment being terminated? Whether an employee's status is employed or terminated requires a separate analysis as it pertains to federal law. The terms "furlough" and "layoff" are sometimes used interchangeably. This can cause confusion.

Furlough

For purposes of this article, the term "furlough" refers to a change in an employee's employment status, in which the employee remains employed but may be working limited hours or no hours at all. Employees may or may not use accrued paid time off during a furlough. Employers can require employees to use paid time off during this time (absent a collective bargaining or other policy or agreement specifying how paid time off may be used). Employees may also be eligible for unemployment benefits under state law.

To determine whether furloughed employees are eligible for benefits, employers will need to review their Employee Retirement Income Security

Act (ERISA) plan document(s), cafeteria plan document(s), and other benefit plan-related documents that govern the terms and conditions of their employee benefit plans (collectively referred to as "plan documents"). An employer's plan documents should address how furloughed employees are treated with respect to eligibility for benefits during the furlough. In general, furloughed employees will either retain or lose their benefit eligibility in accordance with existing plan terms. The loss of eligibility in this context may not align with the intent of the employer given the impact of COVID-19. To the extent an employer intends to make a special exception for furloughed employees in connection with COVID-19, the employer can amend the employer's plan documents and distribute a summary of material modifications (SMM) informing employees of the change.

An employer seeking to amend their plan rules to allow for continued eligibility during furlough, may also require approval from an insurance carrier if the plan is fully insured or if there is a stop-loss insurance policy in place for a self-insured plan.

Layoff

The term "layoff" is used in this article to refer to an employee whose employment has been terminated. That termination may be temporary or permanent. More often, a layoff is accompanied with the expectation that the employee will be reemployed in the near future. A layoff is generally distinguished from a reduction in force, when employment positions are eliminated without an intention to replace them. A reduction in force can occur by involuntarily terminating employees or through attrition.

Layoff will trigger a Consolidated Omnibus Budget Reconciliation Act (COBRA) qualifying event with regard to employer health benefits (medical, dental, vision, health flexible spending account (FSA), etc.). It is at the employer's discretion whether the employer chooses to subsidize premiums for those who elect to continue their benefits under COBRA. In doing so, employers must ensure they are treating all similarly situated employees in the same manner. If the employer intends to provide for any special treatment beyond that normally provided to terminated employees, the employer's plan documents should address any differences in how laid-off employees are treated.

CONSIDERATIONS RELATED TO GHP PREMIUM PAYMENTS

The commencement of an employee furlough, layoff, or other temporary employment status change does not necessarily mean that

coverage under an employer's group health plan (GHP) will terminate. The terms of the employer's plan documents will govern the extent to which GHP coverage continues. Employers with fully insured plans will also need to consider the terms of their insurance carrier contracts. To the extent that an employer is changing the terms of the employer's GHP to accommodate this national emergency, such changes need to be reflected in an amendment to the plan documents and fully and effectively communicated to employees through distribution of an updated summary plan description (or through an SMM).

If an employee is not paid during a furlough, an employer will need to decide how to handle the employee portion of the GHP insurance premium or cost of self-insured coverage for the duration of the temporary employment status change—unless the employer decides to pay for the entire insurance premium or cost of self-insured coverage. Employers could elect to:

- Reduce or waive the employee portion altogether, thereby offering employees a full or partial employee contribution holiday;

- Arrange to have employees pay the employee portion by personal check on an after-tax basis or other means outside of the payroll process while out on furlough; or

- Allow employees to "make up" the employee portion that accrues during the furlough out of the employee's future paychecks after the furlough has concluded and the employee returns to work.

To the extent an employee is required to continue making GHP coverage contributions while on a temporary employment status change, the employee's coverage is contingent on the employee continuing to make those contributions in a timely manner and an employer may terminate the employee's coverage for failure to make such contributions.

ACA Compliance

Pursuant to the Patient Protection and Affordable Care Act (ACA),[1] an applicable large employer (ALE)[2] is required to offer GHP coverage that meets ACA requirements to full-time employees to avoid employer shared responsibility penalties, sometimes referred to as the "pay or play" decision. Full-time employee status for this purpose is subject to the ACA's definition, which generally means working 30 hours or

more per week. Full-time employee status is determined based on the employer's reasonable expectation that the employee will work at least 30 hours per week, or if hours will vary, based on the number of hours worked in a look-back or initial measurement period of up to 12 months (*i.e.*, averaging at least 30 hours per week or 130 hours per month). ACA regulations also permit an employer to use a current month-by-month determination process as well. If an ALE must offer the employee ACA-qualified GHP coverage, that coverage must be affordable,[3] meet minimum value requirements,[4] and offer coverage to the employee's birth and adopted children up to age 26. The GHP coverage must be offered for the duration of the subsequent stability period, which should equal the length of the look-back measurement period.

Employers who are using the look-back measurement method to determine full-time employee status should be aware that to the extent they have furloughed full-time employees, those employees will generally be in a stability period of up to 12 months at the time they are furloughed. As a result, in general, ACA law directs that those employees continue to be offered ACA-qualified GHP coverage at least until the end of their current stability period in order to avoid the employer shared responsibility penalty. This requirement applies regardless of whether the furloughed employee was designated by the employer to be full-time, or the employee was a part-time, variable hour, or seasonal employee and determined during the employer's immediately preceding look-back measurement period to be full-time—the employer must continue to offer the employee regular active full-time employee GHP coverage until the end of the employee's current stability period. Offering COBRA[5] coverage instead of active employee coverage is an offer of coverage; however, offering COBRA will not avoid the risk of employer shared responsibility penalties since that coverage is not likely to meet the affordability requirement.

Failure to comply with the ACA employer shared responsibility requirements could trigger ACA penalties for the employer. The ACA penalties could be significant, particularly if coverage is not made available to at least 95 percent of the employer's full-time employees (as determined under the ACA) for a month and at least one of the employees not offered ACA-qualified GHP coverage obtains coverage on a federal or state health insurance exchange and qualifies for a premium tax credit. Even if the employer continues to provide GHP coverage to at least 95 percent of the employer's full-time employees (including COBRA coverage), the employer could still incur a separate penalty for each full-time employee who is not offered ACA-qualified GHP coverage and who obtains coverage on a federal or state health insurance exchange and qualifies for a premium tax credit.

If the employer decides to change the eligibility provisions of its GHP, the employer should be mindful that the employer's determination of

who is eligible may no longer align with the definition of "full-time employee" under the ACA. Depending on the length of the furlough, layoff, or other temporary employment status change, employers may need to consider how the employment change in 2020 affects the look-back measurement method determination of full-time employee status for GHP coverage in the 2021 plan year (*e.g.*, will the interim weeks before the employee returns to work be ignored, credited at the employee's normally scheduled hours, or counted as zero-hours worked in the calculation).

COBRA Compliance

Because a furlough does not result in an employee's termination of employment, it is not a COBRA qualifying event unless the employee loses eligibility for GHP or health FSA coverage in connection with the furlough due to operation of a plan term, such as loss of eligibility due to a reduction in hours. If an employee does lose eligibility for GHP or health FSA coverage in connection with a furlough, the employee has incurred a COBRA qualifying event based on the employee's reduction in hours. As a result, the employer must issue a COBRA qualifying event and election notice and allow the affected employee to elect COBRA continuation coverage. For those employees who lose GHP and health FSA coverage during a temporary employment status change, as an alternative to COBRA, they may look to a federal or state health insurance exchange to purchase health insurance coverage.

Since a layoff results in an employee's termination of employment, a COBRA qualifying event will have occurred regardless of any temporary post-termination continued GHP or health FSA coverage that the employer may provide. Accordingly, the employer must issue a COBRA qualifying event and election notice to the employee as of the date of the qualifying event. The COBRA qualifying event date is the date employment is terminated or the date GHP and health FSA coverage ends, if later.

In response to the COVID-19 crisis, the Internal Revenue Service (IRS) and the Department of Labor (DOL) have issued joint regulations that temporarily extend the deadline for an employee or any other COBRA qualified beneficiary to elect COBRA continuation coverage or to submit a COBRA premium payment.[6] The purpose of this guidance is to address the problems that employees and their beneficiaries were experiencing in exercising their GHP or health FSA continuation coverage rights. If a COBRA qualified beneficiary's COBRA election period or COBRA premium payment period overlaps March 1, 2020 (*i.e.*, the period does not end until on or after March 1, 2020), these extension regulations allow the qualified beneficiary to delay

submitting the COBRA election or making a COBRA premium payment until after the Outbreak Period. The Outbreak Period is defined as a period that began March 1, 2020, and ends 60 days after the COVID-19 national public health emergency is declared to be over. The qualified beneficiary then has whatever balance of that COBRA election period or premium payment period that is leftover following March 1, 2020, to submit the employee's COBRA election or premium payment—in effect, tolling the balance of that period until after the Outbreak Period.

COBRA example. Assume, for this example, that the National Emergency ends on November 1, 2020, with the Outbreak Period ending on December 31, 2020 (the 60th day after the end of the National Emergency).

- Kevin participates in an employer-sponsored GHP. Due to the National Emergency, Kevin has a COBRA qualifying event when his hours are reduced, and he loses plan eligibility and has no other coverage.

- Kevin is provided a COBRA election notice on April 1, 2020, and without the extension must make a COBRA election within 60 days.

- The extended deadline for Kevin to elect COBRA is now 60 days after December 31, 2020, (the end of the Outbreak Period), which is March 1, 2021.

To the extent that the terms of the employer's GHP or health FSA plan state that a qualified beneficiary's COBRA coverage does not go into effect until the qualified beneficiary submits a COBRA election and pays the initial COBRA premium, it continues to be permissible under this extension guidance for an employer to withhold providing COBRA coverage to the qualified beneficiary until the qualified beneficiary submits the qualified beneficiary's COBRA election and makes the initial COBRA premium payment. In addition, a qualified beneficiary who delays paying a COBRA premium beyond the grace period permitted by COBRA law is not entitled to receive COBRA coverage for each month that the COBRA premium is due until that COBRA premium is submitted. Those are the existing rules under the original COBRA regulations, and those rules continue to be in effect in connection with the IRS/DOL extension regulations.

It should also be noted that if the period during which an employer is required to send a COBRA election notice overlaps March 1, 2020 (*i.e.*, that period does not end until on or after March 1, 2020), the extension regulations permit the employer to delay sending a COBRA election notice until the Outbreak Period is over—in the same manner

as described above for a qualified beneficiary to submit a COBRA election notice and pay COBRA premiums. While that approach is permissible under the extension regulations, it is generally recommended that employers send the COBRA election notice in a timely manner based on the original COBRA requirements anyway. For most employers, that deadline is 44 days from the date of the loss of GHP coverage due to the qualifying event, which includes the employer's 30 day notice period and the plan administrator's 14 day notice period—or a combined 44 days when the employer and plan administrator are the same entity (which is true for most employers). Delaying sending the election notice will hinder those qualified beneficiaries from securing COBRA coverage if and when they determine they need that coverage at some point during the Outbreak Period or the remaining COBRA election period thereafter.

In addition, employers will need to modify their COBRA qualifying-event notice and election materials to reflect the delayed COBRA coverage election and payment opportunities that are available to qualified beneficiaries under the extension regulations. Over the last few years, there has been a substantial increase in the number of class action lawsuits involving alleged deficient COBRA notices.

Those qualified beneficiaries who determine they do not need COBRA coverage will likely delay making the decision to elect COBRA coverage until the need arises, which the extension guidance permits them to do up until after the Outbreak Period is over. If a qualified beneficiary chooses to delay electing COBRA or paying a COBRA premium, the qualified beneficiary will be required to submit all COBRA premiums due and owing since the qualified beneficiary's qualifying event before COBRA coverage can be provided. As a result, it appears likely that a qualified beneficiary who delays electing COBRA or paying a COBRA premium will not be seeking to apply this extension guidance unless the qualified beneficiary has subsequently incurred substantial medical bills, thereby contributing to the adverse selection that is inherent with COBRA continuation coverage.

HIPAA Special Enrollment and Claim Procedures Compliance

The extension regulations discussed above also apply to the 30- or 60-day period to request Health Insurance Portability and Accountability Act (HIPAA)[7] special enrollments. As a result, if an employee or an eligible dependent has a loss of coverage or other HIPAA special enrollment event and the individual's HIPAA special enrollment period overlaps March 1, 2020 (the commencement of the Outbreak Period), the individual can delay enrolling in the employer's plan until the Outbreak Period ends. Following the end of the Outbreak Period,

the individual then has whatever portion of the individual's HIPAA special enrollment period was remaining on or after March 1, 2020, to enroll in the employer's GHP. As with a delayed COBRA election, an individual who delays submitting a HIPAA special enrollment can be required to make up all interim GHP insurance premium or cost of coverage contributions for that individual.

HIPAA special enrollment example. Assume, for this example, that the National Emergency ends on November 1, 2020, with the Outbreak Period ending on December 31, 2020 (the 60th day after the end of the National Emergency).

- Susan gives birth on March 31, 2020.
- The enrollment deadline without any extension would be April 30, 2020 (March 31st plus 30-day HIPAA special enrollment period).
- The extended enrollment deadline is January 30, 2021 (December 31st plus 30-day HIPAA special enrollment period). The coverage effective date is retroactive to March 31, 2020 (assuming Susan pays any back premium contributions).

In addition, the extension regulations also govern ERISA claim procedures in order to assist ERISA benefit claimants having difficulties filing or perfecting their benefit claims. The deadline for filing an ERISA benefit plan claim or an appeal of a denial of an ERISA benefit claim is extended so that whatever period remained in that claim or appeal filing period as of March 1, 2020 (the start of the Outbreak Period) is tolled and then tacked on at the end of the Outbreak Period, thereby giving the claimant the entire benefit claim or appeal period to file the benefit claim or appeal outside of the Outbreak Period. The same approach is applied to the time period a claimant must file a request for an external review of a denied GHP claim or to file information to substantiate a request for external review if the initial request was not complete.

Calendar year health FSA claim example. Assume, for this example, that the National Emergency ends on November 1, 2020, with the Outbreak Period ending on December 31, 2020 (the 60th day after the end of the National Emergency).

- Gary incurred a claim eligible for health FSA reimbursement on December 15, 2019.
- The plan deadline without the extension to submit claims incurred in 2019 is March 30, 2020 (the run-out period is set

in the employer's plan at 90 days after the end of the plan year, which was December 31, 2019).

- The extended plan deadline to submit claims incurred in 2019 is January 30, 2021 (December 31, 2020, plus the 30 remaining days in the individual's run-out period as of the commencement of the Outbreak Period (March 1, 2020).

Cafeteria Plan Compliance

A furlough or other temporary employment status change that does not result in the employee's termination of employment would not qualify as a cafeteria plan midyear qualifying event that would allow the employee to change the employee's benefit elections and account contributions midyear (*i.e.*, outside of initial or annual enrollment) under the cafeteria plan rules. However, if the temporary employment status change affects the employee's eligibility for coverage, the employee enrolls in another GHP or certain other coverage (such as Medicare or Medicaid) or there is a significant change in the terms and conditions of the employer's benefit plan, a midyear election change event may be permitted.

Change in GHP Election

Reduction in Hours

Under the cafeteria plan rules in effect prior to the pandemic, if an employer's cafeteria plan permits a midyear election change due to a reduction in hours, an employee may choose to voluntarily drop the employee's GHP coverage if the employee's hours are reduced (*e.g.*, due to a furlough or other temporary employment status change).

Significant Reduction in Cost

Pre-pandemic existing cafeteria plan rules also provide that if an employer significantly reduces or eliminates the employee GHP contribution in an effort to accommodate employees with reduced hours and compensation, and the employer's cafeteria plan document authorizes an employee to make a midyear election change to a different GHP option in connection with such a significant cost change, employees may request to change their GHP option midyear to a richer, more expensive GHP. If the employer wishes to avoid a large number of employees switching to a richer option, an employer could amend the

employer's cafeteria plan document to prohibit GHP option election changes in connection with that contribution reduction. On the other hand, to the extent that the change in employee GHP contribution is not significant, cafeteria plan rules permit the change to be applied automatically without allowing for an employee GHP option change.

New Flexibility in GHP Elections

In light of the furlough, layoff, reduced hour, and other employment status changes that employees have been facing in connection with the COVID-19 crisis, both employees and employers were frustrated by their limited ability to change GHP and FSA elections under existing cafeteria plan rules. The IRS responded by issuing Notice 2020-29[8] to enable employers to provide their employees with more cafeteria plan flexibility in changing their GHP elections. For calendar year 2020, IRS Notice 2020-29 permits an employer to amend its GHP (including medical, dental, and vision coverage) and cafeteria plan to permit an employee to revoke the employee's existing cafeteria plan GHP election without having to prove that the employee had a cafeteria plan mid-year election change qualifying event.

Under pre-pandemic existing cafeteria plan rules, an employee who has been furloughed does not incur a cafeteria qualifying event unless the employee loses eligibility for GHP coverage in connection with that furlough. If an employee's GHP coverage continues in connection with a furlough or a period during which the employee has reduced hours or compensation, subject to the employee continuing to make premium or cost of coverage contributions, the employee has not incurred a cafeteria plan midyear election change qualifying event. The fact that the employee can no longer afford to make premium or cost of coverage contributions does not constitute a cafeteria plan qualifying event under the existing cafeteria plan midyear election change rules. The new IRS guidance releases the employee from this constraint by allowing the employee to change employer GHP options to a less costly option, or to drop employer coverage entirely by replacing it with cheaper health coverage elsewhere (for example, through a spouse's employer health plan).

This guidance permits an employee to make a new GHP election if the employee initially declined to enroll in coverage, to change an existing election to enroll in a different GHP option or revoke an existing election (subject to the employee providing an attestation in writing that an employee is enrolled or will be enrolling in other health coverage). The guidance does not permit an employee to simply drop employer GHP coverage without having alternative health coverage in place.

An election change made in accordance with IRS Notice 2020-29 can only be applied prospectively. However, to the extent that an employer had allowed an employee to make a GHP option election

change in 2020 prior to the issuance of this new IRS guidance and that change was not allowed under prior IRS guidance, the new guidance can be applied retroactively to that election change if that election change meets the requirements under the new guidance, provided the employer amends its cafeteria plan/GHP plan documents accordingly. In other words, this guidance ratifies prior election changes an employer may have allowed employees to make when prior IRS guidance did not permit those changes.

In order to adopt the new midyear election change opportunities available under IRS Notice 2020-29, the employer must:

- Inform employees of this change in its GHP election process as soon as reasonably possible after the employer adopts this change;

- Administer its cafeteria plan in accordance with the manner in which it adopts this guidance, as well as any changes to the corresponding plans that are subject to cafeteria plan elections (*i.e.*, the employer's medical plan, dental plan, and vision plan, as applicable). Keep in mind that the employer's cafeteria plan only addresses the manner in which employees can make contributions for their employee benefits; in order for an employer's GHP to be properly documented, that plan must have a plan document that spells out when employees can make benefit elections, including in connection with certain life events (*i.e.*, qualifying events) as well as open enrollment.

- Apply the cafeteria plan and other plan changes consistently to all similarly situated employees and their dependents.

- Amend the cafeteria plan document to address these changes no later than December 31, 2021, as well as amending the plan documents for the employer's medical plan, dental plan, and vision plan that are affected by the employer's decision to apply this IRS guidance.

- Ensure the adoption of the benefit plan changes authorized by IRS Notice 2020-29 do not result in discrimination in favor of highly compensated employees, as governed by the Internal Revenue Code nondiscrimination testing requirements.

Otherwise, the regular cafeteria plan qualifying event rules apply.

On its face IRS Notice 2020-29 permits employees to make unlimited election changes for the rest of 2020. The IRS has made it clear, however, that employers are not required to implement all or any part

of this guidance and have full discretion regarding whether and to what extent they apply the guidance. In fact, the IRS specifically states that employers are not required to allow employees to make unlimited election changes in 2020. Moreover, the IRS noted in this guidance that employers will want to consider various factors in limiting application of this guidance, including "the potential for adverse selection of health coverage by employees"—for example, by switching from single to family coverage or from a low cost/lower benefit GHP option to a higher cost/richer benefit GHP option. As a result, an employer should weigh all the major implications involved in applying this guidance and choose carefully what they want to allow employees to do and not do under this guidance in order to avoid potentially major financial burdens and administrative difficulties in conjunction with their application of this guidance.

There appear to be at least two approaches (and probably many more) that an employer may want to consider in applying IRS Notice 2020-29 to the employer's GHP during 2020:

- Provide all employees an additional open enrollment opportunity with fixed beginning and end dates during the course of the year, and for any cafeteria qualifying event that occurs outside this additional open enrollment period apply the usual qualifying event rules; or

- Give all employees one or two (or more) election change opportunities without having to establish the existence of a cafeteria qualifying event, and after those opportunities have been exhausted apply the usual qualifying event rules.

Change in Health FSA Plan Election and Claims Submission

Pre-pandemic existing cafeteria plan rules indicate that a reduction in hours or other change in employment status can also be the basis for allowing an employee to voluntarily stop or reduce their health FSA plan contributions during a furlough, layoff, or other temporary employment status change, provided that such a change is authorized by the employer's cafeteria plan.

In addition to addressing GHP election changes, IRS Notice 2020-29 enables employers to allow employees to make health FSA election changes during 2020 without having to establish that a cafeteria plan midyear election change qualifying event has occurred. The new guidance applies to both general-purpose health FSAs and limited purpose

health FSAs. The purpose of this guidance is to address the difficulties that employees making health FSA contributions were having in securing elective medical procedures and other health care during 2020 as a result of the demand that the COVID-19 pandemic was placing on hospitals and other health care providers. As a result, for 2020 the IRS has thrown wide open the opportunity to make election changes for health FSA plans, which otherwise would be required to be very restrictive in accordance with prior IRS guidance.

Like the guidance applicable to GHP election changes, an employee can only make a prospective health FSA election change under IRS Notice 2002-29. The health FSA election changes available to an employee include revoking an existing election, making a new election, and increasing or decreasing an existing election. As with GHP election changes, if prior to the issuance of Notice 2020-29 an employer allowed an employee to make a health FSA election in 2020 that was not allowed under prior IRS guidance, the new guidance can be applied retroactively to ratify that election change if that election change meets the requirements under the new guidance, provided the employer amends its cafeteria plan/health FSA plan documents accordingly.

Most of the same IRS Notice 2020-29 rules and requirements governing GHP election changes also apply to health FSA election changes in 2020. These include informing employees of this change in the health FSA election process as soon as reasonably possible, administering the employer's health FSA plan in accordance with the manner in which the employer adopts this guidance, applying the health FSA plan changes consistently to all similarly situated employees, amending the client's health FSA and cafeteria plan documents no later than December 31, 2021, and continuing to pass health FSA nondiscrimination testing.

In addition, IRS Notice 2020-29 provides that for an employer with a health FSA plan that has either a non-calendar year plan year or a grace period that ends in calendar year 2020, the employer can amend its health FSA plan to allow employees to apply unused amounts remaining in their health FSA as of the end of the grace period or plan year (*i.e.*, based on a 2019 health FSA election) toward expenses incurred for qualified benefits through December 31, 2020. In other words, the health FSA "use it or lose it" rule is suspended for the rest of 2020. This guidance creates an opportunity for a health FSA plan with a grace period to also allow employees to do a one-time carryover of their health FSA account balances for the rest of 2020, despite the regular IRS rule that prohibits a health FSA plan from offering both a grace period and a carryover opportunity. The employer may want to adopt ordering rules specific to the extended period. For example, specify that 2019 contributions are exhausted before 2020 contributions will be spent.

Please note that this expanded claims arrangement would not apply to a calendar year health FSA plan that does not provide for a grace period or that applies the carryover approach in lieu of a grace period for leftover health FSA funds, since that plan would not have a plan year or claims incurred/grace period ending in the middle of 2020. It should also be noted that if a health FSA plan is amended to provide for this extended claims period, employees who have elected to switch to a high deductible health plan (HDHP) will be precluded from making HSA contributions for the rest of 2020 while the extended claims period is in effect.

Employers have complete discretion in deciding whether and to what extent they want to apply this expanded health FSA election change and extended claims period guidance, including establishing any limits or other rules that preclude the employee from overspending the employee's health FSA account and making an election change inconsistent with that overspending. For example, the client could establish a condition that allows an employee to make an election change only to the extent not inconsistent with what the employee has already incurred in health care expenses through the employee's health FSA account, by providing that any requested decrease in the employee's election cannot drop below what the employee has incurred in health care expenses up to the date of the requested election change.

IRS Notice 2020-33[9] supplements IRS Notice 2020-29 by allowing an employee's changed health FSA election to be applied to qualified health care expenses incurred since the start of the first plan year beginning on or after January 1, 2020, including qualified health care expenses incurred prior to the employee's changed health FSA election. In addition, IRS Notice 2020-33 addresses the health FSA carryover limit by adopting an inflation indexing rule for determining increases in the carryover limit and approving an increase in the health FSA carryover limit from $500 to $550, effective for carryovers to a plan year beginning in calendar year 2021. Please note that the carryover increase guidance in IRS Notice 2020-33 is not COVID-19–related and can be implemented regardless of the pandemic, which will allow employees to carryover additional funds that would otherwise have been forfeited if not used.

Change in Dependent Care FSA Plan Election and Claims Submission

To the extent an employer offers a dependent care FSA plan, under pre-pandemic existing IRS guidance, shutdowns in schools and other childcare facilities likely will trigger a midyear election change

qualifying event for an employee to change or revoke the employee's contributions to a dependent care FSA, regardless of whether a furlough, layoff, or other temporary employment status change has also occurred. Current IRS guidance governing dependent care FSA election changes is substantially more flexible than the IRS rules governing health FSA election changes, in order to accommodate changes in an employee's childcare arrangements or employment situation that affect the need for childcare. If the temporary employment status change results in the employee remaining at home, that may trigger a midyear election change qualifying event, because the employee is in a position to provide care for the employee's children. Cafeteria plan rules permit an employee to change the employee's dependent care FSA plan election in order to address any change in the employee's ability to meet the dependent care requirement that childcare is necessary for the employee and the employee's spouse to be "gainfully employed" and qualify for the tax exclusion under the Internal Revenue Code.

Despite the existing flexibility in dependent care FSA guidance, the IRS decided to broaden the dependent care FSA election change rules to align with the new GHP and health FSA guidance. As a result, IRS Notice 2020-29 allows an employer to amend its dependent care FSA plan to enable employees to make a prospective dependent care FSA election change at any time during 2020 and without having to establish or provide proof that a dependent care FSA election change qualifying event has occurred. The same election change choices are also available with respect to the employee's dependent care FSA, including revoking an existing election, making a new election, and increasing or decreasing an existing election. To the extent an employer had allowed an employee to make a dependent care FSA election change in 2020 prior to the issuance of this new IRS guidance and that change was not allowed under prior IRS guidance, that prior election change is ratified under the new IRS guidance, provided the employer amends its cafeteria plan/dependent care FSA plan documents accordingly.

Similar to health FSA plans, if an employer has a dependent care FSA plan that has a plan year or grace period ending in 2020, IRS Notice 2020-29 permits the employer to amend its dependent care FSA plan to provide for an extended claims period up through December 31, 2020, during which an employee can continue to incur dependent care expenses based on the employee's 2019 plan year dependent care FSA contributions.

Change in HDHP/HSA Election

If an employee is participating in a health savings account (HSA)–qualified HDHP at the time the employee incurs a temporary

employment status change, pre-pandemic existing cafeteria plan rules permit the employee to change the employee's HSA contribution, effective with the start of the next payroll period and regardless of the reason for the change. That HSA contribution change could include an increase or decrease in the employee's contribution as well as stopping all contributions. In the event that the employee is not receiving employer compensation from which to withdraw the employee's HSA contributions on a pretax basis, the employee can make after-tax HSA contributions and deduct those contributions on the employee's income tax return.

Other Welfare Benefit Plan Compliance

The effect on elections for other types of employee welfare benefit plans (such as life insurance and disability plans) during a furlough, layoff, or other temporary employment status change will be determined by the plan documents governing those benefits, including applicable insurance contracts. How the terms and conditions of those plan documents apply during a temporary employment status change will depend, for the most part, on whether the temporary employment status change results in the employee remaining employed or terminating employment. For insured benefits, some insurance carriers have made special arrangements for affected employees to continue their coverage for a temporary period while the employee is on furlough. In addition, state law or the terms of the insurance policy may provide an opportunity for the employee to secure continuation coverage through a conversion policy.

Changes in HSA Law

HSA law precludes an individual participating in an HAS-qualified HDHP plan from making contributions to the individual's HSA if the individual is covered by a non-HDHP health plan that provides coverage for any benefits covered by the HDHP prior to the individual meeting the applicable HDHP deductible. Such alternative non-HDHP coverage is referred to as "impermissible coverage," and under existing pre-pandemic HSA law includes telehealth coverage.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act provides that, for purposes of determining whether an HSA participant has impermissible coverage, telehealth and other remote care services are disregarded. As a result, an HSA participant can receive telehealth and other remote health care services outside of the HDHP before satisfying the applicable deductible and still be able to make HSA

contributions. It should be noted that this CARES Act change permits an employee participating in an HSA-qualified HDHP plan to access telehealth services for *all* health care needs, not just COVID-19–related health care needs. This exception to the HSA impermissible coverage rule is effective through the end of the employer's HSA-qualified HDHP 2021 plan year.

As a follow up to the GHP changes made by the Families First Coronavirus Response Act (FFCRA) and the CARES Act, the IRS issued Notices 2020-15[10] and 2020-29, which provide that until further guidance is issued, an HSA-qualified HDHP may cover COVID-19 testing and treatment without any cost sharing (or reduced cost sharing) before a participant meets the required HDHP deductible. In addition to COVID-19 testing, those IRS notices allow an HSA-qualified HDHP to cover diagnostic testing for influenza A and B, norovirus and other coronaviruses, respiratory syncytial virus (RSV), and any items or services required to be covered with zero cost sharing under the FFCRA. That guidance applies retroactively to expenses incurred on or after January 1, 2020. COVID-19 testing and treatment is discussed in more detail in the following section.

Coverage of OTC Medical Products and Menstrual Products

Another change made by the CARES Act is to eliminate the ACA requirement of a physician prescription in order for account-based plans (including HSAs, health FSAs, and HRAs) to reimburse individuals for the purchase of over-the-counter (OTC) medical products. That prior ACA rule provided an exception from the prescription requirement only for insulin. As a result, under the CARES Act, individuals will no longer need a prescription for OTC medicines and drugs in order to receive reimbursement for such health care expenses from an account-based plan.

In addition, the CARES Act provides that account-based plans can provide reimbursement for menstrual products.

MANDATORY COVERAGE OF COVID-19 TESTING UNDER FFCRA AND CARES ACT

Under the FFCRA, a group health plan (both self-insured and fully insured) and a health insurance issuer offering group or individual health insurance coverage is required to provide COVID-19 testing, without any cost-sharing (including deductibles, copayments, and co-insurance) requirements or prior authorization or other medical

management requirements, for the following items and services furnished effective beginning on March 18, 2020, and for the entire duration of the applicable emergency period:

1. In vitro diagnostic products for the detection of SARS–CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by the Federal Food, Drug, and Cosmetic (FD&C) Act, and the administration of such in vitro diagnostic products; and

2. Items and services furnished to an individual during health care provider office visits (includes in-person and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.[11]

This requirement applies to both grandfathered and nongrandfathered plans subject to ERISA as well as nonfederal government plans and church plans, but does not apply to short-term limited-duration, excepted benefit and retiree-only plans. Medicare, Medicaid, Childrens' Health Insurance Program (CHIP), and other federal health programs must also provide first-dollar coverage for testing.

The CARES Act clarifies that the coverage mandate enacted by the FFCRA is not limited only to diagnostic products approved by the Food and Drug Administration (FDA). In addition, it clarifies that testing performed by in-network providers must be paid at negotiated rates. For testing conducted by non-network providers, health plans must pay the "cash price" listed by the provider on the provider's Web site. Providers are required to post the cash price of the diagnostic test on their Web sites or face civil monetary penalties.[12]

The FFCRA, as amended by the CARES Act, requires plans and issuers to provide coverage for in vitro diagnostic testing for COVID-19[13] for the detection of SARS–CoV-2 or the diagnosis of COVID-19, and the administration of such a test: (1) that is approved, cleared, or authorized under provisions of the Federal Food, Drug, and Cosmetic Act; (2) where the developer has requested, or intends to request, emergency use authorization under the FD&C Act; (3) that is developed in and authorized by a state notifying Health and Human Services (HHS) of its intent to review COVID-19 testing; or (4) other tests deemed appropriate by HHS.[14] On April 11, 2020, the DOL, HHS, and Treasury (collectively, the Departments) issued *Affordable Care Act Implementation Frequently Asked Questions Part 42*, which

indicated that in vitro diagnostic testing includes serological testing for COVID-19.

These items and services include those provided to an individual during health care provider office visits (in-person and telehealth), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product, but only to the extent it relates to the furnishing or administration of the product or the evaluation of the individual for purposes of determining the individual's need for such product.

The items and services furnished to an individual during visits must be covered only to the extent they relate to the testing or evaluation, as determined by the individual's attending health care provider (but not a plan, issuer, hospital, or managed care organization).

The Centers for Disease Control and Prevention (CDC) has urged clinicians to use their judgment to determine if a patient has COVID-19 signs and symptoms and whether they should be tested. The CDC also has encouraged testing for other causes of respiratory illness. For example, if the individual's attending provider determines that other tests (*e.g.*, influenza or blood) should be performed during an in-person or telehealth visit to determine the need for COVID-19 testing, and the result of the visit requires COVID-19 testing, then the coverage must be provided under the FFCRA without cost sharing, prior authorization, or other medical management requirements.

The FFCRA includes both traditional and nontraditional care settings for COVID-19 diagnostic testing, including drive-through screening and testing sites where licensed health care providers administer the testing.

Additionally, these FAQs provide for summary of benefits and coverage (SBC) relief. Under ACA regulations, if a plan makes a material modification to any of the terms of the plan or coverage that would affect the content of the SBC that is not reflected in the most recently provided SBC, the plan must provide notice of the modification to enrollees no later than 60 days prior to the date on which the modification will become effective. The FAQs state that no enforcement action will be taken by the department against any plan or issuer that provides greater coverage for diagnosis and/or treatment of COVID-19 without issuing at least 60 days advance notice. Such notice, however, must be provided as soon as reasonably practicable. To the extent a plan maintains any such changes beyond the emergency period, plans will be required to comply with all other applicable requirements to update plan documents or terms of coverage. Enforcement action will be taken against any plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing COVID-19 diagnosis and/treatment benefits.

The Departments clarify that an employee assistance program (EAP) that provides excepted benefits (*i.e.*, does not provide significant benefits in the nature of medical care, is not coordinated with benefits under another group health plan, and has no employee premiums or contributions as a condition for participation) will not be considered to provide benefits that are significant in the nature of medical care solely because the EAP offers benefits for diagnosis and testing for COVID-19 while a public health emergency is in effect. Further, coverage of onsite medical clinics is an excepted benefit in all circumstances.

Plans and issuers are strongly encouraged to promote the use of telehealth and other remote care services, including notifying consumers of their availability, ensuring access to a robust suite of telehealth and other remote care services, including mental health and other substance use disorder services, and by covering telehealth and other remote care services without cost sharing or other medical management requirements. The Departments will apply the same nonenforcement actions discussed above.

On June 23, 2020, the Departments issued *ACA Implementation Frequently Asked Questions Part 43* (FAQs Part 43) that provided additional guidance concerning the FFCRA and the CARES Act COVID-19 testing requirements.[15] Part 43 clarifies that for purposes of determining which COVID-19 tests are required to be covered, all in vitro diagnostic tests for COVID-19 that have received an emergency use authorization (EUA) are listed on the EUA page of the FDA Web site.[16]

There is also a list of clinical laboratories and commercial manufacturers that have notified the FDA that they have validated their own COVID-19 test and are offering it as outlined in FDA guidance. There are scenarios outlined in FDA guidance for (1) commercial manufacturers that develop COVID-19 diagnostic and serological tests; and (2) laboratories certified under the Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity testing that develop diagnostic and serology testing. The FDA will post the names of entities that provide such notification on its Web site, and if listed it is reasonable to assume that the laboratory or manufacturer intends to request an EUA.

Thus, plans and issuers are required to cover in vitro diagnostic tests for COVID-19 that are on the list and may take reasonable steps to verify that a test meets applicable criteria. States and territories may also authorize laboratories within the state or territory to develop and perform a test for COVID-19 (and as outlined by FDA guidance).[17]

The Departments in FAQs Part 43 clarified that a provider is an attending provider for purposes of FFCRA if the individual is licensed (or otherwise authorized) under applicable law, is acting within the scope of the license, and is responsible for providing patient care.

At-home COVID-19 testing must be covered, when ordered by an attending health care provider who has determined the testing is medically appropriate for the individual based on medical practice and the testing meets the FFCRA criteria without cost-sharing, prior authorization, or other medical management requirements. However, so-called "surveillance" testing or testing conducted to screen for general workplace health and safety (*e.g.*, "return to work" programs) is beyond the scope of FFCRA. There is no limit with respect to the number of diagnostic tests that should be covered if the tests are medically appropriate, as determined by an attending health care provider in accordance with accepted standards of medical practice.

To the extent a facility fee is assessed related to items or services required to be covered (*i.e.*, a fee for the use of facilities or equipment an individual's provider does not own or are owned by a hospital), the plan or issuer must provide coverage for the facility fee. For example, if an individual is treated in the emergency room and the attending provider orders a number of services to determine whether a COVID-19 diagnostic test is appropriate, such as diagnostic test panels for influenza A and B and respiratory syncytial virus, as well as a chest x-ray, and ultimately orders a COVID-19 test, this must be covered without cost sharing, prior authorization, or other management requirements, including any physician fee charged to read the x-ray and any facility fee with respect to those items and services.

The FFCRA and CARES Act prohibit balance billing for COVID-19 testing. As set forth above, the CARES Act provides that if there is no negotiated provider rate for COVID-19 testing, the plan will be reimbursed in the amount of the cash price listed by the provider on a public Internet Web site or the plan may negotiate a lower rate with the provider. Plans that have not negotiated a rate with a provider may seek to determine a rate and will be governed by state laws related to reimbursements. For example, many states have balance billing laws that establish dispute resolution processes in order to determine reimbursement rates for certain items and services. Such dispute resolution processes would apply in these states where no negotiated rate exists. Further, the Departments have noted that civil monetary penalties in an amount not to exceed $300 per day are available for those providers not posting the cash price for COVID-19 testing on its Web site. With respect to out-of-network services, the plan or issuer must reimburse for COVID-19 testing in an amount that equals the cash price listed by the provider on its Web site, or the plan may negotiate a rate that is lower than the cash price.

In FAQs Part 43 the Departments addressed a variety of additional subject matters, including:

- The advanced notice of material modification requirement for the reversal of COVID-19 changes after the pandemic national emergency is over is satisfied if such is provided within a reasonable timeframe in advance of the reversal of changes.

- Relief for telehealth and other remote care services for employees not eligible for any other group health coverage; nondiscrimination standards and specific market reforms continue to apply.

- Grandfathered status would not be lost because an employer later reversed COVID-19 changes and the terms of the plan or coverage that were in effect prior to the pandemic national emergency were restored.

- Nonenforcement action against a plan or issuer that disregards benefits for items and services covered without cost sharing under FFCRA for purposes of the Mental Health Parity and Addiction Equity Act (MHPAEA) and more specifically the "substantial all" and "predominant" tests for financial requirements and quantitative treatment limits.

- Plans and issuers are permitted to waive a standard (including a reasonable alternative standard) for obtaining a reward under a health-contingent wellness program if offered to all similarly situated individuals.

CARES Act legislation also includes provisions addressing the confidentiality of records relating to substance use disorders and the disclosure of protected health information related to COVID-19. That is, the CARES Act provides that, once a patient at a federally subsidized substance use disorder treatment center has given written consent, HIPAA covered entities and business associates may use and disclose information relating to that patient in accordance with the HIPAA rules.

Mandatory Vaccine and Preventive Care Coverage

If the U.S. Preventive Services Task Force (USPSTF) gives a COVID-19 vaccine or treatment an A or B rating, group health plans and other plans subject to the ACA preventive service mandate would be required to cover the vaccine or treatment no later than 15 days after the recommendation is made. Generally, when an item is added to the USPSTF list with an A or B rating, plans are not required to cover

such item until the plan year starting one year after the date of the recommendation. Thus, health plans will need to cover the vaccine quickly and as a preventive service without cost-sharing. Plan amendments will typically not be needed as the full list of preventive services is not included in the plan document but is generally referenced to "approved" preventive services under the law. With so little time employers will need to be monitoring developments, including how the CDC distribution process will work in practice.

In summary, the COVID-19 pandemic national emergency has resulted in substantial changes in health and welfare benefits law. Many of these changes are temporary in nature and will not continue after the pandemic national emergency declaration expires. A number of these changes, however, do appear to be permanent and can be expected to remain in effect long after the pandemic has ended.

Leaves of Absence under FFCRA and CARES Act

Under the FFCRA there are two types of leave of absence that applicable employers must provide: (1) Emergency Paid Sick Leave Act (EPSLA) leave; and (2) Expanded Family and Medical Leave Act (EFMLEA) leave.

Employers with fewer than 500 employees and public employers regardless of size are required to provide 80 hours (generally two weeks) of emergency paid "sick" leave for full-time employees related to certain qualifying coronavirus events listed below:

- The employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19.

- The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

- The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

- The employee is caring for an individual who (1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or (2) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

- The employee is caring for a son or daughter where the school or place of care of the son or daughter has been closed or the childcare provider of such son or daughter has

been closed or the childcare provider of such son or daughter is unavailable, due to COVID-19 precautions.

- The employee is experiencing any other substantially similar condition specified by the Secretary of HHS in consultation with the Secretary of the Treasury and the Secretary of Labor.

Part-time employees are entitled to leave of absence hours "equal to the number of hours that such employee works, on average, over a two-week period." Health care providers and emergency responders may be excluded from such leave.

In general, the required sick pay is calculated based on the full-time employee's regular rate of pay or, if higher, the applicable minimum wage rate. In the case of a leave to care for a family member or child, however, the required sick pay is based on two-thirds of the full-time employee's regular rate of pay.

The maximum amount of required sick pay per employee is $511 per day and $5,110 in the aggregate. For a leave of absence to care for a family member or child, however, the maximum amount of required sick pay per employee is $200 per day and $2,000 in the aggregate.

The FFCRA amends the Family and Medical Leave Act (FMLA) to require employers with fewer than 500 employees to allow employees to take up to 12 weeks of job-protected leave for certain qualifying reasons. The first 10 days of leave can be unpaid, with the remainder having to be paid.

Again, if an employee is unable to work or telework due to a need for leave to care for the employee's child under 18 years of age, because (1) the child's school or place of care has been closed; or (2) the child care provider for the employee's child is unavailable due to a public emergency with respect to COVID-19 that is declared by a federal, state, or local authority, an employer is required to provide the employee up to 12 weeks of job-protected leave.

The FFCRA applies to employees who have been employed for at least 30 calendar days, rather than the 12-month period required under the current FMLA. The first 10 days can be unpaid leave, or the employee can choose to substitute any accrued vacation, personal, or sick leave (including EPSLA). After the initial 10 days, the employer is required to provide paid leave based on an amount that is not less than two-thirds of an employee's regular rate of pay and the number of hours the employee would otherwise be normally scheduled to work. For employees whose schedule varies from week to week, special rules apply to calculate the average number of hours. The FFCRA imposes a minimum on the amount of paid leave, per employee, to no more than $200 per day or $10,000 in the aggregate.

The CARES Act clarifies the limits on amounts employers are required to pay for leaves under the FFCRA:

- The maximum for an employee on EFMLEA is $200 per day (up to a maximum of $10,000 for the leave period).

- The maximum for EPSLA is (1) $511 per day (up to a maximum of $5,110) if the employee is taking leave because of an isolation or quarantine order, to seek treatment of a diagnosis of the virus or to self-quarantine; and (2) $200 per day (up to a maximum of $2,000 in the aggregate) to care for a family member, to care for a child who cannot attend school or child care because of the virus, or under other circumstances provided by the DOL.

The legislation also clarifies EFMLEA eligibility for individuals who are laid off on or after March 1, 2020, and subsequently rehired.

The EPSLA and EFMLEA went into effect on April 1, 2020, and expire on December 31, 2020. There are payroll tax credits for making such leave payments. Those credits are increased for expenses the employer pays or incurs to provide and maintain a group health plan that is excludable from employees' income as accident and health plan coverage.

There are expansive FAQs available addressing common questions around the two types of leave from the DOL and the IRS to which the agencies continue to add guidance.[18] The DOL FAQs are categorized into definitions, eligibility, coverage, application, enforcement, and return to school.

Temporary Rules under FFCRA and CARES Act Relating to Leave

In response to an August 3, 2020, district court decision finding certain portions of the FFCRA invalid, the DOL issued temporary rules on September 16, 2020, effective immediately, that reaffirmed certain regulations, revised other regulations, and further explained the department's position.[19]

The New York district court ruled that four parts of the temporary rule were invalid: (1) the requirement that paid sick leave and expanded family and medical leave (collectively "leaves") are available only if an employee has work from which to take leave; (2) the requirement that an employee may take FFCRA leave intermittently only with employer approval; (3) the definition of an employee who is a "health care provider" that the employer may exclude from eligibility

for FFCRA leave; and (4) employees who take FFCRA leave must provide their employers with certain documentation before taking leave.

The DOL reaffirmed that paid sick leave and expanded family and medical leave may be taken only if the employee has work from which to take leave (applicable to all reasons for leaves), and for purposes of intermittent FFCRA leave, an employee must obtain the employer's approval to take such leave. The DOL revised the definition of "health care provider" to indicate that the term includes employees who are health care providers[20] and other employees that provide diagnostic services, or other services that are integrated with and necessary to the provision of patient care. In addition, the DOL clarified that any leave information the employee is required to provide does not need to be submitted before the leave begins but instead may be given as soon as practicable, and the employee must provide the employer with notice of the leave as soon as practicable under the circumstances.

The New York district court held that the FFCRA's use of the terms "because" and "due to" with respect to the "work availability" requirement were ambiguous as to the causation standard imposed and such work availability was invalid because: (1) the DOL's application to three of the six reasons for taking leave was unreasoned and inconsistent with statutory text; and (2) the DOL did not sufficiently explain the reason for imposing this requirement.

The DOL indicated that it believed that "because" and "due to" and similar statutory phrases have been interpreted by the U.S. Supreme Court to require "but-for" causation and such traditional meaning is the best interpretation of the FFCRA leave provisions. There is no textual basis or other persuasive reason to deviate from the standard meanings of these terms. As a result, the DOL reaffirmed the work availability requirement as consistent with the long-standing interpretation of "leave" in the FMLA and Executive Order 13706 (requiring federal contractors to provide paid sick leave) and as a long-standing principle in the DOL's employee-leave regulations. Additionally, the DOL stated that there must be a legitimate, nonretaliatory reason why the employer does not have work for an employee to perform—for example, it ceased operations or furloughed employees.

With respect to intermittent FFCRA leave, the department reaffirmed its position that employer approval is needed to take such intermittent leave, because that requirement is consistent with longstanding FMLA principles. The New York court recognized that since intermittent leave is not addressed in the FFCRA, the DOL has broad authority to fill in such gaps. The DOL interpreted the absence of a discussion of intermittent leave in the statute as permitting an employee who is reporting to a worksite to take FFCRA leave on an intermittent basis only when taking leave to care for the employee's child whose school, place of care, or child care provider is closed or unavailable due to

COVID-19, and only with the consent of the employer. The other reasons under FFCRA correlate to a higher risk of spreading the virus and would hinder the FFCRA's purposes.

Under FMLA, leave must be taken in a single block of time unless specific conditions are met: (1) medical need for intermittent leave taken due to the employee's or a family member's serious health condition, which the employer may require to be certified by a health care provider; (2) employer approval for intermittent leave taken to care for a healthy newborn or adopted child; or (3) a qualifying exigency related to service in one of the Armed Forces (and not applicable here). The DOL believes the employer-approval condition for intermittent leave under FMLA is appropriate for FFCRA intermittent leave for qualifying reasons that do not exacerbate risk of COVID-19 contagion.

According to the DOL, when intermittent leave is not required for medical reasons, the FMLA balances the employee's need for leave with the employer's interest in avoiding disruptions in the workplace by requiring agreement by the employer for the employee to take intermittent leave. Accordingly, such employer agreement requirements apply to both telework and intermittent leave from telework and provide both employees and employers with flexibility.

Such approval is also appropriate for taking FFCRA leave intermittently to care for a child. The employer-approval condition would not apply to employees who take FFCRA leave in full-day increments to care for children operating on an alternate day basis. For purposes of the FFCRA, each day of school closure constitutes a separate reason for FFCRA leave that ends when the school opens the next day. The same reasoning applies to longer and shorter alternating schedules and is distinguished from the scenario where the school is closed for some period, and the employee wants to take leave only for certain portions of the period for reasons other than the school's in-person instruction schedule. Under the latter case, the leave would be FFCRA intermittent and would require an employer's agreement.

The DOL also revised the definition of "health care services" for purposes of identifying who may be excluded by their employer from taking FFCRA leave. That revision provides that an employee is capable of providing health care services and thus may be a "health care provider," if the employee is employed to provide diagnostic, preventive, or treatment services. The regulation lists as health care providers nurses, nurse assistants, medical technicians, and any other person who directly provides the diagnostic, preventive, treatment, or other services that are integrated with and necessary to the provision of patient care. Included within this definition are employees providing services under the supervision, order, or direction of, or providing direct assistance to, a person who is a health care provider under the

FMLA definition (nurses or nurse assistants and others who directly provide certain services).

Finally, health care providers include employees who may not directly interact with patients and/or who might not report to another health care provider or directly assist another health care provider, but still provide services that are integrated with and necessary components to the provision of patient care. That concept is broader than the term "health care" and may include a laboratory technician who processes test results, which would be viewed as providing diagnostic health care services because the technician's services are an integrated and necessary part of diagnosing the patient and determining the proper course of treatment. The revised definition also provides who is not a health care provider, including information technology (IT) professionals, building maintenance staff, human resources personnel, cooks, food service workers, records managers, consultants, and billers.

The DOL's revised definition of health care services also provides a nonexhaustive list of facilities where health care providers may work, including temporary health care facilities that may be established in response to the COVID-19 pandemic. Typical work locations include a doctor's office, hospital, health care center, clinic, medical school, local health department or agency, nursing facility, retirement facility, nursing home, home health care provider, any facility that performs laboratory or medical testing, pharmacy, or any similar permanent or temporary institution, facility, location, or site where medical services are provided. This list is illustrative and meant to be a helpful guidepost.

According to the DOL's preamble, the New York district court also held that the requirement that documentation be given "prior to" taking leave is inconsistent with the statute's unambiguous notice provision, which allows an employer to require notice of an employee's reason for taking leave only "after the first workday (or portion of workday) for paid sick leave or "as is practicable" for expanded family and medical leave taken for school, place of care, or child care provider closure or unavailability. In response, the DOL clarified that documentation need not be given "prior to" taking paid sick leave or expanded family and medical leave, but rather may be given as soon as practicable, typically when the employee provides notice.

The DOL corrected an inconsistency regarding the timing of the notice for employees who take expanded family and medical leave. The regulations are revised to state that advanced notice of expanded family and medical leave is required as soon as practicable; if the need for leave is foreseeable, that will generally mean providing notice before taking leave. For example, if an employee learns on Monday morning before work that the school attended by the employee's child

will close on Tuesday due to COVID-19–related reasons, the employee must notify the employee's employer as soon as practicable (likely Monday at work). If the need was not foreseeable (for example, the employee learns of the school's closure on Tuesday after reporting for work), the employee may begin to take leave without giving notice but must give notice as soon as practicable.

PANDEMIC EFFECTS ON EMPLOYMENT PRACTICES

Developing a Pandemic Response Plan

Each employer needs to consider and understand the risks for each employee with respect to contracting COVID-19, as this evaluation of risk will inform the employer's other determinations regarding screening and testing. The Occupational Safety and Health Administration (OSHA) has developed a risk pyramid for employers to utilize when evaluating an employee's risk of contracting COVD-19 based on industry and job type.[21] The risk pyramid has four risk levels; each risk level applies to particular industries and certain job functions, coming together to create a matrix approach to the evaluation of risk in the workplace.

1. **For Risk Level 1 (Very High Risk)**, consider employment with a very high potential for exposure to known or suspected sources of COVID-19 during specific medical, postmortem, or laboratory procedures. Potential employees in this category include health care and morgue workers performing aerosol-generating procedures on or collecting/handling specimens from potentially infectious patients or bodies of people known to have, or suspected of having, COVID-19 at the time of death.

2. **For Risk Level 2 (High Risk)**, consider employment with a high potential for exposure to known or suspected sources of COVID-19. Potential employees in this category include those individuals working in health care delivery, health care support, medical transport, and mortuary support who are exposed to known or suspected COVID-19 patients or bodies of people known to have, or suspected of having, COVID-19 at the time of death.

3. **For Risk Level 3 (Medium Risk)**, consider employment that requires frequent or close contact with people who may be infected, but who are not known or suspected patients. Potential employees in this category include those who may have contact

with the general public (*e.g.*, schools, high-population-density work environments, some high-volume retail settings), including individuals returning from locations with widespread COVID-19 transmission.

4. **For Risk Level 4 (Lower Risk)**, consider employment that does not require contact with people known to be, or suspected of being, infected with COVID-19. Potential employees in this category include those employees that have minimal occupational contact with the public and other coworkers.

Considering the risk pyramid in context, the employer should develop a workplace pandemic plan which identifies the potential risks for each employee and the measures the employer will take to minimize or mitigate such risks, such as screening, medical examinations, testing, social distancing, and other factors. In order to perform this task, however, the employer will need to establish certain workforce standards. These standards necessarily implicate, and will require, the collection and archival of personal and confidential employee information as necessary to establish the how, when, what, and where of employee mitigation measures. Accordingly, the employer must consider any legal constraints on the collection and preservation of such disability information and medical examination information collected from employees, which is discussed in the following sections, along with a discussion of medical exams and disabilities-related inquiries.

Disability-Related Inquiries and Medical Exams During the National Emergency

The Americans with Disabilities Act (ADA) covers employers with 15 or more employees, including state and local governments. It also applies to employment agencies and to labor organizations. The ADA's nondiscrimination standards also apply to federal sector employees under Section 501 of the Rehabilitation Act, as amended, and its' implementing rules. The ADA prescribes significant limitations regarding the extent to which an employer may request or obtain medical information from applicants and employees.

The information an employer may obtain is generally divided into three categories during the applicant/employment lifecycle. First, with respect to screening applicants for a position, disability-related inquiries and medical exams are generally prohibited. Moving from applicant status to pre-employment status, medical exams and disability-related inquiries are permitted during the time between when

an employment offer is made and the applicant actually begins work; however, these inquiries and exams must be required for each person within the same job category. After an applicant has commenced with employment, disability-related inquiries and medical exams must be job-related and consistent with a legitimate business necessity.[22] Figure 1 illustrates which medical exam and disability-related inquiries are allowed during the employment process.[23]

Figure 1. Medical Exams and Disability-Related Inquiries During the Employment Lifecycle

Employment phase	Status	Detail
Pre-employment (applicant)	Prohibited	Generally prohibited, but an employer might proceed if there is a significant health emergency such as COVID-19 and the employer makes a conditional job offer to the individual.
Offer to employment commencement (pre-employment)	Permitted	Exams and inquiries are generally permitted provided they are required of each individual within the same job category.
During employment	Permitted	Inquiries and exams are permitted, insomuch as they are job-related and consistent with a legitimate business necessity.
Following termination (post-employment)	Prohibited	After the employment relationship has terminated, an employer may not ask disability-related inquiries or require medical exams of the individual. This is important to remember in the instance of an employee commencing leave and failing to return to work due to COVID-19 exposure and/or symptoms.

Once an applicant has commenced work, additional ADA rules govern disability inquiries and medical exams by the employer. For example, during the COVID-19 outbreak an employer may ask an employee that calls in sick if they have or are experiencing symptoms of COVID-19, including[24]:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches

- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea[25]

Emergency warning signs and symptoms of COVID-19 that may suggest that you need urgent medical attention include:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Bluish lips or face[26]

Additionally, an employer may screen employees re-entering the workplace for such symptoms and may conduct additional screening after an employee re-enters the workplace.[27]

As for the hot topic of onsite temperature screenings, an employer is permitted to screen employees for temperature and deny workplace entry to an individual with an elevated fever upon testing or if they refuse to answer questions about whether they have COVID-19 symptoms. It is important to remember that not all employees that test positive for COVID-19 run a fever with their infection, yet they may be nonetheless contagious.[28] The Equal Employment Opportunity Commission (EEOC) permits such screenings because the presence of an infected or contagious individual in the workplace may pose a "direct threat to health or safety [of coworkers]."[29] Note that employees who are teleworking are not physically interacting with coworkers, and therefore the employer would not generally be permitted to ask such questions.[30]

If an employer suspects that an employee may be COVID-19 positive, or if a specific employee is exhibiting symptoms of COVID-19 in the workplace, the employer may make disability inquiries of the individual and request that the employee submit to medical examination,

including taking the temperature of the employee.[31] However, the employer must consider why they are seeking this information and must assure that the employer has a reasonable belief based on all available facts and circumstances and objective evidence that an individual might have the disease. The EEOC recently discussed this point in the following manner:

> …[T]he ADA requires the employer to have a reasonable belief based on objective evidence that this person might have the disease. So, it is important for the employer to consider why it wishes to take these actions regarding this particular employee. For example, if an employer notices that an employee has a persistent hacking cough, it could ask about the cough, whether the employee has been to a doctor, and whether the employee knows if she has or might have COVID-19. The reason these types of questions are permissible now is because this type of cough is one of the symptoms associated with COVID-19. On the other hand, if an employer notices that an employee seems distracted, then that would be an insufficient basis to ask whether the employee has COVID-19.[32]

Consider also that an employer may wish to interview an employee who is physically coming into the workplace regarding the extent to which they have family members who have COVID-19 or related symptoms. However, the employer's inquiry necessarily needs to be enlarged to be as effective as possible. For example, asking an employee "whether [they have] had contact with anyone who the employee knows has been diagnosed with COVID-19, or who may have symptoms associated with the disease" would produce a better response because this question is more broad and contains generic phraseology.[33] Remember that the Genetic Information Nondiscrimination Act (GINA) prohibits an employer from making disability and medical inquiries about an employee's family members, so phraseology is very important when an employer is making this type of inquiry.

The other question employers frequently raise is whether and to what extent an employer may require a doctor's note certifying fitness for duty from an employee returning to work after a COVID-19 illness. These types of requirements by employers are justified on one of two bases. First, to the extent, the pandemic is truly severe (which it is), this requirement is justified under the ADA standards for disability-related inquiries of employees. Second and otherwise, the EEOC has noted this type of inquiry would not necessarily be a disability-related inquiry. However, remember that the medical system is overwhelmed at the moment dealing with the COVID-19 pandemic, and in the

realities of the current pandemic, doctors may not have the time to write return-to-work certifications for patients. Thus, employers will need to be flexible with these requirements, for example, by accepting email return to work certifications, and in some instances, even phone calls from providers certifying employees for a return to work. Local health departments may devise a methodology to certify fitness, perhaps through forms, stamps, or email certifications, but they have not done so at this time.[34]

Employees returning to the worksite after taking sick leave or from traveling abroad raise special circumstances for the employer, because the employer may want to know why the employee was absent, if the absence was COVID-19–related, or whether the employee has visited an area subject to COVID-19 exposures or quarantine. The EEOC has provided guidance for employers dealing with these situations, as detailed in Figure 2.[35]

Figure 2. Employer Guidance Related to Employees Returning to the Worksite

Activity	Agency Guidance
Refusals. What may an employer do under the ADA if an employee refuses to permit the employer to take his temperature or refuses to answer questions about whether he has COVID-19, has symptoms associated with COVID-19, or has been tested for COVID-19?	Under the circumstances existing currently, the ADA allows an employer to bar employees from physical presence in the workplace if they refuse to have their temperature taken or refuse to answer questions about whether they have COVID-19, have symptoms associated with COVID-19, or have been tested for COVID-19.
Illness at work. During the COVID-19 pandemic, may an employer request information from employees who work onsite, whether regularly or occasionally, who report feeling ill or who call in sick?	Due to the COVID-19 pandemic, at this time employers may ask employees who work onsite, whether regularly or occasionally, and report feeling ill or who call in sick, questions about their symptoms as part of workplace screening for COVID-19.
Absence-related inquiries. May an employer ask an employee why he or she has been absent from work?	Asking why an individual did not report to work is not a disability-related inquiry. An employer is always entitled to know why an employee has not reported for work.
Travel-related inquiries. When an employee returns from travel during a pandemic, must an employer wait until the employee develops COVID-19 symptoms to ask questions about where the person has traveled?	Questions about where a person traveled would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for a certain period of time, an employer may ask whether employees are returning from these locations, even if the travel was personal.

Another significant concern for employers related to employees returning to the worksite relates to onsite COVID-19 testing or COVID-19 antibody testing. To differentiate the two, remember that COVID-19 testing tests whether the individual currently has the illness; whereas, COVID-19 antibody testing tests whether the individual has developed COVID-19 antibodies as the result of exposure to COVID-19. Generally, a positive COVID-19 test means the individual is (or may be) contagious. However, a positive COVID-19 antibody test is not indicative of current infection or contagiousness; thus, a COVID-19 antibody test is not particularly useful in the return-to-work context.

Because disability inquiries and medical exams by an employer are governed by the ADA, employer standing requirements for COVID-19 must pass muster under the applicable standards of the ADA. The ADA requires that for mandatory testing of employees, the test must be "job related and consistent with business necessity."[36] In the instance of a pandemic, where an infected employee may infect other coworkers, this standard is easily overcome by an employer by taking steps to screen employees (either initially upon returning to the worksite or thereafter), which is necessary because an infected employee poses a direct threat to other workers. Note that employers should research their testing methodologies with the CDC and the Food and Drug Administration (FDA), as COVID-19 testing is rapidly evolving and the various test available have differing false positing and negative rates.[37] The employer will want to select a quality test that has a very limited occurrence of false positives or negatives, that is safe to use, and that is minimally invasive for employees.

Keep in mind that in the instance of a negative COVID-19 test, the employer is only assured that the employee does not have COVID-19 *at the time the test is administered*. This does not mean the employee may not acquire COVID-19 on a later date, so testing and screening are most effective when they are conducted on a regular schedule by the employer. For example, the employer may want to conduct general screening for COVID-19 symptoms (including temperature checks) for employees each morning upon reporting to the worksite, and then conduct testing for the presence of active COVID-19 infections on a weekly or monthly basis. Remember that in the instance of a positive COVID-19 test, the employer should notify the employer's local health department concerning the infection.[38]

Confidentiality of Medical Information

Operatively speaking, several different laws (and their supporting regulations) affect the management and disposition of an employee's

medical information that is held by an employer. HIPAA, the ADA, and GINA are three that come to mind, but there are others, too, including many state-level confidentiality laws. While a review of state-level confidentiality laws is beyond the scope of this article, employers are well-suited to research the confidentiality laws enforced in their relative jurisdictions with the assistance of local legal counsel. As for the existing federal guidance, an employer should consider its obligations under the ADA, HIPAA, and GINA seriously and consistently as standards and practices must evolve quickly in light of the rapidly evolving nature of the COVID-19 pandemic.

With regard to the ADA, that law requires employers to keep confidential any medical information they learn about their job applicants and employees.[39] Medical information includes not only diagnosis or treatment information but also the fact that an individual has requested or is receiving a reasonable accommodation related to a disability.[40] Examples of protected information include, without limitation:

- Employer onsite screening records;
- Employee testing information;
- Work-to-work certifications and notices of fitness for duty;
- Request for workplace accommodation related to a disability;
- COVID-19 test results;
- COVID-19 antibody test results;
- Unemployment certifications;
- Disability insurance certifications; and
- An employee's statement that they have, or other information supporting the employees' reasonable belief that they have, COVID-19.

The employer will want to separate these files and assure their continued confidentiality by maintaining these records in a separate employee file containing only medical information. If the employer sponsors a self-funded medical plan, they may have a separate medical file for each employee, but in the instance of a fully insured medical plan, the employer may need to create new files and archival methodologies.[41]

Agency and employee notifications regarding disability-related inquiries bring another regulatory aspect of the ADA into scope for employers. Accordingly, where an employee has tested positive for COVID-19 or is experiencing symptoms of COVID-19 in the workplace, the employer will want to be particularly cautious about the types of information provided to supervisors, coworkers, medical first responders, and health department officials, preserving the identity of the specific individual unless it is absolutely necessary to disclose such information, and only under certain circumstances. Instead, the employer should rely on generic descriptors to identify symptomatic or positive individuals, such as "an individual on the third-shift" or "an individual in the processing department."[42]

Looking to HIPAA, the standards and the obligations change a bit. HIPAA only applies if the employer sponsors a covered entity—meaning, the employer must sponsor a self-funded health plan (referred to as a covered entity) or the employer must be a hybrid entity.[43] A hybrid entity both sponsors a self-funded health plan and deals with medical information as a part of its business—for example, a regional health system or a diagnostic medical testing laboratory. Determining if an employer (or an employer plan) is a covered entity can be a complex inquiry depending on different factors. The Centers for Medicare & Medicare Services maintains an online tool to assist employers with this inquiry.[44]

Once an employer makes the covered entity determination, the employer must consider the substance and context of the protected health information (PHI) that will be used or disclosed in order to make a determination regarding utilization. HIPPA contains a general nondisclosure rule for all PHI. Accordingly, in order to use or disclose PHI, the employer must rely upon a requirement of HIPAA's Privacy Rule or a specific exception to validate the particular use or disclosure.[45] Requirements to disclose refer to the following two circumstances:

1. To individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and

2. To HHS when it is undertaking a compliance investigation or review or enforcement action.[46]

A covered entity is permitted, but not required, to use and disclose PHI, without an individual's authorization, for the following purposes or situations:

1. When providing the PHI to the underlying individual who is the subject of the PHI (unless required for access or accounting of disclosures);

2. Treatment (to the individual), payment (payment and billing information), and health care operations (enrollment and other administrative features);

3. Opportunity to agree or object (where the individual whose information is involved is given the opportunity to agree or to object to the disclosure);

4. Incident to an otherwise permitted use and disclosure;

5. Public interest and benefit activities[47]; and

6. Limited data sets for the purposes of research, public health, or health care operations.[48]

HHS notes that covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.[49]

The employer must also classify the information to be released into various categories based on the amount of information that may be disclosed for the particular utilization of the subject PHI. Generally, there are three status limitations for PHI disclosures: (1) minimum disclosure; (2) de-identified disclosure; or (3) disclosure prohibited unless authorized by the individual.

Minimum disclosures permit the disclosure of only that PHI which is necessary to accomplish the objective of the release. For example, providing a list of COVID-19 symptoms for an ill worker to paramedics or first responders as opposed to providing details regarding the worker's argumentative mental state, the former being symptoms identified by the CDC and the latter being merely observations related to job performance by the employer.

Next is the de-identified disclosure. In this instance, the disclosure is "scrubbed" to provide only information that makes it impossible to identify a specific individual. For example, an employer may advise workers that a co-department worker has tested positive for COVID-19 but may not advise that the individual, Sally Smith, has tested positive for COVID-19. Here, employers should practice caution as sometimes even seemingly de-identified information may identify the individual.[50] For example, perhaps Sally Smith is the only worker in the Department of Accounting that has been absent for the past two weeks. The logical individual would be able to deduce that Sally is the COVID-19 positive worker. For small employers, coworkers might be able to figure out who the employee is, but employers in that situation are still prohibited from confirming or revealing the employee's identity.

The final category of disclosure refers to those disclosures that require an individual authorization for release of information. These are generally the routine release requests that employers and providers receive from one another in processing treatment and claims. However, this category of release is different from the other two categories because they require an individual HIPAA authorization for release of medical information signed by the individual or their personal representative. Personal representatives may include family members, attorneys, accountants, and others, depending on the wishes of the underlying individual and the adequacy of authorization granted by such individual.

Considering the foregoing in context, the question then becomes whether HIPAA grants an employer the discretion to release PHI to first responders, coworkers, supervisors, human resources staff and leadership, health department officials, families of individuals, or personal representatives of individuals presenting at the workplace with symptoms of COVID-19 or after testing positive for COVID-19. To decipher the analytic results, it is necessary to group the disclosures into two categories: public interest disclosures and health and safety disclosures.

For the first group, public interest disclosures, the employer may make the minimum disclosure of PHI (including the identity of an individual and the status of COVID-19 symptoms or test results) to law enforcement, first responders, paramedics, and health department officials, because these disclosures involve the public interest in maintaining the health of first responders and the community at large.[51,52] Next, looking to health and safety disclosures, the employer may notify human resources leadership (and possibly HR staff),[53] coworkers, supervisors, and family members regarding a symptomatic employee or one that tests positive for COVID-19; however, to the extent practicable, these disclosures should de-identify any specific individual. As mentioned earlier and by way of example, by using general terms through disclosing the shift to which the worker reports or the department to which the worker is assigned.

As a note and general reminder, respecting the third category of disclosure; that is, those disclosures that may only be made consistent with the terms of an individual authorization consenting to the release, media inquiries and disclosures, as well as disclosures to personal representatives fall into this category. Accordingly, an employer may not release PHI to the media or to a personal representative without the written consent of the underlying individual. Figure 3 provides a useful summary of the subjects of, and the limitations for, PHI disclosures.

Lastly, with respect to maintenance and disclosure of employee personal information related to COVID-19 symptomatic individuals or testing results, the employer needs to consider the scope and effect of

Figure 3. Lawful Disclosures and Limitations for COVID-19–related Employee Information

To whom	Status	Limitations
Secretary of HHS	Yes	Upon audit or investigation
Law enforcement officers	Yes	Minimum necessary
Paramedics	Yes	Minimum necessary
First responders	Yes	Minimum necessary
Public health officials	Yes	Minimum necessary
Human resources (director or VP)	Yes	Minimum necessary
Human resources (staff)	Maybe	Minimum necessary or de-identified, depending upon circumstances of the request
Coworkers	Yes	De-identified only
Supervisors	Yes	De-identified only
Family members	Yes	Minimum necessary
Personal representatives	No	Unless authorized by the individual
Media	No	Unless authorized by the individual

GINA. GINA contains various provisions of law related to the maintenance and disclosure of genetic information by employers, insurers, and treatment professionals. In the context of COVID-19, the most likely COVID-19 consideration will come into play is regarding questions from employers to employees regarding the health status of the employee's family members. Asking employees about COVID-19 testing does not extend to whether the employee's family members have COVID-19 or symptoms associated with COVID-19. This is because GINA generally prohibits employers from asking employees medical questions about family members. However, the EEOC has indicated that employers may ask employees whether they have had contact with anyone diagnosed with COVID-19 or who may have symptoms associated with the disease, noting:

> …[F]rom a public health perspective, only asking an employee about his contact with family members would unnecessarily limit the information obtained about an employee's potential exposure to COVID-19.[54]

Ultimately, whether and to what extent an employer may disclose health-related information of an employee is heavily dependent on the circumstances for the disclosure and the amount of information the employer seeks to disclose. Specific inquiries may help the employer

to make the disclosure determination effectively and accurately. Some questions to consider include[55]:

- Who is asking for the information?
- Why is the individual asking for the information?
- What will the individual seeking disclosure do with the information if obtained?
- Should the subject employee be advised of the disclosure and given an opportunity to object to the disclosure?
- Can the employer determine the minimum necessary information to disclose?
- If applicable, has the employer or their agent signed a written authorization for release of the information?
- What will be the form of the disclosure (*e.g.*, written, electronic, oral) and is there a less invasive methodology for making the disclosure?
- Does a statutory right or obligation mandate the disclosure (FMLA and other protected leaves of absence, unemployment, workers' compensation, etc.)?

In closing, it is strongly recommended that an employer seek the advice of counsel regarding COVID-19 disclosures. The privacy laws in play are technically complex and their provisions oftentimes overlap. Rarely will the typical employer face an emergency disclosure obligation requiring an immediate disclosure, as these types of disclosures typically only concern medial and law enforcement first responders. Thus, an employer can generally take a moment to consider the scope and effects of a particular disclosure—prior to making the disclosure.

Hiring and Onboarding during the National Emergency

Hiring and on-boarding of new employees can be particularly difficult during the pandemic. The EEOC has released a limited amount of guidance to assist employers with some of the more common situations that may arise. Although the guidance is light, the points covered are nonetheless important for employers to remember. Figure 4 restates this guidance in a summary format[56]:

Figure 4. Hiring and Onboarding During the National Emergency

Employer Action	Permissible	Employer responsibilities
Screening of applicants for symptoms of COVID-19	Yes	An employer may screen job applicants for symptoms of COVID-19 after making a conditional job offer, so long as it does so for all entering employees in the same type of job. (Rule applies regardless of whether the applicant has a disability.)
Taking of an applicant's temperature	Yes	Any medical exams are permitted after an employer has made a conditional offer of employment; however, employers should be aware that some people with COVID-19 do not have a fever.
Delaying the start date for a symptomatic employee	Yes	According to current CDC guidance, an individual who has COVID-19 or symptoms associated with COVID-19 should not be in the workplace, so an employer may delay the employee's start date.
Withdrawing a job offer from a symptomatic individual	Yes	Based on current CDC guidance, this individual cannot safely enter the workplace, and therefore the employer may withdraw the job offer.
Rescinding a job offer based on the results of a post-offer medical examination, if the applicant has a medical condition that puts them at increased risk of complications from influenza	Maybe	Unless the applicant would pose a direct threat within the meaning of the ADA, the employer may not rescind. This determination must be based on reasonable medical judgment that relies on the most current medical knowledge and/or the best available evidence (such as objective information from the CDC). The finding must be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job, after considering, among other things, the imminence of the risk; the severity of the harm; and the availability of reasonable accommodations to reduce the risk.

EMPLOYEE RELATIONS ISSUES ARISING DURING THE PANDEMIC

An employer's role with respect to the national pandemic emergency may involve suggesting or reminding employees that they need to take precautions to (1) protect themselves; (2) protect their coworkers; and (3) limit the opportunities for continued transmission of COVID-19. The propriety of such employer measures must be evaluated under the standards of the ADA and Title VII of the Civil Rights Act of 1964, as well. Primarily, this means employers may need to send workers home at times, deny some workers access to the workplace,

and may need to have some potentially uncomfortable conversations with employees regarding workplace safety and etiquette.

Due to the severity of the COVID-19 pandemic, and as mentioned before, an employer may send an employee home who presents at the workplace with COVID-19 symptoms or who has a positive COVID-19 test resulting from a workplace medical exam, or otherwise. If the employer conducts pre-access screenings, the individual may be denied access to the workplace, and if the employee displays symptoms during the workday, the employer may send the worker home.[57] If an employee experiences symptoms in the workplace or calls in sick to work, the employer may make a limited inquiry of the employee to determine whether the employee should enter or remain in the workplace.[58] Typically, this inquiry would involve the employer questioning the employee about the presence of COVID-19 symptoms, such as fever, chills, cough, or loss of sense of smell or taste, but the employer may not inquire as to general maladies or symptoms that are not influenza-related (such as distraction or irritation).[59]

If an employee returns from work after a period of travel, regardless of whether the travel was for work purposes, the employer does not have to wait for the employee to demonstrate COVID-19 symptoms to make an inquiry of the employee consisting of: (1) the location of the travel; and/or (2) the presence of COVID-19 symptoms by the employee or anyone the employee has come into contact with during the time away from the workplace.[60]

In those instances where the employer suspects that an employee may have a preexisting medical condition that would make the employee more susceptible to COVID-19 infection, an employer is barred from asking the employee directly about those suspicions. However, the employer may, consistent with the terms of the ADA, discuss reasonable accommodations with an employee who voluntarily discloses such information to the employer.[61] Remember that telework is frequently an option for individuals requiring such accommodation and the employer should suggest this as an option where available.

Workplace etiquette should be top of mind for employers during the pandemic. Ask employees to evaluate themselves for signs and symptoms of COVID-19 before coming to work, and to stay home if they are not well.[62] Remind employees to practice frequent handwashing and to cough or sneeze into cloths or face coverings, or into an elbow, if nothing else is available. Employers should practice and encourage social distancing (including avoiding handshakes) and require employees to utilize face coverings while in the workplace. Employees should be kept separate from customers and clients to the extent practicable by utilizing barriers and other devices. Adopting

one-way aisles in the workplace is generally effective, as is identifying marked entrances and exits as one-way to direct traffic in and out of the workplace.[63] Also, where necessary an employer is entitled to require employees to wear personal protective equipment (PPE), such as gowns and gloves.[64]

A final note on returning to work during or after the pandemic: at some point in the future, a vaccine will become available for the treatment of COVID-19. At that point, employers will have to make determinations as to whether they desire employees to present evidence of vaccination before returning to the worksite. While the employer may have the best of intentions regarding a mandatory vaccination requirement for employees, the matter is complicated by the interplay of the ADA and Title VII of the Civil Rights Act. If an employee has a disability that prevents them from taking an influenza vaccine, the ADA would prohibit the employer from enforcing the vaccination requirement, because this would be a reasonable accommodation barring undue hardship (under significant difficulty or expense).[65] Similarly, consistent with the requirements of Title VII of the Civil Rights Act, if the employer receives notice that an employee's sincerely held religious belief, practice, or observance prevents the individual from taking an influenza vaccine, the employer must offer a reasonable accommodation (unless it would pose an undue hardship as defined by Title VII).[66]

Returning to Work after the Pandemic

OSHA suggests a phased return-to-work methodology consisting of three phases of workplace operations designed to minimize the effect to the workplace and the risk to employees of returning to the worksite.[67] It is important to understand that the specifics of an employer's individual situation need to be taken into consideration when utilizing any return-to-work methodology, including such factors as:

- Geographical specifics of the workforce in relation to COVID-19 testing rates;
- Age demographics of the workforce;
- Workforce communications and messaging;
- Safety for employees returning to the worksite;
- Training for managers and supervisors on responding to COVID-19–related employee relations issues; and others.

Most important, resist the temptation to resume worksite operations too quickly and always be amenable to taking steps backward in the reopening plan, just as an employer is willing to take steps forward. This means an employer opening a worksite may need to reduce to a lower phase of the reopening plan if, upon instituting a particular workforce phase, the employer experiences an increase in COVID-19 infection rates; high rates of employee turnover; increasing employee complaints regarding safety; or institution of new community standards by the CDC, local health department officials, or state-level resources.[68]

The phased return-to-work methodology details the following reopening phases[69]:

Phase 1. Businesses should consider making telework available, when possible and feasible with business operations. For employees who return to the workplace, consider limiting the number of people in the workplace in order to maintain strict social distancing practices. Where feasible, accommodations (*i.e.*, flexibilities based on individual needs) should be considered for workers at higher risk of severe illness, including elderly individuals and those with serious underlying health conditions. Businesses should also consider extending special accommodations to workers with household members at higher risk of severe illness. Nonessential business travel should be limited.

Phase 2. Businesses continue to make telework available where possible, but nonessential business travel can resume. Limitations on the number of people in the workplace can be eased, but employers should continue to maintain moderate to strict social distancing practices, depending on the type of business. Continue to accommodate vulnerable workers as identified above in Phase 1.

Phase 3. Businesses should resume unrestricted staffing of worksites for continued operations, but *see footnote 38* for important information regarding reopening plans.

For most employers, the most critical aspect of the reopening plan is development of the written plan of action for the reopening. There are several important aspects of the plan that should be documented and adopted. As shown in Figure 5, OSHA provided a useful chart to walk employers through the assessment.

To be sure, the specifications and examples provide in the foregoing chart are not exhaustive. Employers may supplement these specifications and examples with additional information, assessments, and action factors to improve the success and workability of their respective reopening action plans. Employers should consult the continually evolving guidance provided by the CDC, local and state health department officials, as well as EEOC, DOL, and OSHA recommendations and guidelines.

Figure 5. Factors to Assess in the Reopening Plan

Guiding principle	Specification	Reopening plan examples
Hazard assessment	Including practices to determine when, where, how, and to what sources of SARS–CoV-2 workers are likely to be exposed in the course of their job duties.	Assess all job tasks performed by or job categories held by employees to determine which job tasks or job categories involve occupational exposure. This can be a desktop assessment to maintain social distancing practices. Consider, among other things, exposures from members of the public (*e.g.*, customers, visitors) with whom workers interact, as well as exposures from close contact with coworkers in the workplace. Consider current outbreak conditions in the community.
Hygiene	Including practices for hand hygiene, respiratory etiquette, and cleaning and disinfection.	Provide soap, water, and paper towels for workers, customers, and visitors to wash their hands, and encourage frequent and proper (for at least 20 seconds) handwashing. Provide hand sanitizer with at least 60% alcohol and encourage workers to use it frequently when they cannot readily wash their hands. Identify high-traffic areas, as well as surfaces or items that are shared or frequently touched, that could become contaminated. Target them for enhanced cleaning and disinfection using EPA-registered disinfectants and adherence to CDC guidance for controlling the spread of COVID-19.
Social distancing	Including practices for maximizing to the extent feasible and maintaining distance between all people, including workers, customers, and visitors. Six feet of distance is a general rule of thumb, though social distancing practices may change as changes in community transmission of SARS–CoV-2 and other criteria prompt communities to move through the reopening phases.	Limit business occupancy to a number of workers/customers that can safely be accommodated to allow for social distancing. Demarcate flooring in six-feet zones in key areas where workers, customers, or visitors would ordinarily congregate (*i.e.*, restrooms, check-out lines, areas with time clocks) to encourage people to keep appropriate social distance between themselves and others. Post signage reminding workers, customers, and visitors to maintain at least six feet between one another. Post directional signs in hallways/corridors where the width restricts movement and limits social distancing.

Identification and isolation of sick employees	Identification and isolation of sick employees, including practices for worker self-monitoring or screening, and isolating and excluding from the workplace any employees with signs or symptoms of COVID-19.	Ask employees to evaluate themselves for signs and symptoms of COVID-19 before coming to work, and to stay home if they are not well. Establish a protocol for managing people who become ill in the workplace, including details about how and where a sick person will be isolated (in the event they are unable to leave immediately) while awaiting transportation from the workplace, to their home or to a health care facility. Cleaning and disinfecting spaces the ill person has occupied to prevent exposure to other workers, customers, or visitors. Employers may need to collaborate with SLTT health officials to facilitate contact tracing and notification related to COVID-19 cases or possible exposures.
Return to work after illness or exposure	Including after workers recover from COVID-19 or complete recommended self-quarantine after exposure to a person with COVID-19.	Follow CDC guidance for discontinuing self-isolation and returning to work after illness, or discontinuing self-quarantine and monitoring after exposure, as appropriate for the workplace. Ensure workers who have been exposed to someone with COVID-19 routinely monitor themselves or receive monitoring, including for signs and/or symptoms of potential illness, at work, in accordance with CDC guidance.
Controls	Including engineering and administrative controls, safe work practices, and PPE selected as a result of an employer's hazard assessment.	Select and implement appropriate engineering controls (*e.g.*, physical barriers/shields to separate workers, enhanced ventilation), and administrative controls (*e.g.*, staggering work shifts, limiting break room capacity, practicing social distancing, replacing in-person meetings with video conference calls, ensuring workers wear appropriate face coverings, such as cloth face masks, to contain respiratory secretions), and providing and ensuring workers use appropriate PPE, identified through hazard assessments and in accordance with OSHA's standards.

Workplace flexibilities	Including those concerning remote work (*i.e.*, telework) and sick leave.	Evaluate existing policies and, if needed, consider new ones that facilitate appropriate use of telework, sick, or other types of leave, and other options that help minimize workers' exposure risks. Communicate about workplace flexibilities, and ensure workers understand how to make use of available options (*e.g.*, fatigue management).
Training	Including practices for ensuring employees receive training on the signs, symptoms, and risk factors associated with COVID-19; where, how, and to what sources of SARS–CoV-2 employees might be exposed in the workplace; and how to prevent the spread of SARS–CoV-2 at work.	Train workers in the appropriate language and literacy level about their risks of exposure to SARS–CoV-2; what the employer is doing to protect them, including site-specific measures; and how they can protect themselves. Train workers about wearing cloth face coverings in the workplace, including any employer policies related to their use and considerations for when cloth face coverings could cause or contribute to a workplace safety and health hazard. As required by OSHA standards for PPE, including respiratory protection, and consistent with OSHA and CDC guidance, train workers how to put on, use, and take off PPE; how to clean, maintain, store, and dispose of PPE; and what the limitations of the PPE are.
Antiretal-iation	Including practices for ensuring that no adverse or retaliatory action is taken against an employee who adheres to these guidelines or raises workplace safety and health concerns.	Ensure workers understand their rights to a safe and healthful work environment, whom to contact with questions or concerns about workplace safety and health, and prohibitions against retaliation for raising workplace safety and health concerns. Ensure workers understand their right to raise workplace safety and health concerns and seek an OSHA inspection under the Occupational Safety and Health Act. Ensure supervisors are familiar with workplace flexibilities and other HR policies and procedures, as well as with workers' rights in general.

Employers are responsible for providing a safe working environment for the benefit of their employees. During this national pandemic emergency, the lines of what constitutes a safe working environment may become blurred. However, there is no product or service that is more valuable a commodity than the lives of an employer's workforce. Respecting the seriousness of COVID-19, this is time for thoughtful contemplation of employer responsibilities and liabilities. Employees are depending on their employer to keep them safe more than ever.

NOTES

1. Patient Protection and Affordable Care Act, Pub. L. No.111-148, 124 Stat. 119 (2010).

2. An "applicable large employer" is an employer who employs at least 50 full-time employees and full-time equivalents during the preceding calendar year. 26 U.S.C. § 4980H(c)(2)(a).

3. The ACA affordability standard requires employee contributions for single coverage to be no more than 9.5% (as adjusted by inflation) of the employee's household income. An ALE may use one of three designated safe harbor methods to satisfy that requirement.

4. The ACA minimum value standard requires the GHP to pay at least 60% of the cost of benefits.

5. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 124 Stat. 119 (2010).

6. EBSA Disaster Relief Notice 2020-01, Guidance and Relief for Employee Benefit Plans Due to the COVID-19 (Novel Coronavirus) Outbreak (April 28, 2020).

7. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 100 Stat. 2548 (1996).

8. IRS Notice 2020-29, COVID-19 Guidance Under § 125 Cafeteria Plans and Related to High Deductible Health Plans (May 12, 2020).

9. IRS Notice 2020-33, Section 125 Cafeteria Plans—Modification of Permissive Carryover Rule for Health Flexible Spending Arrangements and Clarification Regarding Reimbursements of Premiums by Individual Coverage Health Reimbursements Arrangements (May 12, 2020).

10. IRS Notice 2020-15, High Deductible Health Plans and Expenses Related to COVID-19 (March 11, 2020).

11. Pub. L. No. 116-127 (2020).

12. Pub. L. No. 116-136 (2020).

13. Plans and issuers must provide coverage for a serological test for COVID-19 that otherwise meets the requirements of § 6001(a)(1) of the FFCRA, as amended by the CARES Act.

14. *https://www.dol.gov/agencies/ebsa/laws/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs/aca-part-42.pdf* (*see* FAQ 3).

15. *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf*.

16. *https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd*.

17. *https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-covd-2#offeringtests*.

18. *https://www.dol.gov/agencies/whd/pandemic/ffcra-questions* and *https://www.irs.gov/newsroom/covid-19-related-tax-credits-for-required-paid-leave-provided-by-small-and-midsize-businesses-faqs*.

19. 29 C.F.R. § 826.

20. 29 C.F.R §§ 825.102 and 825.125 (which are identical).

21. OSHA, Worker Exposure Risk to Covid-19, *https://www.osha.gov/Publications/OSHA3993.pdf*.

22. Note that preservation of the health and safety of an employer's workforce is a legitimate business concern.

23. Equal Employment Opportunity Commission, What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws (Sep. 8, 2020). *https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws*.

24. The EEOC has provided examples of symptoms of COVID-19. *See: https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q1*. An employer may also test for or inquire about symptoms of COVID-19 identified by any local health department or the Centers for Disease Control (CDC). *See* Answer A1. *See also* OSHA, COVID-19 Medical Information for Employers, *https://www.osha.gov/SLTC/covid-19/medicalinformation.html*.

25. This list does not include all possible symptoms. *See* OSHA, COVID-19 Medical Information for Employers (FN2).

26. *Id*.

27. *See FN2 at* Answer A2.

28. *Id. at* Answer A3.

29. *Id*.

30. *See FN3 at* Q1.

31. *See FN2 at*Answer A6.

32. *See FN3 at* Answer A3.

33. *Id. at* Answer A4.

34. *Id. at* Answer A5.

35. *Id. at* Answers A11–A14.

36. *Id. at* Answer A6.

37. For FDA resources on testing, *see*: *https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2*. For CDC resources on testing and screening, *see: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html*.

38. *See FN2 at* Answer B3.

39. The EEOC considers medical information on employees and applicants confidential with the following exceptions: (1) supervisors and managers may be told about necessary restrictions on work duties and about necessary accommodations; (2) first aid and safety personnel may be told if a disability might require emergency treatment; (3) government officials may access the information when investigating compliance with the ADA; (4) employers may give information to state workers' compensation offices, state second injury funds, or workers' compensation insurance carriers in accordance with state workers' compensation laws; and (5) employers may use the information for insurance purposes. 29 C.F.R. §§ 1630.14(b)(1)(i)–(iii), (c)(1)(i)–(iii); 29 C.F.R. pt. 1630 app. § 1630.14(b).

40. *Id. at* Section 3 Introduction.

41. *See generally,* FN2 *at* Answers B1–B5.

42. *Id. at* Answer B6.

43. For purposes of this article, only health plans are considered with respect to the relevant HIPAA obligations. Generally, HIPAA obligations impart upon all health care practitioners and treatment professionals; however, from the employee benefits perspective, the obligations weigh upon self-funded health plans.

44. *See: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AreYouaCoveredEntity*.

45. *See: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html*.

46. 45 C.F.R. § 164.502(a)(2).

47. The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information, and include disclosures such as those required by law, public health activities, for victims of abuse, for health oversight activities, in judicial and administrative proceedings, for law enforcement purposes, for decedents to funeral directors, for tissue donation, research, for serious threats to health or safety, for essential government functions, and instances involving workers' compensation law compliance. *See* 45 C.F.R. § 164.512, *et. sec*.

48. 45 C.F.R. § 164.502(a)(1).

49. *Id. at* FN24.

50. *Id. at* FN2, Answer B5, *noting* "Remember that employer officials who are designated as needing to know the identity of an employee should be specifically instructed that they must maintain the confidentiality of this information. Employers may want to ***plan in advance*** what supervisors and managers should do if this situation arises and ***determine who will be responsible for receiving information and taking next steps***" (*emphasis added*).

51. *See, generally: https://www.hhs.gov/about/news/2020/03/24/ocr-issues-guidance-to-help-ensure-first-responders-and-others-receive-protected-health-information-about-individuals-exposed-to-covid-19.html*.

52. *Id*. HHS' Office of Civil Rights notes, its guidance related to first responders "…clarifies the regulatory permissions that covered entities may use to disclose PHI to first responders and others so they can take extra precautions or use personal protective equipment. The guidance also includes a reminder that generally, covered entities must make reasonable efforts to limit the PHI used or disclosed to that which is the "minimum necessary" to accomplish the purpose for the disclosure."

53. The extent to which an HR staff member would have access to COVID-19–related participant information is heavily dependent upon the reason the staff member requires access to the information. Rank and file HR staff would generally not need to know the specific identity of an individual. Instead, they would generally only have access to de-identified information unless they are required to have individual contact with the employee.

54. *Id*. FN2 at Answer A10.

55. *Id*. FNE at Answers B1 through B8, *generally*.

56. EEOC, Pandemic Preparedness in the Workplace and the Americans with Disabilities Act (Mar. 11, 2020). *See: https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act#q17*, *noting "*The CDC has issued guidance applicable to all workplaces generally, but also has issued more specific guidance for particular types of workplaces (*e.g.*, health care employees). Guidance from public health authorities is likely to change as the COVID-19 pandemic evolves. Therefore, employers should continue to follow the most current information on maintaining workplace safety. To repeat: the ADA does not interfere with employers following recommendations of the CDC or public health authorities, and employers should feel free to do so.*"*

57. Id. at FN35.

58. *Id*.

59. Note that general confusion, as distinguished from distraction, may be a dangerous symptom of COVID-19, *see* OSHA, Covid-19 Medical Information at *https://www.osha.gov/SLTC/covid-19/medicalinformation.html*.

60. Remember that GINA prohibits employers from making disability-related inquiries regarding the family of an employer. The employer may nevertheless ask employees general questions regarding the extent to which the employee may have been exposed "to anyone" with the virus.

61. *Id*. *at* FN35.

62. EEOC, Guidance on Returning to Work (2020) at p.7. *See https://www.osha.gov/Publications/OSHA4045.pdf*.

63. To review these and other commonsense workplace considerations, visit the CDC's Web site at: *https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html*.

64. 29 CFR 1910, Subpart I, and OSHA and CDC guidance on use of PPE.

65. EEOC, Pandemic Preparedness in the Workplace and the Americans with Disabilities Act (Mar. 11, 2020).

66. *Id*. *citing* EEOC, EEOC Compliance Manual Section 12: Religious Discrimination 56–65 (2008), *https://www.eeoc.gov/policy/docs/religion.pdf and noting that*"[an undue hardship as defined by Title VII requires] …"more than de minimis cost" to the operation of the employer's business, which is a lower standard than under the ADA."

67. EEOC, Guidance on Returning to Work (2020), *see: https://www.osha.gov/Publications/OSHA4045.pdf*.

68. *Id*. at p.3, *noting* "Reopening should align with the lifting of stay-at-home or shelter-in-place orders and other specific requirements of the Federal Government and state, local, tribal, and/or territorial (SLTT) governments across the United States, as well as with public health recommendations from the Centers for Disease Control and Prevention (CDC) and other federal requirements or guidelines."

69. *Id*. at pp.4–5.

I Can Get it For You Wholesale: Discount Rates and Withdrawal Liability

Paul A. Green and Lauren P. McDermott

It is common for multiemployer pension plans to use different discount rates for purposes of determining a plan's minimum funding requirements and for valuing liabilities for withdrawal liability. For these plans, two recent district court decisions[1] impose an unwarranted and improper hurdle—an undefined presumption of unreasonableness—that the plan must overcome in order to collect assessments of withdrawal liability. While the *New York Times* case settled prior to a ruling on the merits by the Second Circuit, the *Sofco* case is fully briefed and waiting for a decision from the Sixth Circuit. If left unreversed, the district court's ruling has the potential to dramatically increase the cost to multiemployer plans of enforcing withdrawal liability assessments. This article addresses how withdrawal liability is calculated; the statutory language placing the burden of overturning any actuarial assumptions squarely on the withdrawing employer; why discount rates for funding differ from discount rates used to calculate withdrawal liability; how the district courts in *New York Times* and *Sofco* got it wrong; and the detrimental consequences to multiemployer plans if *Sofco* is not overturned.

WITHDRAWAL LIABILITY GENERALLY

By enacting the Employee Retirement Income Security Act of 1974, as amended (ERISA),[2] Congress sought to ensure that "if a worker

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has been promised a defined pension benefit upon retirement—and if he has fulfilled whatever conditions are required to obtain a vested benefit—he actually will receive it."[3] To further that goal, Congress amended ERISA by enacting the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA),[4] which imposed "withdrawal liability" on employers that cease contributing to underfunded multiemployer defined benefit pension plans.[5] Withdrawal liability requires that, when an employer withdraws from an underfunded plan, the employer must pay its allocable share of the plan's vested pension benefits that current plan assets do not cover.[6] This withdrawal liability reflects the withdrawing employer's *pro rata* share of the difference between the present value of the pension benefits the employers promised their employees and the value of the plan's assets, which generally consist of contributions made by the employers, plus or minus investment gains or losses, benefit payments, and administrative expenses.[7]

Although there are multiple ways to allocate such liability to a withdrawing employer, they all begin from the same starting point: a plan first determines the total value of its vested benefits. Using a variety of actuarial assumptions, such as mortality rates, retirement rates, and anticipated rates of retirement, the plan estimates the expected stream of payments of vested benefits. The plan then applies a discount rate to reduce that stream of payments to a present value. From this present value of vested benefits, the plan then subtracts the value of its assets. The difference between these two numbers is the plan's "unfunded vested benefits" or "UVBs."[8] Next, the plan calculates the proportionate share of the UVBs allocable to the withdrawing employer. Although several methodologies may be used to determine an employer's proportionate share, most are based on the employer's share of the total contributions to the plan over prior years.[9]

Unique to withdrawal liability, MPPAA also added a series of procedures and requirements for withdrawal liability assessments and for employer challenges to those assessments. Initially, an employer seeking to challenge a plan's assessment must file a "request for review" with the plan sponsor, typically the Board of Trustees.[10] If the employer is dissatisfied with the result of the review, the employer must then file a demand for arbitration.[11] Either party may then seek to challenge the arbitration award in court.[12] Each of these steps has specific deadlines, and failure to follow any of them will permanently foreclose an employer's right to challenge the assessment.[13] Notwithstanding the pendency of an employer's challenge to a withdrawal liability assessment, the employer is required to make its periodic withdrawal liability payments in accordance with the assessment.[14] In the event an employer ultimately prevails in its challenge, it is entitled to a refund of any overpayments, with interest.[15]

CHALLENGES TO ACTUARIAL ASSUMPTIONS USED TO CALCULATE WITHDRAWAL LIABILITY

The actuarial assumptions used to calculate withdrawal liability can have an enormous impact on the valuation of the plan's future benefit obligations and, therefore, the amount a withdrawing employer is required to pay. Because of this, withdrawing employers often seek to challenge a plan's assessment by attacking the assumptions used to calculate the plan's UVBs. Historically, this has been a high hurdle.

The standard of review in any arbitration challenging the "actuarial assumptions" used by a plan actuary in an assessment of withdrawal liability is provided in ERISA as follows:

> (B) In the case of the determination of a plan's unfunded vested benefits for a plan year, the determination is *presumed correct unless a party contesting the determination shows by a preponderance of evidence* that—
>
> (i) the actuarial assumptions and methods used in the determination were, *in the aggregate, unreasonable* (taking into account the experience of the plan and reasonable expectations) . . .[16]

This language unambiguously requires the party contesting the plan's determination to prove that the actuary's assumptions were unreasonable. As explained by the Supreme Court in *Concrete Pipe*, any consideration of the reasonableness of the assumptions used by an actuary in valuing a plan's liabilities must be determined by reference to professional standards:

> Section 1401(a)(3)(B) speaks instead of the aggregate reasonableness of the assumptions and methods employed by the actuary in calculating the dollar liability figure. Because a "method" is not "accurate" or probably "true" within some range, "reasonable" must be understood here to refer to some different kind of judgment [from the factual determinations made by the plan sponsor], one that it would make sense to apply to a review of methodology as well as of assumptions. Since the methodology is a subject of technical judgment within a recognized professional discipline, it would make sense to judge the reasonableness of a method by reference to what the actuarial profession considers to be within the scope of professional acceptability in making an unfunded liability calculation. Accordingly, *an employer's burden to overcome the presumption in question (by proof by preponderance*

> *that the actuarial assumptions and methods were in the aggregate unreasonable) is simply a burden to show that the combination of methods and assumptions employed in the calculation would not have been acceptable to a reasonable actuary.* In practical terms it is *a burden to show something about standard actuarial practice*, not about the accuracy of a predictive calculation, even though consonance with professional standards in making the calculation might justify confidence that its results are sound.
>
> . . . . The employer merely has a burden to show that an apparently unbiased professional, whose obligations tend to moderate any claimed inclination to come down hard on withdrawing employers, has based a calculation on a combination of methods and assumptions that *falls outside the range of reasonable actuarial practice*.[17]

The actuarial standards applicable to the selection of a reasonable discount rate for withdrawal liability and the valuation of pension liabilities in general are codified in Actuarial Standard of Practice (ASOPs) Nos. 4 and 27.[18]

DISCOUNT RATE FOR FUNDING PURPOSES VS. DISCOUNT RATE USED FOR WITHDRAWAL LIABILITY

Of all the actuarial assumptions that go into a withdrawal liability assessment, the one that typically has the greatest impact is the discount rate. For this reason, particularly in recent years, employers have focused on attacking the discount rates used for withdrawal liability purposes when they differ from the discount rate used for minimum funding purposes. Specifically, these employers take the position that the discount rate is the discount rate, and it is unfair, unlawful, and unreasonable to apply one discount rate for funding purposes, which affects those employers that have not withdrawn and continue to fund the plan, and a different one for purposes of assessing withdrawal liability, which only affects the employers that have withdrawn from the plan. These employers contend that the use of a lower discount rate, which produces a higher liability, for withdrawn employers is punitive and discriminatory. This argument is, however, premised on a series of misunderstandings and false assumptions.

The economic rationale for using a more conservative (*i.e.*, lower) discount rate for withdrawal liability purposes rather than the discount rate used for funding purposes is compelling. Indeed, it boils down to one simple question: who bears the risk?

Investment return is driven by risk. The riskier the investment, the greater the expected return that will be demanded by an investor to take that risk. The truth of this statement can be demonstrated by a riddle: Which is more valuable: $1,000 worth of government bonds that will pay interest at a guaranteed rate of one percent per year or $1,000 worth of stock for which the expected rate of return is 7.5 percent? The answer, of course, is that they are both worth the same—$1,000—notwithstanding the differences in the expected rate of return. The government bond is risk-free, while the shares of stock are not. Although the shares of stock have the potential to beat their expected rate of return, they are also subject to the risk that they will underperform, and even lose value. In exchange for taking the risk of loss, an investor would be foolish to make the riskier investment unless the investor was likely to get paid for it: this is known as the "risk premium." Indeed, the degree of risk an investor is willing to take is known as "risk tolerance." In short, the greater an investor's risk tolerance, the riskier the investment the investor is willing to make and, in turn, the greater the expected reward.

The key, therefore, to evaluating the reasonableness of any actuarial assumption is the purpose for which that assumption is used. Thus, the calculation of a plan's liabilities in the context of withdrawal liability is distinct from the calculation of a plan's liabilities for determining required minimum funding contributions. Multiemployer plans are required to maintain a funding standard account reflecting specified charges and credits.[19] These charges and credits are applied annually, and include such things as administrative expenses, the cost of benefits being earned under the plan's actuarial cost method, amortization charges for previously-earned benefits, experience gains and losses reflecting the variances between the actuarial predictions and the plan's actual experience on such matters as investment performance, mortality, retirement rates, and so on, and employer contributions.[20] Depending on a plan's experience, the amount of the employer contributions required to satisfy the statutory funding requirements vary from year-to-year. If the contributions payable by the contributing employers are insufficient to satisfy the applicable minimum funding standard for any plan year, the Internal Revenue Code (the Code) imposes additional funding requirements on plans and, potentially, nondeductible excises taxes payable by the contributing employers.[21] Thus, contributing employers bear the ongoing risk of bad experience and of ensuring that a plan continues to satisfy the statutory minimum funding standards.

Withdrawal liability is fundamentally different. By withdrawing from a plan, an employer settles its liability to the plan once and for all and relieves itself (*i.e.*, defeases itself) from all responsibility under the statutory funding standards, along with the ongoing uncertainties

attendant to satisfying those standards. In effect, it is buying an annuity from the plan and the remaining employers, since they now bear all the risk in providing the benefits attributable to the withdrawing employer.

Put in investment terms, the contributing employers now shoulder all the risk. The withdrawn employers, on the other hand, have settled their liabilities once and for all and have defeased themselves of all risk. For this reason, it is only fair that the employers bearing all of the risk—including the risk formerly borne by the withdrawn employers—have the benefit of the risk premium in the form of a higher discount rate. Because the withdrawn employers no longer bear any risk, it is unfair for them to demand the benefit of a risk premium.

For these reasons, perhaps half or more actuaries acknowledge the shifting of risk engendered by an employer's withdrawal by adopting disparate discount rates. In determining a plan's minimum funding requirements, actuaries will typically select a discount rate based upon the anticipated return of a plan's actual mix of assets. Although actuaries may build some conservatism into this rate, generally speaking, the chances of equaling or exceeding the rate are approximately the same as the chances of failing to earn the expected rate or of even losing money.

For withdrawal liability purposes, in recognition of the shifting of risk, actuaries will often take risk off the table with regard to the withdrawing employer by using either a risk-free discount rate or an intermediate rate, somewhere between the risk-free rate and the plan's expected rate of return.

The relevant actuarial standards explicitly recognize and, indeed, encourage this practice:

> 3.9 Selecting a Discount Rate—A discount rate is used to calculate the present value of expected future plan payments. . . . *The actuary should consider the purpose of the measurement as a primary factor* in selecting a discount rate. Some examples of measurement purposes are as follows:
>
> a. Contribution Budgeting—An actuary evaluating the sufficiency of a plan's contribution policy may choose among several discount rates. The actuary may use a discount rate that reflects the *anticipated investment return* from the pension fund. Alternatively, the actuary may use a discount rate appropriate for defeasance, settlement or market-consistent measurements.
>
> b. Defeasance or Settlement—An actuary measuring a plan's present value of benefits on a defeasance or settlement basis

> may use a *discount rate implicit in annuity prices* or other defeasance or settlement options.
>
> c. Market-Consistent Measurements—An actuary making a market-consistent measurement may use a discount rate implicit in the price at which benefits that are expected to be paid in the future would trade in an open market between a knowledgeable seller and a knowledgeable buyer. In some instances, that discount rate may be approximated by market yields for a hypothetical bond portfolio whose cash flows reasonably match the pattern of benefits expected to be paid in the future. The type and quality of bonds in the hypothetical portfolio may depend on the particular type of market-consistent measurement.
>
> The present value of expected future pension payments may be calculated from the perspective of different parties, recognizing that *different parties may have different measurement purposes*. For example, the present value of expected future payments could be calculated from the perspective of an outside creditor or the entity responsible for funding the plan.[22]

Thus, the actuarial guidance acknowledges that the selection of discount rates can vary with the purpose of the calculation, that is, determining funding obligations or settling liabilities. Indeed, it explicitly directs the actuary to consider the purpose in selecting the rate. In valuing a plan's liabilities for purposes of determining the appropriate level of employer contributions, "[t]he actuary may use a discount rate that reflects the anticipated investment return from the pension fund." On the other hand, in valuing a plan's liabilities for purposes of settling or defeasing an employer's liability to a plan (which describes the purpose of withdrawal liability), an actuary may "use a discount rate implicit in annuity prices or other defeasance or settlement options."[23] There is absolutely *no* suggestion that the choice for one purpose forecloses the choice for the other. To the contrary, the explicit declarative that "the purpose of the measurement [is] a primary factor in selecting a discount rate" demonstrates that precisely the opposite is true.[24]

The Pension Benefit Guaranty Corporation (PBGC) requires the use of specified discount rates for valuing plan liabilities in cases of mass withdrawal (the PBGC rate). The PBGC rate is derived by determining the implicit interest rates priced into the cost of commercially available single-premium annuities. It is considered a "risk-free" rate because, in buying an annuity, the buyer absolves itself from any future responsibility for funding the annuity and passes all the risk on to the annuity issuer. It is also considered to be a "market consistent measurement"

because it is based on the actual market price for annuities that provide a stream of payments which precisely match the obligations of the pension plan.[25]

As noted above, actuaries use a range of discount rates for valuing plan liabilities for withdrawal liability purposes. Some actuaries use the funding rate, while others use a defeasance or settlement rate—most typically the PBGC rate. Still others use an intermediate rate—something that is in between the risk-free rate and the funding rate. The most common intermediate rate is known as the Segal Blend, which is a hybrid of a plan's anticipated earnings and a risk-free settlement or defeasance rate. The concept that there is a range of reasonable assumptions is also built into the actuarial standards:

> 3.6.2 Range of Reasonable Assumptions—The actuary should recognize the uncertain nature of the items for which assumptions are selected and, as a result, may consider several different assumptions reasonable for a given measurement. The actuary should also recognize that *different actuaries will apply different professional judgment and may choose different reasonable assumptions. As a result, a range of reasonable assumptions may develop both for an individual actuary and across actuarial practice.*[26]

Notwithstanding the clear language contained in the relevant actuarial guidance, two recent court decisions have led to a flurry of challenges by withdrawing employers related to the use of disparate discount rates for funding and withdrawal liability purposes. To date, there have been four district court decisions specifically addressing this issue. Two of the decisions, *New York Times* and *Sofco*, which we contend were wrongly decided for the reasons outlined below, rejected the use of disparate discount rates for funding and withdrawal liability purposes. Two other cases, *United Mine Workers of America 1974 Pension Plan v. Energy West Mining Company*[27] and *Manhattan Ford Lincoln, Inc. v. UAW Local 259 Pension Fund*[28] reached the opposite result.[29] In the latter two cases, after proper application of the appropriate statutory burdens and examination of the relevant actuarial standards of practice, the courts upheld the arbitrators' decisions that the respective employers had failed to meet their burdens of proof.

HOW *NEW YORK TIMES* AND *SOFCO* GOT IT WRONG

The relevant facts underlying the *New York Times* and *Sofco* cases are nearly identical. Both cases involve participating employers that withdrew from the multiemployer pension plans to which they were

obligated to contribute. In calculating the withdrawing employer's liability, the plans' actuaries utilized the Segal Blend method for purposes of determining the discount rates used to calculate the present value of the plan's UVBs. As stated above, the Segal Blend is an intermediate rate that uses both the market interest rates published by the PBGC—which are essentially "risk free" rates—and the plan's minimum funding investment return rate. While the employers made various challenges to their withdrawal liability calculations, a principle argument was that it was unreasonable as a matter of law to use different rates for purposes of determining a plan's minimum funding requirements and for valuing liabilities for withdrawal liability.[30] In both *New York Times* and *Sofco*, the arbitrators who heard the cases were experts in the complex field of withdrawal liability and affirmed the plans' assessments and calculations against the employers. The employers then appealed the arbitrators' decisions to the appropriate district courts, and the plans filed counterclaims to enforce the decisions.

In clear contravention of the actuarial standards highlighted above, the district courts in *New York Times* and *Sofco* overturned the arbitrators' decisions and found that the plans' use of disparate rates for minimum funding requirements and valuing liabilities for withdrawal liability was unreasonable. While ostensibly applying the appropriate standards, in their decisions the district courts misapplied those standards in a manner contrary to law. Specifically, the district courts: (1) placed the burden on the pension plans to prove that the actuarial assumptions used in their assessments were correct rather than on the withdrawing employer seeking to challenge the assessment as Congress had intended; and (2) substituted their own judgment for that of the arbitrator in clear violation of federal law. While *New York Times* settled prior to a ruling on the merits by the Second Circuit, *Sofco* is, as of this writing, fully briefed, although oral argument has not yet been set.

What the Courts in New York Times *and* Sofco *Got Right*

In both *New York Times* and *Sofco*, the employers made the same argument: that in *Concrete Pipe,* the Supreme Court had ruled as a matter of law that use of disparate rates for funding and withdrawal liability purposes is *per se* unreasonable based upon the similar statutory language applicable to the selection of actuarial assumptions for funding and withdrawal liability purposes. Both the *New York Times* and *Sofco* courts rejected this argument.

Employers that make this argument rely on the following language from the *Concrete Pipe* decision:

> The use of the same language to describe the actuarial assumptions and methods to be used in these different contexts tends to check the actuary's discretion in each of them. "Using different assumptions [for different purposes] could very well be attacked as presumptively unreasonable both in arbitration and on judicial review.
>
> > "[This] view that the trustees are required to act in a reasonably consistent manner greatly limits their discretion, because the use of assumptions overly favorable to the fund in one context will tend to have offsetting unfavorable consequences in other contexts. For example, the use of assumptions (such as low interest rates) that would tend to increase the fund's unfunded vested liability for withdrawal liability purposes would also make it more difficult for the plan to meet the minimum funding requirements of [29 U.S.C.] § 1082."[31]

No court, however, has ever found it *per se* unreasonable to use disparate actuarial assumptions for funding and withdrawal liability purposes, including the district courts in *Sofco* and *New York Times*.[32] While overturning arbitration decisions upholding the use of disparate assumptions, both district courts expressly recognized that neither statute nor case law supports the argument that actuarial assumptions for funding and withdrawal liability must be identical.[33]

In fact, in *Concrete Pipe* itself, the Supreme Court *upheld* an arbitration award in which the arbitrator had rejected the employer's challenge to the plan actuary's use of the Segal Blend.[34] Thus, any claim that *Concrete Pipe* held that the use of disparate discount rates for minimum funding and withdrawal liability purposes is *per se* unreasonable is incorrect. Furthermore, even if such an inference could be drawn from that decision, the fact that the Court's ruling upheld an arbitration decision in which the arbitrator rejected a challenge to the use of the Segal Blend would render such an inference the textbook definition of *obiter dictum*.[35] Furthermore, as explained in *Energy West,* any such inference is directly contradicted by the Supreme Court's own language:

> But the very next sentence in the Supreme Court's opinion dispels any notion that the two rates must be the same as a matter of law: "This point is not significantly blunted by the fact that the assumptions used by the Plan in its other calculations may be

> supplemented by several actuarial assumptions unique to withdrawal liability."[36]

What the Supreme Court did hold in *Concrete Pipe*, is that any consideration of the reasonableness of the assumptions used by an actuary in valuing a plan's liabilities must be determined by reference to the actuarial standards of practice.[37]

Additionally, subsequent to the Supreme Court's decision in *Concrete Pipe,* the standards applicable to actuarial assumptions used for minimum funding purposes was modified, so that the two standards are no longer the same.[38] Previously, both of the standards required only that the actuarial standards be reasonable "in the aggregate." Now, the standard applicable to the actuarial assumptions used for minimum funding purposes must be individually reasonable. As the court stated in *Manhattan Ford*:

> The minimum funding Section, then, requires actuarial assumptions and methods each of which is reasonable. The withdrawal liability Section differs in requiring that actuarial assumptions and methods be found reasonable in the aggregate. The former standard is tighter, more granular; it invites item-by-item comparison in a way the latter does not. Requiring that all assumptions, taken in the aggregate, be reasonable would seem to grant the actuary (and the Arbitrator) more latitude to craft a solution that is reasonable and fair overall, in light of the Plan's experience and expectations.[39]

Thus, with regard to evaluating the appropriateness of the discount rates selected by a plan's actuary for minimum funding and withdrawal liability purposes, not only are these discount rates being used to predict different things, the standards for evaluating those assumptions are now different.

Failure to Apply the Appropriate Statutory Burden

Where the *New York Times* and *Sofco* courts went astray was in their misapplication of the statutory burdens. Both courts substituted their own actuarial judgments in place of the plans' actuaries and required that the plans use the discount rate assumption used to value its liabilities for statutory minimum funding purposes instead of the Segal Blend. These mistakes appear to have arisen from the district courts' misinterpretations of the statutory requirement that withdrawal liability assessments be based on:

> actuarial assumptions and methods which, in the aggregate, are reasonable (taking into account the experience of the plan and reasonable expectations) and which, in combination, *offer the actuary's best estimate of anticipated experience* under the plan . . .[40]

As explained in multiple court decisions, this "best estimate" requirement is not a substantive standard. Rather, it is:

> *procedural only, and does not place a second substantive hurdle* in the path of actuarial assumptions. Rather, it is "principally designed to insure that the chosen assumptions actually represent the actuary's own judgment rather than the dictates of plan administrators or sponsors."[41]

In other words, the "best estimate" requirement is meant to ensure that an actuary was not improperly influenced by third parties. By elevating the "best estimate" requirement into a substantive standard, the district courts in *New York Times* and *Sofco* managed to both eliminate all the statutory presumptions and allocations of the burden of proof and directly violate precedent.

In *New York Times*, although the employer at least produced an expert, it adduced *no evidence* that the actuary's assumptions were unreasonable. As stated by the arbitrator: "[t]he Times's expert did not opine whether the 6.5-percent effective discount rate resulting from the use of the Segal Blend was or was not a reasonable number."[42] In fact, the *only* "evidence" relied upon by the district court was the following:

> Egan's [the Plan actuary's] testimony before the Arbitrator was that a 7.5% percent assumption was her "best estimate of how the Pension Fund's assets . . . will on average perform over the long term." Arb. Tr. 568:3-8 [NYT App. A2, p. A. 188]; see Arb. Tr. 600:3-15 [NYT App. A2, p A. 196](observing that the Segal Blend was "lower" than Egan's best estimate of anticipated plan experience in the long term). *If 7.5% was the Fund actuary's "best estimate," it strains reason to see how the Segal Blend, a 6.5% rate derived by blending that 7.5% "best estimate" assumption with lower, no-risk PBGC bond rates, can be accepted as the anticipated plan experience.* This is especially [true] when the blend includes interest rates for assets not included in the Fund's portfolio. The Segal Blend's applicability is further undermined by Egan's acknowledgement that she had used the Segal Blend as her "best estimate" when[43] calculating [withdrawal] liability "regardless of the particular

> pension plan's actual portfolio of assets." Arb. Tr. 585:10-586:5 [NYT App. A2, p. A.192].

Thus, the only support for the employer's assertion that the actuarial assumptions were unreasonable in the aggregate was the actuary's use of a higher discount rate (7.5 percent) in valuing the plan's liabilities for contributions required to fund the plan rather than the composite 6.5 percent rate she used in valuing the plan's liabilities for withdrawal liability purposes.

In *Sofco*, the lack of evidence purporting to show that the actuary's assumptions were unreasonable is even more glaring. Indeed, as in *New York Times,* the employer adduced no evidence of any kind to challenge any of the plan's actuarial assumptions. Unlike in *New York Times,* however, it did not even produce any expert testimony. Although the district court in *Sofco* does not fully explain the basis for its decision, its reliance on *New York Times* suggests that it based its decision upon the same misconceptions.

In both cases, the courts assumed that the discount rate used for determining the present value of the plan's liabilities for funding purposes and the discount rate used in determining plan liabilities for withdrawal liability purposes are necessarily measuring the same thing: the plan's anticipated rate of earnings. Based on this false premise, the district courts concluded the requirement that the "actuarial assumptions and methods …, in combination, offer the actuary's best estimate of anticipated experience under the plan" means that the interest rate assumption used to calculate withdrawal liability must offer the actuary's best estimate of the anticipated long-term rate of return on the plan's mix of assets. In doing so, the courts directly contradicted their own (correct) holdings which found that funding and withdrawal liability discount rates need not be identical as a matter of law. The courts in effect created their own presumption that any discount rate for withdrawal liability different from the funding rate is presumed to be unreasonable, and imposed on the plans the burden of overcoming that presumption.

As explained above, the discount rates used for these two purposes do not measure the same thing. Although the discount rate used for minimum funding purposes is typically based on the plan's expected rate of return based upon its mix of assets, the discount rate used for withdrawal liability purposes might measure something quite different. In its simplest terms, that rate might be risk-adjusted, reflecting, in whole or in part, the withdrawn employers' settlement of its liabilities and defeasance of risk. This is, of course, explicitly permitted under the relevant actuarial standards.

Thus, the courts' misconstruction of the appropriate standard is directly contrary to the unambiguous statutory language and the Supreme Court's holding in *Concrete Pipe*. As explained above, ERISA

explicitly places the burden of proof on the party challenging the actuarial assumptions to "*show by a preponderance of evidence* that the *assumptions were unreasonable in the aggregate*."[44] The statute contains no language that qualifies the standard of proof or shifts that burden based on whether the plan uses different assumptions for minimum funding and withdrawal liability. Further, the notion that an actuary must somehow "reconcile" the disparity among these assumptions ignores the express directive of the actuarial standards, which acknowledge that determining funding obligations and settling liabilities are two distinct purposes of measurement.

Misapplication of the Standard of Review

As with their decisions regarding the allocation of the burden of proof, the district courts in *New York Times* and *Sofco* also misapplied the appropriate standard for review of the arbitrators' decisions. The relevant provision of ERISA states as follows:

> Presumption respecting finding of fact by arbitrator —In any proceeding under subsection (b) of this section, there shall be a presumption, rebuttable only by a clear preponderance of the evidence, that the findings of fact made by the arbitrator were correct.[45]

In substituting their judgment for that of the arbitrators, the district courts failed to comply with this statutory standard.

In *New York Times*, the district court determined that its review of the arbitrator's decision to reject the employer's challenge to the discount rate assumption was a mixed issue of fact and law subject to the "clear error" standard. As explicitly recognized by the Supreme Court in *Concrete Pipe*, the question of whether a plan's actuarial assumptions for withdrawal liability purposes are "in the aggregate, unreasonable" is factual in nature and must be evaluated with reference to prevailing standards.[46] Thus, while an arbitrator's purported failure to apply a correct standard in evaluating a matter of fact might itself be a mixed question, the underlying factual determination remains just that—a factual determination subject to full statutory deference. This principle has been recognized by several courts when evaluating similar challenges to a withdrawal liability assessment.[47]

The level of deference afforded to findings of fact by arbitrators has been construed as follows:

> The arbitrator was required to assess the facts of this case in light of the rebuttable presumption in favor of the [] Fund, and the

> district court, in turn, was required to review the arbitrator's findings of fact for clear error. We must also review the arbitrator's findings of fact for clear error, which means that we will only disturb the arbitrator's findings if, after reviewing the entire record, we are left with the definite and firm conviction that a mistake has been committed.[48]

In explaining the reasons for this level of deference, the same court stated:

> Furthermore, deference to the findings of the arbitrator is proper because the arbitrators chosen to resolve the complicated issue of withdrawal liability often have relevant expertise in the field of pension law which can contribute significantly to the accuracy of a decision.[49]

The result in *New York Times* and *Sofco* demonstrate the wisdom of this statement.

The arbitrator in *New York Times* determined that the employer had presented no evidence that the plan's actuary's use of the Segal Blend was unreasonable.[50] Instead, the employer's argument consisted solely of testimony that any use of disparate discount rates was *per se* unreasonable as a matter of law—an argument explicitly (and correctly) rejected by both the arbitrator and the district court.[51] The district court, however, failed to accord any discernable deference to the arbitrator's factual determinations regarding the appropriate discount rate. Instead, the district court merely substituted its own judgment for that of the arbitrator.

Even more disturbing, in *Sofco*, the employer did not even attempt to present any evidence at all regarding the discount rate assumption. Rather, citing to *New York Times*, it made the same legal argument expressly rejected by the district court in that case—that the use of disparate interest rates was unlawful. Nevertheless, without citing to any evidence in the record, the district court in *Sofco* relied upon *New York Times* to reverse the arbitrator's decision. In this sense, *Sofco* is on all fours with the erroneous decision in *New York Times*. In both cases, the employer presented no evidence that the use disparate discount rates was unreasonable. In both cases, the employer's sole argument was that the use of disparate discount rates was unlawful and unreasonable as a matter of law. In both cases, the district court correctly *rejected* the employer's argument. Nevertheless, in both cases, the district court ignored the evidence and the statutory presumptions, concluded that the use of disparate rates was unlawful, and itself selected the discount rate the plan was required to use.

The basis for the *New York Times'* court's erroneous decision may best be encapsulated in the following quote:

> [i]n sum, the actuary's testimony,[52] combined with the untethered composition of the Segal Blend and paucity of analysis by the Arbitrator, create "a definite and firm conviction that a mistake has been made" in accepting the Segal Blend; as such, this Court will "set the findings aside even though there is evidence supporting them that, by itself, would be considered substantial." Accordingly, the Arbitrator's decision that the Segal Blend was the appropriate rate to calculate the Times' partial withdrawal is reversed. *In the absence of additional evidence sufficient to support a different rate*, the Times' liability should be recalculated using the 7.5% assumption testified to as the "best estimate."[53]

The arbitrators in *New York Times* and *Sofco* specifically found that the employers presented no evidence that the discount rate used by the plan's actuary was unreasonable. Based on this finding, the arbitrators concluded that the employers had not met their burden. Indeed, the plans should have prevailed even if they presented *no evidence at all* of the reasonableness of the actuarial assumptions. Nevertheless, the district courts relied on their own misunderstanding of actuarial principles to not only shift the burden of proof to the plans and to reject the plans' affirmative evidence supporting the reasonableness of their discount rate assumption but also to substitute their own judgment for that of the arbitrators. This is clearly a misapplication of the appropriate standard.

THE COSTLY BURDEN THESE CASES THREATEN TO IMPOSE ON MULTIEMPLOYER PLANS

The use of different discount rates to determine a plan's minimum funding requirements and value liabilities for withdrawal liability purposes is common. As testified in *New York Times,* more than 30 percent of plans use the Segal Blend to value their unfunded vested benefits for withdrawal liability purposes.[54] Still, other plans use other rates, including the PBGC's risk-free discount rates applicable to pension plan terminations.[55] For these plans using disparate discount rates, the *New York Times* and *Sofco* decisions have perpetuated an unwarranted and improper hurdle—an undefined presumption of unreasonableness—that the plan must overcome in order to collect assessments of withdrawal liability. As explained above, *New York Times* settled prior to a ruling by the Second Circuit. *Sofco*, however, is currently pending before Sixth Circuit. If

left unreversed, this ruling has the potential to dramatically increase the costs to multiemployer pension plans of enforcing withdrawal liability assessments.

In crafting the statutory presumptions in favor of multiemployer plans, Congress specifically anticipated—and rejected—such a result. As stated by the Sixth Circuit:

> The series of presumptions prescribed by the Multiemployer Act were intended by Congress to "ensure the enforceability of employer liability. *In the absence of these presumptions, employers could effectively nullify their obligation by refusing to pay and forcing the plan sponsor to prove every element involved in making an actuarial determination*."
>
> In an attempt to circumvent these problems, Congress granted the presumption in favor of the trustees' calculation of withdrawal liability. The burden of proof is on the employer. In meeting this burden, the test is not which withdrawal determination is the most reasonable but rather whether the challenged determination is unreasonable or clearly erroneous.[56]

That Congress intended for multiemployer plans to not have to surmount unnecessary hurdles in working to ensure their continued ability to provide benefits to their participants and beneficiaries is also manifest in other parts of the law. For example, Congress also required employers to make their withdrawal liability payments even while they are actively disputing their liability for those payments.[57] As stated in the legislative history:

> The committee believes it is extremely important that a withdrawn employer begin making the annual payments even though the period of years for which payments must continue will be based on the actual liability allocated to the employer.[58]

This same Congressional intent is also manifest in another part of the law added at the same time as the withdrawal liability provisions. In concluding that ordinary contract defenses may not be raised in an action by a multiemployer plan under Section 515 of ERISA[59] to collect contributions from a contributing employer, the Sixth Circuit stated:

> The passage of § 515 arose from Congress's concern that "simple collection actions brought by plan trustees [had] been converted into lengthy, costly and complex litigation concerning claims and defenses *unrelated* to the employer's promise and the plans' entitlement to the contributions, and steps [were required] to simplify

> delinquency collection." [*Kaiser Steel Corp. v. Mullins*, 455 U.S. 72, 87 (1982)] (internal quotation marks omitted). As the Seventh Circuit explained:
>
> > [Multi-employer] plans rely on documents to determine the income they can expect to receive, which governs their determination of levels of benefits. . . . Once they promise a level of benefits to employees, they must pay even if the contributions they expected to receive do not materialize. . . . Costs of tracking down reneging employers and litigating also come out of money available to pay benefits. The more complex the litigation, the more the plan must spend. Litigation involving conversations between employers and local union officials—conversations to which plans are not privy—may be especially costly, and hold out especially great prospects of coming away empty-handed.
>
> [*Cent. States, Se. & Sw. Areas Pension Fund v. Gerber Truck Serv., Inc.,* 870 F.2d 1148, 1151 (7th Cir. 1989) (*en banc*).]. Thus, governing law restricts the defenses employers may raise to suits brought to collect delinquent contributions to ERISA funds.[60]

Under the plain language of ERISA and the Supreme Court's explication of that language in *Concrete Pipe,* an employer has an affirmative duty to adduce sufficient evidence to prove that the actuarial assumptions used in a withdrawal liability assessment are unreasonable in the aggregate in order to successfully challenge those assumptions. Furthermore, an arbitrator's finding upholding those assumptions is entitled to deference, reversable only on clear error. By adding what amounts to a presumption of unreasonableness to a plan actuary's assumptions based upon nothing more than the actuary's decision to apply different discount rates for different purposes, the district courts' decisions are both contrary to the plain language of ERISA, the clear expression of Congressional intent, and the controlling case law.

NOTES

1. *New York Times Co. v. Newspaper & Mail Deliverers'- Publishers' Pension Fund,* 303 F. Supp. 3d 236, 254 (S.D.N.Y. 2018); *Sofco Erectors, Inc. v. Trustees of Ohio, Operating Engineers, Pension Fund,* No. 2:19-CV-2238, 2020 WL 2541970, slip. op. at *8–9 (S.D. Ohio May 19, 2020).

2. 29 U.S.C. §§ 1001 *et seq*.

3. *Pension Benefit Guar. Corp. v. R.A. Gray & Co.,* 467 U.S. 717, 720 (1984) (citing to *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 375 (1980)).

4. 29 U.S.C. §§ 1381 *et* seq.

5. ERISA §§ 4201(a), 4203(a), 4205(a), 29 U.S.C. §§ 1381(a), 1383(a), 1385(a).

6. ERISA § 4201(a); 29 U.S.C. § 1381(a).

7. *See R.A. Gray & Co.*, 467 U.S. at 725.

8. ERISA § 4211(b)-(d); 29 U.S.C. § 1391(b)-(d).

9. *See* ERISA § 4211; 29 U.S.C. § 1391.

10. ERISA § 4219(b)(2)(A), 29 U.S.C. § 1399(b)(2)(A).

11. ERISA § 4221(a)(1), 29 U.S.C. § 1401(a)(1).

12. ERISA § 4221(b)(2), 29 U.S.C. § 1401(b)(2).

13. ERISA § 4221(b)(1), 29 U.S.C. § 1401(b)(1).

14. ERISA § 4221(d), 29 U.S.C. § 1401(d).

15. *Id.,* 29 C.F.R. § 4219.31(d).

16. ERISA § 4221(a)(3)(B)(i), 29 U.S.C. § 1401(a)(3)(B)(i) (emphasis added).

17. *Concrete Pipe & Products of California, Inc. v. Constr. Laborers Pension Trust for Southern California,* 508 U.S. 602, 634–35 (1993). *See Board of Trustees, Michigan Food and Commercial Workers v. Eberhard Foods,* 831 F.2d 1258, 1263 (6th Cir. 1987) ("the employer is only entitled to complain if he proves that the actuarial assumptions applied by the trustees in the aggregate are unreasonable.").

18. *http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop027_172.pdf*; *see also*, *http://www.actuarialstandardsboard.org/wp-content/uploads/2020/07/asop027_197.pdf*.

19. IRC §§ 412 and 431, 26 U.S.C. §§ 412 and 431.

20. IRC §§ 431(a), (b)(2), (3), 26 U.S.C. § 431(a), (b)(2), (3).

21. *See* IRC §§ 275(a)(6), 432(a), (b)(2), (e), 4971(a)(2), (b), (g), 26 U.S.C. §§ 275(a)(6), 432(a), (b)(2), (e), 4971(a)(2), (b), (g).

22. ASOP 27, § 3.9 (emphasis added).

23. *Id.*

24. *Id.*

25. *See* ASOP 27, § 3.9(c).

26. ASOP 27, § 3.6.2 (emphasis added).

27. *(Slip op.),* C.A. No. 1:18-cv-01905 (CJN), (D. DC May 22, 2020).

28. 331 F. Supp. 3d 365 (D.N.J. 2018).

29. Of these three cases, only *Energy West* is on appeal. *United Mine Workers of America 1974 Pension Plan v. Energy West Mining Company,* No. 20-07054 (D.C. Cir. Filed Jun 24, 2020). Although appeals were initiated in the other two cases, they were either withdrawn or settled. *Manhattan Ford Lincoln Inc v. UAW Local 259 Pension Fund*, No. 2:17-cv-05076-KM-MAH (3d Cir. Oct. 9, 2018), ECF No. 32; *New York Times Company v. Newspaper and Mail Deliverers'-Publishers' Pension Fund*, No. 18-01140 (2d Cir. Oct. 16, 2019), ECF 127, No. 18-1408, ECF 101.

30. In *New York Times*, the applicable PBGC rates for calculating the Segal Blend were 5.50% for the first 20 years and 5.02% thereafter, and the discount rate used for minimum funding was 7.5%, yielding an effective discount rate of approximately 6.5%. In *Sofco*, the applicable PBGC rates for purposes of calculating the Segal Blend were 2.44% for the first 20 years and 2.74% thereafter and the discount rate for minimum funding was 7.25%.

31. *Concrete Pipe, supra* n.17 at 632–33, quoting from *United Retail & Wholesale Employees Teamsters Union Local No. 115 Pension Plan v. Yahn & McDonnell, Inc.,* 787 F. 2d, 128 at 146–47 (Seitz, J., dissenting in part). *Affirmed* by an equally divided court, 481 U. S. 735 (1987).

32. *Slip op.* at 18–19; *see New York Times, supra* n.1 at 254; *see also Energy West, supra* n.29, *slip op.* at 15–16; *Manhattan Ford, supra* n.29 at 386.

33. *Id.*

34. *See In re Concrete Pipe,* Arbitration Decision, reprinted at Brief for Defendants' Appellees-Cross-Appellants, *Newspaper and Mail Delivers'—Publishers Pension Fund, et al., New York Times*, Case No. 18-1140 (2nd Cir.), p. Add.91–Add.94, ECF 57-4, pp. 27–30.

35. "Latin 'something said in passing.' A judicial comment made while delivering a judicial opinion, but one that is unnecessary to the decision in the case and therefore not precedential (although it may be considered persuasive)." *Black's Law Dictionary* (11th ed. 2019).

36. *Energy West, supra* n.29, *slip op.* at 15, quoting *Concrete Pipe, supra* n.17 at 633; *see Manhattan Ford, supra* n.29 at 387.

37. *Concrete Pipe, supra* n.17 at 635.

38. § 201 of the Pension Protection Act of 2006, Pub. L. 109-280, 120 State. 780, *amending* ERISA § 304(c)(3)(a), 29 U.S.C. § 1084(c)(3)(a), and 26 U.S.C. § 431(c)(3)(a).

39. *Manhattan Ford,* 331 F. Supp 3d at 386–87.

40. ERISA § 4213(a)(1), 29 U.S.C. § 1393(a)(1) (emphasis added).

41. *Rhoades, McKee & Boer v. United States,* 43 F.3rd 1071, 1075 (6th Cir. 1995) citing *Vinson & Elkins v. Comm'r of Internal Revenue,* 7 F.3d 1235, 1238 (5th Cir.1993); *Wachtell, Lipton, Rosen & Katz v. Comm'r of Internal Revenue,* 26 F.3d 291, 296 (2d Cir.1994). *See e.g., Citrus Valley Estates, Inc. v. Comm'r.,* 49 F.3d 1410, 1415 (9th Cir. 1995); *Huber v. Casablanca Indus., Inc.,* 916 F.2d 85, 93 (3d Cir. 1990); *United Mine Workers of Am. 1974 Pension Plan v. Energy W. Mining Co.,* Civ. A. No. 1:18-cv-01905, 2020 BL 192243 (D.D.C. May 22, 2020).

42. The New York Times Co. Appendix A1 (NYT App. A1), p. A.36.

43. *New York Times*, *supra* n.1 at 255.

44. ERISA § 4213(a)(1), 29 U.S.C. § 1393(a)(1) (emphasis added).

45. ERISA § 4221(c), 29 U.S.C. § 1401(c).

46. *Concrete Pipe, supra* n.17.

47. *Eberhard Foods, supra* n.17 at 1262. *See Concrete Pipe, supra* n.17 at 635; *Manhattan Ford*, *supra* n.29 at 379–80.

48. *Sherwin-Williams*, 158 F.3d at 393, citing *Anderson v. City of Bessemer City*, 470 U.S. 564, 570 (1985).

49. *Sherwin-Williams, supra* n.48.

50. NYT App. A1, p. A.36.

51. *New York Times*, *supra* n.1 at 255; NYT App. Al, p. A. 36.

52. The *New York Times'* court's belief that the actuary had testified that the use of the Segal Blend was *not* her best estimate was also erroneous and is flatly contradicted by the record. Deposition of Rosana Egan, *New York Times,* Appendix Vol. II, p. A.192 (2nd Cir. Case No. 18-1140), ECF No. 38, p. 92.

53. *New York Times, supra* n.1 at 256 (citations omitted, emphasis added).

54. NYT App. A1, p. A.34.

55. *See, e.g., Energy West, supra* n.29, *slip op.* at 4.

56. *Eberhard, supra* n.17 at 1260–61, quoting fromH.R. Rep. No. 869, pt. I, 96th Cong., 2d Sess. 1, 86, reprinted in 1980 U.S. Code Cong. & Admin. News 2918, 2954 (citations omitted, emphasis added); *see Concrete Pipe, supra* n.17 at 628 (relying on the same legislative history).

57. *See Findlay Truck Line, Inc. v. Cent. States, Se. & Sw. Areas Pension Fund,* 726 F.3d 738, 742 (6th Cir. 2013); *T.I.M.E.-DC, Inc. v. Mgmt.-Labor Welfare & Pension Funds of Local 1730 Longshoremen's As*sociation, 756 F.2d 939, 946 (2d Cir. 1985) ("The most significant aspect of the notice scheme is that no matter what disputes arise between the old plan sponsor and the employer over the amount of liability, the employer is obligated to pay the withdrawal liability demanded as soon as the plan sponsor has provided notice of the payment schedule under [ERISA Section 4219(b)(1), 29 U.S.C.] § 1399(b)(1).").

58. *Concrete Pipe, supra* n.17 at 628, *quoting* H. R. Rep. *supra* n.56.

59. § 515 of ERISA, 29 U.S.C. § 1145, was added to the law as part of the Multiemployer Pension Plan Amendments Act of 1980, Pub. L. 96-364, which also added the withdrawal liability provisions. ERISA §§ 4201-4225, 4301, 29 U.S.C. §§ 1381-1405, 1451.

60. *Operating Engineers Local 324 Health Care Plan v. G&W Constr. Co.,* 783 F.3d 1045, 1051–52 (6th Cir. 2015) (emphasis added); *see also Benson v. Brower's Moving & Storage, Inc.,* 907 F.2d 310, 314 (2d Cir. 1990).

2020 Parity Tool Issued

Karen R. McLeese

Since the enactment of the federal mental health parity laws almost 25 years ago, compliance with the law has spawned a plethora of litigation, as well as enforcement actions by the Department of Labor's (DOL's) Employee Benefit Security Administration (EBSA).

As background, the Mental Health Parity Act enacted in 1996,[1] as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act in 2008[2] (collectively referred to as MHPAEA herein), provide that if mental health benefits and substance use disorder benefits are to be provided under a plan, the benefits must be offered in parity with covered medical and surgical services. Notably, these laws do not require plans to offer mental health or substance use disorder services. For this purpose, *parity* refers to plan benefits including annual and lifetime limitations, as well as financial and treatment limitations relating to both quantitative and nonquantitative services, as more fully described below.

To assist health insurers, third-party administrators, plan sponsors, and employers in their compliance with the federal mental health parity laws, the tri-governing agencies (Departments of Labor, Health and Human Services, and Treasury) continue to provide tools and guidance. One of these tools, known as the *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*[3] reiterates the requirements of the federal mental health parity laws and provides illustrations of parity, as well as compliance tips.

In its biannual obligation to provide a compliance tool, EBSA released a revised version of the Compliance Tool on October 26, 2020. This Compliance Tool, initially released in 2018, has been modified as a result of public responses received by EBSA, and as a result of its enforcement actions. Of particular note, the revised tool integrates previously issued guidance, provides additional examples and warning signs of potential parity issues, and describes best practices for internal compliance.

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AFFECTED PLANS

As emphasized in Section A of the Compliance Tool, the MHPAEA generally applies to[4]:

- Group health plans sponsored by employers employing 51 or more employees (an increased cost exemption is available for certain large group health plans)[5];
- Grandfathered and nongrandfathered individual policies; and
- Small nongrandfathered insured plans subject to the Affordable Care Act's essential health benefit provisions, which include coverage for mental health and substance use disorder services, including behavioral health treatment.

The MHPAEA does not apply to certain plans, including:

- Retiree-only group health plans;
- Individual or group health insurance coverage offering only excepted benefits;
- Self-insured small private employer plans covering 50 or fewer employees;
- Self-insured nonfederal governmental plans covering 50 or fewer employees; and
- Large self-funded nonfederal governmental employers who opt out of the requirements of MHPAEA.

ANNUAL AND LIFETIME LIMITATIONS

Under the MHPAEA and as illustrated in Section C of the Compliance Tool, annual or lifetime dollar limits for medical and surgical benefits must be comparable to those applicable for mental health benefits and substance use disorder benefits[6]—notably, to the extent that a benefit qualifies as an essential health benefit as defined by the Affordable Care Act,[7] no lifetime or annual limit can be imposed.

FINANCIAL AND TREATMENT LIMITATIONS

As further explained in Sections D and E of the Compliance Tool, mental health, and substance use disorder services must be treated in a substantially similar manner to all covered medical and surgical services under the health plan.[8] For purposes of applying these rules:

- **Financial limits or cost-sharing requirements**[9] include deductibles, copayments, coinsurance, and out-of-pocket maximums. Deductibles and out-of-pocket maximums cannot accumulate separately for medical/surgical benefits, and mental health and substance use disorder benefits, as this would be an impermissible financial constraint.

- **Treatment limits**[10] refer to the frequency of the treatments, number of visits, days of coverage, days in a waiting period, or similar limits. Plans cannot avoid the law by setting up a plan for mental health services or substance use disorder benefits only.

Appendix I of the Compliance Tool provides examples of potentially impermissible limits in the application of these rules.

Quantitative Limitations

A plan cannot impose a financial limit or *quantitative limit* for mental health and substance use disorder benefits that is more restrictive than the financial limit or quantitative limit applicable to all medical/surgical benefits in the same classification.[11] Generally, this applies to six classifications of benefits under a plan:

- Inpatient services (both in- and out-of-network);

- Outpatient services (both in- and out-of-network);

- Emergency care; and

- Prescription drugs.

For purposes of applying the financial and treatment rules to outpatient services, plans may establish two subclassifications; one for office visits (such as physician visits), and one for all other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

Further, if a plan provides in-network benefits through multiple tiers of in-network providers such as an in-network tier of preferred providers with more generous cost sharing to participants than a separate in-network tier of participating providers, the plan can divide its benefits furnished on an in-network basis into subclassifications that reflect those network tiers. Such tiering must be based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.

Coverage for mental health and substance use disorder conditions must include expenses relating to the treatment of eating disorders.[12]

Nonquantitative Treatment Limitations

The financial and treatment limitations described above also apply to *nonquantitative treatment limitations* (NQTL).[13] As further illustrated in Section F of the Compliance Tool, examples of these types of NQTLs include:

- Medical management standards that limit or exclude benefits based on medical necessity or appropriateness, or based upon whether the treatment is experimental or investigative.

- Prescription drug formulary limits.

- Standards for provider admission to participate in a network, including reimbursement rates. Of particular note, Appendix II provides examples of potential warning signs with regard to provider reimbursement rate setting.

- Plan methods for determining usual, customary, and reasonable charges.

- Requirements to use lower-cost therapies in a progression approach, commonly referred to as, "step therapy," or fail-first policies as they apply to inpatient and outpatient treatment.

- Conditioning the availability of a benefit upon completion of a course of treatment. Specifically, a plan cannot require an individual to exhaust employee assistance program (EAP) counseling—*i.e.*, making the EAP a "gatekeeper"—before benefits are available under the plan, unless the same is required for medical/surgical services.

- Comparable provider reimbursement rates and network provider participation standards.

Certain NQTL limits that vary based on clinically appropriate standards of care are permitted. While plans are not required to use the same limits for both medical/surgical and mental health and substance use disorder benefits, the processes or standards of care must still be comparable and applied uniformly.

INTERNAL COMPLIANCE PLAN

Section H of the Compliance Tool provides recommendations for establishing an internal compliance plan. While it is not mandatory for plan sponsors to establish such a program, it would constitute a best practice to ensure compliance. Among the recommendations for developing an internal compliance plan include:

- Conducting training and education;
- Ensuring retention of records and information;
- Conducting internal monitoring and compliance reviews on a regular basis; and
- Responding to potential violations and developing corrective action.

Of particular note, Section H of the Compliance Tool outlines the items a group health plan sponsor may be required to provide in the event of a DOL audit. For example, a DOL examiner may request:

- Documentation of the methodology in the application of NQTLs to both mental health and substance use disorder benefits and medical and surgical benefits offered under the plan;
- Documentation and guidelines, claims processing policies and procedures, or other standards that the plan has relied upon as the basis for determining its compliance with applying NQTL to mental health and substance use disorder benefits and medical and surgical benefits;
- Samples of covered and denied benefit claims relating to mental health and substance use disorder benefits and medical and surgical benefits;

- If a plan delegates management of benefits to another entity, such as a third-party administrator or other service providers, documentation of that entity's compliance with the MHPAEA; and

- Any MHPAEA testing completed by the plan as it relates to the financial requirements or treatment limits applied to mental health and substance use disorder benefits.

COORDINATION WITH OTHER LAWS

All relevant laws must be considered in coordinating the benefits. Many state insurance laws impose parity requirements on individual and group health plans between mental health and substance use disorder benefits and medical-surgical benefits by supplementing the requirements of the MHPAEA.

ENFORCEMENT AND PENALTIES

Plans that fail to comply with the MHPAEA are subject to excise tax penalties of up to $100 per day of noncompliance imposed by the Internal Revenue Service pursuant to Internal Revenue Code Section 4980D.[14] In addition, private lawsuits may be brought under the Employee Retirement Income Security Act.[15]

CONCLUSION

Plan sponsors will want to work with their insurers, or third party administrators, as applicable, to ensure compliance with the law, not only because it is the right thing to do but also because compliance with the law continues to be a priority for the DOL, as evidenced in its annual summary of enforcement action and violation compendium.

NOTES

1. Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997, Pub. L. No. 104-204 (1996).

2. Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343 (2008), as amended by Pub. L. No. 110-460 (Dec. 23, 2008).

3. *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)* (available at: *http://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*).

4. Public Health Service Act (PHSA) §§ 2726(a)(1) and 2726(a)(3) [42 USC § 300gg-26], as amended by the Patient Protection and Affordable Care Act (PPACA) (Pub. L. No 111-148, Mar. 23, 2010). *Also see* 29 CFR 2590.712(e); 26 CFR 54.9812-1(e); 45 CFR 146.136(e).

5. *See* FAQ 11 from "FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation," (Dec. 22, 2010) (available at: *http://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-v.pdf*).

6. *See* 29 CFR 2590.712(b); 26 CFR 54.9812-1(b); 45 CFR146.136(b).

7. 45 CFR 156.115(a)(3).

8. ERISA § 712(a)(3)(i); IRC § 9812(a)(3)(i); PHSA § 2726(a)(3(i)), as amended by PPACA.

9. ERISA § 712(a)(3)(B)(i); IRC § 9812(a)(3)(B)(i); PHSA § 2726(a)(3)(B)(i), as amended by PPACA.

10. ERISA § 712(a)(3)(B)(iii); IRC § 9812(a)(3)(B)(iii); PHSA § 2726(a)(3)(B)(iii), as amended by PPACA.

11. *See* 29 CFR 2590.712(a); 26 CFR 54.9812-1(a); and 45 CFR146.136(a).

12. *See* FAQ 8 from "FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39" (Sept. 5, 2019; (available at: *http://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf*).

13. *See* 29CFR 2590.712(c)(4)(i); 26 CFR 54.9812-1(c)(4)(i); 45 CFR146.136(c)(4)(i).

14. IRC § 4980D.

15. ERISA § 502.

Interim Section 162(m) Guidance: Days Dwindling for NQDC Plan Amendments to Delete Nondeductible Deferred Compensation Delays

Dominick Pizzano, Henrik Patel, and Kenneth Barr

The Tax Cuts and Jobs Act of 2017 (*TCJA*) amended Section 162(m) of the Internal Revenue Code of 1986 (the Code). Section 162(m) generally limits the ability of publicly held corporations to deduct compensation amounts in excess of one million dollars in any year with respect to certain executives of the company that are deemed to be "covered employees" under Section 162(m). The TCJA made a number of changes to Section 162(m), including changing who is a covered employee under that section and generally eliminating the ability of publicly held corporations to exempt performance-based compensation from the one million dollars deduction limitation of Section 162(m), subject to a grandfather rule for certain arrangements. On August 21, 2018, the Treasury Department and the Internal Revenue Service (IRS) released Notice 2018-68, which provides interim guidance on certain issues under the amended Section 162(m). On December 20, 2019, proposed regulations were issued.[1] This column will review some of the issues under Section 162(m), as amended by the TCJA, discussed in this interim guidance including whether publicly held corporations that sponsor nonqualified deferred compensation plans (NQDC) need to review these arrangements to determine whether the plans contain a provision that would require the sponsor to defer distribution of compensation or benefits if the sponsor reasonably anticipates that such distribution would limit the employer's tax deduction due to the limits imposed by Section 162(m). Any

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NQDC plans with language requiring such a delay must be amended by no later than December 31, 2020, in order to permit earlier distribution of such amounts.

HISTORY OF SECTION 162(M)

Section 162(m) generally disallows the corporate tax deduction by any publicly held corporation for remuneration paid with respect to any covered employee to the extent that such remuneration for the taxable year exceeds one million dollars. Section 162(m) was added to the Code in 1993 with the passage of the Omnibus Budget Reconciliation Act of 1993. The intended purpose of the rule was to attempt to dissuade employers from paying excessive executive compensation by substantively increasing the after-tax cost of paying specified key executives amounts over one million dollars. However, the initial rule contained an exception for "performance-based" compensation for "covered employees."

> Before the TCJA, [S]ection 162(m)(4)(C) defined performance-based compensation as "any remuneration payable solely on account of the attainment of one or more performance goals, but only if—
>
> (i) the performance goals are determined by a compensation committee of the board of directors of the taxpayer which is comprised solely of 2 or more outside directors;
>
> (ii) the material terms under which the remuneration is to be paid, including the performance goals, are disclosed to shareholders and approved by a majority of the vote in a separate shareholder vote before the payment of such compensation; and
>
> (iii) before any payment of such remuneration, the compensation committee referred to in clause (i) certifies that the performance goals and any other material terms were in fact satisfied.[2]

Prior to the TCJA, whether an executive was a covered employee was determined on a year-to-year basis that enabled employers to defer payment of excess compensation (*i.e.*, amounts over one million dollars) to a year when such executives were no longer considered covered employees and, hence, the compensation would be deductible.[3]

As a result, the rule prior to the TCJA often failed to produce the desired result, as many employers were able to utilize the performance-based compensation exception to have amounts be fully deductible or were able to defer compensation to a later year when the rules would not limit the deductibility of compensation. Accordingly, publicly held corporations were generally able to continue to establish executive compensation packages at whatever levels they deemed essential to offer competitive total rewards programs.

Consequently, Congress sought to strengthen Section 162(m) under the TCJA by eliminating the above-referenced performance-based compensation exception and by revising the definition of a covered employee to apply over the lifetime of the executives, regardless of their employment status. These revisions did provide some relief to corporations by including a transition rule applicable to certain outstanding compensatory arrangements (commonly referred to as the grandfather rule), which will be discussed below.

The following is a summary of the key terms and features included in the interim guidance under Notice 2018-68 and the Proposed Regulations to Section 162(m).

Applicable Employee Remuneration

Prior to the TCJA, the term "applicable employee remuneration" was generally defined with respect to any covered employee for any taxable year as "the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration for services performed by such employee (whether or not during the taxable year)."[4]

Before the TCJA, applicable employee remuneration did not include remuneration payable on a commission basis or performance-based compensation. The TCJA amended the definition of applicable employee remuneration to eliminate these exclusions, while also adding a special rule for remuneration paid to beneficiaries. This special rule provides that remuneration shall not fail to be applicable employee remuneration merely because it is includible in the income of, or paid to, a person other than the covered employee, including after the death of the covered employee.[5]

Compensation Paid by a Partnership to a Covered Employee

Prior to the TCJA, four private letter rulings issued between 2006 and 2008 included analysis stating that if a publicly held corporation

is a partner in a partnership, then Section 162(m) does not apply to the corporation's distributive share of the partnership's deduction for compensation paid by the partnership for services performed for it by a covered employee of the corporation.[6] Accordingly, such rulings did not limit the otherwise deductible compensation expense of the publicly held corporation for compensation the partnership paid the covered employee. However, upon further review, the IRS determined that such ruling created a potential for abuse, and thus the current guidance states that the application of Section 162(m) is limited to deductions for compensation paid by the publicly held corporation and also covers the deduction for compensation paid to the corporation's covered employees by another party to the extent the corporation is allocated a share of the otherwise deductible item.[7] For example, if a publicly held corporate partner is allocated a distributive share of the partnership's deduction for compensation paid by the partnership, the allocated distributive share of the deduction is subject to Section 162(m) even though the corporation did not directly pay the compensation to the covered employee. As a result, the publicly held corporation must take into account its distributive share of the partnership's deduction for compensation expense paid to the publicly held corporation's covered employee and aggregate that distributive share and the corporation's otherwise allowable deduction for compensation paid directly to that employee in determining the amount allowable to the corporation as a deduction for compensation under Section 162(m).[8]

The Proposed Regulations provide certain transition relief for current compensation arrangements while prohibiting the formation or expansion of these types of structures for the purpose of avoiding the application of Section 162(m). "Specifically, in order to ensure that compensation agreements are not formed or otherwise structured to circumvent this rule, with respect to compensation paid by a partnership, the rule will apply to any deduction for compensation that is otherwise allowable for a taxable year ending on or after December 20, 2019, but will not apply to compensation paid pursuant to a written binding contract in effect on December 20, 2019, that is not materially modified after that date."[9]

Compensation for Services in a Capacity Other than an Executive Officer

Unless specifically excluded, the deduction limitation under Section 162(m) as amended by the TCJA generally applies to all remuneration for services, including cash and the cash value of all remuneration (including benefits) paid in a medium other than cash, unless

specifically excluded.[10] Accordingly, if an individual is a covered employee for a taxable year, the deduction limitation applies to all compensation not explicitly excluded from the deduction limitation, regardless of whether the compensation is for services as a covered employee and regardless of when the compensation was earned.[11] This rule reinforces the IRS position that compensation earned by a covered employee through a nonemployee position, such as director fees, is not excluded and has always been considered applicable employee remuneration for which the deduction is limited by Section 162(m). Under the amended Section 162(m) rules, a covered employee includes any individual who was a covered employee of the publicly held corporation (or any predecessor) for any taxable year beginning after December 31, 2016.[12] Therefore, under the amended Section 162(m), a covered employee remains a covered employee after separation from service. Accordingly, if, after separation from service as an employee, a covered employee returns to provide services to the publicly held corporation in any capacity, including as a common-law employee, a director, or an independent contractor or consultant, then any deduction for compensation paid to the covered employee is subject to Section 162(m).[13]

Privately Held Corporations that Become Publicly Held

Section 162(m), as amended, applies to the deduction for compensation paid to a covered employee that is otherwise deductible for a taxable year of a publicly held corporation. The interim guidance provides that in the case of a corporation that is a privately held corporation that becomes a publicly held corporation, Section 162(m) applies to the deduction for any compensation that is otherwise deductible for the taxable year ending on or after the date that the corporation becomes a publicly held corporation. Furthermore, a corporation is considered to become publicly held on the date that its registration statement of 1933 or the Securities Exchange Act of 1934 (the Exchange Act).[14]

Covered Employee Definition

Before the TCJA, covered employee was generally defined as any employee of the taxpayer if:

- As of the close of the taxable year, such employee is the chief executive officer of the taxpayer or is an individual acting in such capacity; or

- The total compensation of such employee for the taxable year is required to be reported to shareholders under the Exchange Act by reason of such employee being among the four highest compensated officers for the taxable year (other than the chief executive officer).[15]

Section 13601(b) of the TCJA amended the definition of covered employee so that covered employee now means any employee of the taxpayer if:

- The employee is the principal executive officer (PEO) or principal financial officer (PFO) of the taxpayer at any time during the taxable year, or was an individual acting in such a capacity;

- The total compensation of the employee for the taxable year is required to be reported to shareholders under the Exchange Act by reason of such employee being among the three highest compensated officers for the taxable year (other than the PEO and PFO); or

- The individual was a covered employee of the taxpayer (or any predecessor) for any preceding taxable year beginning after December 31, 2016.[16]

Section 13601(c) of the TCJA also provided that a covered employee includes any employee whose total compensation for the taxable year places the individual among the three highest compensated officers for the taxable year (other than any individual who is the PEO or PFO of the taxpayer at any time during the taxable year, or was an individual acting in such a capacity) even if the compensation of the officer is not required to be reported to shareholders under the Exchange Act.[17]

The U.S. Securities and Exchange Commission (SEC) executive compensation disclosure rules generally require disclosure of compensation of the three most highly compensated executive officers if they were employed at the end of the taxable year and up to two executive officers whose compensation would have been disclosed but for the fact that they were not employed at the end of the taxable year.[18] Notice 2018-68 provided that a covered employee for any taxable year means any employee who is among the three highest compensated executive officers for the taxable year, regardless of whether the executive officer is serving at the end of the publicly held corporation's taxable year, and regardless of whether the executive officer's compensation is subject to disclosure for the last completed fiscal year under the applicable SEC rules.[19]

The SEC executive compensation disclosure rules require disclosure of compensation executive officers and defines "executive officers" as follows:

> The term executive officer, when used with reference to a registrant, means its president, any vice president of the registrant in charge of a principal business unit, division or function (such as sales, administration or finance), any other officer who performs a policy making function or any other person who performs similar policy making functions for the registrant. Executive officers of subsidiaries may be deemed executive officers of the registrant if they perform such policy making functions for the registrant.[20]

The preamble to the Proposed Regulations further provides:

> Under the amended definition of covered employee, a PEO and PFO are covered employees by virtue of having those positions or acting in those capacities. The three highest compensated officers (other than the PEO or PFO) are covered employees by reason of their compensation … Because the SEC executive compensation disclosure rules that require disclosure of the three highest compensated executive officers apply only to executive officers, only an executive officer may qualify as a covered employee under [S]ection 162(m)(3)(B).[21]

In the event, a publicly held corporation owns an interest in a partnership, an officer of such partnership is deemed to be an executive officer of such publicly held corporation if the officer performs a policy-making function for the publicly held corporation. As a deemed executive officer of the publicly held corporation, the officer of the partnership may be a covered employee if the officer is one of the three highest compensated executive officers of the publicly held corporation.[22]

TAXABLE YEARS NOT ENDING ON SAME DATE AS FISCAL YEARS

The SEC executive compensation disclosure rules are based on a corporation's fiscal year. Most corporations' fiscal and taxable years end on the same date. There are exceptions, such as the case of a short taxable year as a result of a corporate transaction that does not result in a short fiscal year. In such cases, (1) the publicly held corporation will have three most highly compensated executive officers for the short taxable year (instead of the fiscal year) and (2) the three

most highly compensated executive officers are the officers whose compensation is required to be (or would be required to be) reported to shareholders under the Exchange Act. Therefore, the determination of the three most highly compensated executive officers is made pursuant to the rules under the Exchange Act and the amount of compensation used to identify the three most highly compensated executive officers is determined pursuant to the executive compensation disclosure rules under the Exchange Act, which uses the taxable year as the fiscal year for purposes of making the determination.[23] The following examples illustrate these points:

> **Example 1.** A publicly held corporation uses a calendar year fiscal year for SEC reporting purposes, but has a taxable year beginning July 1, 2019, and ending June 30, 2020. For this corporation, the three most highly compensated executive officers are determined for the taxable year ending June 30, 2020, by applying the executive compensation disclosure rules under the Exchange Act as if the fiscal year ran from July 1, 2019, to June 30, 2020. The same rule applies to short taxable years.[24]

> **Example 2.** Assume the same facts as in Example 1, except that, due to a corporate transaction, the corporation's taxable year ran from July 1, 2019, to March 31, 2020. In this situation, the three most highly compensated executive officers would be determined for the taxable year ending March 31, 2020, by applying the disclosure rules as if the fiscal year began July 1, 2019, and ended March 31, 2020.[25]

COVERED EMPLOYEES AFTER SEPARATION FROM SERVICE

As discussed above, under the TCJA, any covered employee identified for taxable years beginning after December 31, 2016, will continue to be a covered employee for all future taxable years. Accordingly, if an individual is a covered employee for a taxable year after such date, the individual remains a covered employee for all subsequent taxable years, including for years during which the individual is no longer employed by the corporation and years after the individual has died.[26] For example, if a publicly held corporation makes NQDC plan payments to a former PEO after separation from service, then the deduction for the payments generally would be subject to Section 162(m).[27]

PREDECESSOR CORPORATION

Under Section 162(m), as amended by the TCJA, the term covered employee means any employee who was a covered employee of the taxpayer for any preceding taxable year beginning after December 31, 2016, and also means any employee who was a covered employee of any predecessor of the taxpayer for any preceding taxable year beginning after December 31, 2016.[28] The Proposed Regulations use the term "predecessor of a publicly held corporation" instead of "predecessor."[29] An individual who is a covered employee for one taxable year (including a taxable year of a predecessor of a publicly held corporation) remains a covered employee for subsequent taxable years. In certain circumstances, the term "predecessor of a publicly held corporation" includes the publicly held corporation itself if it was a publicly held corporation for a prior taxable year. Specifically, a predecessor of a publicly held corporation includes a publicly held corporation that, after becoming privately held, again becomes a publicly held corporation for a taxable year ending before the 36-month anniversary of the due date for the corporation's U.S. federal income tax return (excluding any extensions) for the last taxable year for which the corporation was previously publicly held.[30]

The term "predecessor of a publicly held corporation" includes a publicly held corporation that is acquired (target corporation), or the assets of which are acquired, by another publicly held corporation (acquirer corporation) in certain transactions. Accordingly, the covered employees of the target corporation in those transactions are also covered employees of the acquirer corporation.[31] The term "predecessor of a publicly held corporation" refers to the type of corporate acquisition in which a publicly held corporation is acquired and describes corporate acquisitions in the following four categories.[32] Note that certain transactions may fall within more than one category, with such redundancy intended to provide certainty as to the application of these rules if a taxpayer is unsure which category covers the acquisition in question.[33]

1. **Corporate reorganizations.** A predecessor of a publicly held corporation includes a publicly held corporation that is acquired or that is the transferor corporation in a corporate reorganization described in Section 368(a)(1) of the Code. For example, if a publicly held target corporation merges into a publicly held acquirer corporation, then any covered employee of the target corporation would become a covered employee of the acquirer corporation.[34]

2. **Corporate divisions.** A predecessor of a publicly held corporation includes a publicly held distributing corporation that distributes or exchanges the stock of one or more controlled corporations in a transaction described in Section 355(a)(1) of the Code (a 355(a)(1) transaction) if the controlled corporation is a publicly held corporation. This rule applies to the distributing corporation only with respect to covered employees of the distributing corporation who are hired by the controlled corporation (or by a corporation affiliated with the controlled corporation that received stock of the controlled corporation as a shareholder of the distributing corporation in the 355(a)(1) transaction) within the period beginning 12 months before and ending 12 months after the distribution.[35]

   For example, if a publicly held distributing corporation exchanges with its shareholders the stock of a controlled corporation for stock of the distributing corporation in a 355(a)(1) transaction, and the controlled corporation is a publicly held corporation after the exchange, then any covered employee of the distributing corporation would become a covered employee of the controlled corporation if hired by the controlled corporation within the period beginning 12 months before and ending 12 months after the exchange. Furthermore, a covered employee of the distributing corporation who becomes a covered employee of the controlled corporation will remain a covered employee of the distributing corporation for all subsequent taxable years because if an individual is a covered employee for a taxable year, the individual remains a covered employee for all subsequent taxable years.[36]

3. **Stock acquisitions.** A predecessor of a publicly held corporation includes a publicly held corporation that becomes a member of an affiliated group (as defined in Section 1.162-33(c)(1)(ii)) of the Proposed Regulations.[37] For example, if an affiliated group that is considered a publicly held corporation pursuant to proposed Section 1.162-33(c)(1)(ii) in the Proposed Regulations acquires a publicly held target corporation that becomes a member of the affiliated group, then the target corporation would be considered a predecessor of the affiliated group. Therefore, any covered employee of the target corporation would become a covered employee of the affiliated group.[38]

4. **Asset acquisitions.** If an acquirer corporation or one or more members of an affiliated group (acquirer group) acquires at least

80 percent of the operating assets (determined by fair market value on the date of acquisition) of a publicly held target corporation, then the target corporation is a predecessor of the acquirer corporation or group. For example, if an acquirer corporation acquires 80 percent or more of the operating assets of a publicly held target corporation, then any covered employees of the target corporation that become employees of the acquirer corporation would become covered employees of the acquirer corporation. For acquisitions of assets that occur over time, the Proposed Regulations provide that generally only acquisitions that occur within a 12-month period are taken into account to determine whether at least 80 percent of the target corporation's operating assets were acquired.[39] Similarly, this asset acquisition rule provides that the target is a predecessor of a publicly held corporation only with respect to a covered employee of the target corporation who is hired by the acquirer (or a corporation affiliated with the acquirer) within the period beginning 12 months before and ending 12 months after the date on which all events necessary for the acquisition have occurred.[40]

The rules for determining predecessors are applied cumulatively, with the result that a predecessor of a corporation includes each predecessor of the corporation and the predecessor or predecessors of any prior predecessor or predecessors.[41]

COORDINATION WITH SECTION 409A: AMENDING PROVISIONS REQUIRING DELAY IN DISTRIBUTIONS

Section 409A of the Code addresses deferred compensation arrangements, including many NQDC plans, and sets forth certain requirements with respect to timing of payments that must be met to avoid current income inclusion and certain additional income tax. NQDC plans that are subject to Section 409A must designate a time and form of payment, among other requirements, to comply with Section 409A.[42] However, there is an exception under Treasury Regulation Section 1.409A-2(b)(7)(i) (the "delay distribution until deductible" rule), which provides that a payment may be delayed past the designated payment date.[43] This exception applies to the extent that the service recipient reasonably anticipates that, if the payment were made as scheduled, the service recipient's deduction with respect to such payment would not be permitted due to the application of Section 162(m).[44] Such delayed payment must generally be paid no later than the service provider's first taxable year in which the deduction of such payment will not be barred by the application of Section 162(m).[45]

If any scheduled payment to a service provider in a service recipient's taxable year is delayed in accordance with the foregoing, such delay in payment is treated as a subsequent deferral election unless all scheduled payments to that service provider that could be delayed under this rule are also delayed.[46] In addition, a subsequent deferral election will violate Section 409A if the election fails to satisfy certain requirements under Section 409A(a)(4)(C).[47] There is a similar "delay distribution until deductible" rule under Treasury Regulation Section 1.409A-1(b)(4)(ii), which permits delayed payments of compensation that otherwise qualify as a short-term deferral under Section 1.409A-1(b)(4)(i).[48]

As previously described, before passage of the TCJA, an individual who was a covered employee for one taxable year would not necessarily remain a covered employee for subsequent taxable years. As a result, he or she would not be a covered employee after separation from service. Accordingly, some NQCP arrangements anticipated that, in these cases, the corporation would have the discretion to utilize the "delay distribution until deductible" rule to postpone payment until the employee separated from service so that he or she would no longer be a covered employee. Because the TCJA amendments to the definition of covered employee fundamentally altered the premise of the "delay distribution until deductible" rule under Treasury Regulation Sections 1.409A-1(b)(4)(ii) and 1.409A-2(b)(7)(i), the question arose as to whether a service recipient may delay the scheduled payment of grandfathered amounts without delaying the payment of nongrandfathered amounts, in circumstances in which the service recipient has discretion to delay the payment. The Proposed Regulations provide in circumstances in which the service recipient has discretion to delay the payment, a service recipient may delay the scheduled payment of grandfathered amounts without delaying the payment of nongrandfathered amounts, and the delay of the grandfathered amounts will not be treated as a subsequent deferral election.[49] Since the TCJA amendments do not apply to grandfathered amounts, the deduction for amounts grandfathered under the amended Section 162(m) is not subject to Section 162(m) when paid to a former covered employee who separated from service. Therefore, the payment of these grandfathered amounts may continue to be postponed consistent with the "delay distribution until deductible" rule.[50]

Even though the "delay distribution until deductible" rule provides that the service recipient has discretion to delay a payment, and that the discretion is not required to be set forth in the written plan, some NQDC plan sponsors may have drafted their documents to explicitly require them to delay a payment if the sponsor reasonably believes the deduction with respect to the payment will not be permitted under

Section 162(m).[51] However, if an NQDC plan arrangement is amended to remove the provision requiring the sponsor to delay a payment if the sponsor reasonably anticipates at the time of the scheduled payment that the deduction would not be permitted under Section 162(m), then the amendment will not result in an impermissible acceleration of payment under Treasury Regulation Section 1.409A-3(j) and such amendment will also not be considered a material modification for purposes of the grandfather rule under Section 162(m) as amended by the TCJA.[52] However, such a plan amendment must be made no later than December 31, 2020.[53] The amendment may apply to both grandfathered and nongrandfathered amounts, but may also be limited to amounts that are not grandfathered.[54] In any event, if, pursuant to such amended plan, the corporation would have been required to make a payment (or payments) prior to December 31, 2020, then the payment (or payments) must be made no later than December 31, 2020.[55]

The Treasury Department and the IRS intend to incorporate these changes into regulations under Section 409A but have indicated that taxpayers may rely on this guidance for any taxable year beginning after December 31, 2017.[56]

Grandfather Rule

The TCJA generally provides that amendments to Section 162(m) apply to taxable years beginning after December 31, 2017. However, the TCJA further provides that such amendments do not apply to remuneration that is provided pursuant to a written binding contract that

- Was in effect on November 2, 2017, and
- Was not modified in any material respect on or after such date.[57]

The preamble to the Proposed Regulations provide that:

> Notice 2018-68 clarified that remuneration is payable under a written binding contract that was in effect on November 2, 2017, only to the extent that the corporation is obligated under applicable law (for example, state contract law) to pay the remuneration under the contract if the employee performs services or satisfies the applicable vesting conditions. Accordingly, the TJCA amendments to [S]ection 162(m) apply to any amount of remuneration that exceeds the amount of remuneration that applicable law obligates the corporation to pay under a written binding contract that

was in effect on November 2, 2017, if the employee performs services or satisfies the applicable vesting conditions.[58]

COMPENSATION SUBJECT TO DISCRETION

As applicable law (such as state contract law) determines the amount of compensation that a corporation is obligated to pay pursuant to a written binding contract in effect on November 2, 2017, some compensation arrangements may provide the corporation with a wider scope of negative discretion than is allowed under applicable law. In such a case, "the negative discretion is taken into account only to the extent the corporation may exercise the negative discretion under applicable law."[59] Such rule is illustrated by the following example:

> An amount of compensation is paid pursuant to a written binding contract under which the corporation is obligated to recover an amount of compensation from the employee if a vesting condition is later determined not to have been satisfied. For example, a vesting condition may be based on the achievement of results reported in the financial statements. In this example, if a corporation pays a bonus based on the financial statements but the financial statements are subsequently restated and demonstrate that the vesting condition was not, in fact, satisfied, then the corporation is required to recover a portion of the bonus from the employee. If, under applicable law, the employee retains the remaining portion of the bonus then, pursuant to the grandfather rules, that remaining portion of the bonus is grandfathered compensation that is not subject to the TCJA amendments. Similarly, if the corporation has discretion to recover compensation (in whole or in part), only the amount of compensation that the corporation is obligated to pay under applicable law that is not subject to potential recovery is grandfathered.[60]

Notice 2018-68 did not address the case where applicable law may provide a corporation with contingent discretion to recover compensation. However, the preamble to the Proposed Regulations provide that "a corporation is not treated as currently having discretion merely because it will have discretion to recover an amount if a condition occurs subsequent to the vesting and payment of the compensation and the occurrence of the condition is objectively outside of the corporation's control."[61] Such rule is illustrated by the following example:

> Pursuant to a written binding contract in effect on November 2, 2017, a corporation may be obligated under applicable law to

> pay $500,000 of compensation if the employee satisfies a vesting condition, but the corporation may be permitted to recover $300,000 from the employee if the employee is convicted of a felony within three calendar years from the date of payment. If the employee is not convicted of a felony within three calendar years from the date of payment, then the $500,000 is grandfathered. If, however, the employee is convicted of a felony within three years after the payment of the $500,000, then the corporation has discretion whether to recover the $300,000 from the employee. Accordingly, if the employee is convicted of a felony within three calendar years after the payment, $300,000 of the $500,000 is not grandfathered. This is true regardless of whether the corporation exercises its discretion to recover the $300,000. Because the corporation may not recover $200,000 of the $500,000 payment in any event, the $200,000 remains grandfathered regardless of whether the employee is convicted of a felony.[62]

EARNINGS ON GRANDFATHERED AMOUNTS IN ACCOUNT AND NONACCOUNT BALANCE PLANS

Earnings credited to account balance plans after November 2, 2017, are not grandfathered when the corporation retains the right under applicable law to amend the plan at any time either to stop or to reduce future credits (including earnings) to the account balance.[63] "Earnings credited after November 2, 2017, on grandfathered amounts are grandfathered only if the corporation is obligated to pay the earnings under applicable law pursuant to a written binding contract in effect on November 2, 2017."[64]

The preamble to the Proposed Regulations provide guidance for earnings with respect plan terminations:

> Section 1.409A-3(j)(4)(ix)(C)(3) provides that, if a service recipient terminates a[n] NQDC plan, then the time and form of payments may be accelerated, but payment may not be made within 12 months of the date of termination of the plan. The definition of written binding contract in Notice 2018-68 and these proposed regulations provides that earnings credited after November 2, 2017, on grandfathered amounts are grandfathered only if the corporation is obligated to pay the earnings under applicable law pursuant to a written binding contract in effect on November 2, 2017. Accordingly, if, under applicable law, the corporation is obligated to continue to credit earnings for amounts under the NQDC plan during the 12 months after terminating the plan, then the earnings would be grandfathered. In

> that case, the grandfathered amount would be the amount that the corporation is obligated to pay under applicable law as of November 2, 2017, plus the 12 months of earnings that the corporation is obligated to credit under applicable law. However, any additional amounts that become payable under the plan after November 2, 2017, and earnings on those amounts would not be grandfathered. Applicable law and the terms of the plan determine the amount of earnings that the corporation is obligated to credit for amounts under the plan during the 12 months after plan termination. Thus, for example, with respect to a non-account balance plan, under applicable law, the amount of earnings that the corporation is obligated to credit might be limited to the difference between the present value of the benefit under the plan as of November 2, 2017, and any increase in present value due solely to passage of time (12 months). Furthermore, with respect to a non-account balance plan that provides for a formula amount (for example, the amount payable under the plan is based on the participant's final salary and years of service), the amount of earnings that the corporation is obligated to credit under applicable law might be limited to a reasonable rate of interest to reflect the time value of money during the passage of time (12 months) applied to the benefit under the plan as of November 2, 2017 (and not reflecting any additional salary increase or years of service accumulated after November 2, 2017).[65]

SEVERANCE AGREEMENTS

Severance payable under a severance agreement can be grandfathered under the new Section 162(m) rules.

> Severance payable under such a contract is grandfathered only if the amount of severance is based on compensation elements the employer is obligated to pay under the contract. For example, if the amount of severance is based on final base salary, the severance is grandfathered only if the corporation is obligated to pay both the base salary and the severance under applicable law pursuant to a written binding contract in effect on November 2, 2017. For this purpose, a corporation may be obligated to pay severance under a written binding contract as of November 2, 2017, even if the employee remains employed as of November 2, 2017, but only with respect to the amount the corporation would have been required to pay if the employee had been terminated as of November 2, 2017.[66]

In cases where a portion of the amount is based on a discretionary or performance bonus or other variable components, each component of the severance formula is analyzed separately to determine the amount of severance that is grandfathered.

> For example, the amount of severance may be equal to two times the sum of: (1) final base salary and (2) any bonus paid within 12 months prior to separation from service. In this example, the amount of severance is based on two components, base salary and bonus. Therefore, the entire amount of severance (based on both components) is grandfathered only if, under applicable law, the corporation is obligated to pay both portions, the base salary and the bonus pursuant to a written binding contract in effect on November 2, 2017.[67]

MATERIAL MODIFICATION

As discussed above, the grandfather rules require that written binding contract is not modified in any material respect on or after November 2, 2017. A "material modification" is defined as follows:

> A material modification occurs when the contract is amended to increase the amount of compensation payable to the employee. If a written binding contract is materially modified, it is treated as a new contract entered into as of the date of the material modification. Thus, amounts received by an employee under the contract before a material modification are not affected, but amounts received subsequent to the material modification are treated as paid pursuant to a new contract, rather than as paid pursuant to a written binding contract in effect on November 2, 2017.[68]

The preamble to the Proposed Regulations further provides that:

> The adoption of a supplemental contract or agreement that provides for increased compensation, or the payment of additional compensation, is a material modification of a written binding contract if the facts and circumstances demonstrate that the additional compensation is paid on the basis of substantially the same elements or conditions as the compensation that is otherwise paid pursuant to the written binding contract in effect on November 2, 2017. However, a material modification of a written binding contract does not include a supplemental payment that is equal to or less than a reasonable cost-of-living increase over the payment made in the preceding year under that written binding contract.

> In that case, only the deduction for the reasonable cost-of-living increase is subject to [S]ection 162(m) as amended by the TCJA. In addition, the failure, in whole or in part, to exercise negative discretion under a contract does not result in the material modification of that contract. Finally, if amounts are paid to an employee from more than one written binding contract (or if a single written document consists of several written binding contracts), then a material modification of one written binding contract does not automatically result in a material modification of the other contracts unless the material modification affects the amounts payable under those contracts.[69]

EARNINGS ON GRANDFATHERED AMOUNTS THAT ARE SUBSEQUENTLY DEFERRED

The preamble to the Proposed Regulations addresses the status of earnings on grandfathered amounts when a contract is modified to defer compensation:

> [I]f the contract is modified to defer the payment of compensation, any compensation paid or to be paid that is in excess of the amount that was originally payable to the employee under the contract will not be treated as resulting in a material modification if the additional amount is based on either a reasonable rate of interest or a predetermined actual investment (whether or not assets associated with the amount originally owed are actually invested therein) such that the amount payable by the employer at the later date will be based on the actual rate of return on the predetermined actual investment (including any decrease, as well as any increase, in the value of the investment). The proposed regulations provide that a predetermined actual investment means a predetermined actual investment as defined in [Section] 31.312(v)(2)-1(d)(2)(i)(B), and also include examples illustrating these rules relating to the treatment of earnings. However, even though the payment of earnings will not result in the contract being materially modified, this generally does not mean that the earnings are treated as grandfathered. For situations in which an employee defers an amount of grandfathered compensation after November 2, 2017, the earnings on the deferred amount are not grandfathered if, as of November 2, 2017, the corporation was not obligated under the terms of the contract to provide the deferral election and to pay the earnings on the deferred amount under applicable law. Pursuant to the definition of written binding contract in Notice 2018-68 and these proposed

> regulations, these earnings are not grandfathered because, as of November 2, 2017, the corporation was not obligated to pay them under applicable law.[70]

MATERIAL MODIFICATION PRIOR TO PAYMENT OF A GRANDFATHERED AMOUNT

If a contract is materially modified after November 2, 2017, but before the payment of a grandfathered amount of compensation, the compensation is treated as paid pursuant to the new contract and therefore is no longer grandfathered.[71] "For example, if, under applicable law, a corporation is obligated to pay $100,000 on December 31, 2020, under a written binding contract in effect on November 2, 2017, then the $100,000 is grandfathered. If, on January 1, 2019, the contract is materially modified, then the $100,000 is treated as paid pursuant to a new contract and is not grandfathered".[72]

ACCELERATION OF PAYMENT OR VESTING

The Proposed Regulations address whether the acceleration of payment or vesting is a material modification under grandfather rules. The preamble of the Proposed Regulations provides:

> [A] modification of a written binding contract that accelerates the payment of compensation is a material modification unless the amount of compensation paid is discounted to reasonably reflect the time value of money. For example, if a corporation is obligated under applicable law to pay compensation on December 31, 2020, pursuant to a written binding contract in effect on November 2, 2017, then the compensation is grandfathered. If the corporation pays the entire amount of compensation on December 31, 2019 without a discount to reasonably reflect the time of value of money, then the entire amount of compensation is treated as paid pursuant to a new contract and is no longer grandfathered. Furthermore, any subsequent payment made pursuant to the contract is not grandfathered because the contract itself was materially modified when the prior payment was accelerated without a discount to reasonably reflect the time value of money.[73]

The issue of the application of the rule for equity-based compensation when the payment is subject to a substantial risk of forfeiture is addressed in the preamble to the Proposed Regulations as follows:

> Compensation received pursuant to the substantial vesting of restricted property, or the exercise of a stock option or stock appreciation right that do not provide for a deferral of compensation, a modification of a written binding contract in effect on November 2, 2017, that results in a lapse of the substantial risk of forfeiture (as defined [Section] 1.83-3(c)) is not considered a material modification. Likewise, with respect to other compensation arrangements, if an amount of compensation payable under a written binding contract in effect on November 2, 2017, is subject to a substantial risk of forfeiture, then a modification of the contract that results in a lapse of the substantial risk of forfeiture is not considered a material modification. Thus, for all forms of compensation, a modification to a written binding contract that accelerates vesting will not be considered a material modification.[74]

ORDERING RULE FOR PAYMENTS CONSISTING OF GRANDFATHERED AND NONGRANDFATHERED AMOUNTS

In the event that an NQDC plan arrangement provides for a series of payments rather than a lump-sum payment, and only a portion of such payments are grandfathered, the grandfathered amount must be identified. In such case, the preamble to the Proposed Regulations provides:

> To identify the grandfathered amount when payment under the arrangement is made in a series of payments, the rules provide that the grandfathered amount is allocated to the first otherwise deductible payment paid under the arrangement. If the grandfathered amount exceeds the payment, then the excess is allocated to the next otherwise deductible payment paid under the arrangement. This process is repeated until the entire grandfathered amount has been paid. For example, assume that a NQDC plan arrangement provides for an annual payment of $100,000 for three years, and only $120,000 is grandfathered. Pursuant to the Proposed Regulations, the entire $100,000 paid in the first year is grandfathered. In the second year, only $20,000 of the $100,000 payment is grandfathered; the remaining $80,000 paid in the second year is not grandfathered. In the third year, none of the $100,000 payment is grandfathered.[75]

IN CONCLUSION

All publicly held corporations should review the interim guidance on Section 162(m) to see how it affects their corporation, including whether their corporation is covered by the rules, determining who is a covered employee, and what contracts and compensation amounts are grandfathered under the new rules. To the extent that there are grandfathered amounts, such amounts must be separated and administratively aggregated to ensure that there are no material modifications to such amounts that would void their grandfathered status. All publicly held NQDC plan sponsors should also review their written NQDC plan documents for provisions requiring the sponsor to delay a payment if the sponsor reasonably anticipates at the time of the scheduled payment that the deduction would not be permitted under Section 162(m). In the event that the NQDC plan documents do contain the above-described distribution delay provisions, the documents must now be amended to remove such language by no later than December 31, 2020, so that the sponsor no longer is required to delay such payments. Accordingly, NQDC plan sponsors should contact their legal, tax, and employee benefit consultants in order to review these options and determine which alternative more closely aligns with their business objectives and budgetary planning.

NOTES

1. *See* 84 Fed. Reg. 70356 (Dec. 20, 2019), that provide further interim guidance on Section 162(m) as amended by the TCJA.

2. 84 Fed. Reg. 70,364; *See, also,* Treas. Reg. §§1.162-27(e)(2) through (e)(5).

3. *See, ante,* footnote 14 for definition of covered employee prior to TCJA.

4. IRC § 162(m)(4).

5. 84 Fed. Reg. 70,363; 26 C.F.R. § 1.162-33(c)(3)(i).

6. PLR 200837024, PLR 200727008, PLR 200725014, and PLR 200614002; 84 Fed. Reg. 70,363.

7. Fed. Reg. 70,363.

8. *Id.; See also* Treas. Reg. § 1.702-1(a)(8)(ii) and (iii).

9. 84 Fed. Reg. 70,363, 70,364.

10. 84 Fed. Reg. 70,364.

11. *Id.*

12. *Id.*

13. *Id.*

14. 84 Fed. Reg. 70,364,70,365.

15. 84 Fed. Reg. 70,359; Under Treas. Reg. § 1.162-27(c)(2), covered employee is defined as follows:

(i) General rule. A covered employee means any individual who, on the last day of the taxable year, is

(A) The chief executive officer of the corporation or is acting in such capacity; or

(B) Among the four highest compensated officers (other than the chief executive officer).

(ii) Application of rules of the Securities and Exchange Commission. Whether an individual is the chief executive officer described in paragraph (c)(2)(i)(A) of this section or an officer described in paragraph (c)(2)(i)(B) of this section is determined pursuant to the executive compensation disclosure rules under the Exchange Act.

16. 84 Fed. Reg. 70,359, 70,360.

17. 84 Fed. Reg. 70,360.

18. *Id.; See* Item 402 of Regulation S-K, 17 CFR 229.402(a)(3).

19. Notice 2018-68; 84 Fed. Reg. 70,360.

20. *See,* 17 CFR § 240.3b-7.

21. 84 Fed. Reg. 70,360, 70,361.

22. 84 Fed. Reg. 70,361.

23. Notice 2018-68; 84 Fed. Reg. 70,360.

24. 84 Fed. Reg. 70,360.

25. *Id.*

26. Notice 2018-68, 84 Fed. Reg. 70,360, 70,361; Prop. 26 C.F.R. § 1.162-33(c)(2)(i)(C).

27. *Id.*

28. IRC § 162(m)(3)(C).

29. *Id.*

30. 84 Fed. Reg. 70,361.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. 84 Fed. Reg. 70,361, 70,362.

36. *Id.*

37. Prop. 26 C.F.R. § 1.162-33(c)(1)(ii)) 84 Fed. Reg. 70,362.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. 84 Fed. Reg. 70,368.

43. Treas. Reg. § 1.409A-2(b)(7)(i).

44. *Id.*

45. *Id.*

46. 84 Fed. Reg. 70,369.

47. *Id. See also,* § 409A(a)(4)(C):" Changes in time and form of distribution. The requirements of this subparagraph are met if, in the case of a plan which permits under a subsequent election a delay in a payment or a change in the form of payment—(i) the plan requires that such election may not take effect until at least 12 months after the date on which the election is made, (ii) in the case of an election related to a payment not described in clause (ii), (iii), or (vi) of paragraph (2)(A), the plan requires that the payment with respect to which such election is made be deferred for a period of not less than 5 years from the date such payment would otherwise have been made, and (iii) the plan requires that any election related to a payment described in paragraph (2)(A)(iv) may not be made less than 12 months prior to the date of the first scheduled payment under such paragraph.

48. 84 Fed. Reg. 70,369.

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. 84 Fed. Reg. 70,369, 70,370.

55. 84 Fed. Reg. 70,369.

56. *Id.*

57. 84 Fed. Reg. 70,365.

58. *Id.*

59. *Id.*

60. 84 Fed. Reg. 70,366.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. 84 Fed. Reg. 70,366, 70367.

66. 84 Fed. Reg. 70367.

67. *Id.*

68. 84 Fed. Reg. 70,367.

69. *Id.*

70. 84 Fed. Reg. 70,367.

71. 84 Fed. Reg. 70,367, 70368.

72. 84 Fed. Reg. 70,368.

73. 84 Fed. Reg. 70,368.

74. *Id.*

75. *Id.*

To Whose Benefit: What *Bostock v. Clayton County* Means for Benefits Practitioners

Danielle Moss, Kait Hulbert, and Gary Tashjian

> "Bias both conscious and unconscious […] keeps up barriers that must come down if equal opportunity and nondiscrimination are ever genuinely to become this country's law and practice."
>
> —Justice Ruth Bader Ginsberg
>
> Dissenting opinion, *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200 (1995)

On June 15, 2020, the Supreme Court issued a landmark decision in *Bostock v. Clayton Cnty.*, holding that Title VII's prohibition against workplace discrimination on the basis of sex extends to prohibit discrimination on the basis of sexual orientation and gender identity.[1] Because Title VII broadly prohibits employers from discriminating against employees in setting their terms and conditions of employment, this decision carries significant implications for the provision of employee benefits. In this column, we briefly describe the relevant case law leading up to the *Bostock* decision, as well as discuss several key considerations for employers following it, including: (1) how it affects the final regulations of the Department of Health and Human Services (HHS) under Section 1557 of the Patient Protection and Affordable Care Act (ACA), which strictly interpreted "sex" to be

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one's biological sex assigned at birth; and (2) what employers should do and/or be thinking about to avoid running afoul of Title VII in this uncertain political landscape.

BACKGROUND

Title VII of the Civil Rights Act of 1964 prohibits covered employers[2] from discriminating against employees on the basis of race, color, religion, sex, and national origin when making certain employment-related decisions, such as hiring, firing, and/or setting the terms and conditions of employment (*e.g.*, group medical insurance).[3]

Although Title VII expressly prohibits discrimination on the basis of sex and has been interpreted to cover pregnancy and childbirth-related conditions, the statute does not expressly prohibit discrimination on the basis of sexual orientation or gender identity.[4] Thus, whether (and to what extent) Title VII may be interpreted to prohibit these additional categories of sex-related discrimination has been hotly debated for decades.[5]

To that end, there have been a number of unsuccessful attempts by Congress to amend Title VII to include sexual orientation and gender identity.[6] However, reform efforts have largely focused on establishing that discrimination based on sexual orientation and/or gender identity necessarily involve discrimination on the basis of sex and are therefore prohibited by Title VII. In fact, this argument gained traction in 1989 when the Supreme Court recognized sex stereotyping as a form of actionable sex discrimination under Title VII,[7] prompting some federal courts to gradually adopt this approach with respect to gender identity more broadly.[8]

Thereafter, certain circuit courts recognized that discrimination based on sexual orientation is also unlawful under Title VII.[9] However, several other circuit courts continued to strictly interpret "sex" as covering only one's sex assigned at birth and therefore determined that gender identity is not protected from discrimination under Title VII.[10]

BOSTOCK V. CLAYTON COUNTY

As a result of the above-described circuit split about whether Title VII prohibits discrimination on the basis of sexual orientation and/or gender identity, the Supreme Court agreed to hear argument in *Bostock*, *Altitude Express,* and *R.G. & G.R. Harris Funeral Homes* to decide the scope of Title VII's sex discrimination prohibition.

At oral argument, petitioners advocated that "when an employer fires a male employee for dating men but does not fire female employees

who date men" the employer engages in discrimination no different than kinds and forms of discrimination "that have been already recognized by every court to have addressed them" as violations of Title VII.[11] Respondents, by contrast, argued against a broad interpretation of "sex" under Title VII, positing that "sex and sexual orientation are independent and distinct characteristics, and sexual orientation discrimination by itself does not constitute discrimination because of sex under Title VII."[12]

In the majority opinion authored by Justice Neil Gorsuch (joined by Chief Justice John Roberts and Justices Ruth Bader Ginsburg, Stephen Breyer, Sonia Sotomayor, and Elena Kagan), the Court was persuaded that, for purposes of Title VII, discrimination on the basis of sex includes sexual orientation and gender identity.[13] The majority relied heavily on the plain language of Title VII, recognizing that "an employer who fires an individual for being homosexual or transgender fires that person for traits or actions it would not have questioned in members of a different sex," and that, as such, "sex plays a necessary and undisguisable role in the decision, exactly what Title VII forbids."[14]

Importantly, the Supreme Court's decision in *Bostock* serves as a floor, not a ceiling. States, localities, and individual employers can (and do) provide greater protections for their LGBTQ+[15] employees that employers operating in those more protective states and localities must be mindful of.[16]

BOSTOCK'S **IMPLICATIONS FOR EMPLOYEE BENEFIT PLANS**

Title VII's protections extend well-beyond the discriminatory terminations in each of the *Bostock*, *Altitude Express,* and *R.G. & G.R. Harris Funeral Homes* cases. As such, the implications of the Supreme Court's decision in *Bostock* on the employer–employee relationship may be broader.

For example, Title VII prohibits discrimination relating to employee benefits plans, including medical, hospital, accident, life insurance and retirement plans, profit-sharing/bonus plans, and medical leave.[17] Additionally, Title VII's prohibition against discrimination encompasses policies, practices, and employment decisions that may appear facially neutral but which may, in actuality, disparately affect LGBTQ+ employees.

It is unclear how far future courts will extend the *Bostock* holding. For example, employers may wish to consider the uncertainty as to how the ruling will be applied to benefits-related provisions such as the following:

- Restricting coverage to opposite-sex spouses or domestic partners;

- Denying coverage to transgender employees or charging transgender employees a higher premium for coverage;

- Failing to cover certain health benefits where medically necessary, including those specific to gay and transgender employees, such as hormone therapy and gender-affirmation surgery;

- Limiting access to sex-specific care based on sex assigned at birth, including, for example, denying coverage for a mammogram to a transgender man; or

- Otherwise discriminating in providing generally-applicable benefits, including the provision of reproductive technology assistance, parental leave programs, adoption benefits, and disability benefits for gender affirmation surgery.

Additionally, plans have recently seen an increase in claims that certain gender-affirmation surgeries (*e.g.*, brow lifts, rhinoplasties, and cheek implantations) are required to be covered. These procedures are often excluded as cosmetic procedures, and participants have challenged those exclusions on the grounds of medical necessity. Post-*Bostock*, however, participants are also beginning to raise Title VII issues, which benefit plan administrators will need to address.

***BOSTOCK'S* POTENTIAL EFFECT ON THE ACA**

On June 12, 2020, shortly before the issuance of the *Bostock* decision, HHS released final regulations under Section 1557 of the Patient Protection and Affordable Care Act. Section 1557 generally prohibits discrimination in certain health programs or activities that receive federal funding or are administered by federal agencies.

The final regulations repealed the prior interpretation of Section 1557 that discrimination "on the basis of sex" encompassed gender identity. The new 1557 regulations permit the categorical refusal of health coverage to transgender participants and the denial of treatment inconsistent with gender identity. In making this determination, HHS apparently relied on the plain meaning of "sex" as one's biological sex assigned at birth, which it asserted to be consistent with federal statutes—including Title IX, which covers educational activities and institutions. However, HHS's stance on the definition

of "sex" may be inconsistent with that applied by the Supreme Court in *Bostock*.[18]

Following *Bostock*, the U.S. District Court for the Eastern District of New York ordered a stay and issued a preliminary injunction precluding the final regulations from taking effect.[19] Further guidance on this issue is expected.

CONCLUSION

Following the Supreme Court's decision in *Bostock*, employers would be well-served to review their employee benefit and compensation practices (including claims procedures as well as antiharassment, nondiscrimination, and reasonable accommodations policies and trainings) to ensure compliance with Title VII's prohibition against sex discrimination. This review should also consider other applicable federal, state, and local laws that may provide more rigorous protections than those afforded by *Bostock*.

For example, Executive Order 11246 continues to bar federal contractors from discriminating based on gender identity and sexual orientation; and state and local laws in California and New York prohibit discrimination on the basis of sexual orientation, gender identity, and gender expression.

Additionally, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits placing limits on mental health treatments that exceed the limits on medical benefits. The mental health parity requirements under the MHPAEA may be particularly relevant when dealing with gender identity treatments, which often necessitate both medical and behavioral health services.

Now, more than ever, it is important to keep in mind that this is a rapidly developing area of law and, particularly in light of conflicting analyses from various government agencies, regular review and advice from experienced employment and employee benefits counsel is critical.

NOTES

1. *Bostock v. Clayton Cnty*., 140 S. Ct. 1731 (2020). *Bostock* was consolidated with *Altitude Express v.Zarda,* 140 S. Ct. 34 (2019), and *R.G. & G.R. Harris Funeral. Homes Inc. v. EEOC,* 139 S. Ct. 1599 (2019) for purposes of oral argument, and addressed in a single opinion.

2. Covered employers are generally considered to be those with 15 or more employees. 42 U.S.C. § 2000e(b).

3. 42 U.S. Code § 2000e–2.

4. Pregnancy Discrimination Act of 1978 (Pub. L. 95–555); 42 U.S.C. § 2000e(k).

5. *Holloway v. Arthur Anderson & Co.*, 566 F.2d 659 (9th Cir. 1977); *Ulane v. E. Airlines, Inc.*, 742 F.2d 1081 (1984); *Price Waterbouse v. Hopkin*s, 490 U.S. 228 (1989); *Oncale v. Sundowner Offshore Servs.*, 523 U.S. 75 (1998); *Dawson v. Bumble & Bumble*, 398 F.3d 211 (2d Cir. 2005).

6. *See, e.g.,* The Equality Act, H.R.5—116th Congress (2019–2020).

7. *Price Waterbouse v. Hopkins*, 490 U.S. 228 (1989) (holding gender stereotyping is sex discrimination in violation of Title VII).

8. *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004).

9. *Baldwin v. Foxx*, EEOC Decision No. 0120133080, 2015 WL 4397641 (EEOC July 15, 2015); *Rene v. MGM Grand Hotel, Inc.*, 305 F.3d 1061 (9th Cir. 2002); *Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018).

10. *Holloway v. Arthur Anderson & Co.*, 566 F.2d 659 (9th Cir. 1977); *Ullane v. E. Airlines, Inc.*, 742 F.2d 1081 (1984); *R.G. & G.R. Harris Funeral Homes Inc.*, 884 F.3d 560 (6th Cir. 2018).

11. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731 (2020), Oral Argument Tr. p. 4.

12. *Id.* at 32.

13. The Court's decision in *Bostock* is distinct from the related analysis under the Equal Protection Clause, which broadly guarantees the "equal protection of the laws." Though not addressed in *Bostock*, there is a separate line of cases articulating treatment of sexual orientation and gender identity under the Equal Protection Clause. (*Romer v. Evans*, 517 U.S. 620 (1996); *Lawrence v. Texas*, 539 U.S. 558 (2003); *Obergefell v. Hodges*, 576 U.S. 644 (2015)). Notably, Justice Gorsuch expressly left open the question of whether sexual orientation or gender identity would be considered a protected class under an equal protection analysis and to what extent religious exemptions may apply. Given the current uncertainty surrounding the makeup of the Court, it is unclear whether an equal protection argument may alter the Court's view on this issue.

14. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731 (2020).

15. For purposes of this article, LGBTQ+ is defined broadly to include all non-heterosexual or non-cisgender individuals.

16. NYSHRL, Exec. Law Art. 15, HRL § 291 (prohibits discrimination in obtaining employment because of sexual orientation and gender identity and expression); NYCHRL, NYC Admin. Code § 8-102 (prohibits discrimination by employers because of gender and sexual orientation); CA FEHA, Gov. Code § 12940(a) (makes refusal to hire or employ because of gender, gender identity and gender expression, or sexual orientation an unlawful employment practice).

17. EEOC Compliance Manual § 3 (Employee Benefits). Certain of these benefits (*e.g.*, medical insurance) may be subject to the Employee Retirement Income Security Act of 1974 (ERISA). Note that ERISA generally preempts state but not federal law and, accordingly, protections under Title VII apply without qualification to many employer-sponsored benefit plans. *See* ERISA § 514 (29 U.S.C. § 1144).

18. 85 FR 37160.

19. *Walker et al v. Azar*, No. 20-cv-2834, 2020 WL 4749859 (E.D.N.Y. Aug. 17, 2020).

Index to Volume 33

No. 1 Spring 2020
No. 2 Summer 2020
No. 3 Autumn 2020
No. 4 Winter 2020

AUTHORS

SUBJECTS

AFFORDABLE CARE ACT (ACA)

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT (CARES ACT)

DEFINED BENEFIT PLANS

DEFINED CONTRIBUTION PLANS

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

EXECUTIVE COMPENSATION

FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

HEALTH BENEFITS

LITIGATION

NONQUALIFIED DEFERRED COMPENSATION PLANS (NDCPs)

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

PROPOSED REGULATIONS

RETIREMENT BENEFITS

SETTING EVERY COMMUNITY UP FOR RETIREMENT ENHANCEMENT ACT OF 2019 (SECURE ACT)