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Message from ERIC President and CEO Annette Guarisco Fildes:

Welcome to the new, rejuvenated version of the Benefits Litigation Update, which we bring you jointly with the law firm of Epstein Becker Green. Our goal is to provide a concise and, we hope, insightful glimpse into recent litigation affecting our world of health and retirement benefits.

This newsletter is focused on the biggest cases affecting ERISA benefits rights and plan administration. Most importantly, it is designed to provide you with a short summary of the cases, let you know why they are significant for you and your plans, and provide you with actionable information. While we believe that this newsletter will be valuable to the lawyers among us, we have also concentrated on making it digestible and worthwhile for non-lawyers to read as well.

As was reinforced in the two prominent U.S. Supreme Court decisions last month, judicial activity greatly influences employee benefits policy in the United States. We fully appreciate the importance of the courts in this sphere and are committed to playing an active role in helping to achieve appropriate judicial outcomes. And we will of course keep you informed of all important developments.

Thank you to the expert legal team at Epstein Becker Green for their contributions to this issue of the *Benefits Litigation Update*.

We welcome your feedback on this newsletter as well as the cases highlighted in this edition.

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ERIC will hold a conference call discussing the cases addressed in this issue on Wednesday, July 29, 2015 from 2 to 3:30 pm EDT.

ERIC members and trial members can register for the call by clicking here. Epstein Becker Green clients who are not members of ERIC can register for the call by sending an email to benefitsligitationupdate@eric.org mentioning Benefit Litigation Update Call in the subject line of the email.

FEATURED ARTICLE

ACA Workforce Management and ERISA Serve Up A Toxic Dish

By Frank C. Morris, Jr., Member of the Firm in the Litigation and Employee Benefits practices

The Affordable Care Act (ACA) requires covered employers to provide health care coverage for all employees who regularly work 30 or more hours per week. It was well publicized that for some employers, the requirement to provide insurance for employees only working 30 hours per week and with coverage that meets the ACA's minimum value and affordability requirements would entail a considerable new expense. As a result, the issue of workforce management became a hot topic in the media and among some employers, especially those employing substantial numbers of lower paid employees who either may not have been eligible for health care coverage or had health care coverage that would not meet standards required for coverage from applicable large employers under the ACA.

Consequently, discussions ensued in some quarters with regard to managing the hours that employees might work. In particular, some employers discussed scheduling employees to keep them below the 30 hour threshold. One alleged attempt to do so has led to a putative class action entitled *Marin v. Dave & Buster's, Inc.*, filed on May 12, 2015 in U.S. District Court for the Southern District of New York. The suit is premised on ERISA Section 510 which states that it is:

> "unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or *for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan* . . ." [emphasis added]

The *Marin* complaint alleges that the employer reduced hours in order to comply with the ACA. To show intent, the *Marin* complaint points out that the employer filed an SEC Form S-1 stating that the ACA "may have an adverse effect on our business" due to providing health insurance benefits "more extensive than . . . benefits we currently provide and to a potentially larger proportion of our employees" which "will increase our expense." Certain statements by the VP for Human Resources are also cited in the complaint.

To succeed in a suit of this type, a plaintiff must show he or she was engaged in activity protected by ERISA Section 510 -- here potentially obtaining health plan rights -- and that the employee suffered an adverse employment action because of that protected activity. The employer, on the other hand, will try to introduce evidence that the action was taken for a legitimate reason and that it was not discriminatory. Notably, under ERISA, there is no claim if the alleged interference with the attainment of benefits is simply a collateral result of an adverse action taken for legitimate reasons.

The Supreme Court has previously held that employers can modify, adopt or terminate a welfare benefit plan, which would include a health benefit plan, at any time so long as the goal is not to interfere with receipt of ERISA covered benefits. As the Court noted, "when an employer acts without this purpose, as could be the case when making fundamental business decisions, such actions are not barred by ERISA Section 510."

The potential difficulty in the Dave & Buster's case arises from company statements that allegedly show that the sole reason for certain actions of the employer was to prevent the attainment of health care coverage. The alternative, preferable view is that the company statements are merely statements of fact that offering richer coverage to more employees will add additional costs to the employer's bottom line. In such circumstances, the courts should not find that proof of a specific intent to discriminate (necessary for a plaintiff to prevail under an ERISA Section 510

claim) is supplied by such statements of fact and the need to confront business realities. Nonetheless, prudent employers who are considering workforce management strategies should exercise discretion and caution with any descriptions of such activities that they make either publicly or internally.

Though the *Marin* suit is premised on ERISA, similar suits in the future may also cite the ACA's anti-retaliation provisions, ACA Section 1558. This provision bars covered employers from adverse employment actions against any employee because they receive a premium tax credit or cost sharing reduction through an Exchange or provided information to the employer, the federal government or any state attorney general that relates to an alleged violation, act or omission that the employee reasonably believes violates any part of Title I of the ACA. (The employee's belief does not have to be correct, it need only be "reasonable.") For example, if an employer reduced an employee's compensation and that employee had received a premium tax credit or contacted a government agency to discuss alleged deficiencies in the employer's plan documents, this could form the basis for an ACA retaliation claim.

Take-aways:

In light of the Dave & Buster's case, it is clear that there are litigation risks involved in workforce management involving healthcare coverage. Nonetheless, because of potential cost savings, some employers may choose to consider and potentially implement workforce management strategies. Nothing in either ERISA or the ACA bars employers from making good faith business judgments as to their workforces and how to best meet business needs. This is true even if there is a potential collateral effect on a participant obtaining benefits under the health plan. What is necessary is that employers contemplating workforce management should do so in a way that minimizes these potential risks. Employers should consider conducting the planning process under the guidance and advice of knowledgeable counsel. The purpose is to structure any plan in a lawful fashion to maximize the potential availability of attorney client privilege in connection with consideration of various workforce management options. Employers should also carefully consider any messaging, no matter the audience, that concerns workforce management and the reasons the employer is considering or undertaking such activities. Any messaging should clearly express legitimate business reasons for such activities to prevent the claim that the purpose of the workforce management was to prevent the attainment of benefits even if that should happen to be a collateral consequence of an employer's actions. Such care will hopefully prevent others from facing Marin-like suits or at the very least provide a strong basis to defend any such claims.

NOTEWORTHY PENDING CASES

Equitable Remedies under *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile*

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Labor and Employment practices

This Fall, the U.S. Supreme Court will return to a topic that continues to vex the lower courts: the use of equitable remedies in the recovery of overpayments or equitable reimbursement under pension and welfare benefit plans.

In *Board of Trustees of Nat'l Elevator Indus. Health Benefit Plan v. Montanile*, 593 Fed. Appx. 903 (11th Cir. 2014), the Eleventh Circuit Court of Appeals upheld a judgment entered against a health benefit plan participant, in favor of the plan, that reimbursed the plan for medical expenses that the participant incurred in an automobile accident caused by a drunk driver. The participant obtained a substantial settlement from the other driver. While the amount

with which the participant was left, after attorney's fees and expenses, exceeded the medical expenses at the time of settlement, by the time the plan instituted suit, substantially less than that amount remained in the participant's possession.

The issue squarely presented is whether a fiduciary can assert an equitable lien even if the participant or beneficiary no longer possesses the specifically identified funds against which the lien is asserted. The Circuit Courts were deeply divided on this issue; the need to resolve this conflict because of its impact on plan administration for regional and nationwide ERISA plans probably contributed to the decision by the Supreme Court to hear the case.

Take-aways:

A practical upshot of the *Montanile* case involves the degree of urgency that will accompany plan efforts to obtain reimbursement through equitable liens. If the fiduciary must consider the potential for the participant spending the money recovered from a third party, then restraining orders and other equitable remedies must be used promptly and proactively to protect the plan's rights.

Gobeille v. Liberty Mutual and ERISA Preemption

By Michelle Capezza, Member of Epstein Becker Green in the Employee Benefits and Health Care and Life Sciences practices

The U.S. Supreme Court will review *Gobeille v. Liberty Mutual* in its next term. This is a case concerning whether the state of Vermont may require all health plans, including insured and self-funded plans, to file reports with the state that contain claims data and other information relating to health care. Vermont's law also specifies how the information must be recorded and transmitted.

The Second Circuit Court, in its decision against Vermont, found that "reporting" is a core ERISA administrative function and that the Vermont law, as applied to compel the reporting of plan data, is preempted.

Take-aways:

This is a case of major significance for employers as it could result in the narrowing of the scope of ERISA preemption in the reporting arena and potentially in other areas as well. The preemption of state laws as they relate to self-insured plans means that large employers have been able to administer uniform plans in all states across the country that can offer the same benefits to all employees. Without this protection, the administrative and financial challenges of complying with 50 state laws – as well as thousands of local rules - could increase exponentially and threaten the viability of uniform national plans.

Telehealth in Texas

By Allison Wils, Director of Health Policy for The ERISA Industry Committee

In an ongoing battle over telehealth in Texas, the Texas Medical Board recently adopted a rule requiring a "face-to-face visit or in-person evaluation" before a physician may provide a prescription for a dangerous drug or controlled substance. This action prompted a legal challenge from Teladoc, a national telehealth vendor, asserting a violation of antitrust law and the Commerce Clause of the Constitution. In May the District Court stopped the rule from taking effect and prevented the Board from implementing or enforcing the rule.

On June 19, 2015, the Board filed a motion to dismiss the suit. On July 6, 2015, Teladoc filed an amended complaint, prompting dismissal of the Board's motion on July 7, 2015. Trial is currently set for February, 2017. We will continue to monitor this case as a part of ERIC's ongoing Telehealth Initiative.

Take-aways:

Requiring a face-to-face visit in Texas would stymie the ability of telehealth providers to operate in Texas and could embolden medical boards in other states to follow suit. This would, of course, diminish the ability of employers to make telehealth services available to employees and their families.

NOTEWORTHY RECENT DECISIONS

Continuing Duty to Monitor Section 401(k) Investments

By Kenneth J. Kelly, Member of the Firm and Chair of the National Litigation Steering Committee

On May 18, 2015, the Supreme Court in *Tibble v. Edison International* ruled a Section 401(k) fiduciary has a continuing duty to monitor investments, to make sure they remain prudent, and to remove imprudent ones. In articulating an obligation distinct from the original prudent selection, the Court held that the fiduciaries could not argue that ERISA's statute of limitations barred claims against plan fiduciaries for not replacing allegedly imprudent investment decisions made more than six years before the lawsuit.

The Supreme Court rejected the Ninth Circuit's holding that "only" a "significant" change could give rise to the duty to review the plan's offerings; rather, the continuing duty to monitor and when necessary change investments may arise from something less. The Court does not provide further detail on appropriate fiduciary actions but simply refers the lower courts and plan fiduciaries to generalized common law trust principles in order to develop the law.

Take-aways:

Practically speaking, the Court has made it easier for plaintiffs to circumvent the six-year limitations period and to challenge investment decisions that might have been prudent when made but which may have become merely less desirable as time passed. In view of the continuing obligation to monitor past selections, one can foresee that the six-year limitations period applying to investment decisions will rarely be invoked as plaintiffs shift their focus to fiduciaries' alleged inaction despite "changes" during the six years preceding the suit. Indeed, even if prudent fiduciaries, upon review, decide to eliminate what might have become an imprudent investment option, a plaintiff could sue, asking "what took you so long to realize a change was essential?", and look for damages going back to the six-year time limit.

Plan fiduciaries who now must monitor investments would do well to thoroughly document their decision making and consider engaging professional consultants to assist in the review.

King v. Burwell Decided: Business as Usual for Employer Plan Compliance under the ACA

By Gretchen Harders, Member of the Firm in the Employee Benefits practice

On June 25, 2015, the U.S. Supreme Court published its decision in *King et al v. Burwell*, *Secretary of Health and Human Services et al,* 576 U.S. (2015) upholding the use of premium subsidies in states with federally-funded state health insurance Exchanges under the Affordable Care Act (ACA). In rejecting petitioner's challenge that the plain language of the statute limited the application of premium subsidies to only those state health insurance Exchanges that were "established by a State," the Supreme Court in a 6-3 decision authored by Justice Roberts found that the ACA should be read in context and in accordance with its structure. In finding so, Justice Roberts explained that the structure of the ACA requires tax credits for individual health insurance coverage to be affordable, thus ensuring the extension of coverage. Accordingly, any interpretation to exclude premium subsidies from individuals residing in those states that had federally-funded state health insurance Exchanges would destabilize the individual health insurance market and prevent the implementation of a major reform of the ACA.

Take-aways:

From a plan sponsor perspective, the decision in *King v. Burwell* does not alter any of the ACA's mandates or requirements. Rather, it provides an additional level of certainty that the ACA requirements remain in effect and are not likely to be subject to any imminent judicial challenge. Employers sponsoring group health plans should therefore continue to be vigilant in pursuing compliance with the ACA mandates and requirements and administer their health plans in the usual course.

A Supreme Decision to Constitutionally Compel Same-Sex Marriages: The Impact on Employee Benefit Plans

By August Emil Huelle, Associate in the Employee Benefits and Labor and Employment practices

On June 26, 2015, the U.S. Supreme Court made history with its highly anticipated decision in *Obergefell v. Hodges*, holding that the Fourteenth Amendment requires states to license a marriage between two people of the same sex and to recognize a legal marriage between two people of the same sex performed out-of-state. The high court's decision in *Obergefell* has far reaching implications for employee benefit plans and will require many plan sponsors and other plan fiduciaries to amend plan documents and change the way in which retirement, health, and welfare benefits are administered.

Take-aways:

The biggest challenges for employers will arise in the area of withholding obligations in states that did not recognize same-sex marriage prior to the *Obergefell* decision. Plan administrators will need to monitor state decisions with respect to the effective date of the decision in particular, especially for health benefits paid to spouses. Some will also need to modify fully-insured health and welfare policies in these states.

Many employers will now face the prospect of deciding whether they wish to maintain domestic partner benefits for same-sex couples – and for opposite-sex couples as well. Although some may wish to simplify plan administration by providing benefits only to married spouses, others may be concerned with same-sex couples who do not wish to get married because of fears of potential discrimination in the areas of housing and employment.

In addition to the plan governance issues created by the *Obergefell* decision, employers should be cognizant of the litigation risks created. For example, if an employer thus far has provided domestic partner benefits to same-sex couples only, keeping this status quo may lead to a discrimination suit by opposite-sex domestic partners excluded from coverage.

Rojas v. CIGNA: Court Limits Ability of Healthcare Providers to Sue ERISA Plans

By John Houston Pope, Member of the Firm in the Employee Benefits, Litigation, and Labor and Employment practices

On July 15, 2015, the Second Circuit Court concluded that the term "beneficiary" will generally not include healthcare providers. *Rojas v. CIGNA Health & Life Ins. Co.*, No. 14-3455 (2d Cir. July 15, 2015). This holding prompted the dismissal of a lawsuit brought by doctors who had been kicked out of an insurer's network and wanted reinstatement. The decision will be influential because it brings the Second Circuit in line with three other federal appeals courts.

The doctors sought a basis to sue the insurer under ERISA, claiming to be beneficiaries because they expected the payment of the benefit from the plan (and had assignments to boot). The doctors alternatively tried to rely on their assignments from the plan participants as a basis for reinstatement. The Court found that the providers could not be considered beneficiaries and that the assignments did not confer any rights to reinstatement. The *Rojas* court did, however, leave open the possibility that a properly drawn assignment of the right to collect benefits on behalf of a plan participant would enable a healthcare provider to sue on those narrow grounds.

Take-aways:

Some plans and plan sponsors have been receiving harassing letters from persons purporting to represent healthcare providers that possess participant assignments and seek reimbursements in excess of what the payment process has already approved. *Rojas* is an important step toward curtailing these tactics by eliminating any statutory basis for healthcare provider suits against plans. To avoid this issue, employers could rebut even the most specifically drafted assignment to a provider by including an anti-assignment clause in a benefit plan. Most courts will enforce anti-assignment clauses in benefit plans, removing this pathway as a basis for a provider suit.

The *Harris v. Amgen* "Stock Drop" Case

By Brandon Ge, Associate in the Health Care and Life Sciences

In May 2015, a sharply split Ninth Circuit Court denied a petition to rehear *Harris v. Amgen*. This is an ERISA case challenging a presumption of prudence for employee stock ownership plans, i.e., under which offering company stock as an investment option is presumed to be prudent.

The plaintiffs in the original case were Amgen employees who participated in employer-sponsored retirement savings plans that constituted individual account plans under ERISA. As an investment option, the company offered an Amgen Common Stock Fund, which the plaintiffs purchased. When the value of Amgen's common stock dropped, the participants filed a class action alleging that Amgen breached its fiduciary duty and violated ERISA by

offering company stock despite knowledge that share prices were artificially inflated. The plaintiffs claimed that plan fiduciaries knew about safety problems with certain drugs before they became public and that they should have discontinued offering Amgen common stock as an investment option. Once the concerns became publicized, share prices decreased significantly.

Back in 2013, the Ninth Circuit held that a presumption of prudence did not apply because Amgen's plans did not require or encourage investment primarily in employer stock. After the United States Supreme Court decided another stock drop case in June 2014, *Fifth Third Bancorp v. Dudenhoeffer,* it vacated the Ninth Circuit's ruling against Amgen and sent the case back to the Ninth Circuit for reconsideration. Nonetheless, the Ninth Circuit maintained its ruling in favor of the plaintiffs that the defendants had not acted prudently in offering Amgen common stock.

Take-aways:

The case could facilitate an increase in "stock drop" litigation, and plan fiduciaries that offer company stock funds as investment options should pay particular attention to developments in this area.

Please send questions, comments, and related requests to Gretchen Young, Gretchen Harders or Adam C. Solander.