Proskauer

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Editor's Overview

It has been a little more than one year since the U.S. Supreme Court altered the legal landscape for litigating ERISA breach of fiduciary duty claims relating to the investment in employer stock funds. This month we took a look at the court decisions since *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), which allege, at least in part, that investment in the employer stock fund was imprudent based on publicly available information. As Joe Clark reviews below, the standard set forth by the Supreme Court appears to be fulfilling its intended role as an appropriate gatekeeper and, with one exception, these claims have been rejected by the courts.

As always, please be sure to review the Rulings, Filings, and Settlements of Interest, which address IRS guidance on 40% excise tax on high-cost health care, final regulations and FAQs n preventive services coverage, subrogation clauses, administrative appeal denial letters and the need to state plan-imposed time limits.

Employer Stock-Drop ERISA Claims Based On Public Information May Not Survive In A Post-*Dudenhoeffer* World*

By Joe Clark

The U.S. Supreme Court's June 2014 decision in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), created a new legal landscape for evaluating ERISA stock-drop claims – *i.e.*, breach of fiduciary duty claims based on the continued investment in employer stock – at the pleadings stage. The Court provided separate guidance for claims based on publicly available information and those based on material, non-public information. For claims based on public information, the Court's comments caused many attorneys to question the continued viability of these claims. This article provides a brief summary of the *Dudenhoeffer* decision's discussion of claims based on public information and of subsequent case law addressing these claims, and then offers a perspective on their future.

The Supreme Court's *Dudenhoeffer* Decision

In *Dudenhoeffer*, participants in Fifth Third Bancorp's profit sharing plan claimed that the defendant plan fiduciaries knew or should have known that Fifth Third stock was overvalued and excessively risky and thus they should have divested or prevented further investment in Fifth Third stock. Although the complaint alleged that the defendants had access to inside information concerning the company's financial well-being, the claim was based in large part on publicly available information showing that Fifth Third had moved from a conservative to a subprime lender and that its portfolio therefore became increasingly exposed to defaults. With respect to the portion of the claim based on public information, the Supreme Court held that when a company's stock is publicly traded, "allegations that a fiduciary should have recognized from publicly available information alone that the market was over- or undervaluing the stock are implausible as a general rule, at least in the absence of special circumstances." In so holding, the Court explained that "a fiduciary usually is not imprudent to assume that a major stock market . . . provides the best estimate of the value of the stocks traded on it that is available to him." The Court vacated the Sixth Circuit's prior opinion, and remanded for further proceedings.

Post-*Dudenhoeffer* Decisions

Since *Dudenhoeffer*, there have been a handful of reported decisions addressing employer stock-drop claims based on publicly available information. As discussed below, in all but one case, plaintiffs' claims have been dismissed.

1. *Gedek v. Perez*, 66 F. Supp. 3d 368 (W.D.N.Y. 2014)

The first post-*Dudenhoeffer* decision on public information claims was decided by a district court in the Western District of New York and involved allegations that the plan fiduciaries imprudently continued to offer, purchase and hold Kodak stock as an option in the plans despite publicly available information that Kodak's performance had no reasonable chance of improving. *Gedek v. Perez*, 66 F. Supp. 3d 368 (W.D.N.Y. 2014). Plaintiffs were participants in the Kodak Savings and Investment Plan and the Kodak Employee Stock Ownership Plan. They alleged that Kodak's downward path was so obvious that it was imprudent to invest in Kodak stock, regardless of its price, and that Kodak had no reasonable chance of improving because Kodak relied on a "dying technology" and was unable to develop new products.

The court denied defendants' motion to dismiss the complaint for failure to state a claim for relief. In so ruling, the court observed that "the complaint recites a history not just of Kodak's inexorable slide toward bankruptcy, but of publicly available information contemporaneously documenting that slide, step by painful step, and accurately forecasting Kodak's bleak future." In response to the argument that there can be no claim if the market is fully aware of the company's financial condition, the court stated that, "the fact that the market, on any given date, may have provided the best available estimate of the 'value' of Kodak stock, does not necessarily reveal much about whether defendants acted prudently in continuing to invest in that stock." The court concluded that the relevant inquiry was "not whether defendants paid an artificially inflated price for Kodak stock, but whether they should have realized that Kodak stock represented such a poor long-term investment that they should have ceased to purchase, hold, or offer Kodak stock to plan participants." With respect to this issue, the court determined that it could not rule, at the pleadings stage, that plaintiffs failed to state a claim that the plan fiduciaries acted imprudently by continuing to offer, purchase and hold company stock.

2. *In re BP p.l.c. ERISA Litig.*, No. 4:10-cv-4214 (S.D. Tex. Jan. 15, 2015).

The next decision came from a district court in Texas involving claims against BP. *In re BP p.l.c. ERISA Litig.*, No. 4:10-cv-4214 (S.D. Tex. Jan. 15, 2015). Plaintiffs were participants in 401(k) plans sponsored by BP North America and claimed that defendants breached their fiduciary duties between January 16, 2007 and June 24, 2010 (the period leading up to, including and subsequent to the Deepwater Horizon explosion) in connection with the plans' investment in the BP stock fund.

After *Dudenhoeffer*, the Fifth Circuit vacated the district court's previous decision in this case. Plaintiffs then sought leave to file an amended complaint to add a breach of fiduciary duty claim based on allegations that "Defendants knew or should have known of the imprudence of [company stock] because of 'publicly available information' as to the riskiness of the [company stock]," such as information about BP's safety track record, and public uncertainty about how BP would respond to the Deepwater Horizon explosion. The court did not allow plaintiffs to amend their complaint to add the claim. First, the court determined that plaintiffs failed to offer any coherent theory as to why the market's valuation of BP based on public information was unreliable. Second, the court found that plaintiffs' claim that BP stock was "excessively risky," and thus imprudent, could not stand where, as here, the stock was widely traded in a public market, and there was no indication that the market was inefficient. The court reasoned that fiduciaries generally are entitled to rely on the market price as an "unbiased assessment of the security's value in light of public information." Finally, the court noted that "[e]ven if *Gedek* [*supra*] can be reconciled with *Dudenhoeffer*, the Court [found] it to be of limited usefulness. The alleged riskiness of BP's stock simply does not conjure the inevitability of 'default, bankruptcy or worse' present in *Gedek*."

3. *In re Citigroup ERISA Litig*., 2015 U.S. Dist. LEXIS 63460 (S.D.N.Y. May 13, 2015), *reconsideration denied*, 2015 U.S. Dist. LEXIS 88045 (S.D.N.Y. July 6, 2015)

Next came a decision from the Southern District of New York in *In re Citigroup ERISA Litig* ., 2015 U.S. Dist. LEXIS 63460 (S.D.N.Y. May 13, 2015). In this case, participants in Citigroup's 401(k) plans alleged that the Citigroup plan fiduciaries "knew or should have known that Citigroup was heavily invested in subprime mortgages and that Citigroup stock was an imprudent investment based on a wide assortment of public information." Plaintiffs detailed (i) media reports about the subprime mortgage crisis; (ii) ratings downgrades of Citigroup securities; (iii) Citigroup's public announcements of quarterly losses; and (iv) the decline in Citigroup stock from $54.26 in June 2007 to $26.94 on January 15, 2008, as the bases for contending that the plan fiduciaries "knew or should have known that Citigroup was in a perilous situation, and that Citigroup stock was a manifestly imprudent retirement investment."

The court first determined that plaintiffs' claims were barred by the applicable statute of limitations, 29 U.S.C. § 1113, reasoning that most of the events giving rise to the complaint occurred more than three years before plaintiffs filed suit, and that these were the very same events characterized by plaintiffs as "widely publicized" and thus rendering "Citigroup's perilous situation . . . 'abundantly clear'" to plan fiduciaries. Therefore, according to the court, plaintiffs had "actual knowledge" of the facts constituting their claim more than three years before they filed suit, and their suit was therefore untimely.

The court also concluded that plaintiffs failed to state a claim for breach of fiduciary duty because they failed to point to any "special circumstance" that would have rendered reliance on the market price imprudent, and instead characterized Citigroup stock as "excessively risky." The court concluded that such risk is accounted for in the market price, and the Supreme Court held that fiduciaries "may rely on the market price, absent any special circumstances affecting [its] reliability." In reaching this conclusion, the court observed that plan fiduciaries are "between the rock and the hard place," because fiduciaries who keep investing in company stock while its price declines may be subject to liability under 29 U.S.C. § 1104(a)(1)(B), while fiduciaries who stop investing and the stock goes up could be liable under 29 U.S.C. § 1104(a)(1)(D). According to the court, "these concerns underlie the reasoning behind the general rule rendering suits implausible when they allege that the fiduciaries should have been able to beat the market." Plaintiffs filed a notice of appeal to the Second Circuit.

4. *Smith v. Delta Air Lines*, 2015 U.S. App. LEXIS 13165 (11th Cir. July 29, 2015)

Most recently, the Eleventh Circuit affirmed the dismissal of employer stock fund claims against Delta Airlines. In *Smith v. Delta Air Lines*, 2015 U.S. App. LEXIS 13165 (11th Cir. July 29, 2015) (unpublished), plaintiff alleged that, from 2000 through 2004, Delta faced increased industry competition from discount airlines, experienced losses of over a billion dollars a year, saw its stock price decline by 92 percent and its debt increase by 42 percent, and dramatically reduced its workforce. Plaintiff alleged that the plan fiduciaries imprudently permitted investment in the Delta stock fund even in the face of Delta's financial condition and concerns about its ability to survive in the industry. The district court dismissed plaintiffs' fiduciary breach claims for failure to state a claim and the Eleventh Circuit affirmed, but the U.S. Supreme Court vacated in light of *Dudenhoeffer*.

On remand, the district court again dismissed, and the Eleventh Circuit again affirmed, characterizing the "crux" of the complaint as an allegation that "Delta fiduciaries should have foreseen that Delta stock would continue to decline." The Court found that plaintiff's prudence claim was just the type of claim that the Supreme Court would deem "implausible as a general rule," since it failed to allege any material inside information about Delta's financial condition that was not disclosed to the market, or any other special circumstances rendering reliance on the market unreliable. The Court concluded that "while [*Dudenhoeffer*] may have changed the legal analysis of our prior decision, it does not alter the outcome."

Proskauer's View

The Supreme Court's ruling in *Dudenhoeffer* has not deterred participants from continuing to pursue claims of imprudence based on publicly available information. But the response of the courts has been generally unfavorable thus far. The Supreme Court's decision in *Dudenhoeffer* and, in particular, its ruling that when a company's stock is publicly traded, "allegations that a fiduciary should have recognized from publicly available information alone that the market was over- or undervaluing the stock are implausible as a general rule, at least in the absence of special circumstances," appears to be fulfilling its intended role as an appropriate gatekeeper. That is, it has forced the lower courts to evaluate such claims so as to divide, as the Supreme Court termed it, "the plausible sheep from the meritless goats." If the first handful of decisions is any indication, the plaintiffs' bar faces an uphill battle in prosecuting fiduciary breach claims of imprudence based on publicly available information.

Rulings, Filings, and Settlements of Interest

New IRS Guidance on 40% Excise Tax Previews Future Regulatory Complexity

By Damian A. Myers and Douglas Dahl

- Although public opposition to the 40% excise tax on high-cost health care is rapidly growing, the IRS continued to develop a regulatory framework for administration of the excise tax through its issuance of Notice 2015-52 on July 30, 2015. Similar to the first notice on this topic, Notice 2015-52 merely identifies various administrative challenges without providing concrete guidance. If nothing else, the new guidance provides another preview into what will undoubtedly be a complex regulatory environment.

By way of background, the Affordable Care Act (or "ACA") added Section 4980I to the Internal Revenue Code (the "Code"), which imposes a 40% excise tax (the "40% Excise Tax") on the excess, if any, of the aggregate cost of applicable coverage provided to an employee over a set dollar limit (the applicable dollar limits will be adjusted for inflation and are subject to additional increases based on age and gender or for certain individuals in high risk professions). The 40% Excise Tax is imposed on the "coverage provider," which is the health insurance carrier in the case of an insured group health plan, the employer with respect to a health savings account or Archer medical savings account, or in all other cases, the "person that administers the plan benefits."

In February 2015, the IRS released the first notice, Notice 2015-16 (discussed here), which was intended to initiate the process of developing regulatory guidance under Code Section 4980I. Notice 2015-16 described potential approaches related to the definition of applicable coverage, the calculation of the cost of applicable coverage and the applicable dollar limit.

The new IRS guidance proposes additional approaches related to (1) identification of the person or entity responsible for paying the tax, (2) determining the cost of applicable coverage, (3) age and gender adjustments to the applicable dollar limit and (4) notice and payment of the 40% Excise Tax. Although many of the approaches described by the IRS could work in the single-employer plan context, the approaches create a number of issues for multiemployer plans and the employers that contribute to them. These issues will be addressed in a future blog. Below is a summary of the key approaches described by the IRS in Notice 2015-52.

Identification of the Coverage Provider

As noted above, Code Section 4980I imposes a tax on the "coverage provider." The coverage provider is easily identified in the case of an insured plan or a health savings account. However, in all other cases, the coverage provider is the "person that administers the plan benefits." Because neither the ACA nor ERISA contains guidance on identifying the person or entity that administers plan benefits, the IRS has proposed two approaches to assist in identifying the coverage provider.

Under the first approach, the coverage provider would be the person or entity responsible for performing day-to-day functions related to administration of the plan (e.g., processing claims or handing participant inquiries). In many cases, this would be a third-party benefits administrator. Under the second approach, the coverage provider would be the person or entity that has the ultimate authority or responsibility with respect to administration. Usually, this would be the plan

administrator that is defined in the plan, such as a benefits administration committee that has been delegated administrative duties.

Either approach will present challenges for employers. For example, a single third-party rarely administers all benefits considered "applicable coverage" under Code Section 4980I. It is not uncommon to have separate administrators for medical benefits, pharmacy benefits, mental health and substance abuse benefits and flexible spending benefits. Employers would need to determine which portion of the 40% Excise Tax should be allocated to each administrator.

Calculation of the Cost of Applicable Coverage

Similar to the first notice, much of the guidance in Notice 2015-52 focuses on issues related to determining the cost of applicable coverage. Below are the key proposals.

- **Timing Issues.** In order to timely pay the 40% Excise Tax, coverage providers must determine the cost of applicable coverage shortly after the taxable period (which the IRS indicated will likely be the calendar year for all taxpayers, regardless of plan year). This presents challenges for self-insured plans that cannot determine the cost of coverage until claims incurred prior to the end of the taxable period are submitted. Therefore, the IRS requested comments on whether a claims run-out period would be appropriate. Additionally, experience-rated insurance policies often provide payments or discounts following a policy year. The IRS has requested comments on how these payments or discounts should be applied to the cost of applicable coverage.

- **Excluding Income Tax Reimbursements from the Cost of Applicable Coverage.** If an entity other than the plan sponsor is responsible for paying the 40% Excise Tax, that entity will likely pass the cost of the tax through to the plan sponsor in the form of increased service fees. Code Section 4980I provides that the cost of applicable coverage does not include amounts attributable to the 40% Excise Tax. However, Code Section 4980I does not address what happens when the same parties that pass on the cost of the 40% Excise Tax also seek reimbursement of income taxes incurred due to the receipt of additional service fees. This raises an important question – should the amount passed-through in the form of increased service fees to reimburse for income taxes (in addition to the 40% Excise Tax reimbursement) be excluded from the cost of applicable coverage? The IRS has requested

comments on administrable methods for excluding income tax reimbursements, including what tax rate to use. The IRS anticipates that excise tax and income tax reimbursements will be excludable from the cost of applicable coverage only if separately billed and identified.

- **Annual Contributions to Account-Based Plans.** The cost of applicable coverage includes employer and employee contributions to account-based plans, such as health savings accounts. The IRS recognized that annual contributions (as opposed to contributions made monthly or per pay period) could trigger a 40% Excise Tax in the month of contribution because the cost of applicable coverage is determined on a monthly basis. To avoid this result, the IRS indicated that it is considering an approach that would allow employers to apply annual contributions on a pro rata basis over the course of the taxable period when determining the cost of applicable coverage.

- **Flex-Credits and Carry-Overs under Flexible Spending Arrangements.** The cost of applicable coverage for benefits provided through a flexible spending arrangement (FSA) is the greater of the employee's contribution to the FSA or the total reimbursements made from the FSA. The IRS stated that when an employer contributes non-elective flex credits to an FSA on behalf of an employee, the cost of applicable coverage includes (1) the employee's contributions, and (2) the amount of non-elective flex credits actually used for reimbursements. This would prevent unused non-elective flex credits from being included in the cost of applicable coverage. The IRS also stated that it is considering a safe harbor approach for amounts carried-over from prior years to prevent double counting. Under this safe harbor, amounts carried-over from previous years will not be included in the cost of applicable coverage. The IRS plans to restrict the availability of this safe harbor if non-elective flex credits are available.

- **Inclusion of Amounts Taxable under Code Section 105(h).** Code Section 105(h) provides that the value of a discriminatory self-insured benefit provided to a highly compensated employee must be included in the employee's income. However, under 2012 guidance related to disclosing the cost of coverage for Form W-2 purposes, the IRS provided that the amount included in income should be excluded. Addressing this discrepancy, the IRS stated that it is the "coverage," not the resulting tax benefit that constitutes "applicable coverage" under Code Section 4980I. In other words, although a highly-compensated employee is taxed on the value of the discriminatory

coverage, that coverage must be included in the cost of applicable coverage under Code Section 4980I.

Other Proposed Approaches

The IRS also described potential regulatory approaches related to the following:

- **Age and Gender Adjustments to the Applicable Dollar Limit.** The applicable dollar limits used to determine whether there is an excess benefit may be increased upward based on the age and gender characteristics of all employees of an employer. The IRS is considering rules allowing employers to determine these characteristics based on a "snapshot" on the first day of the plan year. The IRS also indicated that it is developing age and gender adjustment tables to assist employers in applying the adjustment.

- **Notice and Payment of the 40% Excise Tax.** Under Code Section 4980I, employers are required to calculate the 40% Excise Tax and notify the coverage provider and the Treasury of the amount of the tax, if any. The IRS has not yet determined the form of this notice, but has indicated that coverage providers will likely pay the 40% Excise Tax using Form 720. Form 720 is a quarterly-filed form, but similar to payment of the PCORI fee, the 40% Excise Tax will only be paid once per year.

The IRS set October 1, 2015 as the due date for comments on the latest notice. Given that late date, it is not likely that proposed regulations would be completed before 2016. Employers considering filing comments on IRS Notice 2015-52 should begin to consider those comments now so they can be filed by the due date.

New Final Regulations and FAQs Provide Guidance on Preventive Services Coverage

By Lisa Schlesinger

- Through new FAQs and final regulations, the U.S. Departments of Labor ("DOL"), Health and Human Services ("HHS") and the Treasury (the "Departments") have further clarified various issues related to the preventive care coverage requirement for non-grandfathered group health plans under the Affordable Care Act ("ACA") as related to preventive care coverage.

Background

The ACA requires that non-grandfathered group health plans provide benefits for certain preventive care without cost sharing, including:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") for the individual (except for breast cancer screening, mammography, and prevention, where there are updated USPSTF standards);

- Immunizations for routine use recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC") for the individual;

- For infants, children, and adolescents: evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and

- For women: other evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the HRSA

FAQs on Preventive Care Coverage

Noting that confusion still remained regarding the scope of the preventive care coverage requirements, on May 11, 2015, the Departments issued new sub-regulatory guidance, DOL FAQs Part XXVI, to further clarify these guidelines. Noteworthy clarifications include that:

- Prior guidance had stated that these guidelines and recommendations include coverage for genetic counseling and, if indicated after counseling, BRCA (breast cancer susceptibility genes) testing for women who have positive family history screening results. The new guidance clarified that plans must cover recommended genetic counseling and BRCA genetic testing for women who have not been diagnosed with BRCA-related cancer but who previously had breast, ovarian or other cancer. This would appear to apply to asymptomatic and cancer-free women with a personal history of cancer even if no other family members are known to have the cancer.

Plans must cover, without cost sharing, at least one form of women's contraception in each of the 18 methods identified by the Food and Drug Administration ("FDA"). The 18 methods include: (1) sterilization surgery for women; (2) surgical

sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) shot/injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (progestin only); (9) oral contraceptives (extended/continuous use); (10) patch; (11) vaginal contraceptive ring; (12) diaphragm; (13) sponge; (14) cervical cap; (15) female condom; (16) spermicide; (17) emergency contraception (Plan B/Plan B One Step/Next Choice); and (18) emergency contraception (Ella).

Thus, for example, a plan could not cover some forms of oral contraceptives, some types of IUDs, and some types of diaphragms without cost sharing, but then completely exclude other forms of contraception. Similarly, a plan that covers oral contraceptives cannot impose cost sharing on all items or services within other FDA-identified hormonal contraceptive methods such as the vaginal contraceptive ring or the contraceptive patch.

Within each women's contraceptive method, plans can utilize reasonable medical management techniques, such as imposing cost sharing on some items and services to encourage the individual to use other specific items and services within the particular method. Thus, for example, the plan can cover generic drugs within a method with no cost sharing but impose cost sharing on brand drugs in the same method.

However, if the plan does use reasonable medical management techniques within a particular contraceptive method, it must have "an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome" on the individual (or provider or representative). In addition, the plan must cover a particular service or FDA-approved item without cost sharing if the individual's attending provider recommends that service or item based on a determination of medical necessity for that individual. The plan must defer to the provider's determination. The plan must also make determinations taking into account the type of claim and the medical exigencies in a case involving urgent care.

The Departments will not be enforcing these interpretations until the first plan year beginning at least 60 days after May 11, 2015—meaning that for calendar year plans, this portion of the new FAQ guidance will not apply until January 1, 2016.

- Plans cannot limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender where the attending provider determines that a service is appropriate for the individual (and the individual otherwise satisfies the recommendation/guideline criteria). Thus, for example, if the attending provider determines it appropriate, a plan would be

required to provide a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix.

- If a plan covers dependent children, it must cover, without cost sharing, recommended women's preventive care services for dependent children, including recommended preventive services related to pregnancy, such as preconception and prenatal care.

- A plan cannot impose cost sharing for anesthesia services performed in connection with a colonoscopy performed as a preventive screening procedure for colorectal cancer pursuant to the USPSTF recommendations.

New Final Regulations

On July 14, 2015, the Departments published final regulations further clarifying preventive services coverage. Important changes in the new final rules are as follows:

- Prior Department FAQ guidance on preventive services remains applicable.

- The final regulations explicitly incorporate DOL FAQ Part XII's clarification that plans or issuers may not impose cost sharing on preventive services provided by an out-of-network provider when such services are not offered by an in-network provider.

- The final regulations explicitly incorporate DOL FAQ Part II and Part XXVI clarifications that plans or issuers can rely on the relevant evidence base and established reasonable medical management techniques when determining frequency, treatment, method or setting for providing a recommended preventive service when such coverage limits are not specified in recommendations or guidelines.

- Plans or issuers generally cannot eliminate coverage for preventive services that are no longer recommended during the course of a plan or policy year (*i.e.,* the plan or issuer must usually cover a preventive service until the last day of the plan or policy year in which the recommendation or guideline was narrowed or eliminated). However, plans or issuers are permitted to cease coverage for a preventive service that is no longer recommended during a plan or policy year if:

    - An "A" or "B" rating in the current recommendations of the USPSTF is downgraded to a "D" rating; or

    - An item or service associated with a preventive service is recalled for safety reasons or is determined to pose a significant safety risk by a federal agency regulating that service.

- Prior guidance provides for an accommodation process that allows certain non-profit entities and, due to the Supreme Court decisions in *Burwell v. Hobby Lobby Stores, Inc.*, closely held for-profit entities who have religious objections, not to provide or pay for certain preventive services. The final regulations define "closely held for-profit entity" for this purpose. This new definition takes into account the more than 75,000 comments the Departments received on how to structure the definition. To qualify for a religious objection accommodation, a for-profit entity must be an organization (which can be a personal services corporation) that:

    - Is not publicly traded;

    - Is majority-owned (51% or more) directly or indirectly by five or fewer individuals as of the date of the entity's self-certification or notice to HHS, or has a substantially similar ownership structure (*e.g.*, 49% owned by six people or 45% owned by three people); and

    - Objects to providing contraceptive coverage due to its owners' religious beliefs.

- Prior final regulations explicitly permitted issuers of fully insured plans (that are paying for contraceptive services under the religious objection accommodation) to pay for either (i) all FDA-approved contraceptive services, or (ii) only those services to which the eligible organization has a religious objection. The new final regulations clarify that third party administrators of self-insured plans (and not only issuers of fully insured plans) are permitted the same option.

- The final regulations confirm that the regulations' guidance will apply in the same way to health insurance coverage bought and sold through the Small Business Health Options Program ("SHOP") as to health insurance coverage bought through other avenues.

The new final regulations are effective September 14, 2015, and are applicable starting with the first plan year beginning on or after September 14, 2015—for calendar year plans, the final regulations will not apply until January 1, 2016.

What Employers Should Do

1. Ensure that their plans and summary plan descriptions do not contain provisions that contradict the FAQ or final regulation guidance on preventive services coverage;

2. Review preventive services coverage annually to ensure that preventive services remain covered throughout the full policy or plan year, unless the service is downgraded to a "D" rating or is recalled for safety reasons (or is deemed a significant safety risk); and

3. Analyze plan administration procedures and communicate with outside administrators to confirm that all claims administration and communications with plan participants are consistent with the FAQ and final regulation guidance.

Sixth Circuit Enforces Subrogation Clause

By Neil Shah

- The Sixth Circuit rejected a participant's argument that the plan's subrogation provision was not enforceable because it was only in the plan's summary plan description, and not in the trust agreement that the participant argued was the operative plan document. The Court determined that the subrogation provision was contained within a document that served as the summary plan description as well as the plan document. The Court further ruled that "[n]othing in *Amara* prevents a document from functioning both as the ERISA plan *and* as an SPD." The Sixth Circuit's ruling, *Board of Trustees of the National Elevator Industry Inc. Health Benefit Plan v. Moore*, No. 14-4048, 2015 WL 5010985 (Aug. 25, 2015), is consistent with a recent decision from the Eleventh Circuit, which we previously reported on **here**.

Third Circuit Says ERISA Administrative Appeal Denial Letters Must State Plan-Imposed Time Limits

By Lindsey Chopin

- The Third Circuit recently held that ERISA administrative appeal denial letters must include plan-imposed time limits for commencing a lawsuit challenging the claim

denial, and the failure to provide such notice warranted setting aside the plan's limitation period. *Mirza v. Ins. Adm'r. of Am., Inc.*, 2015 WL 5024159 (3d Cir. Aug. 26, 2015). The ERISA claims regulation provides that adverse determination letters must provide a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action" for benefits. 29 C.F.R. § 2560.503-1(g)(1)(iv). Consistent with the First and Sixth Circuits' rulings on this issue, the Third Circuit determined that the regulation's "time limit" notice requirement applies not only to periods pertaining to when a participant may file an administrative appeal, but also to a plan-imposed limitation period for commencing a lawsuit after an appeal is denied. In so ruling, the Court reasoned that not requiring such notice would permit administrators to "hide the ball" because participants are more likely to read and rely on adverse determination letters than lengthy plan documents. Having found that such notice is required, the Court determined the proper remedy was to set aside the plan's limitation period and to replace it with the most analogous state law period, which the parties agreed was New Jersey's six-year limitation period applicable to breach of contract claims.

Proskauer's Perspective: Given that three circuits already have ruled consistently on these issues, plan fiduciaries should make sure that administrative appeal denial letters specifically set forth plan-imposed time limits. Furthermore, given the courts' tendency not to penalize participants for failure to consult SPDs and plan documents when pursuing a claim for benefits, plan sponsors and administrators should consider whether there is other information pertinent to the claims process to which they should affirmatively alert participants when determining claims for benefits.

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