ERISA Newsletter

Second Quarter 2017

A report to clients and friends of the firm
Edited by Stacey C.S. Cerrone and Russell L. Hirschhorn

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Editor's Overview

Welcome once again to Proskauer's newly revamped ERISA Newsletter. As a reminder, readers can obtain the information in this Newsletter as it is published on our blog.

Our featured article this quarter reviews an interesting circuit split on whether a board of trustees of a Taft-Hartley plan (multiemployer plan) should be considered structurally conflicted when a court reviews its decision to deny a benefit claim or appeal. After reviewing the circuit case law and the rationales behind the decisions, the authors discuss the practical implications for funds operating under the more burdensome rule.

The balance of the Newsletter reviews a number of developments, including updates on the DOL fiduciary rule, the Supreme Court's church plan decision, fee litigation, employer stock fund litigation, retiree benefits, mental health parity, benefit claims, IRS determination letter program, preemption, standing and health care reform.

Are Taft-Hartley Boards Conflicted When Reviewing ERISA Benefits Determinations? Circuit Courts Are Split.*

By Myron Rumeld and Benjamin Saper

Although it has been nearly three decades since the Supreme Court first explained the appropriate standard of review for ERISA benefit claims, there remain unsettled issues that may affect the level of scrutiny that is accorded an administrative determination and, ultimately, the outcome of a claim for benefits. One such issue is whether benefit determinations made by the boards of trustees of Taft-Hartley plans—i.e., multiemployer plans that operate pursuant to the terms of collective bargaining agreements—should be more closely scrutinized by district courts because the boards are considered "structurally conflicted."

On the one hand, Section 302 of the Labor Management Relations Act requires that one-half of the board of a Taft-Hartley plan consist of trustees who are appointed by the employers who fund the plan, and, as such, are arguably motivated to deny the claim for the sake of saving costs. But on the other hand, the other half of the board consists of union-designated trustees who are arguably motivated to grant the claim to help their members. Moreover, the funding requirements for the plan are ordinarily pre-determined by collective bargaining agreements, such that benefit claims determinations do not directly impact employer funding obligations.

A circuit split on the issue has developed, with the Ninth, Sixth, and Fourth Circuits ruling that the boards of trustees of Taft-Hartley plans are not structurally conflicted and the Second Circuit ruling that they are structurally conflicted. This article reviews the underpinnings for the conflict of interest analysis generally and the reasoning of the differing rulings applying this analysis to Taft-Hartley plans. The article then discusses the practical implications for funds operating under the more burdensome Second Circuit rule, including the risk of undergoing additional discovery into the conflict issue, as well as the increased likelihood of an adverse outcome in the case.

Background

Before commencing a claim for benefits under Section 502(a)(1)(B) of ERISA, a plan participant or beneficiary must exhaust his or her administrative claims pursuant to a plan's internal procedures. See, e.g., *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009). Judicial review of benefit claim denials is de novo unless the plan confers discretionary authority on the administrator to determine eligibility for benefits or to construe the terms of the plan. Where such discretion exists, courts review denials of benefits under an abuse of discretion standard. See *Firestone Tire & Rubber Co. v. Burch*, 489 U.S. 101 (1989).For many years, courts struggled in deciding what impact, if any, a plan administrator's conflict of interest should have on the appropriate standard of review. For example, if the plan administrator worked for the company that was responsible for paying benefits, should the plan administrator's decision still be entitled to an abuse of discretion review, or should a less deferential standard of review be applied? *In Metropolitan Life Ins. Co. v. Glen*n, 554 U.S. 105 (2008), the Supreme Court answered those questions and held that a structural conflict is a factor for courts to weigh in determining whether an insurance company abused its discretion in denying a claim for benefits, but does not change the standard of review. Furthermore, the Court stated that the extent to which the structural conflict will impact a court's review will be influenced by such factors as the steps taken to reduce bias in claims determinations, compensation paid to claims decision makers, and a history of biased claims decision making.

Glenn ruled that the existence of a structural conflict "is clear where it is the employer that both funds the plan and evaluates the claims [because] every dollar provided in benefits is a dollar spent by the employer; and every dollar saved is a dollar in the employer's pocket." The Court also found that a structural conflict exists when an insurance company is responsible for paying benefits, as was the case in *Glenn*. The Court did not address, however, whether a structural conflict of interest exists where the claim decision maker is a board of trustees of a Taft-Hartley plan.

Taft-Hartley Plan Boards of Trustees: Conflict or No Conflict?

Since *Glenn*, courts have been divided on whether a board of trustees of a Taft-Hartley plan operates under a structural conflict of interest such that the conflict should be taken into account when reviewing its benefit claims decisions in a lawsuit. The Ninth, Fourth, and Sixth Circuit Courts of Appeals have concluded that boards of trustees of Taft-Hartley plans do not operate under a structural conflict of interest, while the Second Circuit has ruled directly to the contrary.

The Ninth Circuit was the first to address the issue after Glenn. In *Anderson v. Suburban Teamsters of N. Illinois Pension Fund Bd. of Trustees*, 588 F.3d 641 (9th Cir. 2009), the Court found that no conflict existed because the participating employers (not the trustees) fund the plan, the trustees have no personal economic interest in the decision to grant or deny benefits, and the board of trustees consists of both employer and employee representatives who determine employee eligibility under the Plan. Having held that the trustees were not conflicted, the Court did not permit discovery outside of the administrative record and found that the trustees did not abuse their discretion in reducing the plaintiff's disability benefits.

A subsequent district court decision elaborated on Anderson's reasoning. In *Leblanc v. Motion Picture Indus. Health Plan* (C.D. Cal. Dec. 7, 2012), aff'd, 593 F. App'x 729 (9th Cir. 2015), the plaintiff argued that a structural conflict existed because both the contributing employers and the unions shared the same interest in keeping the plan's costs low, since dollars saved from plan funding obligations could be used to increase wages or other benefits. In rejecting this argument, the court explained that the resources of any plan will necessarily be finite, and thus that plan administrators always have a fiduciary obligation to insure the prudent management of plan assets, including when making benefit determinations. Having concluded that there was no structural conflict, the court confined its review to the administrative record and held that the board did not abuse its discretion in reaching its determination and that summary judgment in favor of the board was warranted.

The Sixth Circuit similarly rejected plaintiff's argument that a Taft-Hartley plan's structure created an inherent conflict because the trustees not only approved and denied claims, but also maintained responsibility for ensuring that the plan remain properly funded. *Klein v. Central States, Southeast and Southwest Areas Health and Welfare Pla*n, 346 Fed. App'x 1 (6th Cir. 2009). In so ruling, the Sixth Circuit explained that the board of trustees did not have a profit motive and individual trustees received no personal financial benefit from approving or denying claims. Having concluded there was no structural conflict, the Court reversed the lower court's finding that the plan's determination had been arbitrary and capricious and remanded to the district court for entry of judgment in favor of the plan.

The Fourth Circuit reached a similar conclusion in *Parsons v. Power Mountain Coal Co*., 604 F.3d 177 (4th Cir. 2010). It explained that "[t]he conflict of interest *Glenn* envisioned was one in which the plan administrator had a direct financial stake in eligibility determinations." By contrast, it found, the board of trustees of a Taft-Hartley plan does not suffer any economic hardship when the trustees award additional benefits because the plan is funded by multiple employers whose contribution obligations are prescribed by the collective bargaining agreement and are thus unimpacted by the amount of benefits awarded. Having found that the trustees were not conflicted, the Fourth Circuit affirmed the district court's summary judgment decision enforcing the trustees' decision.

Against this backdrop, the Second Circuit reached a different conclusion in D*urakovic v. Bldg. Serv. 32 BJ Pension Fun*d, 609 F.3d 133 (2d Cir. 2010). The Court held that a board of trustees of a Taft-Hartley plan is conflicted within the meaning of *Glenn*

because the evaluation of claims is "entrusted (at least in part) to representatives of the entities that ultimately pay the claims allowed." According to the Court, "[t]hat the board is…evenly balanced between union and employer does not negate the conflict." Having concluded that a conflict existed, the Court next determined that the trustees' decision to deny benefits was arbitrary and capricious, reversed the district court's ruling, and granted summary judgment in favor of the Durakovic. The Court did not explain whether its ruling that the decision was arbitrary and capricious was dependent on its finding of a structural conflict of interest.

Potential Impacts of the Choice of Conflict Rule

Although ERISA § 502(a)(1)(B) cases are generally limited to the administrative record, the choice to treat multiemployer funds as inherently conflicted may cause defendants to undergo discovery on the conflict of interest issue. Courts have reached varying conclusions on whether and to what extent discovery relating to alleged conflicts of interest should be permitted. Where a plaintiff is able to present sufficient facts to the trial court to invoke substantial concerns about whether a conflict affected a benefit determination, targeted discovery may be permitted. On the other hand, courts are likely to deny conflict-of-interest discovery in cases where the plan administrator implemented safeguards against biased decision making, and where discovery on the alleged conflict of interest is unlikely to change the outcome of the case. Thus, it appears that a rule that Taft-Hartley funds are structurally conflicted will not automatically entitle plaintiffs to discovery but may increase the likelihood that courts will order targeted discovery, especially where a plaintiff alleges facts indicating that a benefits decision was improperly influenced by a conflict of interest.

A default rule that Taft-Hartley plans are conflicted also may impact whether courts ultimately uphold a plan's determination to deny a claim for benefits. As is evident from the decisions discussed above, rulings finding that plan fiduciaries abused their discretion will frequently follow predicate findings that the fiduciaries suffered from a conflict of interest. However, outside of the Taft-Hartley context there are many examples of courts upholding benefits decisions notwithstanding a finding of a structural conflict. Thus, while a finding of a structural conflict may increase the risk of an adverse ruling, a plan suffering from a structural conflict may still mount a successful defense.

View from Proskauer

The circuit split as to whether the board of trustees of a Taft-Hartley fund is structurally conflicted is significant because a finding of a structural conflict could affect the outcome of a benefit claim, and at a minimum could affect the scope of discovery conducted before the claim is adjudicated. It is hoped that the majority rule ultimately prevails, as it appears to be more consistent with the reality of what we observe when representing Taft-Hartley plans. But pending a resolution of the split, Taft-Hartley plans must be administered with an eye toward the risk that their boards will be found to be structurally conflicted.

In order to protect against the potential adverse implications of such a finding, a board of trustees will want to administer their review of benefit claims in a manner that removes any basis for believing that a structural conflict actually affected the benefit determination. Toward that end, a board of trustees should be particularly vigilant in maintaining a complete record of the basis for the determination, including all objective advice on which it relied. Furthermore, it may help if the record makes clear that the full board of trustees participated in the decision, and thus that the decision was not controlled by employer trustees who, according to the Second Circuit, might have an enhanced motivation to deny the claim. If such safeguards are sufficiently documented, reviewing courts are more likely to conclude that discovery into conflict issues is not warranted, and are similarly less likely to conclude that the structural conflict impacted the decision-making process. In short, the same "best practices" that apply to claims administration generally take on particular significance in the Taft-Hartley arena given the uncertain legal environment in which these plans' benefit determinations presently operate.

Highlights from the Employee Benefits & Executive Compensation Blog

DOL Fiduciary Rule

DOL Again Seeks Comments on New Fiduciary Rules and Exemptions

By Russell Hirschhorn, Seth Safra and Benjamin Saper

On June 29, 2017, the Department of Labor ("DOL") requested another round of public comment on its fiduciary rule—this time in the form of a Request ("RFI") for Information. The RFI seeks input on (a) whether to extend the January 1, 2018, applicability date for parts of the rule that are not yet in effect, and (b) changes to make the rule more workable. The RFI expresses an openness to modifying existing exemptions and adopting new ones.

The RFI has two deadlines for submitting comments: 15 days for comments on whether to extend the January 1, 2018, applicability date, and 30 days for other comments. Days will be counted from when the RFI is published in the Federal Register, which we expect will occur during the week of July 3rd.

The RFI has 18 specific questions, all of which are aimed at collecting more information for the DOL's review of whether and how the fiduciary rule affects retirement investors. The tone of the questions suggests that DOL is committed to the basic principle of protecting consumers from conflicts of interest, but open to

constructive feedback to make the rule and its exemptions more workable.

The following are sample themes raised in the RFI:

- DOL wants to know more about innovations in the industry to protect against conflicts of interest, such as technology-driven advice, "clean shares" in the mutual fund industry, and fee-based annuities.
- There are questions about the best interest contract exemption, including whether the contract should be "eliminated or substantially altered" for IRAs. DOL is interested in cost-benefit analysis and proposals for alternative approaches.
- DOL suggests the possibility of a "streamlined exemption" that is based on following model policies and procedures.
- There are questions related to product sales and advice on contributions, including the possibility of exempting recommendations to make or increase contributions and the possibility of expanding the "seller's" exception. (The existing seller's exception is available only if the customer is represented by a sophisticated independent fiduciary.)
- DOL is open to considering special rules for cash sweep services, bank deposit products, and health savings accounts.
- The RFI asks for input on coordination with the SEC, self-regulatory bodies, and other regulators.

Department of Labor's New Fiduciary Rule Will Go Into Effect June 9th

By Russell Hirschhorn, Seth Safra and Benjamin Saper

The Department of Labor has announced that the new fiduciary conflict of interest rule and related exemptions will begin taking effect on June 9, 2017, ending speculation of further delay. At the same time, the Department announced a relaxed enforcement standard for the rest of 2017. See our blog post on the delayed effective date here.

The effect of the Department's announcement is that the new standard for when communications rise to the level of fiduciary advice will go into effect at 11:59 p.m. on June 9th. After that time, service providers who are deemed to provide investment advice—for example, by suggesting a particular investment or strategy, or recommending a rollover—will be subject to ERISA's duties of prudence and loyalty, as well as ERISA's prohibited transaction rules.

This is the first time that ERISA's requirements of prudence and loyalty will expressly apply for advisers to IRAs, HSAs, and other non-ERISA accounts that are subject to the prohibited transaction rules under the Internal Revenue Code. At least for now, however, there will continue to be no private right of action against advisers to non-ERISA accounts for breach of the duty of prudence or loyalty. The consequence of non-compliance will be a self-reporting excise tax under Section 4975 of the Internal Revenue Code.

Between now and the end of the year, the Department will continue to review the fiduciary rule and related exemptions. The Department announced that it intends to publish a Request For Information and that it will be receptive to comments related to the new rule's requirements. Secretary Acosta has also indicated (in a *Wall Street Journal* op-ed) that the Department is hoping to collaborate with the Securities and Exchange Commission on a more uniform standard.

Through the end of the year, the Department "will not pursue claims against fiduciaries who are working diligently and in good faith to comply with the fiduciary duty rule and exemptions, or treat those fiduciaries as being in violation of the fiduciary duty rule and exemptions." This relaxed approach to enforcement is consistent with the Department's emphasis on compliance rather than penalties.

DOL Fiduciary Rule Delayed, But At Least Parts Might Be Here to Stay

By Seth Safra and Russell Hirschhorn

On April 4, 2017, the U.S. Department of Labor issued a final rule postponing applicability of the conflict of interest rule and related exemptions for sixty days, until June 9, 2017. The stated purpose of the extension is to allow more time to: (i) complete the examination required by President Trump's February 3, 2017 memorandum, which focuses on the rule's impact on access to retirement products, advice, and information (see our blog here); and (ii) consider possible changes with respect to the conflict of interest rule and related exemptions based on new evidence or analysis developed pursuant to the examination. The Department stated that it received 193,000 comment and petition letters expressing views on whether it should grant the delay Its 63-page release includes a discussion of the comments and hints of "a more balanced approach than simply granting a flat delay and all associated obligations for a protracted period."

In addition to the general 60-day delay, the Department has delayed most of the requirements for the best interest contract and other new exemptions through January 1, 2018.

In setting separate applicability dates, the Department distinguished between (i) the rule on fiduciary status (who is a fiduciary) and the "Impartial Conduct" standard (acting in the client's best interest), and (ii) the more onerous requirements of the various exemptions. The Department hinted that it might let the rule on fiduciary status and the Impartial Conduct standard go into effect as early as June 9th. In fact, the Department stated:

> "[T]here is fairly widespread, although not universal, agreement about the basic Impartial Conduct Standards, which require advisers to make recommendations that are in the customer's best interest (i.e., advice that is prudent and

loyal), avoid misleading statements, and charge no more than reasonable compensation for services (which is already an obligation under ERISA and the Code, irrespective of this rulemaking."

The Department further stated that it "finds little basis for concluding that advisers need more time to give advice that is in the retirement investors' best interest and free from misrepresentations in exchange for reasonable compensation."

In contrast, the Department observed that the onerous requirements for the various exemptions – including the "best interest contract," which would create a private right of action for IRA clients to sue their advisers over prudence and loyalty – can lead to increased compliance costs in a way that reduces access to retirement products, advice, and information. The Department emphasized a "compliance first" policy, whereby the Department intends to focus more on assistance in eliminating conflicts and improving compliance more generally than on citing violations and imposing penalties.

The Department is continuing to accept comments on the substance of the fiduciary rule and related exemptions: the formal comment period ends on April 17, 2017, but the Department stated that it will be open to helpful comments even after that date.

In sum, the message seems to be that the Department is not leaning toward tossing the rule in its entirety or leaving the fiduciary standard to the SEC, but it remains open to analysis of the rule's impact and thoughtful suggestions for how to reduce conflicts of interest without unduly burdening the retirement advice industry.

Church Plan Exemption

The United States Supreme Court Rules in Favor of Hospitals on "Church Plan" ERISA Exemption

By Howard Shapiro, Stacey Cerrone and Madeline Chimento Rea

The United States Supreme Court unanimously ruled in favor of religiously-affiliated hospitals and healthcare organizations in holding that a pension plan need not be established by a church in order to qualify for ERISA's church plan exemption. Petitioners are religiously affiliated non-profit healthcare organizations appealing decisions by the Third, Seventh, and Ninth Circuit Courts of Appeal that a church must establish an ERISA-exempt church plan. Respondents are current and former employees of these organizations.

Justice Kagan explained that the plain language of the statutory text clearly supported petitioners' view that a pension plan need not be established by a church to qualify for the exemption. Rather, a pension plan can qualify as a church plan if it is maintained by an organization whose principal purpose is to administer or fund a benefits plan or program for church employees if the organization is controlled by or associated with a church ("principal purpose organization") regardless of who established the plan. The Supreme Court's decision left unresolved several key questions, including whether petitioners and similar organizations are sufficiently church-affiliated to qualify for the exemption and whether these organizations' benefit committees are principal-purpose organizations. Justice Sotomayor agreed with the decision and its reasoning but she concurred to note her concern about the potential consequences of leaving employees of these organizations unprotected by ERISA. Justice Gorsuch took no part in the decision. The case is *Advocate Health Care Network v. Stapleton*, No. 16-74 (2017).

Fee Litigation

District Court Dismisses Allegations That Stable Value Fund is Too Conservative

By Neil Shah

A district court in Rhode Island dismissed claims by participants in the CVS Employee Stock Ownership Plan that plan fiduciaries imprudently invested plan assets in the plan's stable value fund. Plaintiffs argued that the stable value fund had an excessive concentration of investments with ultra-short durations and excessive liquidity, both of which caused the fund to underperform comparable stable value funds. The court dismissed the complaint because the stable value fund "was invested in conformance with its stated objective and whether that strategy was prudent cannot be measured in hindsight" simply by judging its performance against industry averages. The case is *Barchock v. CVS Health Corp*., No. 16-601, slip op. (D.R.I. Apr. 18, 2017).

Claims Against Investment Adviser in ERISA Fee Litigation Case Dismissed

By Tulio Chirinos

A federal district court in North Carolina dismissed claims by BB&T Corp.'s 401(k) plan participants that Cardinal Investment Advisors, LLC, the plan's outside investment advisor, breached its ERISA fiduciary duties by allowing the plan to invest in BB&T proprietary funds. The proprietary funds, according to plaintiffs, charged excessive fees and underperformed non-proprietary funds. The court dismissed the complaint against Cardinal because plaintiffs alleged only that Cardinal gave BB&T general investment advice and failed to allege any specific facts that Cardinal breached its fiduciary duty to the plan. The case is *Bowers v. BB&T Corp*., No. 1:15-cv-00732, ECF No. 150 (M.D.N.C. Apr. 18, 2017). Last year, the court summarily denied the BB&T defendants' motion to dismiss because plaintiffs' complaint adequately alleged claims for which relief may be granted. *Bowers v. BB&T Corp*., No. 1:15-cv-00732, ECF No. 58

(M.D.N.C. Apr. 18, 2016). The case against the BB&T defendants is ongoing.

Employer Stock Fund Litigation

Sixth Circuit Dismisses ERISA Stock Drop Action Against Cliffs Natural Resources

By Neil Shah

The Sixth Circuit affirmed the dismissal of ERISA stock drop claims by participants in the Cliffs Natural Resources' 401(k) Plan. The participants alleged fiduciary breach claims based on public and non-public information arising out of the collapse in iron ore prices that caused the company's stock price to decline 95%. With respect to the public information claim, the Court held that a "fiduciary's failure to investigate the merits of investing in a publicly traded company" is not the type of "special circumstance" that can support a claim based on public information, and that plaintiffs also must plead "what, if anything, the fiduciaries might've gleaned from publicly available information that would undermine reliance on the market price." With respect to the non-public information claim, the Court rejected plaintiffs' allegations that a prudent fiduciary could not have concluded that disclosing the inside information or halting additional contributions would do more harm than good. In so ruling, the Court determined that the plan fiduciaries could have concluded that divulging inside information would have caused the company's stock price to collapse, further harming participants already invested in the fund. The Court also determined that closing the fund without explanation might be even more harmful: "It signals that something may be deeply wrong inside a company but doesn't provide the market with information to gauge the stock's true value." The case is *Saumer v. Cliffs Natural Resources, Inc*., No. 16-3449 (6th Cir. Apr. 7, 2017).

Retiree Benefits

Sixth Circuit Issues Trilogy on Retiree Health Benefits

By Madeline Chimento Rea

In three decisions issued on the same day, the Sixth Circuit held that Meritor retirees were not entitled to lifetime health benefits, while retirees at Kelsey-Hayes and CNH Industries were entitled to contractually vested health benefits. In the first case, a group of former Meritor employees filed suit after the company reduced their healthcare benefits. The CBAs provided that retiree healthcare coverage "shall be continued," but also set forth a general durational clause terminating the CBAs after three years and provided that healthcare benefits would remain in effect until the termination of the CBAs. The CBAs also stated that pension benefits were vested and did not say anything similar for retiree health benefits. Taking into account all of these terms, the Sixth Circuit held that the CBAs were unambiguous and that retirees were guaranteed benefits for only the three-year term of the CBAs. *Cole v. Meritor, Inc.*, No. 06-2224, 2017 WL 1404188 (6th Cir. 2017). However, in cases against Kelsey-Hayes Co. and CNH Industrial N.V., the Sixth Circuit ruled against the employers. The principal difference in *UAW v. Kelsey-Hayes* was that the CBA contained a general durational clause that required mutual action to terminate the agreement. The Court determined that there was ambiguity when applying the general durational clause and, after looking at extrinsic evidence, concluded that the CBA vested employees with lifetime healthcare benefits. *UAW v. Kelsey-Hayes Co.*, No. 15-2285, 2017 WL 1404189 (6th Cir. 2017). Similarly, in *CNH Industrial*, the Sixth Circuit found the CBA to be ambiguous because it was silent on the duration of health care coverage and the general durational clause carved out other benefits. Furthermore, the Court observed that eligibility for healthcare benefits was tied to pension eligibility. After looking at extrinsic evidence, the Court determined that the parties intended for retiree healthcare benefits to vest. *Reese v. CNH Indus. N.V.*, No. 15-2382, 2017 WL 1404390 (6th Cir. 2017).

Mental Health Parity Act

New Class Action Lawsuits Asserting Violations of the MHPAEA

By Steven A. Sutro

Banner Health and the Kaiser Foundation were recently hit with separate class action lawsuits challenging their denials of certain mental health care coverage. In the case against Banner Health, plaintiffs challenge Banner Health's exclusion of applied behavior analysis therapy from coverage for autism spectrum disorder as "experimental or investigational." Plaintiffs allege that the failure to provide such coverage violates the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The case against Kaiser Foundation challenges the denial of coverage for residential treatment and hospitalization for eating disorders. Plaintiff alleges that physicians determined that hospitalization was needed to treat his severe eating disorder, but he could not get the required authorization from the Kaiser Foundation and the denial violates the MHPAEA. The cases *are Etter v. Banner Health*, D. Ariz., No. 2:17-cv-01288 (filed May 1, 2017) and *Moura v. Kaiser Foundation Health Plan, Inc*., N.D. Cal., No. 3:17-cv-02475, (filed May 1, 2017).

Summary Plan Description

Fifth Circuit Enforces Reimbursement Provision in One-Page Welfare Plan

By Tulio Chirinos

The Fifth Circuit upheld the reimbursement and subrogation terms found in a welfare benefit plan's one-page SPD that also served as the plan document. Plaintiff, a plan beneficiary, received $71,644.77 from the plan to cover medical expenses incurred as a result of injuries sustained during a laparoscopic exam. Plaintiff's injuries were allegedly the result of medical malpractice for which she received a settlement for more than the amount of her medical expenses. The plan sought to recover the $71,644.77 pursuant to the plan's reimbursement and subrogation clause. Plaintiff refused and instead sought a declaratory judgment that she was not required to reimburse the plan because the plan did not have an ERISA-compliant written instrument in place when the plan paid the medical expenses. The plan countersued seeking reimbursement for the medical expenses and attorneys' fees. Plaintiff first argued that in order for the plan to comply with ERISA it had to have both an SPD and a written instrument and provide detailed information on how the plan is funded and amended. The Fifth Circuit rejected both arguments explaining that: (i) plans commonly use a single document as both the SPD and written instrument and that the practice is widely accepted by courts; and (ii) the plan's brief description of the funding and amendment procedures was sufficient to satisfy ERISA. The Court likewise rejected plaintiff's argument that the plan misrepresented material facts because the SPD referenced a nonexistent "official plan document" noting that such an errant disclaimer does not rise to the level of misrepresentation that would invalidate a plan document. The case is *Rhea v. Alan Ritchey, Inc. Welfare Benefit Plan*., No. 16-41032 (5th Cir. May 30, 2017).

IRS

Protecting Your Qualified Retirement Plan Now that the IRS Determination Program is (Mostly) Closed

By Paul M. Hamburger, Cristopher Jones, Robert Projansky, Seth Safra and Steven Weinstein

A lot has been written over the last few months about what to do now that the IRS has closed its determination letter program for ongoing individually designed tax-qualified retirement plans. Some see this as cause for celebration because we no longer have to go through the trouble of collecting documents, filling out forms, and negotiating with the IRS over renewals of qualification determinations. Another "positive" result of the IRS position is that existing determination letters will no longer expire—although they will become stale as time passes, due to plan changes and legal developments.

But most of the focus seems to have been on fear: as time passes, how will we know whether a retirement or 401(k) plan is still qualified? The answer to this question is important because plan sponsors and administrators have historically relied on determination letters for a host of purposes, including:

- Representations for M&A, financing, and other corporate transactions;
- Representations to auditors;
- Representations to investment trustees and fund managers;
- Government audits; and
- Rollovers and other plan asset transfers.

We have seen a range of ideas, from moving to a prototype or volume submitter plan to obtaining a law firm or consulting firm "opinion" that is marketed as analogous to an IRS determination letter. In our view, a more practical solution is to continue the discipline forced by the old determination program and use that discipline for systematic reviews of ongoing compliance. This does not mean constant full-scale review, but rather setting up a system to ensure that key elements of the plan document and administration will be reviewed periodically (perhaps a little at a time to keep things manageable).

We have developed tools to help clients with this process, ranging from self-help diagnostic checklists (at no cost) to larger-scale compliance reviews with specific analysis and recommendations, all designed to manage compliance risk, add value, and protect confidentiality—think of it as the Proskauer Compliance Resolution System (PCRS).

In considering a prudent path forward, it is important to think about what an IRS determination letter is, and what it isn't. An IRS determination letter reflects the IRS's binding determination that a plan's written document satisfies the formal requirements for tax qualification. An IRS determination letter is binding on the IRS; it precludes the IRS from retroactively disqualifying a plan because of a defect in the plan's language.

But even if a plan has a favorable determination letter, the IRS can still disqualify the plan for many reasons, including.

1. If the IRS discovers that the plan is not operating in accordance with its terms;
2. If the IRS finds that a once-compliant plan document was not amended to comply with a change in law or was amended in a way that violates a technical qualification requirement; or
3. If the IRS finds that the language in a previously approved plan was impermissible and should not have been approved.

In this case, a prior determination letter protects against disqualification retroactively; but the IRS would still require a change going forward, and dealing with the IRS tends to be complicated if the change involves a potential cut-back of benefits or rights.

Separately, a favorable IRS determination letter generally does not help in defense of claims by participants and beneficiaries under Title I of ERISA, such as a claim for benefits owed or a breach of fiduciary duty. So even with an up-to-date determination letter, plan sponsors and administrators need to stay on top of plan document and operational compliance.

Given these limitations, the real question for plan sponsors and administrators is how best to manage ongoing plan qualification and compliance risk. A formal opinion letter from a private third party, like a law firm or consulting firm, might seem like an attractive way to make up for losing the determination letter piece of the puzzle. It is undoubtedly worthwhile to review the plan document—and ideally its administration too—and to correct any defects before the IRS or a disgruntled plan participant discovers them.

But the value in any qualified plan compliance exercise is found more in the quality of the review and steps taken to mitigate risk than in what is written into a third party's formal written opinion. For example, when the IRS audits a qualified plan, the existence of a third-party opinion letter is not likely to affect the auditor's independent findings and may have little or no bearing on the penalties that the IRS may assess if it concludes there is an error. Similarly, in a benefit claim or litigation, a third party's written opinion is not likely to persuade a fact-finder. To the contrary, an opinion can potentially cause harm if it leaves a discovery trail of issues that were identified but not adequately corrected, or issues that were spotted but ultimately resolved without action due to a plan-favorable interpretation of the law.

In most cases, the best value is to emphasize substance over form by working with reliable and pragmatic counsel, and by continuing to allocate resources to proactive plan compliance efforts. Systematic ongoing review is the best way to mitigate risks that arise from a technical web of constantly changing rules and an ever-more-creative plaintiffs' bar.

Compliance reviews come in many varieties. For example, when merging a small and simple plan into a larger, more complex plan, a quick review of required documents and basic processes might be enough. In other cases, a more detailed review is warranted. The important point is that every plan needs to be reviewed periodically to stay up to date and to ensure that operations remain consistent with plan terms and best practices.

At Proskauer, we are partnering with our clients to develop cost-effective compliance review programs. We have developed self-help tools, and we work with clients to understand and manage risk, while maintaining confidentiality and focusing on the needs of their particular organizations.

The Time is Right to Contact Recordkeepers About Hardship Substantiation

By Robert Projansky and Seth Safra

If your 401(k) plan recordkeeper has not talked to your company lately about hardship distributions, it may be time to reach out to the recordkeeper. The short story is that the IRS recently issued an internal memorandum (found here) providing guidance to its employee plans examination group on the substantiation requirements for hardship distributions from a section 401(k) plan. While this is not binding on the IRS as a statement of the law, it is useful in that it provides some indication of how the IRS would approach this issue in an audit.

By way of background, the law provides a list of expenses and costs for which a distribution would be considered on account of immediate and heavy financial need. Historically, plan administrators and recordkeepers have struggled to find a balance between ensuring compliance with the need requirement and making the process more efficient for plan participants. A number of recordkeepers allowed participants to "self-certify" electronically and required little substantiation of the expenses, but IRS officials informally questioned whether self-certification was sufficient—most recently in a 2015 post in *Employee Plans News* that said plan sponsors should retain documentation and that "electronic self-certification is not sufficient documentation of the nature of a participant's hardship."

The latest guidance maintains the position that self-certification alone is not enough, but offers an acceptable alternative to full substantiation.

Specifically, the guidance seems to provide two substantiation options.

First, the recordkeeper could require that a participant provide full underlying documentation (or what it calls source documents) substantiating the claim, such as estimates, contracts, bills and statements from third parties.

Second, the recordkeeper could require that the participant provide a summary of the information contained in the source documents. The summary could be in paper or electronic form or in telephone records. But if the summary is used, there are additional requirements:

- The summary information provided by the participant must include (i) the participant's name; (ii) the total cost of the hardship event; (iii) the amount of distribution requested; and (iv) certification by the participant that the information provided is true and accurate.
- The summary from the participant must also include additional information that depends on the type of hardship. For example, for medical expense hardship, the information must include (i) the name of the person incurring the expense; (ii) the relationship to the participant; (iii) the general category of the purpose of the medical care (e.g.,

diagnosis, treatment, prevention, associated transportation, long-term care); (iv) name and address of the service provider; and (v) the amount of medical expenses not covered by insurance. Each type of hardship has its own enumerated list.

- The recordkeeper must notify the participant that (i) the hardship distribution is taxable and additional taxes could apply; (ii) the amount of the distribution cannot exceed the immediate and heavy financial need; and (iii) hardship distributions cannot be made from earnings on elective contributions or from qualified nonelective or qualified matching contribution accounts (if applicable). Of these requirements, only item (ii) is directly related to the form of substantiation.
- The participant must also agree to preserve source documents and to make them available at any time, upon request, to the employer or recordkeeper.

In addition to the substantiation requirements, the IRS expects the recordkeeper to provide to the employer reports or other access to data on hardship distribution at least annually.

The guidance further suggests that IRS auditors might be skeptical of hardship distributions when summary documentation is used. In particular, the IRS is concerned about cases where an employee has more than two hardship distributions in a plan year. Absent an adequate explanation (e.g., tuition on a quarterly calendar), the IRS might ask for source documents. Auditors might also ask for source documentation if the employee's summary is incomplete or inconsistent on its face.

The IRS's openness to substantiation in a summary form will be welcome news to many administrators and plan sponsors. But accepting summary substantiation will require careful review by the recordkeeper and, even with that review, administrators and sponsors will have to rely on participants to maintain records.

Recordkeepers have now had a few months to process this recent guidance and react.Thus, now is a good time for plan sponsors to contact their recordkeepers to review their processes for approving hardship distributions and decide how best to proceed. Plan sponsors should consider whether the efficiency from reduced documentation is worth the potential for headaches in an IRS audit.

Preemption

Out-of-Network Physician's Claim Against Insurer Not Preempted by ERISA

By Lindsey Chopin

The Second Circuit concluded that a promissory estoppel claim by an out-of-network provider against an insurer was not completely preempted by ERISA and thus remanded the claim to state court for further proceedings. The provider's claim was predicated on its assertion that the insurer made certain representations about coverage for the insured. The Court held that the provider was not the type of party that can bring an ERISA benefit claim because the plan at issue bars assignments of an insured's right to benefits to out-of-network providers. In so ruling, the Court rejected several arguments. First, the Court ruled that a determination about whether the purported assignment was valid under the terms of the plan is not an issue that must be decided under ERISA. Second, the Court determined that the provider's claim could not be construed as a claim for benefits because the provider had no pre-existing relationship with the insurer and was not a valid assignee of benefits. Third, the Court found inapplicable its prior conclusion that a provider's pre-approval telephone call to an insurer can never "give rise to an independent legal duty" enforced outside of ERISA. Here, unlike in previous cases, the provider's lack of a contractual relationship with the plan or the insurer meant that it was not required to call the insurer to receive pre-approval; rather, the provider called the insurer for its own benefit. Thus, the provider's suit to enforce the alleged promises made during the call is one to enforce its own rights that exist independent from the plan. The case is *McCulloch Orthopaedic Surgical Services, PLLC v. Aetna Inc.*, 2017 WL 2173651 (2d Cir. May 18, 2017).

First Circuit Enforces Arbitration of ERISA Dispute

By Madeline Chimento Rea

The First Circuit concluded that, pursuant to the applicable collective bargaining agreement, it was for an arbitrator, not the court, to decide whether the union's claim that the employer failed to properly fund a defined benefit pension plan was preempted by ERISA. The First Circuit explained that the arbitration clause in the CBA clearly applied to the dispute and there is no prohibition on the arbitration of ERISA claims. The case is *Prime Healthcare Servs.–Landmark LLC v. United Nurses & Allied Prof's*, 848 F.3d 41 (1st Cir. 2017).

Standing

Ninth Circuit: Medical Providers Lack ERISA Standing

By Steven A. Sutro

The Ninth Circuit affirmed two district court decisions that concluded medical providers were not "beneficiaries" under Section 502(a) of ERISA and therefore lacked standing to bring an ERISA claim. The Court explained that, in one case, the provider had an assignment from the participants, but the assignment was invalid because the plan contained a non-assignment clause that overrode any purported assignments. In the other case, the assignment to the provider did not include authority to seek declaratory, injunctive, or monetary relief. The Court observed that its holding was in line with its own prior precedent and consistent with decisions in the Third, Sixth, Seventh, and Eleventh Circuits. The case is *DB Healthcare, LLC, v. Blue Cross Blue Shield of Arizona, Inc*., No. 14-16518, 2017 WL 1075050 (9th Cir. Mar. 22, 2017).

Health Care Reform

Health Care Reform Weekly Roundup – Issue 5

By Damian A. Myers

The Senate's health care reform bill was released today, and we will report on that separately. In the meantime, below are key health care reform developments from the week of June 12th.

- CMS Estimates Impact of the AHCA. The Office of the Chief Actuary at the Center for Medicare and Medicaid Services issued a memorandum estimating that, under the American Health Care Act ("AHCA"), the number of insured will be approximately 13 million higher by 2026. Much of the difference from the CBO estimate of 23 million appears to result from differing assumptions regarding its impact on Medicaid enrollees. The memorandum also concluded that while the AHCA is estimated to reduce the average gross premium in the individual insurance market by 13% by 2026, premiums will be approximately 5% higher as a result of the loss of government subsidies.
- AHCA Add-On Legislation Passed by the House. The House of Representatives passed three bills amending the AHCA. These bills – The Verify First Act, The Veterans Equal Treatment Ensures Relief and Access Now (VETERAN) Act, and The Broader Options for Americans Act – were discussed in prior weekly roundups.
- Legislation Introduced to Make ACA Coverage More Affordable for Middle Class Families. Currently under the Affordable Care Act ("ACA"), families making any amount greater than 400% of the federal poverty level receive no financial assistance in the form of premium credits or cost-sharing subsidies for coverage purchased on the Marketplace. New Legislation, The Affordable Health Insurance for the Middle Class Act, would strike this income cap and, as a result, no individual or family would pay more than 9.69% (indexed for inflation) of their monthly income toward health insurance premiums.
- New FAQ Says Eating Disorders are a Mental Illness for MHPAEA Purposes and Requests Comments on Model Forms. Continuing efforts to provide guidance on health care reform issues, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Agencies") have issued a new FAQ related to mental health parity. In general, the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as amended by the ACA and the 21st Century Cures Act provides that quantitative and nonquantitative treatment limitations applied to mental health and substance abuse services cannot be more restrictive than the limitations that apply to substantially all medical and surgical benefits. The FAQ answers one question – whether services for eating disorders must be provided in parity with medical and surgical benefits. The Agencies answer that eating disorders are mental health conditions, the treatment of which is subject to the MHPAEA requirements. Additionally, regulations under MHPAEA and subsequent-related guidance provide that plans are required to disclose information regarding mental health and substance abuse benefits, including nonquantitative treatment limitations and how they are applied to the benefits. In an effort to make required disclosure easier, the FAQ requests comments on whether model forms would be helpful and whether different forms should be created for various types of nonquantitative treatment limitations. The Agencies also released draft disclosure and information request forms and requested comments on those forms.

Health Care Reform Weekly Roundup – Issue 4

By Damian A. Myers

After a brief recess, Congress is back in session and health care reform negotiations continue. Below is a summary of a few, relatively minor, developments that took place during recess and the week of June 5th.

- Senate Optimism. Following closed-door meetings shortly after returning from recess, Senate Republicans indicated that progress had been made on Affordable Care Act (ACA) repeal efforts. Although nothing concrete has been released, comments from various Senators indicate that phased-in, rather than all at once, Medicaid changes and a cap on

income exclusion for employer-provided health care benefits may be on the table. Either way, the Senate GOP has very little margin of error. Senator Rand Paul has already indicated that he would vote against the current proposed repeal legislation, leaving only 51 GOP Senators (and the Vice President if a tie-break is necessary) available to pass legislation.

- AHCA Add-On Legislation Scored. The add-on legislation (see Issue 3 of our roundup) to the American Health Care Act (AHCA) was scored by the Congressional Budget Office (CBO). The CBO estimated that the three pieces of legislation would not have a material revenue impact.
- Cadillac Tax Guidance Coming. IRS officials informally indicated that guidance under Section 4980I of the Internal Revenue Code (the excise tax on high-cost health care, or "Cadillac Tax") remains on its to-do list. The IRS has previously issued Cadillac Tax guidance with Notices 2015-16 (described here) and 2015-52 (described here). The Cadillac Tax was originally set to become effective in 2018, but legislation delayed the effective date to 2020. The AHCA, if enacted in current form, would further delay the effective date to 2026. Given the current opposition to the Cadillac tax on both sides of the aisle, it is unclear whether the Cadillac Tax will ever become effective.
- HHS Requests Health Care Reform Comments. The Department of Health and Human Services (HHS) released a request for comments titled "Reducing Regulatory Burdens Imposed by the Patient Protection and Accordable Care Act & Improving Healthcare Choices to Empower Patients." In this release, the HHS requests comments on promoting consumer choice, stabilizing the individual, small group, and non-traditional insurance markets, improving affordability, and affirming state authority with respect to health insurance regulation. The requests appear to be consistent with President Trump's health care policy objectives and, in particular, Executive Order 12765 ("Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal"). Nevertheless, the ACA is still the law, and as long as that remains true, any regulations issued in connection with this request for comments would need to take the ACA into account.

Health Care Reform Weekly Roundup – Issue 3

By Damian A. Myers

Below are key health care reform developments from the week of May 22nd.

- CBO/JCT Estimate for AHCA Released. The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) released an updated cost estimate for the American Health Care Act ("AHCA"). The latest estimate considered the AHCA as passed by the House of Representatives on May 4, 2017. See our May 26, 2017 blog entry for a summary of key findings in the CBO/JCT report.
- AHCA Add-On Legislation. The House of Representatives Ways and Means Committee released three new pieces of legislation that would modify the AHCA – the Broader Options for Americans Act ("BOA Act"), the Veterans Equal Treatment Ensures Relief and Access Now Act "Veterans Act"), and the Verify First Act (the "Verify Act"). The BOA Act would modify the AHCA by allowing individuals enrolled in unsubsidized COBRA coverage to receive a tax credit. This feature was in the draft AHCA that was first released in March but was not included in the AHCA as passed on May 4th. The Veterans Act would codify existing Affordable Care Act (ACA) regulations and amend the AHCA to permit veterans to choose health coverage provided through the Department of Veterans Affairs or private health coverage eligible for a tax credit. The Verify Act would require relevant government agencies to first verify that a person is a citizen or legally within the US before awarding a premium subsidy to that person.
- Contraceptive Coverage Opt-Out Regs Coming. The Office of Management and Budget indicated last week that it is reviewing "interim final regulations" regarding religious-based objections to contraceptive coverage. The ACA requires that health plans treat contraceptives as preventive care, and thus, cover contraceptives without cost-sharing. Exceptions have been made for religious institutions and private companies objecting to the mandate on religious grounds. The key issues are the procedures these organizations must follow to opt-out of the mandate and whether employees of the organizations will be able to obtain free contraceptives through other means.

Health Care Reform Weekly Roundup – Issue 2

By Damian A. Myers

Below are key health care reform developments from the week of May 15th.

- ACA Repeal Efforts. Efforts to repeal and replace the Affordable Care Act (ACA) continue despite slowing down as the House of Representatives' American Health Care Act (AHCA) is being considered by the Senate. The Senate has formed a bipartisan working group to explore the possibility of passing bipartisan ACA repeal legislation. No details have been provided as to what a Senate ACA repeal bill would look like, but Senate leadership has indicated that at least some of the ACA-related tax provisions may need to remain in place.
- CBO Estimate Coming. On a related note, reports last week indicated that the House of Representatives has not yet formally sent the AHCA to the Senate. The House is waiting for the Congressional Budget Office (CBO) estimate of the

AHCA as passed in early May. The CBO announced that the estimate should be publicly released on May 24th.

- New Legislation. As more and more insurance carriers are electing to leave the ACA Marketplaces, individuals are finding that coverage eligible for premium and cost-sharing subsidies is unavailable. A new bill introduced in the House of Representatives, the Freedom from the ACA Tax Penalty Act, would provide relief from the individual mandate tax penalty for people who cannot purchase Marketplace coverage because there are no options available.
- Direct Enrollment under SHOP. Data shows that enrollment in Federal-facilitated Small Business Health Options Program (SHOP) Marketplaces is far below that previously estimated by the CBO. As a result, the Centers for Medicare and Medicaid Services (CMS) announced that it intends to propose regulations that would permit direct SHOP Marketplace enrollment though insurance carriers or with the use of an agent or broker. Currently, in order to have access to the Small Business Health Care Tax Credit, employers must enroll in the SHOP Marketplace through HealthCare.gov.
- ACA Cost-Sharing Reduction Payments At Risk. *House of Representatives v. Price* (formerly *House of Representatives v. Burwell*) is again in the news as the Justice Department was required to determine whether to continue defending the lawsuit by May 22nd. This litigation, brought by the House of Representatives, claims that the cost-sharing reduction payments permitted under the ACA are unconstitutional because they were not specifically appropriated by Congress. A district court ruled in favor of the House of Representatives last year. In February, the House and Justice Department filed a joint motion to place the proceedings on hold. On Monday, the Justice Department requested another 90-day abeyance. While the proceedings are on hold, the cost-sharing reduction payments will continue.

Health Care Reform Weekly Roundup – Issue 1

By Damian A. Myers

Efforts to repeal and replace the Affordable Care Act ("ACA") are in full swing as the U.S. Senate considers whether to modify the House of Representative's American Health Care Act ("AHCA") or draft its own ACA repeal legislation. In the meantime, employers and other plan sponsors are still required to comply with the ACA. To keep our readers up to date, Proskauer's Health Care Reform Task Force will monitor and report on health care reform developments on a regular basis. In that regard, below is our first Health Care Reform Weekly Roundup.

This past week was generally quiet in terms of ACA repeal developments. However, there were a few developments under the ACA.

- ACA Repeal Efforts. As we previously reported, the House of Representatives passed the AHCA and sent the legislation to the Senate for consideration. Almost immediately, Senators indicated that the AHCA would not be passed as written and that the Senate preferred to draft its own legislation. Nevertheless, it is likely that many components of the AHCA will find their way into Senate legislation. See our May 4th and March 9th blog entries for descriptions of the AHCA provisions most relevant to employers and plan sponsors.
- ACA Affordability Percentage Adjustment. To avoid an employer shared responsibility penalty, the ACA requires that applicable large employers (i.e., generally those with more than 50 full-time employees and equivalents) offer minimum essential coverage that is affordable and has minimum value to their full-time employees. Under the statute, the affordability threshold is set at 9.5% of household income, but the IRS has issued regulations providing for alternative methods of determining affordability. The 9.5% threshold is indexed for inflation, with the 2017 threshold being 9.69%. The IRS recently issued Rev. Proc. 2017-36, which (among other things) set the affordability threshold for 2018. Interestingly, the 2018 affordability threshold will *decrease* to 9.56%. Employers and other plan sponsors should consider this lower threshold when determining employee contribution rates.
- ACA Preventive Care Recommendations. The United States Preventive Services Task Force ("USPSTF") recently issued two new recommendations regarding preventive coverage services. Under the ACA, non-grandfathered group health plans must cover preventive services without cost-sharing (this does not apply to out-of-network services). Among the various definitions of preventive services are those that the USPSTF recommends with an "A" or "B" rating. On April 25, 2017, the USPSTF gave a "B" rating to screening for preeclampsia in pregnant women. This recommendation would require non-grandfathered plans to cover without cost-sharing preeclampsia screening for plan years beginning on or after April 25, 2018. Additionally, on May 9, 2017, the USPSTF gave a "D" recommendation to thyroid cancer screening for patients who exhibit no symptoms of the disease. A "D" recommendation means that this screening does not need to be covered without cost-sharing.

Better Care Reconciliation Act – Key Takeaways for Employers and Plan Sponsors

By Damian A. Myers and Steven Weinstein

On June 22, 2017, the Senate released its much anticipated health care reform legislation – the Better Care Reconciliation Act ("BCRA") (linked to amended version released June 26, 2017). In many respects the BCRA is similar to the House of Representatives' American Health Care Act (which was described

in our March 9, 2017 and May 4, 2017 blog entries). However, the BCRA differs from the AHCA in several important respects.

As of the date of this blog entry, the BCRA does not have sufficient support to pass a vote in the Senate and House GOP members have indicated that they would reject the bill. Therefore, Senate leadership has delayed a vote on the BCRA until after the July 4th holiday recess. Nevertheless, as we provided for the AHCA, below are key takeaways for employers and plan sponsors and a few comparisons between the AHCA and BCRA. A more detailed comparison between key provisions of the Affordable Care Act ("ACA"), the AHCA, and the BCRA is provided at the end of this blog.

1. Individual and Employer Mandates. Like the AHCA, the BCRA would essentially repeal the ACA's individual and employer mandates effective after December 31, 2015. Both bills do this by "zeroing-out" the penalties for not having minimum essential coverage (individual mandate) or for not offering adequate minimum essential coverage to full-time employees (employer mandate). Outside of the effective repeal of the employer mandate, the AHCA's and BCRA's impact on group health plans appears to be minimal. However, if either the AHCA's 30% surcharge or the BCRA's 6-month waiting period becomes law, it is likely that plan sponsors will be required to provide notices similar to the certificates of creditable coverage required in the pre-ACA era

In the absence of an individual mandate, the AHCA and BCRA have different methods of incentivizing individuals to maintain continuous health coverage. Under the AHCA method, insurance carriers would be required to charge a 30% premium surcharge to those who fail to have continuous coverage (i.e., a break in coverage of 63 days or more would trigger the surcharge). The BCRA would require insurance carriers to apply a 6-month blanket coverage waiting period to any individual with a 63-day or more break in continuous coverage during the prior 12 months.

Outside of the effective repeal of the employer mandate, the AHCA's and BCRA's impact on group health plans appears to be minimal. However, if either the AHCA's 30% surcharge or the BCRA's 6-month waiting period becomes law, it is likely that plan sponsors will be required to provide notices similar to the certificates of creditable coverage required in the pre-ACA era.

2. BCRA Retains ACA's Subsidy and Tax Credit Program. The Senate appears to have rejected AHCA's elimination of cost-sharing subsidies and premium tax credits available only for coverage purchased on the Marketplace. The AHCA would have replaced the ACA's program with an advance tax credit program available to individuals purchasing individual market insurance (not just Marketplace coverage) or enrolled in unsubsidized COBRA coverage. Under the AHCA, the amount of the tax credit would be based on age and would be available only to individuals with income less than $75,000 (individual) or $150,000 (jointly with a spouse).

The BCRA, however, maintains the ACA's cost-sharing subsidies and premium tax credit program, albeit with some modifications. Under the BCRA, cost-sharing subsidies and premium assistance would be determined based on age, with younger individuals getting more assistance than older individuals, and income. Household income in excess of 350% of the federal poverty line would disqualify an individual from cost-sharing subsidies and premium assistance, in contrast to the ACA's 400% threshold. Additionally, under the BCRA, the premium tax credit would be based on a benchmark plan that pays 58% of the cost of covered services (in contrast to the ACA's use of the second-lowest cost silver (70%) plan). This lower value of coverage effectively reduces the amount of premium assistance an individual can get.

3. Employer Reporting Obligations to Continue. Although the individual and employer mandates would be repealed, it is likely that the ACA reporting obligations (Forms 1094-B/C and 1095-B/C) would remain in place, at least in some forms. As noted above, the BCRA retains the ACA's cost-sharing subsidies and premium assistance, the availability of which is conditioned on an individual not being enrolled in employer-sponsored coverage. Therefore, the IRS would likely still need to obtain coverage information from employers.

4. Cadillac Tax Repealed Subject to Reinstatement. Like the AHCA, the BCRA effectively delays the so-called Cadillac Tax until 2025. The Cadillac Tax was originally slated to be effective in 2018, but it was delayed until 2020 in prior budget legislation.

5. Most ACA-Related Taxes Repealed. The BCRA would also repeal most of the tax reforms established under the ACA. Most relevant to employers and plan sponsors would be the elimination of the contribution limit on health flexible spending accounts (HFSAs), the ability reimburse over-the-counter costs under HFSAs and health savings accounts (HSAs), the increase in HSA contribution limits, and elimination of the Medicare surcharge applied to high-earners.

6. Popular ACA Reforms Remain. As was the case under the AHCA, the BCRA would keep many popular ACA market reforms and patient protections in place. These include:

- The requirement to cover dependent children until age 26;
- The prohibition on waiting periods in excess of 90 days;
- The requirement for individual and small group plans to cover essential health benefits;
- The prohibition against lifetime or annual dollar limits on essential health benefits;
- The annual cap on out-of-pocket expenditures on essential health benefits;
- Uniform coverage of emergency room services for in-network and out-of-network visits;
- Required first-dollar coverage of preventive health services;

- The prohibition of preexisting condition exclusions;
- Enhanced claims and appeals provisions; and
- Provider nondiscrimination.

7. ERISA Preemption for "Small Business Health Plans." The BCRA would add a new Part 8 to ERISA for "small business health plans." Currently, some states have enacted insurance laws that prohibit small employers from risk-pooling their employees in a single, large group insurance plan. New Part 8 of ERISA would preempt these state laws and allow the formation of "small business health plans," which, generally, are plans sponsored by an association on behalf of its employer members. Small business health plans must meet certain organizational and financial control requirements and apply to the Department of Labor for certification.

8. Employee Tax Exclusion Remains Intact. Like the AHCA, the BCRA does not currently include a limitation on the employee tax exclusion that would result in imputed taxes to employees if the value of health coverage exceeds a certain amount. This absence, however, does not necessarily mean that such a limit will not eventually be imposed. It is possible that Congress will consider limiting tax incentives for both retirement and health and welfare plans when broader tax reform is considered.

9. HFSA/HSA Expansion. As mentioned above, the BCRA includes the same modifications to the HFSA and HSA rules as the AHCA. The BCRA would remove the annual contribution cap on HFSAs. Additionally, HFSAs and HSAs would now be able to reimburse on a non-taxable basis over-the-counter medication without a prescription. The annual contribution limit to HSAs would be equal to the out-of-pocket statutory maximum for high-deductible health plans. Spouses would both be able to make catch-up contributions to the same HSA.

It is still too early to tell whether the BCRA will fare better than the AHCA. In any event, we will continue to monitor legislative efforts and will provide updates as substantive developments occur.

CBO Releases Updated Cost Estimate of American Health Care Act of 2017

By Damian A. Myers and Lisa Schlesinger

On May 24, 2017, the Congressional Budget Office ("CBO") and the staff of the Joint Committee on Taxation ("JCT") released a cost estimate for H.R. 1628, known as the American Health Care Act of 2017 (the "AHCA"). The CBO and the JCT issued cost estimates for prior versions of the AHCA on March 23, 2017 and on March 13, 2017. A summary of the key CBO and JCT estimates is provided below.

Federal Deficit Estimated to Decrease, But Not as Significantly as in Prior AHCA Versions

The CBO and the JCT estimated that enacting the version of the AHCA passed by the House of Representatives on May 4, 2017 would result in a net reduction of the cumulative federal deficit of $119 billion over the course of the 10-year period from 2017 to 2026.

This estimate results in $31 billion less in savings than the March 23, 2017 CBO estimate (which estimated a $150 billion deficit reduction) and $218 billion less in savings than the March 13, 2017 CBO estimate (which estimated a $337 billion deficit reduction). As was the case in prior estimates, the primary source of deficit reduction is the curtailment of outlays for Medicaid and the replacement of premium and cost-sharing subsidies under the Affordable Care Act ("ACA") with a new tax credit program for nongroup health coverage. The primary source of deficit increase is the repeal of ACA-related taxes.

Number of People Uninsured Estimated to Increase, But Not as Significantly as in Prior AHCA Versions

The CBO and the JCT estimated that, in 2018, 14 million more individuals will be uninsured under the AHCA than under the ACA. Further, it is estimated that the number of uninsured individuals will rise to 19 million in 2020 and to 23 million in 2026. These numbers are equal to or slightly less than the prior CBO estimates, as shown in the chart below:

	May 24, 2017 CBO Estimate of Number of Uninsured Individuals	March 23, 2017 CBO Estimate of Number of Uninsured Individuals	March 13, 2017 CBO Estimate of Number of Uninsured Individuals
2018	14 million more than under ACA	14 million more than under ACA	14 million more than under ACA
2020	19 million more than under ACA	21 milion more than under ACA	21 milion more than under ACA
2026	23 million more than under ACA	24 million more than under ACA	24 million more than under ACA

The CBO and the JCT indicated that the small reduction of expected uninsured individuals would stem, in part, from employers viewing the nongroup insurance market as less favorable to employees, which would lead more employers to offer group health coverage.

States Would Have the Flexibility to Waive "Essential Health Benefits" and "Community Rating" Requirements, Resulting in Significantly Different Coverage, Premium, and Out-of-Pocket Experience Based on State Residency

As enumerated in our May 4th blog entry on the passage of the AHCA, the legislation would allow states to waive the ACA provision that restricts how insurance providers determine

premium rates (under the ACA, insurers in the individual and small group market can only take into consideration the coverage tier, community rating, age (as long as the rates do not vary by more than 3 to 1), and tobacco use).

In addition, the legislation would allow states to waive the essential health benefits ("EHBs") requirement under the ACA. Waiver of the EHBs requirement could result in higher out-of-pocket costs to individuals, according to the CBO and the JCT, because the ACA's prohibition on annual and lifetime limits only apply to EHBs. Thus, a less restrictive definition of EHBs means that more services can be subjected to annual or lifetime limits.

The AHCA's impact on nongroup insurance premiums would depend on whether the states waive ACA requirements. For the 2020 to 2026 period, the CBO and the JCT estimate that:

Approximately 1/2 of the population will reside in states that will not seek waivers to the EHBs requirement or the community rating requirement. As was noted in the prior CBO estimates, premiums in these states are expected to be approximately 10% lower on average than under current law after 2020.

Approximately 1/3 of the population will reside in states that will make moderate changes to the EHBs requirement and/or the community rating requirement. Premiums in these states are expected to be approximately 20% lower on average than under the ACA after 2019, since the coverage is expected to generally be less comprehensive than under current law.

Approximately 1/6 of the population will reside in states that will seek waivers to the EHBs requirement and/or the community rating requirement. Premiums in these states are expected to vary significantly depending on a person's health condition and level of benefits coverage. Premiums would be significantly lower for individuals with low expected health care costs, but "less healthy people would face extremely high premiums," according to the CBO and JCT report. This premium disparity could result in a highly volatile nongroup insurance market, which would ultimately cause many individuals to forego insurance coverage.

The CBO and the JCT highlighted that the above percentages of estimated state activity remain uncertain and are subject to a number of key factors. These include the actions and coverage decisions of states prior to the enactment of the ACA, current market conditions, and the concerns of state insurers and market participants.

Impact on Employer-Sponsored Plans Minimal

The CBO and JCT report indicates that the AHCA impact on employer-sponsored plans will be minimal. Nevertheless, the AHCA may lead to greater flexibility in employer-sponsored benefit design because employers with large group and self-insured plans could design their EHBs package on a state that has waived the ACA's EHBs requirement. See our May 4th blog entry for more information on the EHBs requirements for large group and self-insured plans.

Next Steps for the AHCA

Although the AHCA has been passed in the House and a cost estimate has been provided by the CBO and the JCT, there remains a considerable amount of uncertainty surrounding the legislation. The AHCA is now being reviewed by the Senate, which will likely take the CBO cost estimate into account when analyzing the legislation.

IRS Announces HSA and HDHP Limitations for 2018

By Damian A. Myers

On May 4, 2017, the IRS released Revenue Procedure 2017-37 setting dollar limitations for health savings accounts (HSAs) and high-deductible health plans (HDHPs) for 2018. HSAs are subject to annual aggregate contribution limits (i.e., employee and dependent contributions plus employer contributions). HSA participants age 55 or older can contribute additional catch-up contributions. Additionally, in order for an individual to contribute to an HSA, he or she must be enrolled in a HDHP meeting minimum deductible and maximum out-of-pocket thresholds. The contribution, deductible and out-of-pocket limitations for 2018 are shown in the table below (2017 limits are included for reference).

HSA/HDHP Limitations		
	2017	**2018**
Maximum HSA Contribution (Employee + Employer)	Self-Only: $3,400 Family: $6,750	Self-Only: $3,450 Family: $6,900
Catch-Up Contribution Limit	$1,000	$1,000
Minimum HDHP Deductible	Self-Only: $1,300 Family: $2,600	Self-Only: $1,350 Family: $2,700
HDHP Out-of-Pocket Max	Self-Only: $6,550 Family:$13,100	Self-Only: $6,650 Family: $13,300

Note that the Affordable Care Act (ACA) also applies an out-of-pocket maximum on expenditures for essential health benefits. However, employers should keep in mind that the HDHP and ACA out-of-pocket maximums differ in a couple of respects. First, ACA out-of-pocket maximums are higher than the maximums for HDHPs. As explained in our May 9, 2014 blog entry, the ACA's out-of-pocket maximum was identical to the HDHP maximum initially, but the Department of Health and Human Services (which sets the ACA limits) is required to use a different methodology than the IRS (which sets the HSA/HDHP limits) to determine annual inflation increases. That methodology has resulted in a higher out-of-pocket maximum under the ACA. The ACA out-of-pocket limitations for 2018 were announced in the 2018 Notice of Benefit and Payment Parameters and are shown in the table below (2017 limits are included for reference).

ACA Out-of-Pocket Limitations		
	2017	2018
Self-Only	$7,150	$7,350
Family	$14,300	$14,700

Second, the ACA requires that the family out-of-pocket maximum include "embedded" self-only maximums on essential health benefits. For example, if an employee is enrolled in family coverage and one member of the family reaches the self-only out-of-pocket maximum on essential health benefits ($7,350 in 2018), that family member cannot incur additional cost-sharing expenses on essential health benefits, even if the family has not collectively reached the family maximum ($14,700 in 2018).

The HDHP rules do not have a similar rule, and therefore, one family member could incur expenses above the HDHP self-only out-of-pocket maximum ($6,650 in 2018). As an example, suppose that one family member incurs expenses of $10,000, $7,350 of which relate to essential health benefits, and no other family member has incurred expenses. That family member has not reached the HDHP maximum ($14,700 in 2018), which applies to all benefits, but has met the self-only embedded ACA maximum ($7,350 in 2018), which applies only to essential health benefits. Therefore, the family member cannot incur additional out-of-pocket expenses related to essential health benefits, but can incur out-of-pocket expenses on non-essential health benefits up to the HDHP family maximum (factoring in expenses incurred by other family members).

Employers should consider these limitations when planning for the 2018 benefit plan year and should review plan communications to ensure that the appropriate limits are reflected.

House of Representatives Passes American Health Care Act – What it Means and Next Steps

By Damian A. Myers

Today, the House of Representatives passed the American Health Care Act (the "AHCA"). The AHCA was previously introduced in March but supporters failed to muster sufficient support to bring the legislation to a vote. Recently, however, the AHCA was given new life after House members agreed to an amendment that would allow states to waive certain aspects of the Affordable Care Act ("ACA"). The AHCA is being touted by some as the law that "repeals and replaces" the ACA, though many of the ACA's provisions remain intact.

The key takeaways outlined in our March 9th blog entry on the AHCA have not been altered by the new amendment. The individual and employers mandates would still be repealed, though the employer reporting obligations under Section 6055 and 6056 of the Internal Revenue Code would likely continue. In place of the individual mandate would be the surcharge applied on individual market premiums to individuals who have a lapse in coverage of more than 63 days. The AHCA would repeal most of the ACA-related taxes, but many of the popular aspects of the ACA, such as coverage of dependents until age 26 and free coverage of preventive care, will remain in place.

The new amendment would allow states to waive the ACA provision that restricts how insurance providers determine premium rates. Currently, the ACA requires that insurers in the individual and small group market set premium rates taking into consideration only the coverage tier, community rating, age (as long as the rates do not vary by more than 3 to 1), and tobacco use. The amended AHCA would allow states to submit an application to apply a higher age rating ratio and to include health status of an individual as a basis for determining the premium rate. In order to allow insurance companies to apply health status as a rate factor, applying states would need to establish high-risk insurance pools for individuals who might not be able to afford insurance coverage due to health conditions.

Additionally, the amended AHCA would allow states to waive the essential health benefits requirement under the ACA in lieu of establishing their own definitions of essential health benefits. Under the ACA, insurance plans in the individual and small group markets must cover the following essential health benefits – ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services and additional treatment, prescription drugs, rehabilitative services and devices, lab services, preventive care, and pediatric services.

It is currently being reported that the amended AHCA contains a provision that would allow employers providing health benefits through large-group insurance policies or self-insured plans to avoid the ACA's prohibition on imposing annual and lifetime dollar limits on essential health benefits. The AHCA, as amended, does not contain an explicit provision to that effect. However, its interplay with the existing ACA rules could have the same effect.

Here's why – Large-group insurance and self-insured plans, while not required to cover essential health benefits, cannot apply annual and lifetime dollar limits to those benefits when they do cover them. Since the term "essential health benefits" is not defined, the regulations require large-group insurance and self-insured plans to select a federal or state benchmark plan to determine which of their benefits are essential health benefits and therefore cannot be subject to these dollar limits. Current ACA regulations allow sponsors of large-group insurance and self-insured plans to select any federal or state benchmark for this purpose. Under the ACA, every state had to have a benchmark covering each of the essential health benefits. Under the AHCA, it is possible for states to apply to use a very narrow definition of essential health benefits, thus allowing large-group insurance plans and self-insured plans to select those states' benchmarks

and apply annual and lifetime dollar limits to the benefits not included in them. Of course, even if the AHCA becomes law, it remains to be seen whether plans will end up doing so in practice.

Although the AHCA has been passed in the House of Representatives, there remains a considerable amount of uncertainty. The AHCA now moves to the Senate, which will likely wait for the Congressional Budget Office report before acting. Once that report is issued, political and public pressure could cause the Senate to reject the legislation. Additionally, there is some question as to whether the state waiver amendment is permissible under the budget reconciliation process (for a description of this process, see our November 10th blog entry). If the Senate parliamentarian determines that the amendment is not permitted, some Congress members may withdraw their support. Even if the Senate does decide to act, it is likely that the Senate will significantly modify the legislation, meaning that it will go to conference committee for reconciliation.

We will continue to provide updates as the AHCA advances through Congress.

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