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Employee Benefits & Executive Compensation ADVISORY ■

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The ACA: New Concerns for Employer Plan Sponsors Under the Fair Labor Standards Act and ERISA § 510

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The Affordable Care Act (ACA) anti-retaliation provisions have been in effect for several years, but have so far largely gone unnoticed. Now that employees can get financial assistance through the Health Insurance Marketplace, employers should revisit these provisions and carefully structure their actions to limit potential exposure. In addition, a recent lawsuit brought by employees under ERISA suggests employers should use care when taking employment action that might impact health benefits. As a result, employers and insurers should consider implementing and/or updating and revising their employment policies and procedures now.

The ACA § 1558 Anti-Retaliation Provisions

ACA § 1558 added § 18C to the Fair Labor Standards Act (FLSA). This section provides protection for employees for certain conduct related to the ACA. The Occupational Safety and Health Administration (OSHA), which typically does not have responsibility for benefit matters, is responsible for enforcing the ACA's anti-retaliation provisions. Most employers did not notice these anti-retaliation provisions due to the more immediate demands the ACA placed on them. Nonetheless, without much fanfare, OSHA issued interim final regulations implementing the ACA's anti-retaliation provisions in February 2013.

Who must follow the ACA anti-retaliation rules?

Employers and insurers are subject to the ACA anti-retaliation rules. For these purposes, "employer" is defined under FLSA § 3 as "any person acting directly or indirectly in the interest of an employer in relation to an employee and includes a public agency." However, "employer" does not include any labor organization (i.e., union), except when it is acting as an employer, or anyone acting as an officer or agent of the labor organization. A "person" is "an individual, partnership, association, corporation, business trust, legal representative, or any organized group of persons."

Not only are employees protected from retaliation by employers, they are also protected from retaliation by the insurance issuer that provides employer-sponsored health insurance coverage to the employee.

How is "employee" defined?

The FLSA has a circular definition of employee. An "employee" is "any individual employed by an employer." With some exceptions, most governmental (including federal and state) employees are employees under the FLSA. However, for governmental employers, "employee" excludes an individual who is not subject to the civil service laws of the state, political subdivision or employing agency and who holds a public elective office (and certain of their staff members).

OSHA interprets the definition of "employee" consistent with its interpretation under other whistleblower statutes that it administers and the Secretary of Labor's interpretation under the anti-retaliation provision in FLSA § 15(a)(3). Accordingly, "employee" is interpreted broadly to include current employees, former employees and applicants for employment.

What activities are protected?

FLSA § 18C protects employees from retaliation because they received a premium tax credit or subsidy under the ACA. In addition, an employer cannot retaliate against an employee because the employee:

- Provided, caused to be provided, or is about to provide or cause to be provided to the employer, the federal government or a state attorney general information about any violation or any act or omission he reasonably believes to be a violation of Title I of the ACA (or an amendment made by Title I of the ACA);
- Assisted or participated in proceedings about these violations; or
- Objected to or refused to participate in, any activity, policy, practice or assigned task that the employee (or other person) reasonably believed violates Title I of the ACA, or any order, rule, regulation, standard or ban under Title I of the ACA.

The protected ACA Title I provisions include health insurance reforms such as those that:

- Prohibit annual and life limits.
- Require coverage of preventive care.
- Extend dependent coverage to age 26.
- Provide patient protections related to emergency services and selection of primary care providers, as well as OB/GYNs.
- Prohibit rescissions of coverage (i.e., certain retroactive cancellations).

How are ACA retaliation complaints filed?

The ACA's anti-retaliation procedures generally follow the whistleblower protections under the Consumer Product Safety Improvement Act. A complaint can be made by an individual who reasonably believes retaliation occurred. Specifically, the complainant must have a subjective, good faith and an objectively reasonable belief that the conduct in question violated protected conduct. The "reasonable belief" standard does not provide a significant obstacle to filing a complaint.

A complainant must file a complaint within 180 days of the alleged violation. This 180-day period commences once the employee is aware or reasonably should be aware of the employer's decision. Complaints do not need to be in any particular form; OSHA will accept oral or written complaints in any language. The complaint is merely intended to alert OSHA to alleged retaliation and the complainant's desire for OSHA to investigate.

What happens after OSHA receives the complaint?

After receiving the complaint, OSHA determines if "the complaint, supplemented as appropriate by interviews of the complainant," alleges "the existence of facts and evidence to make a prima facie showing." If so, and the employer or insurer does not show clear and convincing evidence that it otherwise would have taken the same action despite the protected activity, OSHA will conduct an investigation to determine if there is reasonable cause to believe that retaliation occurred.

During the investigation, the complainant only needs to show that the protected activity was "a contributing factor" to the alleged adverse action. The complainant meets this burden if the complaint on its face, supplemented as appropriate by interview of the complainant, alleges facts and either direct or circumstantial evidence that the protected activity was a contributing factor. For example, the complainant's burden may be satisfied if he shows that the adverse action took place shortly after protected activity. OSHA will end its investigation if the complainant does not make this prima facie showing, or if the employer or insurer demonstrates by clear and convincing evidence that it would have taken the same adverse action absent the protected activity.

During the investigation, the complainant must prove by a "preponderance of the evidence" that the protected activity contributed to the adverse action. If the complainant can show this, then the employer or insurer will be charged unless it proves by clear and convincing evidence that it would have taken the same action absent the prohibited rationale.

OSHA will order appropriate relief if it finds there is reasonable cause to believe the complaint has merit. This relief includes preliminary reinstatement, affirmative action to abate the violation, reinstatement with the compensation of that position (including back pay) and terms, conditions and privileges associated with that employment, as well as compensatory damages plus costs and expenses (including attorneys' fees and expert witness fees) reasonably incurred for, or in connection with, the complaint.

Can OSHA's ruling be appealed?

Any party can appeal OSHA's determination to a Department of Labor (DOL) administrative law judge (ALJ) within 30 days of receiving OSHA's findings and any preliminary order. If objections are timely filed, an order of preliminary reinstatement will take effect, but the remaining provisions will not take effect until the end of the administrative proceedings. In appropriate circumstances, OSHA may order that the complainant receive the same pay and benefits that he received before termination, but not actually return to work. An employer can file a motion with the ALJ to stay the preliminary order of reinstatement, but these motions are "granted only based on exceptional circumstances." To establish exceptional circumstances, the employer must show that it qualifies for equitable injunctive relief (i.e., irreparable injury, likelihood of success on the merits, a balancing of possible harms to the parties and that the public interest favors a stay). As part of the appeal, employers can request an award of attorneys' fees (not exceeding $1,000) only if the complaint was frivolous or brought in bad faith.

Significantly, OSHA noted that there is "no statutory basis for allowing the employer to recover the costs of economically reinstating an employee should the employer ultimately prevail." If OSHA orders back pay, interest is computed by compounding daily the IRS interest rate for underpayment of taxes, which is generally the federal short-term rate plus 3 percent.

How are ALJ hearings conducted?

Hearings before the ALJ are conducted de novo on the record without formal rules of evidence. The judge can exclude evidence that is immaterial, irrelevant or unduly repetitious. However, OSHA's determination on whether to proceed with an investigation and its particular investigative findings are not subject to review by the ALJ. Thus, the judge cannot generally remand cases to OSHA to conduct an investigation or make further factual findings.

Notably, the Assistant Secretary of OSHA can participate as a party or amicus curiae at any time during the administrative proceedings, although it does not expect to do so regularly. In addition, the IRS, U.S. Department of Health and Human Services and DOL's Employee Benefits Security Administration can also participate as amicus curiae at any time in the proceedings.

A party can file an appeal to the DOL's Administrative Review Board (ARB) within 14 days of the ALJ's decision. The ARB accepts appeals at its discretion and not as a matter of right. If the ARB does not notify the parties within 30 days of filing that the case has been accepted for review, or if either party disagrees with the ARB's decision regarding a complaint it accepted for review, then either party can request review by the U.S. Court of Appeals for the circuit where the violation allegedly occurred or the circuit in which the complainant resided on the date of the violation.

Can complaints be brought in a district court?

In limited circumstances, a complainant could bring an action in U.S. district court. Specifically, a complainant may file a de novo action in district court: (1) within 90 days of receiving OSHA's written findings at the close of its investigation if a final decision has not been issued by the DOL; or (2) if more than 210 days have passed since filing the complaint and a final decision has not been issued by the DOL.

New Risk of ERISA § 510 Claims – *Marin v. Dave & Buster's*

What is this case about?

On May 8, 2015, a federal class action lawsuit was filed in the Southern District of New York against the restaurant chain Dave & Buster's. The lawsuit alleges that the company violated the Employee Retirement Income Security Act of 1974 (ERISA) by moving full-time employees to part time to avoid the ACA. On February 9, 2016, the court denied Dave & Buster's motion to dismiss this lawsuit.

In *Marin v. Dave & Buster's*, the plaintiffs alleged that some employees who were receiving health care coverage had their hours cut to avoid providing them ongoing health insurance benefits. Moreover, the plaintiffs alleged

that the company stated that their hours were cut to reduce the company's health care expenses.[1] This, according to the plaintiffs, violated § 510 of ERISA, which makes it "unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan … or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan."

The defendant argued, on a motion to dismiss the complaint, that the conduct alleged was entirely legal. Specifically, the reduction in hours was for the purpose of avoiding the provision of *future* benefits to which plaintiffs had no legal right. Although the district court rejected this argument, it is possible that it will ultimately prevail or that it would prevail in another district or circuit. Indeed, the defendant clearly could have achieved the same goal, legally, simply by excluding the plaintiffs from eligibility *first*, and *then* reducing the hours in order to avoid excise taxes. While the district court in *Dave & Buster's* allowed the case to go forward, other courts may not consider it sensible to distinguish between two very similar means to achieving what is clearly a legal result – no coverage and reduced hours.

The *Dave & Buster's* case has struck fear into the hearts of many employers, for good reason. Many employers have struggled with the impact of the Affordable Care Act on benefit costs. The ACA imposes excise tax penalties under Internal Revenue Code ("Code") § 4980H against employers with at least 50 full-time or full-time equivalent employees ("applicable large employers") if they do not offer coverage to their full-time employees (generally employees working 30 or more hours per week). The ACA does not impose these requirements and penalties for part-time employees. Due to the 4980H excise tax requirements – and the potential draconian penalties for errors – many employers have sought to change plan eligibility and employment practices to avoid, or at least minimize, their coverage obligations and penalty risks under Code § 4980H. However, the *Dave & Buster's* case shows that employers would be well advised to approach these changes cautiously.

When should employers worry about an ERISA § 510 claim?

By its express terms, ERISA § 510 precludes actions taken by an employer "against a participant or beneficiary." An employee who has never been eligible under a plan is not a participant. But since ERISA § 510 also prohibits "interfering with the attainment of any right to which such participant *may become entitled* under the plan," plaintiffs making an ERISA § 510 claim might argue that they have standing to file suit because but for their reduction in hours, they would be plan participants. The courts have not fully addressed that argument in this context, so prior precedent on how courts have interpreted ERISA's definition of participant might be helpful.

Under ERISA § 3(7), a "participant" is an employee or former employee "who is or *may become* eligible" to receive benefits under an employee benefit plan. In *Firestone Tire & Rubber Co. v. Bruch*, 498 U.S. 101 (1989), the Supreme Court held that the term "participant" means "either an employee in, or reasonably expected to be in, currently covered employment." That means "participant" includes employees who are eligible to be covered, but not enrolled. However, if a class of employees is not eligible to participate in a plan, courts have held that they are not participants under ERISA. *See Piner v. Dupont de Nemours & Co.*, 238 F3d 414 (4th Cir. 2000).

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[1] Those allegations may be sufficient to confer standing, but plaintiffs still must make a prima facie case showing that the employer: (1) engaged in conduct prohibited by Section 510 (2) taken for the specific purpose of interfering (3) with the attainment of a right to which the employee may become entitled. If the employee meets this burden, the burden then shifts to the employer to show that there was a legitimate, nondiscriminatory basis for the challenged conduct. If the employer makes that showing, then the burden then shifts back to the employee to prove that the purportedly legitimate basis was a pretext for interference or discrimination.

Based on this precedent, if a participant who is currently enrolled in or eligible for the plan establishes that his or her hours were reduced to prevent future eligibility, under the plaintiffs' theory in *Dave & Buster's*, he or she would establish a prima facie case under ERISA § 510. The employer would then have to establish that plan coverage was not the primary motivation for its action. However, if an individual was never eligible for coverage (or if the plan were amended to remove coverage for the employee before the hours were reduced), it seems unlikely that the employee could establish a prima facie case under ERISA § 510 because the reduction in hours would be for the legitimate purpose of minimizing excise taxes, not for the purpose of denying benefits. (But note that minimizing excise taxes is still not a legitimate basis for retaliation against an employee for obtaining an ACA subsidy or premium tax credit, even though such action could result in the employer paying an excise tax.)

What do the plaintiffs allege the company told them?

In their lawsuit, the plaintiffs allege that Dave & Buster's management expressly communicated to them that their hours were being cut to avoid the cost of ACA compliance. The plaintiffs allege that Dave & Buster's scheduled two meetings at its Times Square location in June 2013 and required all employees of that location to attend. At the meetings, the general manager and assistant general manager announced that compliance with the ACA would cost as much as "two million dollars," so they planned to reduce the number of full-time employees at the location. The plaintiffs also allege that similar meetings took place at other locations. The plaintiffs' allegation is that the company reduced their hours to less than 30 per week with the "intent and the purpose, in whole or in part," of interfering with their attainment of rights as participants under the company's health plan. As relief, the plaintiffs requested reinstatement, restoration of plan benefits, backpay plus interest, reimbursement of medical expenses and attorneys' fees.

When can employers take actions that might impact coverage eligibility?

Generally, ERISA was not intended to, and cannot, override basic business decisions regarding workforce staffing. However, a clear indication that the desire not to offer coverage was the primary motivator falls closer to the ERISA § 510 line. In fact, in denying Dave & Buster's motion to dismiss, the court emphasized that "[t]he critical element is intent of the employer – proving that the employer specifically intended to interfere with benefits."

However, we think business considerations often will prevent an ERISA § 510 claim like this from succeeding, even if the plaintiffs' theory in Dave & Buster's ultimately prevails. For example, valid business considerations that impact workforce hours and are unrelated to benefit eligibility might include a change in business environment, changes in the economy or simply the business value of having a smaller number of more experienced full-time employees who receive assistance from part-time employees as needed. In addition, we note that avoidance of excise taxes would not give rise to a claim under ERISA § 510, so the structuring of the transaction could be critical. Nonetheless, *Dave & Buster's* shows that careful employer communication is as important, if not more important, as the business reason for making the change. Employers that can clearly point to legitimate business reasons are more likely to survive an ERISA § 510 claim, but if they mention benefits among those reasons, they might incur significant costs in resolving a lawsuit. In other words, employers that communicate business reasons that are unrelated to benefits have a greater chance of seeing their motion to dismiss granted.

Dave & Buster's may not be all bad news for plan sponsors. In fact, many employers already have plan designs that limit their exposure to ERISA § 510 claims based on the ACA. For example, Code § 4980H does not mandate coverage, but merely imposes a potential excise tax on employers that do not offer full-time employees coverage.

An employer that historically required employees to work 35 hours a week for coverage would not have interfered with eligibility of employees who worked 30-35 hours per week if it restricted those employees to working 29 hours or less per week. After all, employees who worked 30-35 hours in this example were not eligible for coverage previously and arguably did not have a reasonable expectation that they would be. In other words, they are no worse off, from a benefits perspective, after the change regarding their hours.

Cases involving health plan amendments suggest that ERISA § 510 claims would not succeed even if an employer changed plan eligibility solely due to the ACA's "employer mandate tax." While most cases alleging ERISA § 510 violations involve pension plans, ERISA § 510 claims against welfare plans have typically failed in part because ERISA gives plan sponsors the right to amend and terminate welfare plans "for any reason at any time." *Curtiss-Wright Corp v. Schoonejongen*, 514 U.S. 73, 78 (1995).

Ultimately, the interaction between the ACA and ERISA § 510 presents many new questions for the courts. It is impossible to know what the *Dave & Buster's* court and the courts that consider similar suits will decide. However, current precedent can help guide employers on the steps they should take to reduce their risk. Moreover, the *Dave & Buster's* case shows that employers should make employment decisions and craft their communications regarding those decisions carefully to reduce the risk of ERISA § 510 claims.

Steps Employers Can Take to Reduce Their Risk Under ERISA § 510 and FLSA § 18C

As noted, once a prima facie case is made, employers and insurers must provide "clear and convincing evidence" that they would have taken the same action to avoid an investigation of a retaliation complaint under FLSA § 18C. Similarly, employers will typically have to show that they had a legitimate, nondiscriminatory basis for the challenged conduct that was not a pretext to survive ERISA § 510 claims. In many cases, this will mean that the employer must prove a negative. As a result, employers and insurers should take steps to help ensure that they provide this evidence, such as:

- Amending (or creating) an anti-retaliation process to include ACA-protected activities.
- Affirmatively stating and documenting the non-coverage reasons underlying employment decisions, such as profitability, employee performance and business conditions, and avoidance of excise taxes, as is often done to show compliance with other employment laws. Employers should be clear to have valid business reasons regarding employment changes, and preferably, not tie them to plan coverage.
- Create a firewall between employees who make hiring, firing, compensation, disciplinary and workforce decisions and those who have access to information regarding Exchange subsidies and credits. Because HIPAA requires a similar firewall for privacy and security, this should be a relatively easy action for many employers.
- Appoint someone to address employees' concerns. This procedure should not involve employees who make hiring, firing, compensation, workforce or disciplinary decisions. Many complainants will be satisfied if they feel their concerns have been heard.
- Employers can also reduce their risk of ERISA § 510 claims by limiting employment changes to employees who already are not eligible for health coverage, or, for even greater security, who were never eligible for health coverage. For example, employers might want to place limits on the hours of new hires only. Similarly, an employer might want to limit hours only for current employees who otherwise have not met the plan's eligibility requirements at any time.

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