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Bridging the Retirement Gap: Crack the Nest Egg Before Taking Social Security

Hiding in plain sight is a simple, low-cost, and effective tool to meaningfully increase retirement income: newbie retirees should live off their 401(k), individual retirement account (IRA), or other savings and delay taking Social Security, ideally until age 70. Each year a person postpones Social Security from age 62 until 70, his or her benefit increases by roughly 8 percent. As an added bonus, those lifetime Social Security benefits, including the 8-percent bump, will be increased annually for inflation. In effect, the retiree is buying an annuity from Social Security.

An October 2019 paper from the Center for Retirement Research at Boston College confirms that this Social Security delaying tactic can have significant advantages for retirees. Employers should educate, and perhaps encourage, near retirees to consider this approach.

Here's how it could work. Many employers, through their 401(k) administrator, HR department, or financial wellness vendor, already educate employees about Social Security as they approach their early 60s. The message could be tweaked to highlight that each year a retiree begins Social Security before age 70 costs them an 8-percent benefit reduction. This is a reverse of the usual explanation that benefits increase 8 percent for each year payment is delayed past 62. Although the math is the same, people react more strongly to avoiding losses than forgoing gains.

Employers could provide estimates of each near retiree's Social Security benefits based on payroll data and offer to help workers get actual numbers from Social Security. Then, with the estimated or actual number in hand, employers can suggest that, upon retirement, the individual postpone his or her Social Security checks and instead begin withdrawing the same amount from his or her 401(k) account. Ideally, the retiree will have a large enough nest egg and the discipline to wait until age 70 (when the 8-percent bump ends) or at least until his or her unreduced retirement age (somewhere between 66 and 67, depending on birth year). But each month of waiting will add value. Ideally, the plan should offer the retiree using his or her 401(k) as a bridge to higher Social Security benefits a lifecycle or other fund consistent with systematic withdrawals. The investment could be limited to enough money to cover the expected withdrawals or cover the entire account. Perhaps the installment-friendly investment fund should be the default (with an opt-out) for anyone electing the bridge.

Although financial experts uniformly agree that an annuity is an ideal retirement product for most retirees—offering longevity protection,

professional investment management, and budgetary certainty—virtually no one will take this advice. (*See* "Modernizing the American Private Pension System Plan for the Future of Work" in the Winter 2018 issue of *Benefits Law Journal*.) The Social Security delaying tactic offers a frictionless way for retirees to increase their guaranteed lifetime income without the emotional and economic baggage surrounding annuities. It even has some advantages over traditional annuities.

First, it is reversible. If the retiree's health, financial, or other circumstances change, he or she can simply start Social Security payments and stop or modify the 401(k) withdrawals. Second, the value of the 8-percent Social Security increase is actually higher than what an individual could buy from an insurance company. Social Security doesn't have marketing costs, a profit motive, or charge for administration or legal compliance, and has lower mortality charges than an insurance company. Third, is simplicity: the retiree only has to decide when to start collecting benefits. With annuities, the retiree has to choose which insurance company and then select from a menu of product feature such as term certain and survivor benefits. Although these options can offer added value, having to make a decision, especially one of such importance, paralyzes many people.

Delaying Social Security is not for everybody. People with known health issues who are likely to fall on the short end of the mortality curve would be better off taking benefits as early as possible. The same holds for a retiree with scant savings who should maintain a rainy day fund rather than use it to cover daily living expenses. Married couples also should consider the impact of early versus late claiming on their spousal and survivor benefits.

Then there's the risk that the Social Security Trust Fund will run dry (currently projected for 2034) causing an across-the-board benefit reduction. These funding crises, however, occur roughly every generation and each time the President and Congress have (at the last minute) adopted solutions that left current and near retirees protected. Even though we live in politically strange times, I expect the next fix will be no different.

Employers should get involved. A Social Security bridge is as inexpensive and effective retirement benefit as they come. Most 401(k) plans already allow for installment payments, but for those that don't, adding installments would require a simple plan amendment and very likely no added recordkeeping costs. Enhancing the financial education program for near retirees to highlight the potential advantages of waiting should not take much doing as the concepts are easy to understand. Indeed, recordkeepers and financial wellness vendors should jump into the act as ideal way to add value and win business.

I've heard some concern that employers should be careful of potential fiduciary liability from promoting a Social Security bridge. As long

as the decision rests with the retiree, educating folks, and facilitating Social Security-like 401(k) withdrawals should be risk-free to employers. In time, as this idea proves its worth, employers may consider making a Social Security bridge the default distribution option, although more cautious employers would want a regularity protection.

A Social Security bridge will not help people lacking a workplace savings program and/or not saving enough (or at all). It certainly will not resurrect pension plans and is not a substitute for the heavy policy lifting needed to offer a secure path for the typical worker. These types of solutions will take legal and political change. Nevertheless, to move the needle *right now*, a Social Security bridge is doable, essentially cost-free, and simple. Let's go!

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

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Introducing the Individual Coverage and Excepted Benefits HRA

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The following article reviews the final rule permitting the integration of a health reimbursement arrangement (HRA) with individual health insurance coverage or Medicare to meet the market reform provisions established under the Affordable Care Act (ACA), and reviews the conditions set forth under which certain account based plans, including HRAs, will be considered an excepted benefit.

On October 12, 2017, the President issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States."[1] Pursuant to the Executive Order, the President directed the Departments of Treasury, Labor, and Health and Human Services (the Departments) to either propose regulation or revise guidance to "expand the use and flexibility of Health Reimbursement Arrangements."[2] On October 29, 2018, the Departments published a notice of proposed rulemaking entitled, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans."[3] As customary, the notice of proposed rulemaking permitted the public to submit comments to the Departments on or before December 28, 2018. After careful review of the comments received by the public, the Departments issued the final rule on June 20, 2019. The final rule is effective on August 19, 2019, and is applicable to plan years beginning on or after January 1, 2020. Provisions of the final rule applicable to the premium tax credit and special enrollment periods in the individual market, however, are effective on January 1, 2020.[4]

BACKGROUND

An HRA is an employer-funded arrangement that reimburses employees for medical expenses incurred by the employee, the

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employee's spouse, and/or dependents.[5] An HRA must meet three general requirements:

1. It must be funded solely by the employer;

2. It must be used to pay for qualified medical expenses; and

3. Any reimbursement must be adjudicated and substantiated.[6]

Because an HRA reimburses employees for medical care expenses, the HRA is a group health plan under the Public Health Service Act (PHS) and the ACA, which requires all group health plans to comply with its market reform provisions.[7] While HRAs will generally comply with most requirements under the PHS and ACA, HRAs will fail to comply with PHS Sections 2711 and 2713, the prohibition of annual limits on essential health benefits (EHBs) and the prohibition of cost sharing on preventive services, respectively.

In the preamble to the 2010 interim final rules regarding Section 2711, the Departments noted that an HRA will meet the market reform requirements by integrating with a group health plan.[8] Thereafter, subregulatory guidance issued by the Departments set forth the method of integration and specifically excluded integration with individual market coverage.[9] Treasury also issued subregulatory guidance, which provided that an employer payment plan (EPP) that either reimburses or pays directly Medicare Part B or D premiums cannot be integrated with Medicare.[10] An EPP, however, may be integrated with other group health plan coverage to comply with the market reform provisions.

Pursuant to subregulatory guidance, integration requires the employee, the employee's spouse, and dependents to be enrolled in the HRA to also be enrolled in another group health plan that meets the market reform requirements (the compliant group health plan). The group health plan may be offered by the same employer or by another employer (*e.g.*, a spouse's plan). Moreover, the compliant group health plan must offer the employee the opportunity to permanently opt out of and waive future reimbursements from the HRA, at least annually, and either forfeit reimbursements at the termination of employment or permit the employee to permanently opt-out of future reimbursements.[11]

INDIVIDUAL COVERAGE HRA

Pursuant to the final rule, beginning January 1, 2020, an HRA may be integrated with individual health insurance coverage[12] and Medicare[13] to comply with the market reform requirements. Similar to traditional

HRA integration rules, an individual coverage HRA (ICHRA) will be integrated if the employee, the employee's spouse, and dependents are enrolled in individual health insurance coverage for each month the individual is covered by an ICHRA.[14] In addition, the ICHRA must comply with opt-out and forfeiture provisions, notice requirements, and reimbursement substantiation requirements, as follows:

- **Opt-out and forfeiture provisions.** The employee and the employee's spouse and dependents must be offered the opportunity to opt out of the ICHRA at least once annually during enrollment and must either forfeit or opt out of reimbursements following termination of employment.[15]

- **Notice requirements.** The employee must be provided a notice prior to the beginning of the plan year, within 90 days of the start of the plan year. If the ICHRA is established less than 120 days before the beginning of the first plan year, however, or the employee becomes eligible after the beginning of the plan year, the notice may be provided with less than 90 days notice. In addition, the notice must contain certain information, which includes, but is not limited to: (1) a description of applicable terms, including opt-out and waiver provisions and substantiation; (2) information regarding the premium tax credit; and (3) the employee's duty to notify of termination or cancellation. The Departments also issued a sample notice that may be used by the employer to comply with this requirement.[16]

- **Substantiation.** The employee is required to substantiate that he or she and any applicable spouse and dependents are enrolled in individual health insurance for any month covered by the ICHRA. The employee is required to substantiate coverage prior to enrollment, the "initial substantiation," and each time the employee requests a reimbursement for a medical expense: the "subsequent substantiation." In order to substantiate coverage, the employer is required to establish reasonable procedures for its employees.[17]

Employee Classification

The final rule sets forth rules to determine an employee class, defines specific employee classes, and imposes a class size requirement under certain conditions. In order to extend flexibility to employers, the final rule provides that the determination of an employee class

is determined without regard to commonality rules that would otherwise treat multiple entities as a single employer. The final rule also specified employee classes, as follows:

- **Full time, part-time, and seasonal employees.**[18] The final rule provides the employer may elect either definition available under Internal Revenue Code Section 54.4980H-1(a)(38) or Section 1.105-11(c)(2)(iii)(C) to determine part-time or seasonal employee status. Pursuant to Code Section 54.4980H-1(a)(21), a full time employee is defined as an employee that worked at least 30 hours per week during any calendar month as determined using the look-back measurement or the monthly measurement methods. In contrast, under Code Section 1.105-11(c)(2)(iii)(C), a part time employee is an employee that works less than 25 hours and a seasonal employee is an employee that works less than seven months annually. However, depending on the industry or the typical hours of the business, a part time employee will be an employee that works less than 35 hours during a week and a seasonal employee is an employee that works less than nine months annually.

- **Salaried and nonsalaried employees.**[19]

- **Same rating area.**[20] Employees whose primary site of employment is in the same rating area as defined under 45 CFR 147.102(b), which provides that a state is permitted to establish more than one rating area within the state.

- **Collective bargaining agreement.**[21] Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates.

- **Waiting period.**[22] Employees who have not satisfied a waiting period for coverage, so long as the waiting period complies with Code Section 54.9815-2708. A waiting period under Code Section 54.9815-2708 is defined as not exceeding 90 days.

- **Nonresident aliens.**[23] Nonresident aliens with no US-based income.

- **Temporary employees.**[24] Employees who, under all the facts and circumstances, are employees of an entity that hired

> the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under Code Sections 414(b), 414(c), 414(m), or 414(o).

The final rule also imposes a class size requirement that applies to employers that offer a traditional group health plan and an ICHRA to different employee classes. Specifically, the requirement restricts an employer from excluding an employee class from traditional group health plan coverage. The class size requirement applies to the employee classes below (the "applicable employee classes") or an employee class created by combining an applicable employee class and any other employee class.[25] The applicable employee classes are as follows:

1. Full time and part time employees[26];

2. Salaried and nonsalaried employees; and

3. Employees whose primary site of employment is in the same rating area.[27]

The class size requirement must be determined prior to the beginning of the plan year and is based on the number of employees the employer reasonably expects to employ as of the first day of the plan year. The class size is 10 for an employer with fewer than 100 employees, 10 percent of the total number of employees rounded to the nearest whole number for an employee with 100 to 200 employees, and 20 for an employer with more than 200 employees. Thereafter, the employer will satisfy the applicable class size requirement for the plan year based on the number of employees offered the ICHRA as of the first day of the plan year.[28] The employer will not fail to satisfy the class size requirement if the employer's size or number enrolled changes throughout the year.

The Same Term Provisions

The employer is required to offer all employees in the same class coverage under the ICHRA under the same terms and conditions.[29] Furthermore, the employer is prohibited from offering the employee the choice of coverage between the traditional group health plan and the ICHRA. Thus, employees within the same employee class cannot be offered variations in coverage, reimbursement, or annual

limits.[30] A variation in reimbursement or annual limit does not exist if the employee is offered a prorated amount because of midyear enrollment.[31]

The rule does permit variations based on age or family size if the method used to determine the variation is established prior to the start of the plan year.[32] Specifically, the employer is permitted to increase the reimbursement amount based on age if the maximum dollar amount available to the oldest participant is not more than three times the maximum dollar amount available to the youngest participant.[33] Regarding family size, a variation is permitted so long as all members of the employee class receive the benefit of the variation with an increase in dependents.

The New Hires and Former Employees

Pursuant to the final rule, an employer may extend coverage to new hires and former employees, even if other members of the employee's class or former class are not extended coverage in the ICHRA. Under the new hire rule, the employer may establish a new hire sub-class to extend coverage. The new hire sub-class may also establish different new hire sub-classes by establishing different new hires dates, so long as the new hire date is prospective. Moreover, an employer may discontinue or re-establish the sub-class at any time. Regarding former employees, the employer is permitted to offer some, but not all, former employees coverage under an ICHRA.[34] If the offer of coverage is extended to more than one former employee in the same class, the coverage must, however, be provided under the same terms and conditions.

Individual Health Insurance Coverage: ERISA Plan Status

A welfare plan pursuant to Section 3(1) of the Employee Retirement Income Security Act (ERISA) is defined as "any plan, fund or program," that is "established or maintained by an employer or employee organization" for the provision of health benefits "through the purchase of insurance or otherwise."[35] Individual health insurance coverage integrated with an HRA may be considered a group health plan or part of a group health plan under this definition.[36] As a result, individual health insurance may be required to comply with PHS provisions applicable to group health plans (*e.g.*, risk pool requirements, rating rules, or medical loss ratios). To prevent conflicting requirements, the final rule modifies the definition of welfare plan under ERISA. Moreover, the

final rule codifies a safe harbor that would exempt individual health insurance coverage from ERISA, Title I. To comply with the safe harbor, the following conditions must be met:

1. The purchase of any individual health insurance coverage is completely voluntary for employees.

2. The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage.

3. Reimbursement for nongroup health insurance premiums is limited solely to individual health insurance coverage.

4. The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.[37]

5. Each plan participant is notified annually that the individual health insurance coverage is not subject to ERISA.

The preamble to the final rule offers two examples regarding conditions two and four. Regarding condition two, the preamble notes that a plan sponsor may select or endorse a particular issuer by designing a private exchange to limit the employee's choice of issuer or to promote certain issuers over others.[38] Regarding condition number four, the preamble notes that the receipt of compensation to cover the cost of operating an ICHRA would constitute improper consideration.[39]

EXCEPTED BENEFIT HRA

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an excepted benefit offers health coverage incidentally (*e.g.*, accident-only coverage, disability, limited scope dental, or vision) and is generally exempt from PHS Sections 2711 and 2713.[40] As a result, an excepted benefit is not required to be integrated with a group health plan. There, however, may be instances where an HRA may not meet the excepted benefit requirements under HIPAA requiring the HRA to comply with the market reform provisions. To remove potential limitations on employers that want to offer an HRA that may otherwise not meet the requirements of an excepted benefit, the final rule sets forth guidelines to determine whether an HRA or other

account-based plan will be an excepted benefit. By complying with the guidelines, the HRA would be an excepted benefit and exempt from PHS Sections 2711 and 2713.[41] The final rule outlines the following criteria:

1. **Not an integral part of the plan.** Group health plan coverage must be made available by the same plan sponsor, for the same period, to the participants offered the excepted benefit HRA (EBHRA). The employee is not required to enroll in the other group health plan coverage in order for the EBHRA to maintain its status as an excepted benefit.

2. **Benefits provided must be limited in amount.** The maximum annual limit cannot exceed $1,800, indexed for inflation, for plan years beginning January 1, 2021.[42] The amounts may be carried over from one year to the next and will not affect the excepted benefit status.

3. **Cannot reimburse premium for certain health insurance coverage.** The HRA or other account-based group health plan can generally reimburse any medical care expense as defined under Internal Revenue Code Section 213(d), including premiums for excepted benefit coverage and continuation coverage (*i.e.*, Consolidate Omnibus Budget Reconciliation Act (COBRA) coverage). An EBHRA, however, cannot reimburse premiums for individual health insurance coverage, group health plan coverage, or Medicare Part A, B, C, or D.

4. **Must be available to all similarly situated individuals under the same terms**. The EBHRA must be made available to all similarly situated individuals. Participants may be treated differently based on bona fide employment-based classification consistent with the employer's usual business practice.[43]

THE PREMIUM TAX CREDIT

Beginning 2014, individuals who do not qualify for Medicare or Medicaid and are otherwise not offered group health coverage through an employer are eligible for a refundable tax credit (the "premium tax credit") to pay for coverage purchased through the Exchange.[44] If an employer makes available group health coverage that meets the minimum essential, minimum value, and affordability standards, the individual will be ineligible for the premium tax credit, even if

the individual declines coverage. Generally, an HRA that is not an excepted benefit will meet the minimum essential coverage standard, which may disqualify an individual from the premium tax credit.[45] In accordance, the final rule provides that an individual will be ineligible for the premium tax credit if enrolled in an ICHRA. An individual that opts-out of or waives future reimbursements from the ICHRA would, however, remain eligible for the premium tax credit. On September 30, the Departments issued additional proposed rules related to the minimum value and affordability provisions.[46] (See the Federal Benefits Developments column in this issue.)

CONCLUSION

The final rule expands the flexibility available to employers when offering health coverage. While the final rule codifies requirements applicable for integration with individual health insurance coverage and the safe harbor for excepted benefits, an HRA must still comply with other regulatory guidance. For example, eligibility is limited to employees as defined under the Internal Revenue Code, a terminated employee must be offered continuation coverage (*i.e.,* COBRA), and any offer must comply with the nondiscrimination provisions available under HIPAA, the Internal Revenue Code, and the Age Discrimination and Employment Act. Moreover, the Departments will issue ancillary guidance related to special enrollment periods, the employer mandate, and other applicable tax provisions. The additional regulatory requirements applicable to HRAs or entities offering HRAs are beyond the scope of this article, but remain important considerations when designing and implementing an HRA.

NOTES

1. E.O. 13813 of Oct 12, 2017.

2. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 *Fed. Reg.* at 28888, 28911 (June 20, 2019).

3. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, A Proposed Rule, 83 C.F.R. § 54420 (October 29, 2018).

4. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, *supra* n.2 at 288888.

5. An HRA is not created by any specific provision of the Internal Revenue Code, but is tax exempt to the employer and employee under IRC §§ 105 and 106 as established by subregulatory guidance issued by the Internal Revenue Service. *See* IRC § 106(e) and § 6041(f).

6. As defined under IRC § 213(d). The HRA may either reimburse any medical expense or be limited to copayments, co-insurance, deductibles, premiums, or medical care expenses that are not essential health benefits. The difference depends on whether the HRA meets the minimum value standard.

7. The market reform provisions do not apply to plans with less than two participants or to excepted benefits. *See* IRS Notice 2013-54, 2013-40 I.R.B. 287, II.D.1 (Sept. 13, 2013); DOL Tech. Rel. 2013-3, II.D.1 (Sept. 13, 2013).

8. *See* Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37187, 37190-37191 (June 28, 2010).

9. *See* FAQs About Affordable Care Act Implementation (Part XI), January 24, 2013.

10. *See* IRS Notice 2015-17.

11. Integration does not require the same Form 5500, Plan Document, or Plan.

12. Health care sharing ministries are not considered individual health insurance coverage and cannot be used for integration. The Departments generally provided that individual health insurance coverage may be used to meet Sections 2711 and 2713 of PHS because individual health insurance coverage is required to comply with these provisions and permitting their integration would be a minor extension of sub-regulatory guidance. Finally, excepted benefits will not meet the requirement of individual health insurance coverage.

13. The final rules permit enrollment in Medicare Part A and B or Part C to comply with the integration requirements.

14. An individual is considered enrolled in individual health insurance coverage even if the individual has not paid for coverage if the nonpayment occurs during the grace period. Once the individual fails to pay for individual coverage and coverage is cancelled or terminated, the individual is required to notify the plan sponsor of the ICHRA. The effective date of cancellation is the date the individual's coverage is terminated. The plan sponsor is required to reimburse medical care expenses while the individual remains enrolled in the individual health insurance coverage, including the applicable nonpayment period. However, the plan sponsor is prohibited from reimbursing medical expenses once the individual's health insurance coverage is cancelled, including retroactive cancellation. The plan sponsor may limit the period provided to reimburse medical expenses. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, *supra* n.2.

15. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, *supra* n.2.

16. *Id.* at 29004.

17. *Id.* The plan sponsor must obtain substantiation prior to any reimbursement. The Departments provide that substantiation may include an attestation from the participant or a third-party document (*e.g.,* letter from issuer). The plan sponsor may rely on the third-party document or the participant's attestation unless the plan sponsor has knowledge the participant will not be enrolled in individual health insurance coverage for the plan year.

18. *Id.* at 29006.

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.* at 28907. An exception exists if the class is composed of employees who have not satisfied the waiting period.

26. *Id.* at 28914. The employer is permitted to switch between definitions, but to do so, the employer must define the term prior to the beginning of the plan year in the applicable plan document.

27. *Id.* at 28975. For employees in the same rating area, the minimum class size requirement does not apply if the geographic area defining the class is a state or a combination of two or more entire states.

28. *Id.* at 28993. The final rule sets forth a special condition for student employees. If the employer is a higher education, as defined under the Higher Education Act of 1965, and it offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. The student employee is excluded when determining the applicable class size minimum.

29. *Id.* at 29007, 29000. The terms and conditions requirement includes the provisions of the final rule and any other applicable regulation, including ERISA and the IRC. For example, the preamble to the final rule provides that if the employer offers a pretax salary reduction arrangement pursuant to IRC Section 125, the employer must extend the pretax salary reduction to all employees.

30. *Id.* Carryover amounts are disregarded for purposes of determining the same terms and do not count towards the annual limit. The transfer, however, must be available to all participants in the class of employees.

31. *Id.* at 28907. The method used to determine the amount available to the new hire or the dependent must be the same for all classes of employees. The employer is also permitted to either offer the maximum amount or the prorated amount to the employee. If the employer offers an HSA-compatible HRA and a non-HSA compatible HRA, the plan sponsor is considered to offer the individual coverage HRA under the same terms.

32. *Id.* at 28988.

33. *Id.* at 28989.

34. *Id.* at 29002. A former employee is defined as an employee that is no longer providing services to the employer.

35. 29 U.S. Code § 1002(1).

36. *Id.* at 28948.

37. *Id.* at 28948–28949.

38. *Id.* at 28950.

39. *Id.* at 28951.

40. Public Law 104-191.

41. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, *supra* n.2 at 28888, 28892.

42. *Id.* at 29013. The annual adjustment is determined based on the Chained Consumer Price Index for All Urban Consumers, unadjusted (C-CPI-U), which is published by Department of Labor.

43. 29 C.F.R. §2590.702(d). A bona fide employee classification includes full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations.

44. *See* IRC § 5000A(f)(1).

45. *See* IRS Notice 2013-54, 2013-40 I.R.B. 287, II.D.4; DOL Tech. Rel. 2013-3, II.D.4 (Sept. 13, 2013).

46. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, *supra* n.2 at 28888, 28941, 28944.

Recent Trends in ESOP Litigation

Patrick C. DiCarlo

Congress sought to promote employee stock ownership plans (ESOPs) as a means for promoting employee capitalism and a tool for corporate finance. To implement this goal, Congress exempted ESOPs from certain Employee Retirement Income Security Act (ERISA) requirements related to plan investments in employer securities, and provided an exemption from the prohibited transaction rules in certain circumstances.[1] ESOPs, like other individual account plans that invest in employer securities, also have an exemption from ERISA's diversification requirement and corresponding limited exemption from the prudence requirement.[2] ESOP fiduciaries, however, remain subject to ERISA's fiduciary duties generally and prohibited transaction rules. The Department of Labor (DOL) and private plaintiffs are also authorized to bring litigation against ESOP fiduciaries to enforce the fiduciary and prohibited transaction requirements.

This tension between Congress's desire to promote such plans and the robust fiduciary and prohibited transaction requirements that still apply, has led to a large volume of ESOP litigation. Such cases arise in the context of both publicly traded and privately held employer securities. With respect to publicly traded stock held in ESOPs, there has been much litigation, but the Supreme Court's opinion in Fifth Third Bancorp v. Dudenhoeffer, *has made it difficult for plaintiffs to succeed where the fiduciaries are relying on the publicly traded price to establish the value.[3] With respect to privately held stock, however, the valuation issues are much more complex, and continue to give rise to much litigation. This article explores some of the recent trends in litigation over ESOPs that invest in privately held stock.*

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From a defense perspective, one of the most challenging aspects of ESOP litigation is the fact that the defendants will bear the burden of proving that the prohibited transaction exemption applies. In other words, the underlying ESOP transaction, or aspects of it, almost certainly constitutes prohibited transactions, and the burden of proof is on the defendant to show that an exemption to the prohibited transaction rules applies.[4] The pertinent statutory language provides an exemption if the plan purchases the stock for no more than "adequate consideration" and that term, in the context of closely held securities, is defined (in pertinent part) as: "… the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with the regulations promulgated by the Secretary."[5] The Secretary of Labor has only *proposed* regulations (in 1988), but never adopted any. Nevertheless, and somewhat frustratingly, the DOL frequently cites its proposed regulations in litigation, and a number of courts have relied upon aspects of the proposed regulation.[6]

Further, several courts have found that the "good faith" requirement means that the fiduciary who authorized the transaction, usually the trustee, must have followed a prudent investigation as to the merits of the transaction before authorizing the deal, or the prohibited transaction exemption does not apply. In other words, even if the trustee gets the purchase price right but does not conduct a prudent investigation, some courts have found the exemption does not apply, and the transaction is a nonexempt prohibited transaction potentially subject to an excise tax of 100 percent of the amount involved.[7] Thus, the process the trustee follows in evaluating and negotiating the transaction, and the documentation of that process, is a hugely important issue in terms of avoiding or winning ESOP litigation.

In litigating whether the trustee followed a prudent process, the DOL often argues that a prudent process necessitates certain requirements that are nowhere found in the statute, the proposed regulations, the case law, or any other guidance from the DOL. As a result, this type of litigation can feel very much like the DOL regulating retroactively through litigation positions rather than simply setting forth the requirements in actual regulations as the statue authorizes. These arguments also engender a number of important procedural questions that remain open in several jurisdictions. Examples of these issues include the following:

- Whether discretionary review applies in fiduciary litigation generally and/or in ESOP litigation specifically;

- The effect, if any, of congressional intent to promote ESOPs;

- Whether allegations that an initial acquisition of employer stock was overpriced is sufficient, standing alone, to demonstrate the requisite harm to the plan;

- Whether liability can be established by showing a single flaw in the process that affected the valuation, even if the overall process was prudent;

- Whether the independent stock valuation must tax effect pass-through entities (such as S corporations and partnerships), and, if so, at what rate;

- Whether the legally mandated "put option" can be taken into consideration for purposes of the initial stock valuation; and

- Whether proffered expert valuation or fiduciary process testimony is sufficiently grounded in facts, data, and reliable principles and methods to be admissible.

Each of these issues is explored in more detail below.

STANDARD OF REVIEW

Several circuits have applied the arbitrary and capricious standard of review in cases alleging fiduciary breach—both generally and in the ESOP context specifically.[8] Only the Fifth and Ninth Circuits have taken a different view.[9] As the Seventh Circuit has recognized: "In general, judicial review of the decisions of an ERISA trustee as of other trustees is deferential unless there is a conflict of interest …."[10] The Seventh Circuit approach, however, does not apply deferential review to all fiduciary decisions, but rather, only "a decision that involves a balancing of competing interests under conditions of uncertainty" is reviewed for abuse of discretion.[11]

Even if a deferential standard of review is not applied, the substantive rules for evaluating whether fiduciaries acted prudently may yield a very similar result. ERISA's duty of prudence requires a fiduciary to discharge his or her duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."[12] The test for determining whether a fiduciary has satisfied this duty of prudence is whether the fiduciary, at the time he or she engaged in the challenged transactions, employed the appropriate methods to investigate the merits of the investment and to structure the investment.[13]

The court must focus on whether the fiduciary engaged in a reasonable decision-making *process*, consistent with that of a prudent person acting in a like capacity.[14] A fiduciary's investments are prudent if he or she "[h]as given appropriate consideration to those facts and circumstances that ... are relevant to the particular investment ... involved ... and [h]as acted accordingly."[15] "[C]ourts have readily determined that fiduciaries who act reasonably—*i.e.*, who appropriately investigate the merits of an investment decision prior to acting—easily clear this bar."[16] Thus, even without a discretionary standard of review, the underlying standard of conduct provides substantial latitude within a zone of reasonableness.

This is a critically important issue because, absent discretion, the door is open to the imposition of liability for any material mistake by a fiduciary and the second-guessing of discretionary decisions by federal courts. Refusing to defer to reasonable decisions that appear "wrong" with the benefit of hindsight, and imposing liability anytime a court disagrees with such a decision, in effect makes fiduciaries strictly liable for any mistake, even when it cannot be said that such mistakes rise to the level of a lack of good faith, as the operative statute requires.[17] This appears contrary to congressional intent.

BALANCING CONGRESSIONAL INTENT

Congress has adopted several tax provisions that specifically encourage employee stock ownership through ERISA plans.[18] In passing the Tax Reform Act of 1976, Congress explicitly stated its concern that courts should refrain from erecting barriers that would interfere with the goal of promoting employee stock ownership through ERISA plans:

> The Congress is deeply concerned that the objectives sought by [the laws encouraging ESOPs] will be made unattainable by regulations and rulings which treat employee stock ownership plans as conventional retirement plans, which reduce the freedom of the employee trusts and employers to take the necessary steps to implement the plans, and which otherwise block the establishment and success of these plans.[19]

Accordingly, the Supreme Court has recognized that "Congress sought to encourage the creation of ESOPs."[20] In *Dudenhoeffer*, the Supreme Court also recognized that ERISA represents a "careful balancing" between enforcing rights under a plan and the creation of such plans.[21] In "interpret[ing] ERISA's fiduciary duties," courts may have to take account of competing congressional purposes, including

a "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering" benefit plans.[22] It is not clear how this balancing will play out in particular cases, but it is definitely another argument in favor of deferring to arguably wrong but reasonable decisions by plan fiduciaries.

PROOF OF LOSS TO PLAN

ERISA Section 409(a) provides that a breaching fiduciary "shall be personally liable to make good to such plan any losses to the plan resulting from each such breach …."[23] Thus, it is generally recognized that in order to recover damages for a fiduciary breach, the plaintiff must prove that the alleged breach caused a loss to the plan. In contrast, proof of damages is not necessary to establish a prohibited transaction.

The way this issue comes up in ESOP litigation is generally that the plaintiff is arguing that the initial acquisition of employer stock by the plan was overpriced, and thus the plan suffered a "loss" in the sense that it paid an inflated price to acquire the stock, even if the plan has not actually realized a loss in a subsequent sale or valuation, and even if no participant has realized a loss when cashing out of the plan. This theory, however, is inconsistent with the approach the Supreme Court has taken in the securities fraud context, and some circuits have adopted the same rule in ESOP litigation.[24]

For example, as the Sixth Circuit stated in an ESOP case:

> In *Dura Pharmaceuticals, Inc. v. Broudo*, 544 U.S. 336, 125 S.Ct. 1627, 161 L.Ed.2d 577 (2005), the Court held that "an inflated purchase price will not itself constitute … economic loss." *Id.* at 342, 125 S.Ct. 1627. Rather, stock must be purchased at an inflated price and sold at a loss for an economic injury to occur. *Id.* This reasoning was described by the Court as "pure logic," and while *Dura* was decided in the securities-fraud context, its common-sense analysis is equally applicable here.[25]

In fact, in *Taylor* the court held that that the plaintiff lacked Article III standing because she had sold *most* of her overvalued stock at a profit.[26] The *Taylor* court netted the sales in which losses were realized against sales that resulted in a realized gain.[27]

Such cases give rise to the argument in ESOP cases that the plan has not suffered a loss if the value of the stock increases after the initial stock purchase. For example, a plan may pay a certain price to initially acquire employer stock, then see the value of the stock decrease in the next, or next few, annual valuations (perhaps due to additional

debt the employer took on to establish the plan), but then subsequent valuations show an increase in value over the original purchase price. In these scenarios, questions arise as to whether the plan itself was harmed by the allegedly inflated initial valuation and, if so, how that harm is calculated. If the initial overvaluation is not sufficient under a *Dura* analysis, are the damages limited to whatever amounts were paid out to participants before the price rebounded? If we are measuring damages by harm to some individual participants, can it be said that the plan itself was harmed at all?

Plaintiffs will argue that the prudence determination must be made based on the information known at the time of the decision. With respect to damages, this argument, however, is difficult to square with the *Dura* rule. Furthermore, positive future performance will be relevant to the reasonableness of growth assumptions in the valuation.[28]

OVERALL PRUDENCE

The early cases in this area are very much an example of the maxim that bad facts make bad law. A good case in point is the Sixth Circuit's opinion in *Chao v. Hall Holdings*.[29] In *Hall Holding*, the trustees were not independent, but rather were employees of the sponsor. Further, although they were the trustees of the ESOP, "they had very little to do with the major decisions that concerned it."[30] Neither trustee had substantial input on the price that was to be paid by the ESOP.[31] One testified that he never consulted with legal counsel regarding the ESOP. The other testified that he never consulted with the valuation professional hired and did not know what documents the valuator was provided.[32] The valuator was not told that the purpose of the valuation was for an ESOP, and he simply provided a valuation based on control of the entire company.[33] Indeed, the district court noted that the defendants had stated that the ESOP trustees did not have "any discretion whatsoever about how to invest the loan proceeds at the establishment of the ESOP," but rather simply carried out "a pre-determined step in an integrated sponsor-directed program."[34] The Sixth Circuit concluded that the important decisions "were simply made with no input from the people that had a fiduciary duty to be involved in the decisions."[35]

Hall Holding and cases like it, however, have been distinguished by the Seventh Circuit on the basis that they involved egregious facts that showed an overall imprudent fiduciary process.[36] In *Keach*, plaintiffs argued primarily that the ESOP valuation was too high because it did not consider the risks associated with possible state regulation of the company's sweepstakes promotions. The court was troubled

by the lack of focus on this issue but found it did not negate the reasonableness of the overall analysis.[37] The court distinguished other circuit court opinions on the basis that those facts demonstrated a process that was imprudent taken as a whole.[38] This illustrates a central dispute in many ESOP cases, which often come down to whether a mistake, or more than one, by the trustee or valuator is sufficient to render the overall investigation imprudent, and what standards should be applied to make that determination.

TAX EFFECTING PASS-THROUGH ENTITIES

There is a debate in the valuation community about whether to deduct estimated tax liability from the valuation of a pass-through entity that is not itself subject to tax. At least one circuit has affirmed the IRS's position that a zero-percent rate is appropriate in this situation as the entity being valued does not have tax liability. Other courts have found that pass-through entities do have tax advantages (avoiding taxation at both the entity and personal levels), but that a zero-percent rate overstates this advantage.

The Sixth Circuit has affirmed a tax court ruling that a zero-percent rate was appropriate to tax effect an S corporation because such a corporation pays no taxes at the corporate level.[39] This result is consistent with a 2014 Job Aid for IRS valuation analysts titled "Valuation of Non-Controlling Interests in Business Entities Electing to Be Treated as S Corporations for Federal Tax Purposes". That documents states: "… no entity level tax should be applied in determining the cash flows of an electing S Corporation. In the same vein, the personal income taxes paid by the holder of an interest in an electing S Corporation are not relevant in determining the fair market value of that interest." Using a zero-percent rate is also consistent with the fact that the contemplated buyer, the ESOP, is a completely tax-exempt entity.

Two state cases have concluded that a zero-percent tax effect overstated the value of a S corporation, but using the same rate that would apply to a C corporation understated such value.[40] In *Kessler*, the court recognized that a number of cases, including *Gross*, had recognized the "advantages of S corporation status by refusing to tax affect the corporation's earnings at all."[41] The court also found, however, that the primary advantage of an S corporation is the avoidance of a tax at both the entity and personal levels.[42] The court then did a calculation of the tax effect of a $100 distribution from an S corporation and a C corporation, and showed the total tax paid would be higher for a C corporation. The court found this difference equated to an effective tax rate of 29.4% for an S corporation, based on the old 35% C corporation tax rate.[43]

No cases have been found in which the court simply approved the use of the C corporation rate for an S corporation, or, worse, just applied the selling owner's assumed 4-percent personal rate to the S corporation's value.[44] The DOL has taken the position in litigation that a 4-percent rate is customary and thus should be used in this context. The DOL, however, has not publicized this position in regulations or any other guidance. It is also not clear that expert testimony on this issue would be sufficient in light of the debate within the valuation community and the absence of specific principles and methods or other criteria for determining this issue.

CAN THE PUT OPTION BE CONSIDERED?

Federal law requires that participants in ESOPs have a right to "put" the stock back to the sponsor at the value established by a required annual valuation at certain points, such as when they leave employment or retire.[45] For that reason, it is nearly universally accepted valuation practice to consider this legally required put option in assessing the appropriate discount for lack of marketability in the private ESOP context. Obviously, lack of marketability is less of a concern if the owner has a legally required put option to sell back the shares.

The DOL has argued that the put option cannot be considered because the valuation standard requires that the valuation be based on a hypothetical willing buyer, not a specific ESOP buyer. The DOL has also taken the position that the put option should not be considered for purposes of the valuation for an initial acquisition of stock, although it can be for purposes of subsequent valuations, because the put option does not "exist" until the plan is established. These positions are inconsistent that the valuation standard is the same in pre- and post-ESOP formation, so there is no logical basis why that same standard would dictate two diametrically opposed outcomes. It is also not clear why a put option that will exist on the day the plan is formed should not be considered for purposes of a valuation "as of" the same date. Finally, the purpose of a marketability discount is to make an adjustment to reflect the actual (not hypothetical) ability of the purchaser to sell the acquired stock. Ignoring the put option would just be making the unwarranted assumption that the stock would be less marketable than everyone knows it actually will be.

The closest the DOL can come to identifying significant legal authority to support this argument is the Seventh Circuit's opinion in *Eyler v. C.I.R.*[46] In *Eyler*, the Seventh Circuit addressed a situation in which no fiduciary had made a good-faith determination regarding the fair market value of the stock at issue, and the defendant was arguing that the IRS had clearly erred in applying *any* marketability discount

at all. The Seventh Circuit found the fact that "the put option had no fixed price" supported its conclusion that the Tax Court did not clearly err in determining that the marketability discount should not apply.[47] *Eyler*, however, does not contain a substantive analysis of the issue, but rather just stands for the proposition that the IRS did not clearly err in applying a marketability discount.

Similarly unavailing is the DOL's argument that its proposed regulations support its position. The proposed regulation provides: "the existence of the 'put' option should be considered for valuation purposes only to the extent it is enforceable and the employer had and may reasonably be expected to continue to have, adequate resources to meet its obligation."[48] Note that the proposed, but never finalized, regulation does not say that the put option can *never* be considered; rather, it says only that the for the put to be considered, the employer has to be reasonably expected to have the ability to meet its obligations.[49]

DAUBERT MOTIONS IN ESOP LITIGATION

There are major advantages from a defense perspective in challenging the admissibility of plaintiff's expert testimony under the *Daubert* standard. It can often be challenging for plaintiffs to establish that their expert's opinions are sufficiently grounded in sufficient facts or data and based on reliable principles and methods. Further, once the challenge is made, the burden is on the proponent of the evidence to show that it is admissible.[50]

Federal Rule of Evidence 702 provides that a witness who is qualified as an expert by "knowledge, skill, experience, training, or education" may testify in the form of an opinion or otherwise if:

1. The expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;

2. The testimony is based on sufficient facts or data;

3. The testimony is the product of reliable principles and methods; and

4. The expert has reliably applied the principles and methods to the facts of the case.[51]

As interpreted in *Daubert*, Rule 702 grants district courts discretion in determining whether a proposed expert's testimony is admissible based on whether it is both relevant and reliable. The Supreme Court

has identified several nonexclusive factors that lower courts may consider in assessing reliability:

1. Whether a theory or technique can be (and has been) tested;

2. Whether the theory or technique has been subjected to peer review and publication;

3. Whether the technique has a high known or potential rate of error; and

4. Whether the technique enjoys general acceptance within the relevant scientific, technical, or other specialized community.[52]

Thus, parties in ESOP litigation need to carry their burden of proving that their expert's opinions are sufficiently well grounded to be reliable.

These requirements must be satisfied by the information in the required report. A party using a retained expert is required to furnish a report containing "a complete statement of all opinions to be expressed and the basis and reasons therefore" as well as "the facts or data considered by the witness in forming them …."[53] "Expert reports must include 'how' and 'why' the expert reached a particular result, not merely the expert's conclusory opinions."[54] A party shall not be permitted to use any information not so disclosed as evidence at trial.[55] Parties generally cannot supplement the opinions expressed in their expert reports, and the basis and reasons therefore, with subsequent deposition testimony.[56]

Thus, consideration should always be given in ESOP litigation as to whether the experts' reports are sufficiently well grounded in reliable principles and methods to be admissible. If the report itself contains only conclusory opinions on certain issues, those opinions will likely not be admissible, even if the expert can provide further support in his or her deposition, or support can be provided by argument of counsel. Issues like the tax rate for pass-through entities and consideration of the put option are ripe targets for such challenges. Similarly, testimony about what a prudent fiduciary process would have required in a particular case may be inadmissible if based only on the expert's general education and experience and not otherwise supported.

CONCLUSION

Much of the confusion in this area could be resolved if the DOL would adopt regulations governing the determination of "adequate

consideration" in the context of privately held securities. Prudence determinations will always involve context-intensive inquiries into the particular facts of unique situations, but some of the more global issues, such as whether the legally mandated put option should be considered and the appropriate tax rate to use for a pass-through entity, can and should be determined on an across-the-board basis. There is no reason to litigate these issues individually, and fairness requires letting trustees and valuation professionals know what the rules are up front. Adopting such regulations would also give employers considering ESOPs more confidence that the transaction can be structured in a legally compliant way that eliminates excessive ligation risk. This would further congressional intent to promote ESOPs while retaining robust enforcement tools to go after bad actors.

NOTES

1. *See* 29 U.S.C. § 1107(b)(2)(B)(3); 26 U.S.C. § 4975(e)(7); and 29 U.S.C. § 1108(e).

2. 29 U.S.C. §§ 1104(a)(1)(C) & (2).

3. *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2016).

4. *See, e.g., Henry v. Champlain Enters., Inc.*, 445 F.3d 610, 619 (2d Cir. 2006).

5. 29 U.S.C. § 1002(18)(B).

6. *See, e.g., Henry*, *supra* n.4 at 619.

7. *See, e.g., Donovan v. Cunningham*, 716 F.2d 1455 (5th Cir. 1983); *cf. Herman v. Mercantile Bank, N.A.*, 143 F.3d 419 (8th Cir. 1998) (even if trustee fails to make good faith determination, he or she is insulated from liability if a hypothetical prudent fiduciary would have made the same decision anyway).

8. *See, e.g.,Caterino v. Barry*, 8 F.3d 878, 883 (1st Cir. 1993); *Edwards v. Wilkes–Barre Publishing Co. Pension Trust*, 757 F.2d 52, 56–57 (3d Cir. 1985); *Foltz v. U.S. News & World Report, Inc.*, 865 F.2d 364, 374 (D.C.Cir. 1989); *Ganton Technologies, Inc. v. National Industrial Group Pension Plan*, 76 F.3d 462, 466–467 (2d Cir. 1996); *Hunter v. Caliber System, Inc.*, 220 F.3d 702, 710-711 (6th Cir. 2000) ("we find no barrier to application of the arbitrary and capricious standard in a case such as this not involving a typical review of benefits.").

9. *Donavan v. Cunningham*, 716 F.2d 1455, 1473–1474 (5th Cir. 1983); *Howard v. Shay*, 100 F.3d 1484, 1488-89 (9th Cir. 1996).

10. *Armstrong v. LaSalle Bank Nat. Assoc.*, 446 F.3d 728, 732 (7th Cir. 2006) (citing *Firestone Tire & rubber Co. v. Bruch*, 489 U.S. 101, 111–115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989)).

11. *Armstrong*, *supra* n.10 at 733.

12. 29 U.S.C. § 1104(a)(1)(B).

13. *Pfeil v. State Street Bank and Trust Co.*, 806 F.3d 377, 384 (6th Cir. 2015).

14. *Pfeil*, *supra* n.13 at 384.

15. 29 C.F.R. § 2550.404a–1(b)(1).

16. *Tatum v. RJF Pension Inv. Comm.*, 761 F.3d 346, 356 (4th Cir. 2014); *see also Pfeil*, *supra* n.at 385.

17. 29 U.S.C. § 1002(18)(B).

18. *See*, *e.g.,* IRC § 404(a)(9) (special tax deductions for plan sponsors), IRC § 404(k) (special tax deductions for plan sponsors), IRC § 1042 (income tax deferral for sellers of stock to ESOPs), and IRC § 415(c)(6) (favorable treatment for certain annual additions to participants' accounts).

19. Tax Reform Act of 1976, Pub.L. No. 94-455, § 803(h), 90 St at. 1590 (1976).

20. *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 424 (2014).

21. *Id.* (citing *Conkright v. Frommert*, 559 U.S. 506, 517 (2010)).

22. *Id.* at 425 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)).

23. 29 U.S.C. 1109(a).

24. *See, e.g., Brown v. Medtronic, Inc.*, 628 F.3d 451, 456 (8th Cir. 2010) ("The Court in Dura did not face a question of ERISA fiduciary duties. Regardless, the Court pronounced a rule that it described as 'pure logic.' Presumably any such rule founded on basic concepts of loss and injury and characterized as 'pure logic' should find broad application in ERISA, securities law, and other contexts where plaintiffs describe their injuries in terms of stock price changes.") (internal citations omitted); *see also Martone v. Robb*, 902 F.3d 519, 524 (5th Cir. 2018).

25. *Taylor v. KeyCorp.*, 680 F.3d 609, 613 (6th Cir. 2012).

26. *Id.*

27. *Id.* at 615.

28. *See, e.g., In re PWS Holding Corp.*, 228 F.3d 224, 234 (3rd Cir. 2000) ("[a]ctual performance … following [a] transaction is evidence of whether the parties' projections were reasonable."); *VFB LLC v. Campbell Soup Co.*, 482 F.3d 624 (3rd Cir. 2007) ("A company's actual subsequent performance is something to consider when determining ex post the reasonableness of a valuation …").

29. *Chao v. Hall Holdings*, 285 F.3d 415 (6th Cir. 2002).

30. *Hall Holding*, *supra* n.29 at 433.

31. *Id.*

32. *Id.*

33. *Id.* at 430.

34. *Reich v. Hall Holding Co. Inc.*, 990 F.Supp. 955 (N.D.Ohio 1998) (quoting defendants' summary judgment memorandum).

35. *Hall Holding*, *supra* n.29 at 434.

36. *See Keach v. U.S. Trust Co.*, 419 F.3d 626, 638 (7th Cir. 2005).

37. *Keach*, *supra* n.36 at 637.

38. *Id.* at 637–639.

39. *Gross v. Commissioner*, 272 F.3d 333, 353-54 (6th Cir. 2001).

40. *Delaware Open MRI Radiology Assoc. v. Kessler*, 898 A.2d 290 (Del.Ct. Ch. 2006); *Bernier v. Bernier*, 449 Mass. 774, 873 N.E.2d 216 (2007).

41. *Kessler*, *supra* n.40 at 328.

42. *Id.*

43. *Id.* at 330; *see also Bernier*, *supra* n.40 at 790–791 (adopting *Kessler* approach).

44. *See Bernier*, *supra* n.40 at 787 (no cases cited, or found, "that apply the presumed thirty-five per cent rate of taxation of a C corporation to estimate the fair market value of an S corporation using the income approach.").

45. 26 U.S.C. § 409(h).

46. *Eyler v. C.I.R.*, 88 F.3d 445, 453 (7th Cir. 1996).

47. *Id.*

48. Proposed Regulation Relating to the Definition of Adequate Consideration, 53 *Fed.Reg.* 17,632, 17,633 (May 17, 1988).

49. *Id.*

50. *See, e.g., Nelson v. Tennessee Gas Pipeline Co.*, 243 F.3d 244, 251 (6th Cir. 2001) (the proponent of an expert bears the burden of demonstrating that the expert's testimony satisfies *Daubert*).

51. Fed.R.Evid. 702; *see Daubert v. Merrell Dow Pharms. Inc.*, 509 U.S. 579, 588 (1993).

52. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 593–594, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147–150, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999); *see also General Electric Co. v. Joiner*, 522 U.S. 136, 146, 118 S.Ct. 512, 139 L.Ed.2d 508 (1997) (district court not required to admit expert testimony "that is connected to existing data only by the *ipse dixit* of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.").

53. Fed.R.Civ.P. 26(a)(2)(B).

54. *R.C. Olmstead, Inc., v. CU Interface, LLC*, 606 F.3d 262, 271 (6th Cir. 2010).

55. Fed.R.Civ.P. 37(c)(1).

56. *See e.g., United States ex rel. Tennessee Valley Authority v. 1.72 Acres of Land in Tennessee*, 821 F.3d 742, 751 (6th Cir. 2016) (excluding incomplete expert report).

Regulation Best Interest: You May Be More Prepared Than You Thought

Kristina M. Zanotti

From the time it was finalized on April 6, 2016,[1] until the Fifth Circuit's decision to vacate it on March 15, 2018,[2] many brokers, investment advisers, and other financial institutions took significant steps to prepare for full compliance with the Department of Labor's (DOL) Fiduciary Rule[3] and the related Best Interest Contract (BIC) Exemption.[4] If fully implemented, the DOL Fiduciary Rule could have significantly changed how investment advice was provided to retirement plan clients, but, before its transition period was over, the Fifth Circuit stepped in and vacated the rule. Those entities implementing changes to prepare for full compliance were now faced with decisions: did everything done get unwound? Were all their preparation wasted? And complicating factors even further, what action would the Securities and Exchange Commission (SEC) take?

On June 5, 2019, the SEC adopted Regulation BI (the BI stands for Best Interest)[5] along with a new disclosure form, Form CRS (for Customer Relationship Summary).[6] In addition, the SEC issued two new interpretations under the Investment Advisers Act of 1940, one regarding the fiduciary standard of conduct for investment advisers[7] and the other regarding the "solely incidental" prong of the broker-dealer exclusion from the definition of investment adviser.[8] This article focuses on Regulation BI.

Broker-dealers and natural persons who are associated persons of a broker or a dealer (such as registered representatives) (collectively, "broker-dealers," unless otherwise indicated) must comply with Regulation BI by June 30, 2020.

When considering the new requirements under Regulation BI, broker-dealers may be pleased to learn that not all of their work preparing to implement the now defunct DOL Fiduciary Rule has gone to waste. While not the same, Regulation BI has some of the same principles, and some of the same preparation done to prepare for the DOL Fiduciary Rule translates well into compliance with Regulation

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BI. Although the DOL Fiduciary Rule technically only applied to retirement plans, many market participants intended to implement compliance more broadly, as it would be difficult to maintain different structures for retirement customers versus taxable accounts. Regulation BI applies to all accounts for retail customers, whether retirement or otherwise.

A "retail customer" means a natural person, or the legal representative of a natural person,[9] who receives a recommendation regarding a securities transaction or investment strategy from a broker-dealer and who uses the recommendation primarily for personal, family, or household purposes. Unlike Financial Industry Regulatory Authority (FINRA) rules, which define a natural person with total assets of at least $50 million as having an "institutional" account,"[10] Regulation BI does not have a wealth-based exclusion from the definition of retail customer. Regardless of the total amount of assets, a natural person using a securities recommendation primarily for personal, family, or household purposes would be considered to have a "retail" account. Individual retirement accounts (IRAs), 401(k)s, and other participant-directed retirement plans are considered accounts for retail customers, as saving for retirement is a "personal, family or household" purpose.[11]

Regulation BI requires broker-dealers to act in the best interest of retail customers when making a recommendation of any securities transaction or investment strategy involving securities (including account recommendations such as recommendations to roll over assets). This includes making such recommendation without placing the financial or other interest of the broker-dealer making the recommendation ahead of the interest of the retail customer. If the broker-dealer complies with four obligations in connection with making the recommendation, Regulation BI considers the best interest obligation satisfied.

1. **Disclosure obligation.** The broker-dealer must provide the retail customer full and fair disclosure, in writing, of all material facts relating to the scope and terms of the relationship with the retail customer, including the broker-dealer's role in providing the recommendation and scope of services, applicable fees and costs, and conflicts of interest. The SEC also indicated that the use of the terms "adviser" or "advisor" by a broker-dealer that is not also a registered investment adviser or a supervised person of a registered investment adviser would violate Regulation BI's disclosure obligation.

2. **Care obligation.** The broker-dealer must exercise reasonable diligence, care, and skill to understand the potential risks,

rewards, and costs associated with the recommendation. Not only must the broker-dealer have a reasonable basis to believe that the recommendation could be in the best interest of at least some retail customers but the broker-dealer must also have a reasonable basis to believe that the recommendation is in the best interest of the particular retail customer, based on the customer's investment profile and the potential risks, rewards, and costs associated with the recommendation. If the recommendation relates to a series of transactions, the broker-dealer must have a reasonable basis to believe that such series is not excessive and is in the retail customer's best interest when taken together. In each case, the broker-dealer cannot place its own financial or other interest ahead of the interest of the retail customer.

3. **Conflict of interest obligation.** The broker-dealer must establish, maintain, and enforce written policies and procedures reasonably designed to identify and disclose, or eliminate, all conflicts of interest associated with its recommendations. This includes:

    - Identifying and mitigating any conflicts that create an incentive for a person associated with a broker-dealer, such as a registered representative, to place the broker-dealer's interest ahead of the interest of the retail customer.

    - Identifying and disclosing any material limitations placed on the recommendations that may be made to the retail customer—such as if recommendations are limited to only proprietary products—and any associated conflicts those limitations may have. The broker-dealer must prevent such limitations and associated conflicts from causing the broker-dealer from placing its own interest ahead of the interest of the retail customer.

    - Identifying and eliminating any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific securities or specific types of securities within a limited period of time.

4. **Compliance obligation.** In addition to the written policies and procedures specifically designed to address conflicts of interest, the broker-dealer must establish, maintain, and enforce written policies and procedures reasonably designed to comply with Regulation BI as a whole.

A number of common steps that financial institutions, including broker-dealers, were taking to prepare for the DOL Fiduciary Rule translate well into compliance with the obligations imposed by Regulation BI, including the following:

1. **Best interest verification.** To comply with the DOL Fiduciary Rule, many financial institutions prepared "best interest checklists" or other tools to evaluate an investor's profile and verify that a recommendation was in the best interest of the customer. Don't throw out those checklists! These or similar tools may be useful in complying with Regulation BI's care obligation and documenting such compliance.

2. **Written policies and procedures.** In preparation for compliance with the DOL Fiduciary Rule and related BIC Exemption, financial institutions were expected to adopt policies and procedures reasonably designed to mitigate conflicts of interest. These policies and procedures can be adapted and expanded to cover the policies and procedures required by Regulation BI.

3. **Conflicts of interest.** The DOL Fiduciary Rule focused financial institutions on identifying, disclosing, and mitigating or eliminating conflicts of interest, and that same focus continues as an important component of Regulation BI.

4. **Compensation.** Preparing for compliance with the DOL Fiduciary Rule and BIC Exemption caused many financial institutions to examine their compensation structures, particularly the same types of high-pressure sales contests that would need to be eliminated under Regulation BI. In addition, while Regulation BI does not require broker-dealers to change their traditional compensation structures, allowing them to continue to receive commissions or transaction-based compensation (the types of compensation that would have required exemptive relief if broker-dealers were fiduciaries under ERISA under the defunct DOL Fiduciary Rule), Regulation BI continues the broader focus on fee transparency, requiring full disclosure of costs and fees.

5. **New products.** The DOL Fiduciary Rule spurred the creation of new products and share classes, such as "clean" shares. The continuing focus on investment cost as an important, although not the only, factor means that products with greater fee transparency and lower cost are likely to survive and may become even more prominent as broker-dealers make recommendations designed to comply with Regulation BI.

Rulemaking in the standards of conduct/fiduciary area may not be finished. DOL still has the issue on its agenda with a potential release date for proposed rulemaking slated for December 2019. Upheaval at DOL, with Secretary of Labor Acosta's resignation and his replacement by Eugene Scalia leaves the timeline for any rebooted DOL fiduciary rulemaking uncertain. If DOL, however, does issue new rulemaking, it is likely to have considerable overlap with Regulation BI. Just as preparing to comply with the vacated DOL Fiduciary Rule has led to many financial institutions taking steps that remain applicable in preparing to comply with Regulation BI, steps taken to comply with Regulation BI are likely to be helpful in complying with any future DOL rulemaking.

NOTES

1. 81 *Fed. Reg.* 20946 (Apr. 8, 2016).

2. *Chamber of Commerce, et. al. v. Acosta,* No. 17-10238 (5th Cir. March 15, 2018), mandate issued June 21, 2018.

3. Definition of the Term "Fiduciary"; Conflict of Interest Rule—Retirement Investment Advice, 81 Fed. Reg. 20946 (Apr. 8, 2016).

4. Best Interest Contract Exemption, 81 *Fed. Reg.* 21002 (Apr. 8, 2016).

5. Regulation Best Interest: The Broker-Dealer Standard of Conduct, 84 *Fed. Reg.* 33318 (July 12, 2019).

6. Form CRS Relationship Summary; Amendments to Form ADV, 84 *Fed. Reg.* 33492 (July 12, 2019).

7. Commission Interpretation Regarding Standard of Conduct for Investment Advisers, 84 *Fed. Reg.* 33669 (July 12, 2019).

8. Commission Interpretation Regarding the Solely Incidental Prong of the Broker-Dealer Exclusion From the Definition of Investment Adviser, 84 *Fed. Reg.* 33681 (July 12, 2019).

9. The SEC indicated that it interprets "legal representative" to include only "nonprofessional" legal representatives, such as a nonprofessional trustee who represents the assets of a natural person. 84 *Fed. Reg.* at 33325.

10. FINRA Rule 4512(c)(3).

11. 84 *Fed. Reg.* at 33343.

A Refresher on Interest Rates and Pension Liability

Nicholas Carnaval

With the release of the latest corporate bond yield curve and a recent announcement by the Federal Reserve regarding a second rate cut since July,[1] now is a good time to review how interest rates affect traditional defined benefit (DB) pension plans.

BACKGROUND

DB plans are generally designed to provide income to employees once they retire for the remainder of their lives, and in many cases the remainder of their spouses' lives. Plan sponsors expect to make these payments to retirees and their spouses for upward of 50 years. In order to determine an actuarial liability (the value of future promised payments in today's dollars), the expected pension payments are discounted to today using prevailing interest rates. Pension liability and interest rates have an inverse relationship, meaning that lower interest rates result in larger liabilities and vice versa. Although certain types of DB plans are permitted to report liabilities using an interest rate based on the expected return of their supporting asset portfolios, corporate DB plan sponsors must discount expected cash flows using prevailing high-quality corporate bond rates. With the current sustained low interest rate environment and large pension liabilities booked by corporate sponsors of DB plans, it's no wonder these types of plans are getting a lot of attention. Add in market volatility, and you have an influx of sponsors searching for ways to de-risk their plans and unload pension liabilities.

DURATION

One useful measure for understanding how sensitive pension liability is to swings in interest rates is called duration. The higher a

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plan's duration (measured in years), the more sensitive it is to changes in interest rates. In general, for every decrease (or increase) of 100 basis points, pension liability will increase (or decrease) by about one percent per year of duration. For example, assume the Acme, Inc. Pension Plan is a traditional DB plan with a duration of 15 years. If interest rates fall 100 basis points, the Acme plan will experience an increase in pension liability of approximately 15 percent (1% × 15).[2] Various characteristics affect a plan's duration, including plan design, assumptions about participant behavior, and demographics of covered employees. Because DB plans are designed to pay promised benefits over a long period of time, they have relatively high durations and are sensitive to changes in interest rates.

ACCOUNTING PERSPECTIVE

Accounting standards require corporate DB plan sponsors to report pension liability at the end of each fiscal year based on high-quality corporate bond yields in effect at that time. A widely used method for determining pension liability under the accounting standard is to develop a single-equivalent interest rate (or discount rate) such that a plan's expected cash flow produces the same liability whether discounting using the single-equivalent rate or the Financial Times Stock Exchange (FTSE) Pension Discount Curve. The FTSE Pension Discount Curve, along with representative duration and discount rate measures known as the FTSE Pension Liability Index, is published monthly.

A recent publication contains some eyebrow-raising figures. The August 2019 FTSE Pension Liability Index shows the lowest discount rates since the Pension Discount Curve was created in 1994.[3] According to the Index, a plan with an intermediate duration (approximately 16.6 years) is expected to produce a discount rate of 2.90 percent. That represents a drop of 43 basis points from July and a whopping 124 basis points since December.

Following the Acme example from before, a 124 basis point drop in discount rate for a plan with a 15-year duration translates to almost a 19-percent increase in liability (1.24% × 15 = 18.6%). In other words, if the Acme, Inc. Pension Plan was valued at $100 million on December 31, 2018, it would be valued at about $118.6 million today, all else being equal.

If record-low interest rates hold through year end, many corporate DB plan sponsors may be forced to book significant liability losses during 2019. Today's gloomy outlook doesn't improve when the Federal Reserve announces a second rate cut and leaves open the possibility for yet another cut before year-end.[4] Luckily, liability is only half of

the equation. DB plan sponsors should see significant asset gains so far this year, which would help offset some of the expected liability losses.

FUNDING PERSPECTIVE

Pension liability is in the eye of the beholder. Although a sponsor's financial statements may state that the DB plan's accounting liability is $100 million, it doesn't mean the plan's liability at that same point in time is $100 million when determining minimum contribution requirements under Internal Revenue Service (IRS) regulations or insurance premiums for protection under the Pension Benefit Guaranty Corporation (PBGC). Although the relationship between interest rates and pension liability holds true, the method of developing interest rates and determining liability differs depending on the purpose.

Interest rates for minimum funding and PBGC insurance purposes are still based on high-quality corporate bonds; however, they are smoothed values taking into account historical rates. For determining PBGC premiums, interest rates are based on averaged rates for up to 24 months prior to the valuation date.[5] For minimum funding purposes, interest rates are generally based on a similar average but are smoothed even further by holding the 24-month average up to averaged rates over the last 25 years (including a period when long-term interest rates were nearly 9 percent!). Because of this averaging, plan sponsors are protected from sudden swings in interest rates like the 43 basis point drop experienced in the FTSE Curve from July to August.[6] As interest rates have continually declined over the past couple of decades, however, these averages have crept down as well. Plan sponsors have generally seen about a 20 basis point drop in funding interest rates (the rates held up to the 25-year average) each year over the past few years.

Going back to our trusty Acme example, this translates to an *annual* increase in funding liability of around 3 percent due solely to those much higher interest rates of 25 years ago falling out of the averaging period. To make matters worse, the corridor around which the 24-month average is held up to the 25-year average is set to widen starting in 2021, placing more weight on today's low rates and less on the rates of yesteryear. This translates to real dollars for plan sponsors in the form of larger PBGC insurance premiums, higher capital requirements, and professional fees related to onerous calculations and filings for underfunded plans.

WHAT ARE PLAN SPONSORS TO DO?

The current sustained low interest rate environment has taxed DB plan sponsors and soured DB plans for many corporate executives. Sponsors have looked for ways to mitigate exposure to pension risk. One popular de-risking method has been to offer former vested employees a one-time lump sum payment in lieu of a monthly income in retirement, thereby ridding the sponsor of any future obligations. The benefits of this strategy include decreasing the size of the plan and reducing PBGC premiums; but according to IRS rules, these lump sum offerings must be calculated using current interest rates. Like pension liability, a participant's one-time lump sum value has an inverse relationship with interest rates that makes offering these types of windows more and more expensive as interest rates continue to drop. Also, because many sponsors have already offered lump sum windows, repeated offerings may produce diminished returns.

Other plan sponsors have unloaded pension liability for their retired populations to insurance carriers. The benefits of this strategy are similar to those of lump sum windows; however, insurance carriers use conservative assumptions (like even-lower interest rates) and include profit margins in calculating costs.

An alternative to removing pension risk may be to manage it through investment strategies. Duration matching and liability-driven investing strategies aim to match a plan's particular cash flow expectations to unique equity and fixed-income portfolios. Theoretically, an asset portfolio can be developed such that it is immune to changes in interest rates. In other words, the funded status remains constant because when interest rates decline and pension liability rises, the plan's asset portfolio is expected to rise in lock-step.

Another risk management strategy is to fund a plan through borrowing. Plan sponsors may be able to take advantage of historically low interest rates by borrowing enough capital to fully fund their plans and avoid paying costly PBGC premiums. A sponsor may be able to realize returns through asset management that outweigh the current cost of capital.

CONCLUSION

Traditional DB pension plans can be costly to maintain and the current sustained low interest rate environment has not helped. Market volatility is just another risk plan sponsors must deal with. Useful measures like duration can help sponsors more easily understand how their plans are affected by changes in interest rates. Duration can also

be a useful tool in de-risking DB plans and protecting them from swings in rates.

Now that we have a good understanding of interest rates and their effect on pension liability, one question remains: what happens if rates go negative?

NOTES

1. Borak, D. (September 18, 2019). "The Fed cut rates for the second time this year." CNN Business. Retrieved Oct. 4, 2019, *https://www.cnn.com/2019/09/18/economy/federal-reserve-rate-jerome-powell/index.html*.

2. Investopedia. "Duration." *Retrieved* Oct. 4, 2019. *https://www.investopedia.com/terms/d/duration.asp*.

3. *https://www.soa.org/sections/retirement/ftse-pension-discount-curve/*.

4. Investopedia, *supra* n.1.

5. Plan sponsors have a choice between two methods of determining liability for PBGC premium purposes. The Standard Method is based on a one-month average for the month prior to the valuation date. The Alternative Method is based on a 24-month average of spot rates.

6. Plan sponsors can elect to use a full yield curve approach, which does not reflect any averaging. In such cases, plan sponsors are subject to swings in interest rates as the applicable yield curves are updated regularly.

Federal Courts Distinguish Between 'Complete' Preemption and 'Conflict' Preemption under ERISA

Lauren Bikoff

In general, Section 514(a) of the Employee Retirement Income Security Act (ERISA) preempts any state law that "relates to" an employee benefit plan. In lieu of allowing state law causes of action against ERISA plans, Section 502(a)(1)(B) authorizes a plan participant or beneficiary to bring an action under the federal law to recover benefits due under a plan. Thus, historically, the federal courts have interpreted those provisions of ERISA as precluding lawsuits in which plaintiffs assert claims under state law against employee benefit plans governed by ERISA. In a number of recent cases, however, federal courts have drawn a distinction between two types of ERISA preemption—"complete" preemption and "conflict" preemption (also termed "express" preemption). According to the courts that decided these cases, "complete" preemption arises when a state cause of action seeks the same relief available under ERISA Section 502(a)(1)(B). In contrast, "conflict" preemption, which arises under the general preemption provision of ERISA Section 514(a), merely states a federal defense to a state cause of action. This article looks at how various courts have ruled on these preemption provisions.

The Supreme Court first addressed the issue of ERISA preemption in 1981 in its decision in *Alessi v. Raybestos-Manhattan, Inc.*[1] In that case, the Court ruled that the reduction of pension benefits by workers' compensation benefits was not unlawful under ERISA and that a New Jersey law prohibiting such offsets was preempted by ERISA. The Court found that the New Jersey statute in question "related to" pension plans governed by ERISA "because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law."

The Court went no further in that case, stating, "We need not determine the outer bounds of ERISA's preemptive language to find this New Jersey provision an impermissible intrusion on the federal regulatory

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scheme." This case, however, started a pattern of the Supreme Court broadly interpreting the language in ERISA Section 514(a) stating, "relate to any employee benefit plan."

In 1983, the Supreme Court held, in *Shaw v. Delta Air Lines, Inc.*, that state regulation will withstand ERISA preemption only in areas not covered by or explicitly exempted from ERISA; if preemption would interfere with a federal interest, such as the enforcement of federal labor law; or if the state action is "too tenuous, remote, or peripheral."[2] (463 U.S. 85).

The concept of "conflict" preemption stems from the Supreme Court's 1990 ruling in *Ingersoll-Rand v. McClendon*,[3] in which the Court held that ERISA Section 514(a) preempted an employee's state law claims of wrongful discharge arising out of a dispute with his employer over pension benefits.

THE DEEMER CLAUSE

The U.S. Supreme Court addressed the deemer clause in its 1990 ruling in *FMC Corp. v. Holliday*.[4] In this case, the Court held that the deemer clause exempts self-funded ERISA plans from state laws that regulate insurance within the meaning of the savings clause.

Cynthia Ann Holliday was covered as a dependent under FMC's self-funded health care plan, which contained provisions reserving the right of subrogation. After Holliday was injured in an automobile accident, the plan paid the bulk of her medical bills.

In 1987, Holliday filed a lawsuit arising from the accident. FMC then notified her that it intended to exercise its right of subrogation with respect to any recovery from the suit. After Holliday recovered approximately $50,000 from the driver in the accident, FMC filed suit in the U.S. District Court for the Western District of Pennsylvania seeking to assert its right of subrogation. At trial, Holliday cited as her defense a Pennsylvania law that bars subrogation. FMC countered that the state law was preempted by ERISA.

The district court first determined that the state law "related to" the FMC plan, and the parties agreed that the law regulated the business of insurance. Thus, the issue was whether the deemer clause applied to the plan, and the district court ruled that the deemer clause did not operate to preempt the state statute. FMC appealed the district court's decision, and the Third Circuit U.S. Court of Appeals upheld the ruling.

In its analysis, the Third Circuit initially determined that the Pennsylvania law "related to" an employee benefit plan. The appellate court then, however, concluded that the savings clause applied

because the law regulated the insurance industry by barring subrogation rights of an insurer paying medical costs to a covered accident victim.

The Third Circuit then went on to conclude that the deemer clause did not apply. According to the court, Congress intended the deemer clause to prevent states from regulating ERISA plans under the guise of regulating the insurance industry. The court concluded that the Pennsylvania law was not enacted to avoid ERISA's preemption provisions. Consequently, the Third Circuit ruled that the state law was not preempted by ERISA and, therefore, that the FMC plan was barred from asserting a right of subrogation.

MC then took the case to the Supreme Court, which reversed the Third Circuit's ruling and reaffirmed its own decision in *Metropolitan Life Insurance Company v. Massachusetts,*[5] stating that Congress intended different regulatory treatment for employee benefit plans that are insured and those that are self-funded. According to the Court, employee benefit plans that are fully insured are covered both by ERISA and by the insurance laws and regulations of the different states, but plans that are self-funded are subject only to ERISA.

In its opinion, the Court stated, "Our interpretation of the deemer clause makes clear that if a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the state may not regulate it." The Court thus concluded that because FMC's plan was self-funded, the Pennsylvania law was preempted by ERISA and the plan therefore could exercise its right of subrogation.

THE *GILES* CASE

In a 1999 decision, the Fifth Circuit U.S. Court of Appeals held that a member of a health maintenance organization (HMO) whose son died while under the care of a participating provider may pursue claims of negligence and vicarious liability against the HMO in state court. The decision came in *Giles v. NYLCare Health Plans, Inc. and NYLCare Health Plans of the Gulf Coast, Inc.*[6]

Bridgett Giles was enrolled in NYLCare Health Plans of the Gulf Coast through an employee benefit plan provided by her employer. After her son Alex died while under the care of a participating provider, Giles filed suit in state court against NYLCare Health Plans, the two doctors who treated her son, and the medical group that employed one of the doctors. In the suit, Giles asserted state law claims of negligence, vicarious liability, breach of contract, misrepresentation, and breach of warranty. The underlying basis of Giles' complaint was that

one of the doctors failed to diagnose her son's heart defect, resulting in his death.

NYLCare removed the case to the U.S. District Court for the Southern District of Texas, asserting that Giles' claims were preempted by ERISA. Giles then amended her complaint to drop the breach of contract, misrepresentation, and breach of warranty claims, conceding that those claims were preempted by ERISA. Giles, however, also filed a motion seeking to have her negligence and vicarious liability claims returned to state court, and the district court granted that motion, noting that ERISA did not preempt those claims. NYLCare appealed that decision, but the Fifth Circuit affirmed the district court's ruling.

On appeal, NYLCare argued that the case was under federal jurisdiction because of ERISA and, hence, that the district court erred in returning Giles' remaining claims to state court. In rejecting that argument, the Fifth Circuit explained, "There are two types of preemption under ERISA. First, ERISA may occupy a particular field, resulting in complete preemption under section 502(a). Section 502, by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief, regardless of how artfully pleaded as a state action. Alternatively, ERISA might preempt a state law cause of action by way of conflict-preemption (also known as ordinary preemption) under section 514."

According to the appellate court, "The presence of conflict-preemption does not establish federal question jurisdiction. Rather than transmogrifying a state cause of action into a federal one—as occurs with complete preemption—conflict-preemption serves as a defense to a state action. Hence, when a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction. When a complaint contains only state causes of action that the defendant argues are merely conflict-preempted, the court must remand for want of subject matter jurisdiction. We now clarify that a district court has discretion to remand a case involving solely arguably conflict-preempted causes of action."

Alternatively, NYLCare argued that Giles was engaging in "forum manipulation." The Fifth Circuit, however, disagreed, stating, "She simultaneously moved to amend to delete her completely-preempted federal claims and moved for remand. Her obvious objective was to change the forum by getting back into state court. We do not see this as forum manipulation, but rather as a legitimate attempt to try her state law claims in the forum of her choice. She did not move to eliminate valid causes of action simply to defeat federal jurisdiction, but only deleted causes of action that ERISA completely preempted anyway."

SAME OUTCOME IN *BAUMAN*

In another 1999 decision, the Third Circuit U.S. Court of Appeals ruled that ERISA did not preempt parents' state law claims of negligence and vicarious liability against an HMO arising out of the death of their newborn daughter. The ruling came in *Bauman v. U.S. Healthcare, Inc*.[7]

Steven and Michelle Bauman were members of the Health Maintenance Organization of New Jersey, a subsidiary of U.S. Healthcare. On May 16, 1995, Bauman gave birth to Michelina at Kennedy Hospital in Washington Township, N.J. In accordance with the benefits precertification provided by the HMO, Bauman's pediatrician discharged Bauman and her daughter from the hospital after 24 hours.

On May 18, the day after Michelina was discharged, the Baumans noticed that she was ill. The Baumans made numerous telephone calls to the pediatrician, but she did not advise them to bring Michelina back to the hospital. The Baumans also contacted U.S. Healthcare and requested an in-home visit by a pediatric nurse, but the company refused to provide such a nurse. Michelina had contracted a strep infection that was undiagnosed and untreated. The infection developed into meningitis and she died that same day.

Subsequently, the Baumans filed a medical malpractice suit against U.S. Healthcare, the HMO, the hospital, and the pediatrician in New Jersey state court. The suit included four claims against U.S. Healthcare: (1) that the company was vicariously liable for the negligence of the hospital and the pediatrician; (2) that Michelina did not receive timely diagnosis and treatment of her infection; (3) that U.S. Healthcare negligently adopted policies that discouraged physicians from readmitting infants to the hospital when health problems arose after discharge; and (4) that medically appropriate care for Michelina required an in-home visit by a pediatric nurse.

U.S. Healthcare removed the case to the U.S. District Court for the District of New Jersey, contending that the Baumans' state law claims were preempted by ERISA. The district court dismissed the claim against the company regarding the in-home nurse visit, but returned the remaining claims to state court. U.S. Healthcare appealed, and the Third Circuit held that the Baumans could pursue all four of their claims against the company.

On appeal, U.S. Healthcare argued that the Baumans' claims were "completely" preempted by ERISA Section 502(a)(1)(B). In rejecting that argument, the Third Circuit explained, "As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant,

monitoring available funds, and keeping records. Claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted. In contrast, when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors, or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care."

In holding that the Baumans could pursue all four of their claims against U.S. Healthcare in state court, the Third Circuit noted that none of the claims was a claim to recover benefits due under the plan falling within the scope of ERISA Section 502(a). Rather, the Baumans' claims were for direct negligence, vicarious liability, and inadequacy of medical care.

Subsequently, U.S. Healthcare appealed the Third Circuit's ruling to the Supreme Court, but the Court declined to hear the case.

MISREPRESENTATIONS AS TO PENSIONS

ERISA did not preempt plaintiffs' state law claims of fraud arising out of misrepresentations made by their employer regarding an early retirement incentive package. This was the ruling of the Tenth Circuit U.S. Court of Appeals in *Felix et al. v. Lucent Technologies, Inc.*[8]

The plaintiffs in the case are a group of former employees of Lucent Technologies who worked at a manufacturing facility in Oklahoma City known as the Oklahoma City Works (OKCW). As a result of financial difficulties, Lucent decided to sell off its manufacturing facilities, including the OKCW. In an effort to make it more attractive to potential purchasers, Lucent decided to reduce the number of long-term senior employees at the OKCW.

On February 19, 2001, Lucent entered into an agreement with the International Brotherhood of Electrical Workers pursuant to which OKCW employees who were eligible for retirement would receive a payment equal to 110 percent of the amount of the termination allowance to which the employee would be entitled if the employee was laid off, subject to a maximum of 32 years of service, plus a "special pension benefit" in the amount of $11,000. In addition, for those OKCW employees who were not yet eligible for retirement, Lucent would add five years to such employees' age and service to make the employees eligible for retirement. Employees had until May 29, 2001, to accept the early retirement offer, and retirement would become effective on June 30 of that year.

Lucent distributed written materials to its employees regarding the early retirement incentive benefits, and the company held meetings

with employees at which the benefits were outlined. At each meeting, Lucent representatives stated that the early retirement offer was a one-time, final offer that was a take-it-or-leave-it proposal, and that any delay in accepting the offer would not result in any additional benefit. In reliance upon those statements, more than 1,000 eligible Lucent employees retired on June 30, 2001. Subsequently, Lucent entered into an agreement with Celestica, Inc., a Canadian telecommunications company, pursuant to which Celestica took over the operation of the OKCW and hired certain remaining Lucent employees on November 30, 2001. Contrary to its previous representations, on October 1, 2001, Lucent agreed to pay the remaining OKCW employees who were eligible for retirement the original early retirement benefits, plus an additional payment of a "special one-time pension benefit" in the amount of $15,000.

In a lawsuit filed in Oklahoma state court, the plaintiffs alleged that Lucent had committed fraud through misrepresentations to encourage the plaintiffs to take early retirement. In the suit, the plaintiffs sought the additional $15,000 benefit, the value of an additional year of service that was lost by accepting the June 30 retirement date, and punitive damages. Lucent removed the case to the U.S. District Court for the Western District of Oklahoma, which held that the plaintiffs' claims were preempted by ERISA. The plaintiffs appealed, and the Tenth Circuit reversed the district court's ruling.

In rendering its decision, the Tenth Circuit initially explained, "Important to understanding the propriety of removing the instant case is the distinction between 'conflict preemption' under section 514 of ERISA and 'complete preemption' under section 502(a) of ERISA. We have explained that ERISA preemption under section 514 is not sufficient for removal jurisdiction and that a state law claim is only 'completely preempted' if it can be recharacterized as a claim under section 502(a). The difference between preemption and complete preemption is important. When the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under section 514, the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption. It lacks power to do anything other than remand to the state court where the preemption issue can be addressed and resolved."

According to the Tenth Circuit, "A plaintiff must have standing to sue under section 502(a) before his or her state law claim can be recharacterized as arising under federal law subject to federal jurisdiction under the doctrine of complete preemption." Citing ERISA Section 502(a)(1), which authorizes a participant to bring an action "to recover benefits due under the terms of the plan," the court stated, "Here, plaintiffs do not seek 'to recover benefits due under the terms of the plan.' Neither plaintiffs nor defendants contend that plaintiffs

are entitled to the additional benefits under the plan. Rather, plaintiffs claim that they were fraudulently induced to take early retirement, to their financial detriment; they seek monetary damages from their employer (not from the pension plan) for that alleged fraud. That is not a claim 'to recover benefits due under the terms of the plan,' and therefore falls outside the scope of [ERISA Section 502(a)(1)]."

The Tenth Circuit went on to state, "Because no party disputes that plaintiffs are 'former employees,' we may only find they have standing to sue under ERISA if they have either a reasonable expectation of returning to covered employment or a colorable claim for vested benefits. Plaintiffs do not assert any statutory or contractual right to reinstatement, nor do they even request reinstatement. Thus, they do not have a reasonable expectation of returning to such employment. Nor have plaintiffs asserted a colorable claim to vested benefits, as they do not claim that they are entitled to benefits under the terms of their plan as it existed at the time of their retirement. Rather, they claim that they should receive damages for the loss of the additional benefits under the later package (*e.g.,* the $15,000 lump sum and the year of service) because they would have been participants under that package but for defendant's misrepresentations. The terms of the later October package explicitly excluded plaintiffs, and they do not argue that they have a colorable claim."

According to the Tenth Circuit, "In conclusion, we refuse to second-guess Congress' policy choices in ERISA, and we hold that plaintiffs are not 'participants' so as to bring their fraud claims within the reach of section 502(a)(1). We thus hold that the district court erred in finding complete preemption. Upon remand, the state court will be free to consider dismissal under section 514's conflict preemption provision, but that issue is not properly before us."

COURT FINDS PREEMPTION IN *DANCA*

Arriving at a different conclusion, the First Circuit U.S. Court of Appeals held in a 1999 decision that ERISA preempted a health plan participant's state law claims alleging that an insurance company and a utilization review firm made negligent medical decisions in the course of a precertification requirement. The First Circuit's decision came in *Danca v. Private Healthcare Systems, Inc., and Phoenix Home Life Mutual Insurance Co.*[9]

Pamela Danca was covered by a health insurance policy issued by Phoenix Home Life. Private Healthcare Systems (PHS) was the utilization review firm hired by Phoenix Home Life to perform precertification for a proposed course of medical treatment for plan beneficiaries. Under the terms of the policy, failure to obtain precertification could

result in reduced payment, or no payment at all, for the services for which precertification should have been sought.

Danca had a long history of mental illness and had received inpatient psychiatric care at McLean Hospital. On September 21, 1994, Danca sought treatment for a new episode of mental illness, and her physician recommended that she return to McLean. After consultation with the physician, Phoenix Home Life and PHS, however, denied precertification for treatment at McLean and instead precertified Danca's admission to Emerson Hospital.

According to Danca and her family, Emerson Hospital provided Danca with inadequate care, failing to provide treatment similar to that which had proven helpful at McLean for the earlier episodes of her mental illness. Danca subsequently required hospitalization at a third facility, where the care also was allegedly inadequate. As a result of the allegedly inadequate care that Danca received, she attempted suicide by self-immolation, causing severe burns and permanent disfiguring injuries.

Subsequently, Danca and her family filed suit against Phoenix Home Life, PHS, and a number of other defendants in Massachusetts Superior Court. The suit alleged, among other claims, that the defendants acted negligently by failing to ensure that medical decisions in the course of precertification were made and overseen by capable personnel in a competent manner and by failing to follow the recommendations of Danca's treating physician. The defendants removed the case to the U.S. District Court for the District of Massachusetts, asserting that the plaintiffs' claims were preempted by ERISA. The district court agreed and dismissed the plaintiffs' claims, and the First Circuit affirmed that ruling.

Initially, the First Circuit distinguished between complete preemption and conflict preemption. As explained by the First Circuit, complete preemption arises when a cause of action is filed under a state law that constitutes an "alternative enforcement mechanism" to ERISA Section 502(a). In contrast, conflict preemption, which arises under the general preemption provision of ERISA Section 514(a), merely states a federal defense to a state cause of action.

In holding that the plaintiffs' state law claims were completely preempted, the First Circuit explained, "Although we recognize that the allegedly negligent decision-making and consultation at issue here may be characterized as medical in nature, this fact alone does not remove the state causes of action from the scope of section 502(a). Nor does the fact that the allegedly negligent conduct was not in itself a final 'benefits' determination, but only a part of a precertification decision, control. What matters is that the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. As such, any state law-based attack on this conduct

would amount to an 'alternative enforcement mechanism' to ERISA's civil enforcement provisions contained in ERISA section 502(a)."

EIGHTH CIRCUIT AGREES IN *HULL*

Shortly after the First Circuit handed down its decision in *Danca*, the Eighth Circuit U.S. Court of Appeals ruled that ERISA preempted a participant's state law claims of malpractice and vicarious liability against a health care plan and the plan administrator for denying a particular type of stress test. The Eighth Circuit's ruling came in *Hull v. Fallon et al.*[10]

Jeffrey D. Hull was an employee of Prudential Insurance Company and a participant in a health insurance plan issued by Prudential Health Care Plan. In January 1996, Hull went to his primary care physician complaining of shortness of breath, chest pain, and arm pain. The physician was a member of the Prudential plan.

According to Hull, on two occasions, once in January and again in February, his primary care physician contacted Richard H. Fallon, a physician and the administrator of the Prudential plan, regarding his diagnosis and treatment plan for Hull. On those two occasions, Hull's physician requested authorization to administer a thallium stress test. Fallon, however, denied both requests and instead authorized a treadmill stress test.

Subsequently, Hull filed a medical malpractice action in state court against Fallon, the Prudential plan, and a number of other defendants, alleging that he suffered a myocardial infarction and developed additional heart disease as a result of Fallon's denial of the thallium stress test. In addition, Hull claimed that the Prudential plan was vicariously liable for Fallon's alleged negligence. The defendants removed the case to the U.S. District Court for the Eastern District of Missouri, which held that Hull's claims were preempted by ERISA. Hull appealed, but the Eighth Circuit affirmed the district court's ruling.

In rendering its decision, the Eighth Circuit explained the doctrine of "complete preemption." Quoting from the Supreme Court's opinion in *Metropolitan Life Insurance Company v. Taylor,*[11] the Eighth Circuit stated that the "complete preemption" doctrine "provides that to the extent that Congress has displaced a plaintiff's state law claim, a plaintiff's attempt to utilize the displaced state law is properly recharacterized as a complaint arising under federal law. Thus, federal question jurisdiction exists—and the case may be removed to federal court—if Hull's state law claims arise in an area that has been displaced by ERISA."

Turning to the facts of the case, the Eighth Circuit stated, "The district court found that the gravamen of Hull's claims is that he was

denied a thallium stress test. We agree. Hull contends that his claim does not arise from his relationship with the plan and the fact that it denied a requested benefit, but rather from a doctor-patient relationship between himself and Dr. Fallon, the plan administrator. Other than responding to two calls from Hull's treating physician, who called for authorization for the thallium test, Dr. Fallon had no relationship with Hull other than as the plan administrator."

The Eighth Circuit continued, "The district court found that Dr. Fallon denied the thallium test as part of a determination of benefits owed by the plan. We agree with the district court's reasoning and conclude that Hull's claims are preempted by ERISA. In short, although Hull's characterization of his claims sound in medical malpractice, the essence of his claim rests on the denial of benefits. As a plan participant, he could have brought an action under section 502(a). Because his claims relate to the administration of benefits, they fall squarely within the scope of section 502(a). Therefore, Hull's claims are completely preempted by ERISA."

Finally, the appellate court added, "Plan administrators necessarily exercise medical judgment in determining benefits due under the plan. To find that Hull's claims are not preempted would be to expose plan administrators to varying state causes of action for claims within the scope of section 502(a). This would pose an obstacle to the purposes and objectives of Congress."

Subsequently, Hull filed a petition for review of the Eighth Circuit's decision with the Supreme Court, but the Court denied the petition.

PREEMPTION FOUND IN *PRYZBOWSKI*

The Third Circuit revisited the issue in a 2001 decision and ruled that ERISA preempted a beneficiary's state law claims of negligence against an HMO and a physician practice group for delaying approval of necessary surgery for the beneficiary. The ruling came in *Pryzbowski v. U.S. Healthcare, Inc. et al.*[12]

Linda Pryzbowski was enrolled in the Health Maintenance Organization of New Jersey, a wholly owned subsidiary of U.S. Healthcare offered by her husband's employer. On November 10, 1993, Pryzbowski sought treatment from Medemerge, a physician practice group under contract with U.S. Healthcare to provide health care services, for severe back pains that she had been experiencing for several days. Pryzbowski previously had undergone numerous surgeries for her back, all of which were covered under her previous health care plan.

On November 29, 1993, Pryzbowski underwent a test that revealed that she had a herniated disc; the test also revealed a neurostimulator

that had previously been surgically implanted. Medemerge referred Pryzbowski to an orthopedic surgeon, who in turn referred her to a neurosurgeon. The neurosurgeon concluded that he should not be "fiddling" with the implanted neurostimulator and recommended that Pryzbowski return to the surgeon who had implanted it.

Based on those two reports, Medemerge sent a request to U.S. Healthcare on December 15, 1993, for a consultation with the neurosurgeon who had last performed surgery on Pryzbowski. Although that neurosurgeon was not a participating provider in U.S. Healthcare's plan, U.S. Healthcare approved the consultation. On January 19, 1994, the neurosurgeon concluded that Pryzbowski required surgery and follow-up care by several specialists, all of whom also were outside U.S. Healthcare's network. Over the next few months, Pryzbowski sought U.S. Healthcare's approval for the recommended surgery and the related services, and U.S. Healthcare eventually granted that approval. Pryzbowski underwent the surgery on July 7, 1994. Pryzbowski, however, continued to suffer from severe back pain after the surgery, and her neurosurgeon concluded that the persistent pain most likely was caused by the "significant delay" that occurred between the onset of Pryzbowski's symptoms and the surgery.

Subsequently, Pryzbowski filed suit against U.S. Healthcare, Medemerge, and three of its physicians in New Jersey state court. In the suit, Pryzbowski alleged that U.S. Healthcare "negligently and carelessly delayed in giving its approval for the necessary surgery," thereby causing her severe and permanent injury, emotional distress, and future expenses for medical care. The suit further alleged that Medemerge and the three physicians "negligently and carelessly delayed in authorizing and/or obtaining authorization from U.S. Healthcare" for the surgery. The defendants removed the case to the U.S. District Court for the District of New Jersey, which dismissed Pryzbowski's claims on the grounds that they were preempted by ERISA. Pryzbowski appealed, but the Third Circuit affirmed the district court's ruling.

In rendering its decision, the Third Circuit initially explained, "There are two separate but related preemption issues that arise under ERISA, both of which are presented in this case. The application of express preemption, set forth in section 514(a) of ERISA, arises in connection with Pryzbowski's claims against Medemerge and the physician defendants. Her claims against U.S. Healthcare raise the issue of complete preemption, a jurisdictional concept based on section 502(a) of ERISA."

With regard to Pryzbowski's claims against U.S. Healthcare, the Third Circuit noted that ERISA Section 502(a) allows a beneficiary of an ERISA-regulated plan to bring a civil action "to recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to future benefits under the terms of the

plan." The Third Circuit then cited several of its own prior decisions as well as decisions of the Supreme Court, and stated, "The ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of section 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action."

Turning to the facts of the case, the Third Circuit observed that underlying Pryzbowski's claims of negligent delay was "the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists. These activities fall within the realm of the administration of benefits. Had Pryzbowski sought to accelerate U.S. Healthcare's approval of the use of out-of-network providers, she could have sought an injunction under section 502(a) to enforce the benefits to which she was entitled under the plan, thereby using the provisions of the civil enforcement scheme provided by Congress." Thus, the court held that Pryzbowski's claims against U.S. Healthcare were completely preempted by ERISA Section 502(a).

Finally, with respect to Pryzbowski's claims against Medemerge and the three physicians, the Third Circuit again cited Supreme Court precedent, and explained, "The issue of express preemption arises in other contexts than challenges to state statutes. One of the most frequent is the reliance by HMOs and insurance companies on section 514(a) in defending suits brought by beneficiaries arising out of the denial of plan benefits." The court then added, "Thus, suits against HMOs and insurance companies for denial of benefits, even when the claim is couched in terms of common law negligence or breach of contract, have been held to be preempted by section 514(a). The rationale for these holdings is that the decision whether a requested benefit or service is covered by the ERISA plan falls within the scope of the administrative responsibilities of the HMO or insurance company, and therefore 'relates to' the employee benefit plan. The same rationale has been applied by courts holding that suits against HMOs for delay in authorizing benefits were preempted under section 514(a). In contrast, claims challenging the quality of care are not preempted by section 514(a)."

In its opinion, the Third Circuit concluded, "We note that, as a result of the enactment of ERISA and the substantial changes in the delivery of health care, new legal issues regarding rights and responsibilities have arisen. The law remains, to some extent, in a state of flux. It is for Congress and not the courts to decide whether it is sound policy for our health care system to limit or channel the relief available or whether ERISA should allow for broader remedies for beneficiaries in the world of managed care."

DISCLOSURE OF MEDICAL RECORDS

In a 2002 decision, the Fourth Circuit U.S. Court of Appeals held that ERISA did not preempt a plaintiff's state law claims against her employer and the administrator of a long-term disability (LTD) plan alleging that the defendants violated a state medical record confidentiality statute and certain other state laws. This decision came in *Darcangelo v. Verizon Communications, Inc. and CORE, Inc.* 292 F.3d 181 (4th Cir. 2002).[13]

In the case, Frances Darcangelo filed a lawsuit in Maryland state court against her employer—Verizon Communications—and the administrator of Verizon's LTD plan—CORE, Inc. In her suit, Darcangelo asserted that the defendants violated a Maryland medical record confidentiality statute, and also violated state laws prohibiting deceptive trade practices, invasion of privacy, negligence, and breach of contract. The defendants removed the case to the U.S. District Court for the District of Maryland, contending that Darcangelo's state law claims were preempted by ERISA. The district court agreed with that contention and dismissed Darcangelo's suit. Darcangelo appealed, and the Fourth Circuit reinstated all of her claims except the breach of contract claim.

The gist of Darcangelo's complaint was that CORE, acting as the agent of Verizon, solicited and disseminated her private medical information in order to assist Verizon in its efforts to declare Darcangelo a "direct threat" to her coworkers so that she could be fired. Under the Americans with Disabilities Act (ADA), an employer may terminate an employee and have an affirmative defense against an ADA discrimination claim if the employer can prove that the employee posed a "direct threat," that is, a significant risk to the health or safety of others that could not be eliminated by "reasonable accommodation."

In reinstating four of Darcangelo's five state law claims, the Fourth Circuit initially explained, "In considering the district court's jurisdiction over Darcangelo's complaint, we must distinguish between ordinary conflict preemption and complete preemption. Under ordinary conflict preemption, state laws that conflict with federal laws are preempted, and preemption is asserted as a federal defense to the plaintiff's suit. As a defense, it does not appear on the face of a well-pleaded complaint, and, therefore, does not authorize removal to federal court. Thus, when presented with claims under state law that are said to implicate ERISA, a court (be it state or federal) must determine whether the claims are preempted by ERISA section 514. But ERISA preemption of a state claim, without more, does not convert a state claim into an action arising under federal law."

"In the case of complete preemption, however, Congress so completely preempts a particular area that any civil complaint raising this select group of claims is necessarily federal in character. That is to

say, the doctrine of complete preemption converts an ordinary state common-law complaint into one stating a federal claim. Thus, when a complaint contains state law claims that fit within the scope of ERISA's section 502 civil enforcement provision, those claims are converted into federal claims, and the action can be removed to federal court."

With respect to Darcangelo's claims of negligence, invasion of privacy, violation of Maryland's medical record confidentiality statute, and violation of the state's deceptive trade practices law, the Fourth Circuit stated, "If CORE obtained Darcangelo's medical information in the course of processing a benefits claim or in the course of performing any of its administrative duties under the plan, these claims would be 'related to' the ERISA plan under section 514 and would therefore be preempted. If, on the other hand, CORE was not performing any of its duties as plan administrator, but obtained the information solely to assist Verizon in establishing that Darcangelo posed a threat to her coworkers, then Darcangelo's first four claims would not be related to the plan. Reading the complaint in the light most favorable to Darcangelo, we conclude that she alleges conduct by CORE that is not 'related to' its duties under the plan. Accordingly, Darcangelo's first four claims are not related to the plan and therefore are not preempted."

Turning to Darcangelo's claim of breach of contract, the Fourth Circuit explained, "Because the contract in question is an ERISA plan, this claim is clearly preempted. ERISA section 502 permits plan participants to bring an action to enforce the participant's rights under the terms of the plan. Accordingly, an action to enforce the terms of a contract, when that contract is an ERISA plan, is of necessity an alternative enforcement mechanism for ERISA section 502 and is therefore 'related to' an ERISA plan and preempted by section 514."

The Fourth Circuit went on to conclude, "To sum up, Darcangelo's complaint alleges non-fiduciary wrongful conduct on the part of CORE and Verizon that is unrelated to their duties under the ERISA plan. Thus, her four state claims for invasion of privacy, negligence, deceptive trade practices, and medical privacy violations are not preempted. We emphasize that this ruling is based on what was presented to us on appeal, namely, Darcangelo's complaint. We do not rule out the possibility that further factual development, perhaps in summary judgment proceedings, might establish that the four state law claims are preempted."

STATE LAW CLAIMS FOR LTD BENEFITS

ERISA preempted a plaintiff's state law claims seeking reinstatement of long-term disability benefits. This was the ruling of the Eighth Circuit in *Estes v. Federal Express Corporation, et al.*[14]

Jamie N. Estes was an employee of Federal Express Corporation who was receiving LTD benefits. Federal Express, however, discontinued Estes' LTD benefits after it determined that she was no longer "totally disabled" as defined by the plan. In response, Estes filed suit against Federal Express in Missouri state court, seeking reinstatement of her LTD benefits. Federal Express removed the case to the U.S. District Court for the Eastern District of Missouri, arguing that Estes' claims were preempted by ERISA. The district court agreed and dismissed Estes' suit and, on appeal, the Eighth Circuit affirmed that ruling.

In a succinct opinion, the Eighth Circuit explained, "Estes' state law claims are preempted if the claims 'relate to' an employee benefit plan, such that they (1) have a connection with or (2) reference to such a plan. We have also stated a claim relates to an ERISA plan when it premises a cause of action on the existence of an ERISA plan. The plan administrator determined Estes no longer qualified as 'totally disabled' under the ERISA plan and terminated her long term disability benefits. Estes then filed state law claims founded exclusively on her challenge to the defendants' termination of those long term disability benefits under the ERISA plan. Having reviewed the record, we are satisfied the district court correctly determined Estes' state law claims are preempted by ERISA."

Alternatively, Estes argued that the district court had erred by prematurely deciding the defendants' affirmative defense of preemption. The Eighth Circuit, however, likewise rejected that argument, concluding "In their notice of removal, the defendants raised the doctrine of complete preemption, contending all of Estes' state law claims 'fall within ERISA's civil enforcement scheme.' Estes was unmistakably placed on notice of the defendants' ERISA preemption contention. The doctrine of complete preemption establishes more than a defense to a state-law claim. The Supreme Court has explained 'the preemptive force of a statute is so extraordinary that it converts an ordinary state common-law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.' The district court did not act prematurely and did not err in addressing the ERISA preemption issue."

STATE LAW FRAUD CLAIMS

In another 2004 decision, the Fifth Circuit held that ERISA preempted a plaintiff's state law claims of fraud in connection with her former employer's refusal to pay her employee benefits. The case is *McGowin v. Man-Power International, Inc. and ExxonMobil Chemical Company*.[15]

Anita McGowin formerly performed services for ExxonMobil Chemical Company while on the payroll of a third-party employer, ManPower International. McGowin came to work for ManPower only after learning of a job opportunity at ExxonMobil that the company required to be filled by one of ManPower's employees, rather than by a direct employee of ExxonMobil. As a condition of obtaining employment with ManPower, McGowin signed a statement acknowledging that she was an employee only of ManPower. McGowin received weekly paychecks and insurance benefits from ManPower, and she reported ManPower as her employer on her income tax returns.

Following her termination from ManPower and the end of her duties at ExxonMobil, McGowin filed suit against both companies in Texas state court. In her suit, McGowin asserted state law claims of age discrimination, intentional infliction of emotional distress, fraud, and conspiracy to commit fraud in connection with ExxonMobil's refusal to pay her ERISA benefits. According to McGowin, ExxonMobil falsely informed her that she was not an employee of ExxonMobil and thus was not entitled to its employee benefits. The defendants removed the case to the U.S. District Court for the Eastern District of Texas, which held that McGowin's state law claims were preempted by ERISA and, consequently, were barred by her failure to exhaust administrative remedies. McGowin appealed, but the Fifth Circuit affirmed the district court's ruling.

In rendering its decision, the Fifth Circuit initially explained, "The district court correctly determined that McGowin's claims are completely preempted by ERISA. Complete preemption exists when a remedy falls within the scope of or is in direct conflict with ERISA section 502(a), and therefore is within the jurisdiction of federal court. Section 502, by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief, regardless of how artfully pleaded as a state action. If McGowin could have brought her claim under ERISA, the cause of action is completely preempted and provides a basis for federal jurisdiction."

According to the Fifth Circuit, "McGowin seeks a form of relief provided by section 502(a)(1)(B), which affords a beneficiary a federal cause of action 'to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.' Moreover, a court could not find fraudulent ExxonMobil's representations that McGowin is not eligible for benefits without first determining whether the statement is truthful, *i.e.,* without clarifying her right to benefits under the plan. McGowin may characterize her cause of action as arising under the common law of fraud, but she seeks a determination of her

eligibility for benefits under an ERISA-governed plan, and she prays for relief specifically provided by section 502(a)(1)(B). Such a claim is completely preempted by ERISA."

The Fifth Circuit went on to conclude, "The district court also correctly determined that McGowin's ERISA claims are barred by her failure to exhaust administrative remedies. Claimants seeking benefits from an ERISA plan must first exhaust available administrative remedies under the plan before bringing suit to recover benefits. McGowin does not dispute that she failed to initiate an administrative claim for benefits with ExxonMobil. Rather, she argues that her failure to do so should be excused on the ground that administrative review would be futile and that she was denied 'meaningful access' to the review process. A failure to show hostility or bias on the part of the administrative review committee is fatal to a claim of futility. McGowin makes no such showing. Moreover, McGowin's conclusional allegation that she was denied 'meaningful access' to the administrative process is unpersuasive."

MEDICAL MALPRACTICE CLAIM PREEMPTED

ERISA preempted a state law claim of medical malpractice stemming from an insurance company's refusal to approve payment for a bloodless hip surgery for a beneficiary who is a Jehovah's Witness. This was the ruling of the Seventh Circuit U.S. Court of Appeals in *Klassy v. Physicians Plus Insurance Company et al.*[16]

Jim and Barbra Klassy, who are Jehovah's Witnesses, were participants in an HMO offered by Physicians Plus Insurance Company. In 2001, when Klassy began experiencing pain in her hip, she went to a Physicians Plus primary care physician. That physician in turn referred Klassy to an orthopedic surgeon who was a participating physician in the HMO. After being examined by the surgeon, Klassy requested authorization from Physicians Plus for a surgical revision to her hip. As a Jehovah's Witness, Klassy, however, believes that the Bible prohibits blood transfusions. Accordingly, Klassy requested that the surgery be performed by an out-of-network physician who was the only known physician who could perform a "bloodless" surgery. After Physicians Plus denied that request, Klassy traveled to Arkansas and paid for the bloodless surgery herself.

Subsequently, Klassy and her husband filed suit against Physicians Plus in Wisconsin state court, asserting state law claims of medical malpractice and negligence. Physicians Plus removed the case to the U.S. District Court for the Western District of Wisconsin, which held that Klassy's state law claims were preempted by ERISA. The district court then offered Klassy the opportunity to amend her complaint to

state a claim under ERISA, but she appealed instead, and the Seventh Circuit affirmed the district court's ruling.

In rendering its decision, the Seventh Circuit initially explained, "Although the Klassys presented their claim as a state law malpractice claim, if the claim is within the scope of Section 502(a) of ERISA it is completely preempted, no matter how the Klassys have characterized it. Section 502(a) provides that 'a civil action may be brought by a participant to recover benefits due to him under the terms of his plan.' This court has set forth three factors for use in determining whether a claim is within the scope of Section 502(a) and thus completely preempted: whether the plaintiff is eligible to bring a claim under that section; whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via Section 502(a); and whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law."

Turning to the facts of the case, the Seventh Circuit stated, "These factors make clear that the Klassys' claim, although framed as a medical malpractice claim, is really a Section 502(a) denial of benefits claim. First, as plan participants, the Klassys are eligible to bring a claim under Section 502(a). Second, the basis of the Klassys' claim is that [Physicians Plus] did not approve payment for the bloodless surgery, which concerns her rights 'to recover benefits due to her under the terms of her plan.' Finally, to determine whether [Physicians Plus] was negligent in refusing to approve the out-of-network surgery requires a determination of whether the surgery was covered."

The Seventh Circuit went on to conclude, "To the extent that [Physicians Plus] improperly denied coverage of the bloodless hip surgery (as opposed to the traditional hip surgery that was approved), the Klassys could have sought reimbursement in an ERISA action. In fact, the district court gave the Klassys an opportunity to amend their complaint to allege an ERISA denial of benefits claim, but the Klassys instead appealed. ERISA provides a remedy for plan participants wrongfully denied benefits. However, such claims must be brought under ERISA and creatively pleading a denial of benefits claim as a state law claim does not defeat the broad preemptive force of ERISA. Thus, although the Klassys might have succeeded under ERISA and obtained payment for the bloodless surgery, because they instead opted to pursue a state law claim that is preempted, the district court properly dismissed their complaint."

STATE LAW CLAIMS AGAINST HMO

ERISA completely preempted a beneficiary's state law claims that an HMO plan's subrogation provision was illegal under Maryland law,

but the beneficiary's claims must be resolved in federal court as claims arising under ERISA. These were the conclusions of the Fourth Circuit in *Singh v. Prudential Health Care Plan*.[17]

Sabriyanam Singh was a participant in the Prudential Health Care Plan, an HMO operating in Maryland. After Singh was involved in an automobile accident in March 1998, Prudential paid Singh $950 in connection with her injuries sustained in the accident. Singh also filed a claim against the other party involved in the accident, and in settlement of that claim, Allstate Insurance Company paid Singh $5,000 in February 1999.

Based on a subrogation provision in the HMO plan document, Prudential asserted a subrogation claim against the $5,000 settlement for reimbursement of the $950 payment that it had made to Singh. Singh paid the subrogation claim, but then filed suit against Prudential in Maryland state court. In her suit, Singh alleged that the Prudential plan's subrogation provision was illegal under the Maryland HMO Act, which has been construed by state courts as prohibiting HMOs from pursuing subrogation with respect to their members' claims against third parties; and that Prudential was unjustly enriched and negligently misrepresented its right of subrogation. Prudential removed the case to the U.S. District Court for the District of Maryland, which dismissed Singh's claims on the grounds of ERISA preemption. Singh appealed, and the Fourth Circuit reached a split decision in the case.

With respect to Singh's state law claims, the Fourth Circuit cited ERISA Section 502(a), which authorizes participants to bring a civil action to recover benefits due under a plan. The court then explained, "If a state-law claim falls within the scope of section 502(a), the complete preemption doctrine provides that the state-law claim is necessarily federal in character such that it arises under federal law. In this case, the complaint, relying on state-law causes of action, seeks remedies that undoubtedly fall within the scope of section 502(a). Relying on theories of unjust enrichment and negligent misrepresentation under Maryland law, Singh's complaint seeks a declaratory judgment that the subrogation term of the plan is illegal under the Maryland HMO Act, that Prudential negligently misrepresented its rights under the plan, that the HMO members need not pay subrogation claims asserted by Prudential, and as to those members who have already paid, that Prudential has been unjustly enriched. Because Singh's state-law claims cannot be resolved without passing on the validity of the subrogation term of her ERISA plan, those claims are within the scope of section 502(a) and therefore are completely preempted."

The Fourth Circuit, however, went on to state, "Because we have found that Singh's claims are completely preempted, leading to their conversion into federal claims and their removal to federal court, those completely preempted claims must now be decided by the

district court. This does not mean that all of Singh's claims for damages asserted under state law must be recognized by the district court on remand. Rather, the district court must consider only remedies authorized by section 502(a) and must reject all others."

APPLICATION TO STATE AWP LAW

In a 2005 decision, the Eighth Circuit held that ERISA preempts Arkansas' any-willing-provider (AWP) statute as it applies to self-funded health care plans, but not as it applies to insured health care plans. The case is *The Prudential Insurance Company of America, et al. v. National Park Medical Center, Inc., et al.*[18]

HMO Partners is an HMO that offers insured health care plans to employers. Tyson Foods sponsors a self-funded health care plan. Both the HMO Partners plans and the Tyson plan offer closed provider networks. HMO Partners creates its own provider networks; while Tyson maintains various agreements with insurance companies under which the insurance companies may agree not only to perform third-party administrative and claims processing services for the Tyson plan but also to provide the plan access to various provider networks in the geographic areas in which Tyson's employees are located.

The Arkansas Patient Protection Act of 1995 (Arkansas PPA) is an AWP law that was enacted to ensure that patients had the opportunity to see the health care provider of their choice. As provided by the Arkansas PPA, a health care insurer is prohibited from excluding from participation any health care provider that is willing to accept the health care plan's operating terms and conditions.

After Arkansas passed the Arkansas PPA, various physicians and hospitals sought admission into otherwise exclusive provider networks by expressing a willingness to accept the terms and conditions of participation. HMO Partners and Tyson then sought a declaratory judgment in the U.S. District Court for the Eastern District of Arkansas that the Arkansas PPA was preempted by ERISA, as well as a permanent injunction against the enforcement of the Arkansas PPA. In 1997, the district court granted judgment in favor of HMO Partners and Tyson, and the court later amended its order to hold that the Arkansas PPA was preempted by ERISA only insofar at it relates to ERISA plans. The insurer defendants appealed, and in its first ruling in the case in 1998, the Eighth Circuit held that the Arkansas PPA was preempted by ERISA in its entirety, not just as it relates to ERISA plans. All of the parties appealed, and in its second ruling in the case, the Eighth Circuit reached a split decision.

In rendering its decision, the Eighth Circuit initially cited the U.S. Supreme Court's 2003 decision in *Kentucky Association of Health Plans*

v. Miller[19] in which the Court held that ERISA did not preempt two Kentucky AWP statutes. The Eighth Circuit then explained, "There are two types of preemption under ERISA: 'complete preemption' under ERISA section 502, and 'express preemption' under ERISA section 514. Complete preemption occurs whenever Congress so completely preempts a particular area that any civil complaint raising this select group of claims is necessarily federal in character. In contrast, ERISA's express preemption clause preempts any state law that 'relates to' any employee benefit plan. The Supreme Court's decision in *Miller* only considered whether the respective AWP laws were preempted under ERISA's express preemption clause."

With respect to express preemption, the Eighth Circuit cited ERISA's "savings" clause, which saves from preemption state laws that regulate insurance. The court then stated, "As *Miller* makes plain, it is not the case that a statute must regulate only traditional insurance companies to be a statute specifically directed toward entities engaged in insurance. Rather, that statute need only regulate entities engaged in the activity of insuring. While the *Miller* Court's rejection of our prior reasoning to support the conclusion that the Arkansas PPA was not saved from express preemption under ERISA does not necessarily compel a holding that the Arkansas PPA is saved from preemption, we see no reason why the *Miller* Court's reasoning would not require such a result in this case. In particular, the *Miller* Court's holding that a law that regulates noninsuring entities can be saved from preemption eliminates any concern about whether the Arkansas PPA is specifically directed toward entities engaged in insurance. Thus, we hold that the Arkansas PPA is a state law specifically directed toward entities engaged in insurance." Accordingly, the Eighth Circuit held that ERISA does not preempt the Arkansas PPA as it applies to insured plans.

However, the Eighth Circuit then cited ERISA's "deemer" clause, which states that no employee benefit plan will be deemed to be in the business of insurance. According to the court, "Under the deemer clause a self-funded ERISA plan, such as Tyson's, cannot be deemed to be an insurance company or other insurer subject to state regulation because of the savings clause. The *Miller* decision only interpreted ERISA's savings clause. The *Miller* Court did not consider the effects of the deemer clause because no self-funded ERISA plan was a party to that case. The Arkansas PPA provides that it 'shall not apply to self-funded or other health benefit plans that are exempt from state regulation by virtue of ERISA.' Under this exemption, self-funded ERISA plans, such as Tyson's, are not directly regulated by the Arkansas PPA. Thus, we hold that not only does the Arkansas PPA exempt the Tyson plan and other self-funded ERISA plans from direct regulation but also that ERISA preempts any indirect state regulation of those plans because of the deemer clause."

Turning to the issue of complete preemption, the Eighth Circuit concluded, "Because we hold that ERISA saves the Arkansas PPA from preemption with respect to insured ERISA health benefit plans, we must now consider whether the doctrine of complete preemption under ERISA applies to the Arkansas PPA's civil penalties provision. We hold that ERISA's civil enforcement provision completely preempts the Arkansas PPA's civil penalties provision, but only with respect to suits that could have been brought under ERISA."

STATE LAW TORTIOUS INTERFERENCE CLAIMS

A state law claim for tortious interference with a contract that happened to be a pension plan subject to ERISA was not "completely preempted" by ERISA Section 502(a)(1)(B), according to the Sixth Circuit Court of Appeals at Cincinnati. Hence, the district court lacked jurisdiction over the case and the case was remanded to the state court. The case is *Gardner v. Heartland Industrial Partners*.[20]

An investment firm agreed to sell its interest in an automotive supplier to a second investment firm. The seller, however, failed to disclose the fact that the automotive supplier would owe certain former executives approximately $13 million as a result of the sale. This obligation arose under a change-of-control provision in the supplier's Supplemental Executive Retirement Plan (SERP) in which the former executives were participants. The SERP was a plan subject to ERISA. The second investment firm threatened to back out of the deal when it found out about the $13 million SERP obligation. In response, the supplier's board of directors simply declared the SERP invalid. The deal then closed about a month later. A month after the deal closed, the auto supplier notified the former executives that it had invalidated the SERP. In response, the former executives filed a suit in Michigan state court against the first investment firm and the current executives of the auto supplier for tortious interference with contractual relations.

The defendants moved the case to federal court contending that the claim was completely preempted under ERISA. The federal district court found that it was and dismissed the action. On appeal, the Sixth Circuit reviewed the district court's dismissal *de novo*.

ERISA Section 502(a)(1)(B) provides that a civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. The Supreme Court has said that this provision is part of a civil enforcement scheme whose comprehensive and carefully integrated character provides "strong evidence that Congress

did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Thus, when a state law claim by its nature falls within the scope of ERISA Section 502(a)(1)(B), two consequences follow: (1) the claim is deemed to be a federal claim for purposes of federal question jurisdiction and thus removal and (2) the claim is preempted.

The issue in this case was whether the state law claim was within the scope of ERISA Section 502(a)(1)(B)for purposes of this rule. A claim is within the scope of ERISA Section 502(a)(1)(B) for this purpose if two requirements are met: (1) the plaintiff complains about the denial of benefits to which he is entitled "only because of the terms of a ERISA-regulated employee benefit plan" and (2) the plaintiff does not allege the violation of any legal duty independent of ERISA or the plan terms.

The appellate court focused on the second requirement. It noted that the defendants' duty not to interfere with the SERP agreement arose under Michigan tort law, not under the terms of the SERP itself. Also, this duty was not derived from or conditioned upon the terms of the SERP. "Nobody needs to interpret the plan to determine whether that duty exists," the court said. Thus, the court ruled that the plaintiffs' claim was based upon a duty that is independent of ERISA and the plan terms.

Since the second requirement for preemption was not met, the appellate court ruled that the district court lacked jurisdiction over the case. Hence, the district court's holding was reversed and the case was remanded to the state court.

CONCLUSION

ERISA Section 502 outlines employees' rights under ERISA, including the right to recover benefits according to the terms of the plan or to enforce the employee's rights under the plan.

ERISA preempts state law in two ways. Complete preemption arises when a state cause of action seeks the same relief available under ERISA Section 502(a)(1)(B), which authorizes a plan participant or beneficiary to bring an action under federal law to recover benefits due under a plan. Conflict preemption arises under the general preemption provision of ERISA Sec. 514(a), which merely states a federal defense to a state cause of action. The federal courts have drawn a distinction between complete preemption and conflict preemption, and the two are mutually exclusive. The case law has clarified three threshold issues with regard to ERISA preemption:

1. Whether a program or insurance policy constitutes a "plan" as defined by ERISA;

2. Whether a state law or claim "relates to" an employee benefit plan; and

3. Whether ERISA Section 514(b)'s "savings" clause or "deemer" clause applies. The savings clause saves from preemption state laws that regulate insurance, while the deemer clause provides that no employee benefit plan will be deemed to be engaged in the business of insurance.

Understanding ERISA preemption is key to choosing the proper forum in which to litigate ERISA claims.

NOTES

1. *Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504 (1981).

2. *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85 (1983).

3. *Ingersoll-Rand v. McClendon,* 498 U.S. 133 (1990).

4. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

5. *Metropolitan Life Insurance Company v. Massachusetts,* 471 U.S. 724 (1985).

6. *Giles v. NYLCare Health Plans, Inc. and NYLCare Health Plans of the Gulf Coast, Inc.,* 172 F.3d 332 (5th Cir. 1999).

7. *Bauman v. U.S. Healthcare, Inc.,* 193 F.3d 151 (3d Cir. 1999).

8. *Felix et al. v. Lucent Technologies, Inc.,* 387 F.3d 1146 (10th Cir. 2004).

9. *Danca v. Private Healthcare Systems, Inc., and Phoenix Home Life Mutual Insurance Co.*, 185 F.3d 1 (1st Cir. 1999).

10. *Hull v. Fallon, et al.,* 188 F.3d 939 (8th Cir. 1999).

11. *Metropolitan Life Insurance Company v. Taylor, supra* n.1.

12. *Pryzbowski v. U.S. Healthcare, Inc. et al.,* 245 F.3d 266 (3d Cir. 2001).

13. *Darcangelo v. Verizon Communications, Inc. and CORE, Inc.,* 292 F.3d 181 (4th Cir. 2002).

14. *Estes v. Federal Express Corporation, et al.,* 417 F.3d 870 (8th Cir. 2005).

15. *McGowin v. Manpower International, Inc. and ExxonMobil Chemical Company,* 363 F.3d 556 (5th Cir. 2004).

16. *Klassy v. Physicians Plus Insurance Company, et al.,* 371 F.3d 952 (7th Cir. 2004).

17. *Singh v. Prudential Health Care Plan,* 335 F.3d 278 (4th Cir. 2003).

18. *The Prudential Insurance Company of America, et al. v. National Park Medical Center, Inc., et al.,* 413 F.3d 897 (8th Cir. 2005).

19. *Kentucky Association of Health Plans v. Miller,* 538 U.S. 329 (2003).

20. *Gardner v. Heartland Industrial Partners,* 715 F.3d 609 (6th Cir. 2013).

ICHRA: The Guidance Keeps On Coming

Karen R. McLeese

As discussed in *"The New HRA: A Boon or a Bust?"*[1] the current Administration is continuing to encourage the use of health reimbursement arrangements (HRAs) as a way for employers to offer health coverage to their employees. (*See also* "Introducing the Individual Coverage and Excepted Benefits HRA" in this issue.)

As background, a health reimbursement arrangement (HRA) is a fully employer funded account to be used to pay qualifying medical expenses.[2] Generally, an HRA is a health plan subject to the insurance market reform provisions of the Affordable Care Act (ACA).[3] By design, an HRA is not compliant with certain aspects of these market provisions unless it is integrated with group health coverage. Otherwise, the HRA must be excepted. The concept of integration with group coverage was expanded to individual coverage by way of final regulations issued on June 20, 2019,[4] as more fully discussed in the above-referenced *Benefits Law Journal* articles. Specifically, an Individual Coverage HRA (ICHRA) can be used to reimburse premiums for individual health coverage obtained through the public marketplace or private market.

Two outstanding issues have arisen with regard to offering an ICHRA:

1. ICHRA coordination with the ACA's employer shared responsibility provisions; specifically, the obligation to offer minimum essential coverage (MEC) by offering an ICHRA, and the obligation to offer adequate and affordable health coverage. As a reminder, an employer employing 50 or more full-time employees is known, in ACA parlance, as an applicable large employer (ALE). An ALE, while not obligated to offer health coverage to its employees, is at risk of a penalty if health coverage is not offered to its full-time employees (FTEs). The Internal Revenue Code (Code) Section 4980H(a) penalty is assessed for any month the ALE fails to offer MEC to at least 95 percent of its FTEs. The Code Section 4980H(b) penalty is assessed when coverage fails to be adequate and affordable. Both penalties are

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contingent upon at least one FTE qualifying for premium assistance. For 2020, the annualized "no coverage" penalty pursuant to Code Section 4980H(a) is $2,570; the annualized "inadequate or unaffordable" penalty pursuant to Code Section 4980H(b) is $3,860.

2. Effect of ICHRA integration with the Code Section 105(h) discrimination rules.

To provide clarification on these two matters, the IRS issued proposed reliant regulations on September 30, 2019.[5]

In summary, an ICHRA is an HRA that is integrated with individual coverage. In other words, an individual can only participate in an ICHRA if the individual and his or her dependents actually enroll in individual coverage for each month covered by the HRA. The employer offering an ICHRA must obtain an attestation from HRA participants and their dependents that they are, in fact, covered by acceptable individual coverage for the plan year. Such attestation must be accomplished on an annual basis. Furthermore, ICHRA participants are required to substantiate individual coverage each time reimbursement is sought.[6]

According to the proposed reliant regulations, an ICHRA is deemed to be MEC. Thus, an employer offering an ICHRA to its FTEs would satisfy its obligations to offer MEC.[7]

As to whether the plan meets the minimum value standard, which requires the plan to cover a minimum of 60 percent of the total allowed cost of benefits expected to be incurred under the plan, and the affordability standard, the proposed reliant regulations indicate that if an ICHRA meets affordability standards described below, it will be deemed to meet minimum value standard.[8] Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.78 percent (indexed for 2020[9]) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

AFFORDABILITY SAFE HARBORS

Under an ICHRA, the affordability standard is based on the excess of premium for self-only coverage under the lowest cost silver plan (LCSP) offered in the rating area where the employee resides, over the self-only amount the employer makes newly available to the employee under the ICHRA. Notably, it is only new amounts added each year that are considered in the calculation of the employee's cost. If this

amount does not exceed the indexed household income threshold, then the ICHRA is deemed affordable. For this purpose, the employer can use any of the three safe harbors currently available: the Form W-2 determination, the rate of pay method, or the federal poverty line standard.[10]

For purposes of determining the LCSP for a location, the Centers for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight (CCIIO) provides a tool (ICHRA Employer Lowest Cost Silver Plan Premium Lookup Table[11]) that can be used by individuals and employers. This tool allows users in states participating in the federal marketplace and state-based marketplaces using the federal platform to access the LCSP data by geographic location. The CCIIO is working with states that operate their own marketplace platforms to provide similar information.

To illustrate the affordability calculation for purposes of an ICHRA, following is one of several examples provided by CCIIO[12] that is based on the employee's residence:

- Jane (single, no dependents) estimated household income in 2020 is $51,000.
- Jane's employer offers its employees an ICHRA starting on January 1, 2020, that reimburses $2,400 of medical care expenses for single employees with no children.
- The self-only monthly premium for the LCSP offered through the marketplace for the rating area where Jane resides is $500.
- Jane's required contribution is $300, which is lower than the product of the required contribution percentage and her household income divided by 12.
- The calculation would be:
    - $500 – $200 = $300 (Jane's required contribution: self-only LCSP monthly premium – monthly ICHRA amount)
    - ($51,000 × .0978)/12 = $415.65 (1/12th of the product of Jane's household income for the tax year and the required contribution percentage)

In this example, the ICHRA is deemed affordable, and Jane would not be eligible for the premium tax credit.

LOCATION SAFE HARBOR

These regulations propose that the employer can use the LCSP rate, or the employment location to which the individual is required to report;[13] thus, reducing the number of locations that the employer needs to calculate. If the employee's location changes midyear, then the employee's primary site of employment is treated as changing no later than the first day of the second calendar month after the employee has begun performing services at the new location.

LOOK-BACK MONTH SAFE HARBOR

The proposed rules also provide a look-back month safe harbor[14] wherein an employer with a calendar year plan can use the LCSP for self-only coverage for January of the prior year.[15] For a noncalendar year plan, the employer can use the LCSP for January of the current year.[16]

AGE-BASED SAFE HARBOR

These proposed rules do not include an age-based safe harbor.[17] The IRS is seeking comments about how to coordinate this type of calculation with the current premium tax credit rules. Some suggested proposals are to use the LCSP for the lowest age band in the individual market based on the employee's location, or calculate the rate based on the employee's age on the first day of the ICHRA plan year.

APPLICATION OF CODE SECTION 105(H) DISCRIMINATION RULES

These proposed regulations also address ICHRA integration with the Code Section 105(h) discrimination rules.[18] Generally, an HRA is a self-funded health plan subject to the Code Section 105(h) discrimination rules, which impose tax consequences if a plan discriminates in favor of highly compensated employees. According to these proposed reliant regulations, an ICHRA that only reimburses individual health premiums will be exempt from these rules. If the ICHRA reimburses expenses such as deductibles, copays, and the like, in addition to premiums, it would be subject to the Section 105(h) discrimination rules.

The regulations propose that as long as ICHRA complies with the ICHRA classification standards listed below,[19] including the age-based

standard (wherein the oldest age classification cannot exceed three times the youngest age classification), it would be deemed compliant with the Section 105(h) discrimination rules. Under an ICHRA, permissible classes of employees include the following:

- Full-time, part-time, and seasonal employees;
- Employees working in the same geographic location (generally, the same insurance rating area, state, or multistate region);
- Employees in a unit of employees covered by a particular collective bargaining agreement;
- Employees who have not satisfied a waiting period;
- Nonresident aliens with no U.S.-based income;
- Salaried workers and nonsalaried workers (such as hourly workers);
- Temporary employees of staffing firms; or
- Any group of employees formed by combining two or more of these classes.

The ICHRA could also be offered to former employees; however, if it is offered to one or more former employees within a class of employees, then the HRA must be offered to the former employees on the same terms as to all other employees within the class.

The Code Section 105(h) rules will be deemed satisfied though in actual operation and could be discriminatory if, for example, a significant portion of highly compensated individuals benefit. As a reminder, among other characteristics, a highly compensated individual includes the top 25 percent of the total employee population, as determined by pay.[20]

Generally, class determination is based on the common law status of an employer. This is true even if the employer is part of a control group. For determining certain classes of employees, for example, full-time versus part-time employees, employees located within certain geographic areas, or salary versus hourly employees, a minimum class size equal to the lesser of 20 employees, or 10 percent of the workforce, must be satisfied. This is to ensure that employers do not establish small classes targeted at certain populations.

NOTICE OBLIGATION

Once an ICHRA has been established, the sponsoring employer is obligated to provide a written notice about the availability of the program to all eligible employees at least 90 days prior to the beginning of each plan year. For the first year of compliance, if the employer adopts the ICHRA within 120 days prior to the beginning of the plan, the 90-day advance notice period can be shortened to the date that the individual first becomes eligible for the plan.[21] The Department of Labor provides a model notice[22] that can be used for this purpose, which must be customized to the particular ICHRA. In practicality, the employer should provide the notice in time for its employees to review their marketplace options. Generally, the open enrollment period in the federal marketplace runs from November 1 through December 15 each year.

Reporting and Disclosure Obligations

An employer establishing an ICHRA would be subject to Code Sections 6055 and 6056 reporting obligations. As background, the Forms 1094 and 1095 are used to satisfy the Code Section 6055 and 6056 reporting requirements. The Forms 1094-B and 1095 B-series is used for reporting MEC by insurers and sponsors of self-funded plans. However, self-insured ALEs file the Form 1095-C and use Part III of that form, rather than Form 1095-B, to report information required under Code Section 6055. The Forms 1094-C and 1095-C series is used for reporting employer provided coverage by an ALE subject to the ACA's shared responsibility requirement. The IRS is currently reviewing the need to modify these reporting rules as they apply to an ICHRA.[23] This is due, in part, because the penalty for individuals who fail to obtain MEC has been reduced to zero by the Tax Cuts and Jobs Act enacted on December 20, 2017. Until further guidance is provided, employers should be prepared to satisfy these future reporting obligations.

Effective Date

These regulations become effective for periods beginning after December 31, 2019. While these rules are proposed, they are reliant regulations. Therefore, an employer planning to establish an ICHRA can rely on this guidance.

NOTES

1. Federal Benefits Developments, "The New HRA: A Boon or a Bust?" *Benefits Law Journal*, Vol. 32, No. 3, Autumn 2019 (Oct. 1, 2019).

2. Rev. Rul. 2002-41, 2002-28 I.R.B. 75 and IRS Notice 2002-45, 2002-28 I.R.B. 93.

3. IRS Notice 2002-45, 2002-28 I.R.B. 93.

4. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 26 C.F.R. Parts 1 and 54; 29 C.F.R. Parts 2510 and 2590; 45 C.F.R. Parts 144, 146, 147, and 155, 84 Fed. Reg. 28888 (June 20, 2019).

5. Application of the Employer Shared Responsibility Provisions and Certain Nondiscrimination Rules to Health Reimbursement Arrangements and Other Account-Based Group Health Plans Integrated With Individual Health Insurance Coverage or Medicare, 84 Fed. Reg. 51471 (Sept. 30, 2019).

6. Treas. Reg. § 54.9802-4(c)(5); DOL Reg. § 2590.702-2(c)(5); HHS Reg. § 146.123(c)(5). *Also see* FAQs on New Health Coverage Options for Employers and Employees: Individual Coverage and Excepted Benefit Health Reimbursement Arrangements, Individual Coverage HRA Model Attestations (June 13, 2019), *https://www.irs.gov/pub/irs-utl/health_reimbursement_arrangements_faqs.pdf*).

7. Preamble to Prop Reg. REG-136401-18.

8. Prop. Reg. § 54-4980H-5(f)(2).

9. IRS Rev. Proc. 2019-29 (I.R.B. 2019-32, Aug. 5, 2019).

10. Prop. Reg. § 54.4980H-5(f)(5).

11. ICHRA Employer Lowest Cost Silver Plan Premium Lookup Table, available under "Individual Coverage HRA (ICHRA) Employer Premium Resources" from CCIIO's Web page *Employer Initiatives, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives.html*.

12. Example provided in CCIIO's "Individual Coverage Health Reimbursement Arrangements: Pre-Open Enrollment Period Training, Fall 2019," *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/ICHRA-Pre-Open-Enrollment-Period-Training.pdf*.

13. Prop. Reg. § 54.4980H-5(f)(6)(i).

14. Prop. Reg. § 54.4980H-5(f)(4)(i).

15. Prop. Reg. § 54.4980H-5(f)(4)(A).

16. Prop. Reg. § 54.4980H-5(f)(4)(B).

17. *See* "Age Related Issues" in Preamble to Prop Reg REG-136401-18.

18. Prop. Reg. § 1.105-11(c)(3)(i)(B)(2).

19. *As defined in* Reg. § 54-9802-4(d)(2).

20. IRC § 105(h); 26 C.F.R. § 1.105-11(d).

21. Treas. Reg. § 54.9802-4(c)(6); DOL Reg. § 2590.702-2(c)(6); HHS Reg. § 146.123(c)(6).

22. Text of "Individual Coverage HRA Model Notice," *https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB87/individual-coverage-model-notice.pdf*.

23. *See* "Reporting Under Sections 6055 and 6056" in Preamble to Prop Reg REG-136401-18.

Cal Fire! The California Supreme Court Singes the 'Vested Rights' Doctrine

James P. Baker

Public school teachers, police, firefighters, and other state and local government employees accept their jobs with the understanding that their relatively low salaries are backed up by excellent pension benefits. In July 2019, Moody's Investors Service estimated that U.S. public pensions are underfunded by $4.4 trillion. U.S. public pension underfunding is larger than the economy of most developed countries. For example, Germany, the world's fourth largest economy, is expected to produce $4.2 trillion in 2019 as measured by its gross domestic product. The $4.4 trillion dollars in public pension underfunding is also so large that it equals one fifth of the $22 trillion in U.S. national debt.

Compounding the problem of out-of-control costs is that governmental plans are lightly regulated. Congress exempted itself and other employee benefit plans sponsored by governmental employers from the rigors of complying with the Employee Retirement Income Security Act of 1974 (ERISA). This "comprehensive and reticulated statute" regulates most aspects of employee benefit plans in the private sector. Although ERISA contains cradle-to-grave regulations for qualified retirement plans in the private sector, it does not contain any vesting or funding rules for public sector retirement arrangements.[1]

In February 2011, California's Little Hoover Commission, an independent oversight agency, wrote to Governor Jerry Brown, stating:

> California's pension plans are dangerously underfunded, the result of overly generous benefit promises, wishful thinking, and an unwillingness to plan prudently. Unless aggressive reforms are

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> implemented now, the problem will get far worse, forcing counties and cities to severely reduce services and lay off employees to meet pension obligations…
>
> The state must exercise its authority—and establish the legal authority—to reset overly generous and unsustainable pension formulas for both current and future workers.[2]

The report found that local governments:

> [F]ace the prospect of increasing required contributions into their pension funds by 40% to 80% of their payroll costs for decades to come. It is practically enough money to fund a second government, and it will—a retired government workforce. . . ."
>
> Public employees also share in the prospect of a very different California, as cities such as Los Angeles, San Diego, San Francisco, and San Jose prepare to spend one third of their operating budgets on retirement costs in coming years. Pensions are at the center of what will be an intensifying fight for diminishing resources from which government can pay for schools, police officers, libraries, and health services.[3]

The Hoover Commission concluded: "The math doesn't work." . . .

> Payroll growth—in terms of both compensation for public employees and the number of employees—has ballooned pension liabilities. The minimum retirement age has dropped to 55—earlier, for public safety employees—as people live longer, creating an upside-down scenario where governments potentially will send retirement checks to an employee for more years than they earn paychecks. At the same time, state and local governments have increased what used to be considered a good pension into pensions that are the most generous in the country.[4]

THE CALIFORNIA TIME BOMB

California's public pension debt was reported to be $1.052 trillion in 2017, the last year of complete data. Recently reported public pension accounting reports indicate public pension debt is now more than $1.109 trillion. California's pension debt per household is more than $81,000.

The terms and conditions of public employment in California are in general controlled by statute or ordinance rather than by contract.[5]

Nevertheless, "[u]nlike other terms of public employment, which are wholly a matter of statute, pension rights are obligations protected by the contract clause of the federal and state Constitutions." The United States and the California Constitutions prohibit the impairment of contractual rights. Article I, Section 10, of the U.S. Constitution states: "No state shall . . . pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility." The California Constitution similarly states at Article I, Section 9, "A bill of attainder, ex post facto law, or law impairing the obligation of contracts may not be passed."[6]

In the seminal case of *Kern v. City of Long Beach*,[7] the California Supreme Court reversed course from *Pennie v. Reis*[8] and announced:

> [P]ublic employment gives rise to certain obligations which are protected by the contract clause of the Constitution, including the right to the payment of salary which has been earned . . . . Since a pension right is an 'integral portion of contemplated compensation'. . . it cannot be destroyed, once it is vested without impairing a contractual obligation.[9]

The *Kern* case involved unusual facts. Mr. Kern had been a member of the city of Long Beach's Fire Department for 19 years and 11 months. When he began working as a firefighter, the city had a provision in its charter that provided a pension for firefighters equal to 50 percent of their annual salary after completing 20 years of service. For 15 years of his service, 2 percent of Mr. Kern's salary had been deducted and paid into the pension fund. On March 29, 1945, 32 days before Mr. Kern completed the required 20 years' service, a new section was added to the city charter repealing the pension provisions and eliminating pensions for all persons not then eligible for retirement.[10] Upon completing his 20 years of service, Mr. Kern requested that he be retired and paid a pension. The city refused and Mr. Kern filed suit.[11] The Supreme Court in *Kern* decided that Mr. Kern's right to his pension benefits vested upon his acceptance of employment.[12]

The Supreme Court, while recognizing the unilateral nature of a public employee's pension rights, did not make them unchangeable:

> Thus it appears, when the cases are considered together, that an employee may acquire a vested contractual right to a pension but that this right is not rigidly fixed by the specific terms of the legislation in effect during any particular period in which he serves. The statutory language is subject to the implied qualification that the governing body may make modifications and changes in the system. The employee does not have a right to any fixed or

> definite benefits, but only to a substantial or reasonable pension. There is no inconsistency therefore in holding that he has a vested right to a pension but that the amount, terms, and conditions of the benefits may be altered.[13]

The Supreme Court concluded that Mr. Kern had a vested pension right and that the city of Long Beach, by completely repealing his pension, had improperly attempted to impair its contractual obligations.[14]

A more modern and refined version of this "vested rights" doctrine was set forth by the California Supreme Court in the leading case of *Betts v. Board of Administration*:

> A public employee's pension constitutes an element of compensation, and a vested contractual right to pension benefits accrues upon acceptance of employment. Such a pension may not be destroyed, once vested, without impairing a contractual obligation of the employing public entity [*citing Kern*]. The employee does not obtain, prior to retirement, any absolute right to fixed or specific benefits, but only to a "substantial or reasonable pension."[15]

In summary, "[b]y entering public service an employee obtains a vested contractual right to earn a pension on terms substantially equivalent to those then offered by the employer."[16]

Under *Kern* and its progeny, determining whether a particular change to retirement benefits impairs a vested right involves a two-step inquiry. The first question is whether the change actually alters the contract between the employer and the employee. If it does, the next question is whether the change constitutes a reasonable modification.

LOOKING AT THE TERMS OF THE CONTRACT

In California, whether a proposed change impairs a vested right under a public pension plan depends upon how the member's rights are defined under the terms of the governing "contract."[17] Thus, the nature and extent of a member's vested right to a retirement benefit must be ascertained from the language of the statute and other legally operative documents such as resolutions implementing the retirement plan.[18]

The case law bears out the conclusion that the scope of a member's vested right is defined by the terms of the promise. For example, the California Supreme Court has held that if a member's contribution rate under a pension plan is fixed and the pension plan does not give the plan sponsor the right to change the rate, any increase in that rate

would constitute an impairment.[19] In contrast, where the plan terms state that a member's contribution rate is subject to adjustment based upon actuarial assumptions, an increase in the member's contribution rate attributable to changes in such actuarial assumptions is not an impairment.[20]

CAL FIRE AND THE AIRTIME CONTROVERSY

In 2003, the California legislature enacted Government Code Section 20909. It allowed eligible members of the California Public Employees' Retirement System (CalPERS) to purchase up to five years of nonqualifying service credit. This optional benefit is commonly referred to as "airtime."

Fast-forward 10 years later, the California Legislature reversed course by enacting the California Public Employees' Pension Reform Act of 2013 (PEPRA).[21] The PEPRA eliminated airtime. This change, however, only applied prospectively. Any CalPERS member who had exercised their option to purchase airtime retained it.

In *Cal Fire Local 2881 v. California Public Employees' Retirement System*,[22] the Cal Fire plaintiffs argued that "airtime" benefits were vested rights protected from change by the California Constitution's Contract Clause.[23] That clause restricts the power of states to enact laws affecting a "substantial impairment of contracts, including contracts of employment."[24] The vested rights doctrine in California has evolved into the following: (1) a public employee's contract is formed and vests as of the first day of employment; (2) any proposed disadvantages to the pension contract must be offset by comparable new advantages; and (3) the pension contract protects not only what an employee has earned, but also what he or she might possibly earn in the future.[25]

The Cal Fire plaintiffs pointed to *Retired Employees Association of Orange County, Inc. v. County of Orange*,[26] as support for its position that airtime was a vested right.[27] The *Orange County* case presented the question of whether retiree medical benefits that had been provided through a series of express collective bargaining agreements were protected by the vested rights doctrine. In *Orange County*, the Supreme Court found the existence of collective bargaining agreements critical to its conclusion that an implied contractual and vested right could have been created.[28] "Where the relationship is governed by contract, a county may be bound by an implied contract (or by implied terms of a written contract) as long as there is no statutory prohibition against such an agreement."

In rejecting the Cal Fire plaintiffs' claim that "air rights" were protected, the California Supreme Court stated:

> It was critical to Retired Employees' holding that the legislative enactment on which the implied contractual rights were premised was a resolution approving an express contract of employment. *Id*. at 1187.
>
> The County Board's ratification of this contract provided the requisite clear manifestation of intent to create contractual rights. Nothing of the sort occurred in connection with the opportunity to purchase ARS credit. The Legislature did not engage in any sort of negotiation with the public employees covered by Section 20909, let alone ratify an express or implied contract reflecting its terms. The Legislature simply enacted a statute granting the opportunity to purchase ARS credit. As *Retired Employees* noted, such statutes, which announce a policy rather than create a contract, "are inherently subject to revision and repeal." *Retired Employees*, *supra*, at p. 1185.[29]

State law does not normally create contractual rights but "merely declares a policy to be pursued until the legislature shall ordain otherwise."[30]

In *Cal Fire*, a unanimous California Supreme Court held that "air time" was not entitled to constitutional protection.

> We conclude that the opportunity to purchase ARS credit was not a right protected by the contract clause. There is no indication in the statute conferring the opportunity to purchase ARS credit that the Legislature intended to create contractual rights.[31]

The Supreme Court explained that the terms and conditions of public employment are ordinarily considered to be statutory rather than contractual. They are subject to modification at the discretion of the governing legislative body.[32]

> Constitutional protection can arise, however, (1) when the statute or ordinance establishing a benefit of employment and the circumstances of its enactment clearly evince an intent by the relevant legislative body to create contractual rights or, (2) when, even in the absence of a manifest legislative intent to create such rights, contractual rights are implied as a result of the nature of the employment benefit, as is the case with pension rights.[33]

Although public employees may hold implied vested contractual rights that are tied to the performance of service, the Court found that the air time benefit was not connected to any actual service. The option for air time was not a contractually binding offer. Air time

did not induce any employee to work for the state. Pension benefits, the classic example of deferred compensation, are tied directly to a public employee's service, and their value directly relates to how long the employee works for the state. There was no basis on which the Court could conclude that the opportunity to purchase air time was granted in exchange for an employee's service, prior to the employee's election to purchase the service credit. The amount of air time was simply a matter of employee choice. It had no relationship to any requirement that the employee work for a certain amount of time for the state.

The Court explained that "[w]e have never held, however, that a particular term or condition of public employment is constitutionally protected solely because it affects in some manner the amount of a pensioner's benefit . . . a term and condition of public employment that is otherwise not entitled to protection under the contract clause does not become entitled to such protection merely because it affects the amount of an employee's pension benefit."

Because the Court held that the opportunity to purchase air time was not a vested contractual right, it did not reach the issue of whether PEPRA's elimination of the air time benefit unconstitutionally impaired the contractual rights of public employees. The Court thus sidestepped the California vested rights question—for now. Two cases squarely presenting the vested rights question are pending before the California Supreme Court.[34]

WHAT IS NEXT?

In February 2011, the Little Hoover Commission made four recommendations to California legislatures:

1. To reduce growing pension liabilities of current public workers, state and local governments must pursue aggressive strategies on multiple fronts.

2. To restore the financial health and security in California's public pension systems, California should move to a "hybrid" retirement model.

3. To build a sustainable pension model that the public can support, the state must take immediate action to realign pension benefits and expectations.

4. To improve transparency and accountability, more information about pension costs must be provided regularly to the public.

In 2012, then Governor Jerry Brown attempted to follow the Little Hoover Commission's advice and proposed a number of significant changes to the laws governing California's public pensions. As noted above, the legislature did approve the elimination of "air time." The legislature also raised the age for retirement with full pension benefits from 50 to 57 for newly hired public safety workers and from 55 to 67 for newly hired civil servants. It also required minimum contributions from employees toward their pensions to supplement the much-larger taxpayer funded contributions. These changes applied to most employees of the state, counties, cities, and local districts. Excluded from these changes were employees of the University of California and cities like San Francisco, Los Angeles, San Diego, and San Jose, which manage their own pension systems. Governor Brown's proposal to start a new hybrid pension system was rejected. In its place, the legislature approved a cap on the salary that could be used to calculate employee pensions. The current cap is $117,020 for workers who participate in Social Security and $140,424 for those who do not.

One thing is certain, the problem of public pension debt keeps getting bigger. Between January 2011 when Governor Brown retook the office of governor and January 2019 when he left, California's annual bill for retirement obligations reached $11 billion—nearly double what it was in 2011. Since the legislative changes in the 2012 law apply mainly to newly hired employees, savings have trickled in slowly. The question is not really whether California's pension debt will explode over the next 10 years, the real question is whether California's leaders will have the courage to save California's public pension system.

NOTES

1. ERISA § 4(b)(1), 29 U.S.C. § 1003(b)(1).

2. *Id.*, p. 53.

3. *Id.* at (iii).

4. *Id.* at p. (iv).

5. *See Miller v. State of California*, 18 Cal.3d 808, 813 (1977) ("It is well settled in California that public employment is not held by contract but by statute.")

6. *United Firefighters of Los Angeles City v. City of Los Angeles*, 210 Cal.App.3d 1095, 1102 (Ct. App. 1989).

7. *Kern v. City of Long Beach*, 29 Cal.2d 848 (1947).

8. Pennie v. Reis, 132 U.S. 464 (1889).

9. *Id.* at 853.

10. *Id.* at 850.

11. *Id.*

12. *Id.* at 852.

13. *Id.* at 855.

14. *Id.* at 856.

15. *Betts v. Board of Administration*, 21 Cal.3d 859, 863 (1978).

16. *Carman v. Alvord*, 31 Cal.3d 318, 325 (1982) (*citing Betts*), and to earn additional pension benefits pursuant to improved terms conferred during continued employment. *See Betts*, 21 Cal.3d at 866 ("An employee's contractual pension expectations are measured by benefits which are in effect not only when employment commences, but which are thereafter conferred during the employee's subsequent tenure"). This means that the employee has a vested right not merely to preserve the pension benefits already earned, but also to continue to earn benefits under the terms previously promised through continued service. *See Legislature v. Eu*, 54 Cal.3d 492, 530 (1991) ("We conclude that incumbent legislators had a vested right to earn additional pension benefits through continued service"); *see also Pasadena Police Officers Assoc. v. City of Pasadena*, 147 Cal.App.3d 695 (Ct. App. 1983) ("the employee has a vested right not merely to preservation of benefits already earned pro rata, but also, by continuing to work until retirement eligibility, to earn the benefits, or their substantial equivalent, promised during his prior service").

17. *See Int'l Ass'n of Firefighters v. City of San Diego* 34 Cal.3d 292, 302 (1983).

18. (*see, e.g., Id.* at 302 (looking to city charter and ordinance); *Ventura County Retired Employees' Ass'n v. County of Ventura*, 228 Cal.App.3d 1594, 1598–1599 (Ct. App. 1991) (looking to the Government Code to determine an employer's obligations), *rev. denied*, 1991 Cal. Lexis 3034 (1991); *Orange County Employees' Ass'n, Inc. v. County of Orange*, 234 Cal.App.3d 833, 843–844 (Ct. App. 1991) (looking to the Government Code), *rev. denied,* 1991 Cal. Lexis 5658 (1991); *Thorning v. Hollister School. Dist.*, 11 Cal.App.4th 1598, 1607–1608 (Ct. App. 1992) (looking to official declaration of policy issued pursuant to Government. Code); 2000 Cal. AG Lexis 3 (Jan. 28, 2000) (benefits provided pursuant to city resolution adopted under Government Code)), and judicial construction of those provisions or similar provisions at the time the contractual relationship was established. *Kern*, 29 Cal.2d at 850, "[I]t is necessary to perceive the terms of the contract and to utilize those terms to measure the claimed impairment." *Lyon v. Flourney*, 271 Cal.App.2d 774, 783, (Ct. App. 1969), appeal dismissed, 396 U.S. 274 (1970).They are the reasonable expectations of the employee that are protected. *See generally Allen v. Bd. of Admin.*, 34 Cal.3d 114 (1983); *see also Ass'n of Blue Collar Workers v. Wills*, 187 Cal.App.3d 780, 792 (Ct. App. 1986) (right vested in employees is their "reasonable expectation" that the city would meet its statutory obligation to fund past-service liability).

19. *See generally Allen v. City of Long Beach*, 45 Cal.2d 128 (1955); *see also Abbott v. City of Los Angeles*, 50 Cal.2d 438, 451–453 (1958) (changes, including imposition of member contributions where plan provisions previously required full cost to be paid by employer, held invalid); *Wisley v. City of San Diego*, 188 Cal.App.2d 482, 486 (Ct. App. 1961) ("It is obvious that the increase in the percentage of the employee's contribution to the retirement fund is a detriment").

20. *See Int'l Ass'n of Firefighters*, 34 Cal.3d at 300, 302-303; *see also Pasadena Police Officers Ass'n*, 147 Cal.App.3d at 711 (because the authority of the retirement Board to adopt and approve actuarial assumptions was a condition of entitlement to benefits at all times, the decision of the Board in the exercise of that authority to use an assumption as to salary inflation in calculating contributions did not deprive

members of vested rights); *accord Walsh v. Board of Admin.*, 4 Cal.App.4th 682, 700 (Ct. App. 1992) ("If the modification of Walsh's retirement benefits was consistent with the reservation of power to the Legislature, then it was valid regardless of whether the [retirement system] can be said to have granted contractual rights to members of the Legislature").

21. Government Code § 7522 *et seq.*

22. *Cal Fire Local 2881 v. California Public Employees' Retirement System*, 6 Cal.5th 965 (2019).

23. *Id.* at 971.

24. *Allen v. Board of Administration* (1983), 34 Cal.3d 114, 119 (1983).

25. *Allen v. City of Long Beach*, 45 Cal.2d 128, 131 (1955).

26. *Retired Employees Association of Orange County, Inc. v. County of Orange*, 52 Cal.4th 1171 (2011).

27. *Cal Fire, supra* n.22 at 980–981.

28. *Orange County, supra* n.26 at 1133.

29. *Id.* at 981.

30. *National Railroad Passenger Corp. v. Atchison, Topeka & Santa Fe Railway Co.*, 470 U.S. 451, 465–466 (1985).

31. *Id.* at 970–971.

32. *Id.*

33. *Id.* at 970.

34. *Marin Ass'n of Public Employers v. Marin County Employees' Retirement Ass'n.*, 2 Cal.App.5th 674 (2016), *Alameda County Deputy Sheriff's Ass'n v. Alameda County Employees' Retirement Ass'n*, 19 Cal.App.5th 61 (2018).

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