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BENEFITS LITIGATION UPDATE

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Message from ERIC President and CEO Annette Guarisco Fildes:

Welcome to the Spring edition of *Benefits Litigation Update*, brought to you by The ERISA Industry Committee (ERIC) and the law firm Epstein Becker & Green.

As a new Congress, and a new executive branch, work on major legislation to reform the nation's health system, as well as the tax system (likely to include the retirement system), it's easy to focus on Washington – but legal developments in benefits are just as important, and often times a significant court case can have more practical effects on businesses' benefits administration that whatever exciting new legislation is being debated in Congress.

The new Administration started with a bang, issuing an executive order on the first day that could later have wide-ranging effects on plan sponsors as they endeavor to comply with the Affordable Care Act. Later, another executive order raised the bar for federal agencies developing new regulations, which could also result in either more regulatory freedom, or less certainty for plan administration. There are more questions than answers – which suggests that some answers going forward may be decided in the courts.

And the courts have been busy too! As you will see in this BLU issue, significant cases concerning prescription drugs, pension plans, fees on plan sponsors, and more continue to promulgate. We've taken some of the most interesting, and most impactful, of these cases and highlight them below. As you know, the BLU is not designed just for lawyers; rather, this is publication that breaks down complicated court decisions and legal analysis in a way that anybody can digest and understand.

I would like to once again thank the team at Epstein Becker & Green for their expert legal insights and for their impressive contributions to this issue of the Benefits Litigation Update.

As always, we welcome your feedback on this newsletter as well as the cases highlighted.

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ERIC will hold a conference call discussing cases addressed in this issue on **Wednesday, April 5, 2017** from 2:00 to 3:30 pm EST.

ERIC members and trial members can register for the call by clicking here. If you are a prospective member and would like to participate in the call, please contact ERIC at (202) 789-1400 or by email at memberservices@eric.org.

FEATURED ARTICLE

Texas Court Dismisses Section 1557 Transgender Discrimination Claim

By Cassandra Labbees, Associate, Employee Benefits practice

In a notable recent court decision highlighting transgender issues and employer- sponsored benefit plans, in *Baker v. Aetna Life Ins. Co*, Aetna Life Insurance Co. ("Aetna") defeated a claim by a transgender employee of L-3 Communications Integrated Systems LP ("L-3") who alleged that Aetna's denial of her disability benefits constituted discrimination based on her gender identity. Baker is a participant in L-3's group health plan and short- term disability benefits plan ("STD Plan"). Aetna is the third party administrator ("TPA") of the group health plan and the claim fiduciary and administrator of the STD Plan.

In 2011, Baker began transitioning from male to female. In 2015, after consulting with a health care professional who determined that breast implants were medically necessary to treat gender dysphoria, Baker scheduled surgery and sought benefits under the STD Plan to cover her post-surgery recovery. Coverage under the group health plan and benefit claims under the STD Plan were denied. Filing suit against Aetna and L-3, Baker alleged that Aetna and L-3 discriminated against her based on her gender identity in violation of Section 1557 of the Affordable Care Act (the "ACA"), that Aetna denied her benefits under the STD Plan in violation of ERISA, and that Aetna and L-3 violated Title VII by discriminating against her based on her sex.

The court held that there is no controlling precedent that recognizes a cause of action under Section 1557 for discrimination based on gender identity. The court also held that ERISA does not recognize such a claim and that it is up to Congress to decide whether it wants to create in ERISA a protection that the statute does not expressly provide. Lastly, regarding Baker's Title VII claims, the court found that Aetna was not an employer of Baker under the "single employer" test or the "hybrid economic realities/common law control" test. However, the court declined to dismiss Baker's Title VII claims against L-3, finding Baker did sufficiently argue that she was denied employee benefits due to her sex.

Takeaways

While the Northern District of Texas declined to find a cause of action for gender identity discrimination under Section 1557 of the ACA, there are several cases of gender identity or transgender discrimination pending that may further impact the law for these benefit claims. There is little likelihood, however, that a claim of gender identity discrimination would be successful under ERISA. If the ACA is completely repealed under the Trump administration, Section 1557 would no longer be available and transgendered employees would be limited to claims under Title VII, to the extent that employees are successful in arguing that discrimination on the basis of gender identity constitutes sex discrimination.

NOTEWORTHY PENDING CASE

Biologics and Biosimilars: *Amgen v. Sandoz*

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

As employers consider ways to rein in rising specialty drug costs and/or improve current year spending on pharmacy benefits, biologics and biosimilars have taken center stage. As with the use of generics, biosimilars are forms of biologics that are similar to the more costly brand name biologic drug, but are not considered to have any meaningful clinical differences with the brand name biologics. As illustrated by recent litigation over an FDA-approved biosimilar, the hope for employer group health plans of having quick and ready access to biosimilars still has not materialized.

On January 13, 2017, the U.S. Supreme Court granted review of a biosimilar decision under *Amgen Inc. v. Sandoz Inc.*, 794 F.3d 1347, 1351 (Fed. Cir. 2015). The case involves a biologic marketed by Amgen as Neupogen, which boosts white blood cells in cancer patients. Sandoz developed a biosimilar to Neupogen to be marketed by Novartis as Zarxio, which was approved by the FDA. In *Amgen v. Sandoz*, the Federal Circuit reviewed the Biologics Price Competition and Innovation Act ("BPCIA"), which provides a mechanism for biosimilar applicants to confer with the original biologics reference product sponsors to clear patent disputes (the so-called "patent dance"), thus providing a quicker way for biosimilars to reach the market. The Federal Circuit reviewed the patent dance and notice provisions of BPCIA and determined that the patent dance provisions were optional; however, the requirement that a biosimilar applicant provide 180-day advance notice to the patent holder of commercialization of the biosimilar is mandatory. The 180-day advance notice requirement begins after FDA licensure of the biosimilar. The emerging biosimilar industry criticized the decision as effectively providing the biologics reference product sponsors an additional 180 days of exclusivity for the biologic.

A decision by the US Supreme Court will provide a clearer view of the requirements that apply to the biosimilar industry to take their products to market. Whether the decision will speed up the process or serve to expand the availability of biosimilars remains to be seen.

Takeaways

As rising specialty drug costs are consistently a concern in controlling health care spending for employer plan sponsors, biosimilars offer a potential opportunity to provide lower cost biologic drugs. Plan sponsors should monitor legal trends in this area and periodically reach out to their specialty pharmacy providers and/or pharmacy benefit management organizations to inquire over the use and availability of biosimilars as a plan benefit.

NOTEWORTHY DEVELOPMENT

ACA Information Reporting: It's Not Over Until It's Over

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

While many employers who sponsor group health plans anxiously await repeal of the Patient Protection and Affordable Care Act ("ACA") and its compliance requirements, employers should be mindful that the ACA information reporting requirements remain in effect and must be followed. The IRS has provided limited relief. In IRS Notice 2016-70, the IRS granted a 30-day extension to applicable large employers ("ALEs") (as determined on a controlled group basis) that are subject to the employer mandate to provide their full-time employees with the Form 1095-C by March 2, 2017 (with this extension also applying to Form 1095-B filers). The due dates for filing the required forms with the IRS remain unchanged (the forms are still due by February 28 (March 31, if filed electronically) unless a timely request for an extension was filed on a Form 8809 with the IRS). This Notice also provided relief for incorrect or incomplete information reported, provided there was a good faith effort to comply with the reporting requirements.

The extension of the good-faith filing relief in connection with timely filed forms (albeit incorrect or incomplete) is important because all employers subject to the reporting requirements that fail to comply are otherwise subject to penalties under the tax code. These penalties are for failure to file correct information returns and failure to furnish correct payee statements. Generally, the penalty for an incorrectly filed information return is $260 per return, with the total penalty for a calendar year not to exceed $3,193,000; and the penalty for an incorrectly filed payee statement is $260 per statement, with the total penalty for a calendar year not to exceed $3,193,000. Increased

penalties without limitations apply if there was an intentional disregard for the requirement to file the returns and furnish the required statements; however, there are possible penalty waivers if the failure was due to reasonable cause and not willful neglect. Thus, employers that do not take advantage of the extension of the good faith filing standard to timely file their required forms will remain subject to a reasonable cause analysis for any penalty determinations.

The IRS has begun its enforcement of the ACA shared responsibility provisions by issuing Letter 5699 Request for Employer Reporting of Offers of Health Insurance Coverage (Forms 1094-C and 1095-C) to employers it deems to be ALEs and from whom it has not received the 2015 filings. The IRS is seeking confirmation of ALE status and compliance with the reporting obligations for the 2015 cycle. The Letter instructs the ALE who receives it to respond within 30 days and make the proper filings if it has not already done so. Absent a specific repeal of the ACA's reporting requirements or a directive to cease penalty enforcement efforts related to the information reporting, it appears that the IRS will continue to seek out non-filers. This effort is in part to collect the projected revenues that were forecasted to pay for the insurance premium tax credits and subsidies eligible individuals have received to date under the ACA.

Takeaways

Employers must continue to monitor ACA repeal and replace initiatives and should continue to comply with existing law. By taking prompt action, employers may rely on a good faith standard and potentially reduce penalties that could be assessed.

NOTEWORTHY RECENT DECISION

Snyder Part 2 – Michigan Tax Statute Not Preempted

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

The Sixth Circuit Court of Appeals once again held that a Michigan statute imposing a one percent tax on medical claims paid within the state is not pre-empted by ERISA. Preemption does not apply even though the statute requires self-insured plans and third party administrators (TPAs) to maintain records of payments, report such transactions to the state, and devise methodologies for compliance (not necessarily to collect taxes). *Self-Insurance Inst. of Am., Inc. v. Snyder,* 761 F.3d 631 (6th Cir. 2016)

In light of the Supreme Court's decision in *Gobeille v. Liberty Mutual* in March 2016 (discussed in issue 12 of the ERIC reporter), in which it held that a Vermont statute requiring medical claims data collection and reporting was pre-empted, and the Supreme Court's subsequently vacating an earlier decision in *Snyder* in light of *Gobeille*, this decision may have come as a surprise to observers.

The Sixth Circuit applied an ERISA analysis where preemption occurs if the state law "mandate[s] . . . something" *and* the mandate "fall[s] within the area that Congress intended ERISA to control exclusively." It held that the tax statute does not "directly regulate" the administration of ERISA plans (as did the statute in *Gobeille*, requiring Vermont plans to contribute to a healthcare claims database), but rather only "peripherally" or "incidentally" affected plan administration. Moreover, the taxing power is a traditional state function, and in two previous cases (*DeBuono v. NYSA-ILA* and *Blue Cross v. Travelers*), the Supreme Court held that New York's hospital gross receipts tax and tax surcharges were not preempted. Finally, although the Michigan statute states that carriers and TPAs "shall" develop and implement a methodology by what they "will" collect in taxes, Michigan avoided an argument that tax collection alters the relationships with ERISA-covered entities by "interpreting" this wording as "permissive." (Certiorari was *denied* in this second decision, indicating perhaps that the Supreme Court agreed with the analysis.)

Takeaways

Whether a state scheme imposes unacceptable "direct" administrative burdens on plans and administrators—thus triggering ERISA preemption—appears to be in the eye of the beholder. While the brand-new tax reporting burden in Michigan is nowhere near the comprehensive data collection scheme preempted in *Gobeille*, its record keeping and reporting requirements are similar to the ones preempted in *Gobeille*. The decisive fact to the Circuit Court was that the reporting related to taxation, a traditional state function.

CASE SUMMARIES

Employee Benefit Plans as Affiliates of Their Sponsors: *Rothstein v. AIG, Inc.*, 837 F.3d 195 (2d Cir. 2016)

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

Suppose your company settles a class action securities lawsuit. Consistent with ordinary practice in those types of settlements, the agreement (which the Court approves) defines the group eligible to receive the benefits of the settlement to exclude any parent, subsidiary, affiliate, officer, or director of the company. Does this exclusion prevent the benefit plans sponsored by the company from collecting "a slice of the settlement pie?"

Several years ago the Chicago-headquartered Seventh Circuit Court of Appeals said the exclusion applied. It reasoned that the benefit plans governed by a committee, which the company effectively controlled through its appointment and removal power, must be considered "affiliates" of the company. *In re Motorola Securities Litigation*, 644 F.3d 511 (7th Cir. 2011). This opinion influenced several federal district courts in other jurisdictions, including California and New York, to hold similarly, excluding benefit plans from recovery in settlements.

The Second Circuit recently disagreed. In *Rothstein v. AIG, Inc.*, 837 F.3d 195 (2d Cir. 2016), the New York-based federal appeals court recognized that benefit plans are not an affiliate of the employer that sponsors them. *Rothstein* expressly disagreed with the *Motorola* case, explaining that *Motorola* "did not consider the role of ERISA in shaping the contours and limits on an employer's 'control' over a sponsored plan." *Id. at 207*. The fiduciary obligations imposed by ERISA on the personnel who administer the benefit plans insulates them, for these purposes, from whatever control may lie in the employer's appointment and removal power.

The *Rothstein* court also observed that the exclusion of affiliates and others from a settlement class typically is written into agreements to prevent the alleged wrongdoers from sharing in the settlement. Benefit plans and their participants, however, are not wrongdoers seeking to profit from their own wrongs.

The opinion in *Rothstein* is a win for the role of ERISA in insulating benefit plans (particularly retirement plans) from arbitrary and self-interested conduct by plan sponsors. It surely will be cited many times to underscore that plan administrators may be presumed to act in the interests of participants and beneficiaries, absent hard evidence to the contrary.

Takeaways

Benefit plan administrators should be alert to ensure that their plans do not suffer wrongful exclusion from any class action settlements that might otherwise be unavailable to the sponsoring employer. Courts are willing to view plans as distinct entities under the law that may properly share in settlement proceeds, even if the plans' sponsors may not.

Profits (And Losses) In the Face Of Fraud: *Trustees of Upstate New York Engineers Pension Fund v. Ivy Asset Management,* 843 F.3d 561 (2d Cir. 2016)

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

The collapse of the pernicious Ponzi scheme of Bernie Madoff in 2008 echoed through the economy. Many investors thought they had a valuable portfolio that was, in fact, worth nothing or next to nothing. Benefit plans could be counted among Madoff's victims.

In *Trustees of Upstate New York Engineers Pension Fund v. Ivy Asset Management*, 843 F.3d 561 (2d Cir. 2016), a Taft-Hartley pension fund sought to hold its investment manager responsible for a failure to realize greater profits that could have been earned if the advisor had pulled out of the Madoff funds earlier.

The fund placed an initial investment of $13 million with Madoff in the early 1990s, adding another $6 million by 1999. Over time, it made withdrawals reflecting a net profit of nearly $33 million. When Madoff's frauds were discovered, the stated value of the account exceeded $50 million, none of which could be recovered because the fund was considered a "net winner" over time.

The fund's trustees sued the investment manager for breach of fiduciary duty, claiming it should have pulled the money out at an earlier date when the paper profits were still huge, and reinvested it elsewhere. The trustees also sought a refund of performance fees paid to the investment manager, some or all of which related to the imaginary or unrecoverable profits. They further sought compensation for having increased the vested pension benefits of participants in 1999 when they believed they had a lucrative portfolio of assets invested with Madoff. The court rejected all of these claims, essentially because the fund suffered no real losses.

The court explained that the "loss of fictitious profits" is not actionable because the law does not allow recovery for "a missed chance for enjoyment of a fraud." The established method for setting forth a loss as a result of imprudent investment of plan funds is to show that, had the funds been available for other investments, those investments would have earned more than they actually earned as (allegedly imprudently) invested. In a line worth highlighting, the court said that "the valid measure" for this comparison "is a prudent alternative investment, not an alternative Ponzi scheme."

Fees paid to the investment manager could not be recovered by the plan because the trustees could not prove that that these fees "exceed[ed] the profit that the Plan derived in excess of what it would have made from a prudent alternative investment." To constitute a loss, these fees must be greater than the "extraordinary profits" that the plan made from the fraudulently inflated investments.

The added expense of an increase in plan benefits (based on the mistaken belief about the fund's financial position) could not form the basis for a claim because the fund did not demonstrate that it lacked sufficient funds to cover its increased obligations. While the amount of the fund's surplus declined when the books were revised to reflect the write-off of the monies the trustees thought they still had with Madoff, the fund still enjoyed a surplus. The allegedly imprudent investment strategy, then, did not cause an actual loss.

Takeaways

(1) Expectations about profits that investments may realize do not determine the fiduciary's duty of prudence, particularly when the profits are the result of the misdeeds of others.

(2) Suits against investment managers can be difficult because the proofs must demonstrate that the losses are real, relative to what a prudent alternative investment would have yielded.

(3) These causation and loss principles apply equally to claims that might be brought by participants in employer-sponsored benefit plans. They must demonstrate real losses, measured against prudent alternative investment strategies, to justify a recovery.

Please send questions, comments, and related requests to James Gelfand, Gretchen Harders, John Houston Pope, or Adam C. Solander.