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Message from ERIC President and CEO Annette Guarisco Fildes:

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

As one of the three co-equal branches of the federal government, the judiciary branch is always on the radar of plan sponsors, and we do what we can to influence their decisions. ERIC and our allies have been active over the past several months in advancing employer interests in key lawsuits.

On July 2nd, ERIC filed an amicus brief with the 7th Circuit Court of Appeals in the *Equal Employment Opportunity Commission (EEOC) v. Flambeau* case. We urged the court to protect employers' abilities to offer comprehensive wellness plans. The case is discussed in this update, as are the regulations recently finalized by the EEOC, which specifically cite both *Flambeau* and *Seff*.

And an update about another case ERIC weighed in on, *Gobeille v. Liberty Mutual,* good news: we won! The court sided with the employer community, as ERIC had urged in our amicus brief. You may recall, this was the case in which Vermont demanded that all health plans active in the state, even self-funded plans, report into a state claims database. Luckily, the Supreme Court decided that this law was preempted by ERISA!

Hoping to continue our winning streak, ERIC will file an amicus brief in *Teladoc v. Texas Medical Board*. On appeal before the 5th Circuit Court of Appeals, this case explores whether the Board should be considered a state actor and therefore be exempt from antitrust laws, or is not a state actor and can be sued for violation of antitrust laws. This is an important case for telehealth and medical boards, but could also have an impact on other issues and state regulatory boards.

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

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

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ERIC will hold a conference call discussing cases addressed in this issue on Wednesday, July 20, 2016 from 2:00 to 3:30 pm EDT.

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

FEATURED ARTICLE

New Preemption Battleground between States and Local Governments: Benefits and Wages

By Jeffrey H. Ruzal, Senior Counsel in the Employment, Labor & Workforce Management Practice, Gretchen Harders, Member in the Employee Benefits practice, and Kristopher D. Reichardt, Associate in the Employment, Labor & Workforce Management Practice

Alabama's recently enacted state preemption law, which bans cities in the State from raising wages above the federal minimum, has come under fire. On April 28, 2016, two low wage workers, the Alabama National Association for the Advancement of Colored People ("NAACP"), and Greater Birmingham Ministries filed a federal lawsuit against the State of Alabama seeking to dismantle this new law. *See Lewis et al. v. Bentley et al.*, Case No. 16-cv-00690 (N.D. Ala. filed Apr. 28, 2016). The lawsuit also seeks to restore the city of Birmingham's minimum wage law, which would raise the minimum wage in that city to $10.10 by 2017. The NAACP's case was brought under the Fourteenth Amendment to the U.S. Constitution, which provides equal protection under the law. Birmingham's population is mostly African-American and allegedly was disproportionately affected by the preemption law.

This case is indicative of a growing trend; a similar preemption lawsuit has been filed on behalf of Flagstaff, Arizona, and Miami Beach, Florida has indicated that it will challenge Florida's state preemption law.

Lawsuits are on the rise in this area because a growing number of cities and localities are seeking to increase minimum wages and want to mandate benefits (*e.g.*, paid sick leave and time off) above state or federal minimums, prompting state legislatures to fight back with preemption laws. However, if these new lawsuits challenging state preemption are any indication, it appears that cities and localities that have implemented wage and benefit mandates at the municipal or local level are not deterred and will continue to challenge these state legislative initiatives.

Rise and Effect of Preemption Laws

Preemption laws essentially prevent cities and other municipalities from raising wages and mandating benefits by reserving the authority to the state to make laws in those areas. These laws are an exercise of the state's authority to grant and rescind local governments' (*e.g.*, cities and counties) power to enact municipal ordinances. Over a dozen of these types of wage and benefit preemption laws have been passed to-date, and there are similar laws pending in approximately six state legislatures with additional states expected to propose similar legislation later this year.

These laws are the brainchild of state legislatures reacting to a rash of employer-restrictive employment laws that have been passed at the local level in certain states. This recent trend in employment-related legislation on the state and local levels arguably suggests that the United States Congress may have been too passive in enacting similar legislation. However, many of these states share the concern that employer-restrictive employment laws may result in a state, city or locality being less "business friendly," which will adversely affect commerce and states' economies.

City and Local Employment Laws Provide Added Complexity to Employers

Local laws generally add significant complexity in maintaining workplace policies, wages, and benefits. Employers who have facilities or who conduct business within cities or other jurisdictions must first be aware of those additional laws. They must also track additional jurisdictions that are actively passing laws providing additional mandatory benefits, in order to ensure that their policies are in compliance. Oftentimes, these laws (and their subsequent dismantling through preemption) have additional consequences that drive up costs for employers.

Some employers may elect to offer the higher level of benefits provided by a municipality in order to ensure uniformity. Other employers have elected to track both levels of benefits, which could result in difficulties when employees work only part time, or pass through, a municipality with a higher benefit (e.g., paid sick leave). This is leading employers to hire additional consultants to ensure they are in compliance, and sometimes to employers simply paying fines rather than complying with the patchwork of conflicting laws.

What Should Employers Do Now

Pre-emption laws and litigation challenges will undoubtedly create complications for employers who must continually be on the lookout for local law requirements. The determination of which local laws are pre-empted will require employers to look beyond the difficult task of ensuring compliance with these local laws, and continually monitor legal developments at the state level. Employers will need to be mindful of the nuances of the interplay between state and local laws.

NOTEWORTHY PENDING CASE

EEOC v. Flambeau UPDATE: EEOC Appeals Finding That ADA Benefit Plan Safe Harbor Trumps EEOC Wellness Program Voluntariness Attack

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

In the spring *Benefits Litigation Update,* we discussed *EEOC v. Flambeau* in which EEOC sued Flambeau on the claim that the company was compelling employees to submit to medical examinations and thus violating the Americans with Disabilities Act ("ADA"). Prior to this case, Flambeau sponsored a self-funded group health plan and in 2011 adopted a wellness program, which included a health risk assessment ("HRA") and biometric screening (the "Wellness Program"). In 2012 and 2013, Flambeau offered company-paid health insurance only to employees who participated in the Wellness Program. As a result, it discontinued health coverage for an employee who did not complete the HRA and biometric test. The employee filed an EEOC charge and that is what led to this lawsuit.

Flambeau defended by arguing that its Wellness Program fell within the ADA safe harbor for bona fide benefit plans (42 U.S.C. 12201(c)(2)). The district court agreed with Flambeau and followed the Eleventh Circuit decision in *Seff v. Broward County* (2012), which had found that the wellness plan in question fell within the ADA safe harbor. The judge in *Flambeau* cited statements by Flambeau's benefit consultants that they relied on the aggregate wellness data to classify health risks and determine plan costs and premiums under the health plan. The court rejected the EEOC's argument that the safe harbor did not apply because the wellness program provisions were not in a Summary Plan Description. EEOC appealed that *Flambeau* decision to the Seventh Circuit. Its argument on appeal cites to its final ADA Wellness rule which states EEOC's view as to why *Seff* was wrongly decided and that EEOC's ADA rule's voluntariness requirements do apply to wellness programs, even if they are part of the employer's health plan. In a bit of bootstrapping, EEOC argues that the Seventh Circuit should give deference to its new rule and, on that basis, reverse the district court decision.

TAKEAWAYS: In light of both *Seff* and *Flambeau*, employers are well-advised to make their wellness programs one of the terms of their health benefit plans or to assure that a wellness program is itself a bona fide benefit plan so that they can better argue the program satisfies the ADA's bona fide benefit plan safe harbor. Therefore the wellness program would be outside of the EEOC's review of its "voluntariness," unless and until EEOC's contrary view prevails in the Seventh Circuit or other courts.

NOTEWORTHY DEVELOPMENT

EEOC Issues Final ADA and GINA Wellness Program Rules

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

On May 17, 2016, the EEOC published final rules under the Americans with Disabilities Act ("ADA") and the Genetic Information and Nondiscrimination Act ("GINA") concerning all wellness programs that ask employees questions about disabilities and/or require medical examinations. The rules are effective January 1, 2017 and require that wellness programs must be "reasonably designed to promote health or prevent disease," with a "reasonable chance" of doing so; must not be "overly burdensome"; must not violate employment discrimination laws; and may not use "highly suspect" methods.

The final ADA rule expressly permits employers to offer limited incentives (reward or penalty) for participation in qualifying wellness programs, up to a maximum of 30 percent of the total cost of *employee-only* coverage. "Total cost" includes financial, in-kind, and "de minimis" incentives (like a t-shirt, an improved parking space, or a casual dress day). Under the rule "voluntary" programs neither require employees to participate, nor deny or limit coverage under the employer's group health plans on the basis of participation in the wellness program. Employers may not take adverse employment actions or retaliate against employees who do not participate.

The final ADA rule expands current medical information confidentiality rules: (1) covered entities may receive medical information collected through a wellness program *only* in aggregate terms that do not identify individuals, except as needed to administer the plan; and (2) a covered entity may not require an employee to agree to disclosure of medical information (except as permitted to carry out specific wellness program-related activities), or to waive ADA confidentiality protections, as a condition for participating in or receiving a wellness program incentive. Adherence to HIPAA Privacy Rules likely satisfies the confidentiality obligation.

The EEOC's final rule departs from the Affordable Care Act's ("ACA's") 2013 Tri-Agency Regulations by extending to participatory programs the 30 percent incentive limit under health-contingent wellness programs (unlimited under the Tri-Agency Regulation). The final ADA rule also excludes the additional tobacco cessation incentive if the program includes medical exams that test for nicotine/tobacco; programs without the exam or disability-related inquiry may offer a 50 percent incentive (based on employee attestation). The EEOC's 30 percent limitation could significantly affect affordability and reduce incentives for participation—particularly essential for tobacco cessation. The ADA rule still calculates the 30 percent incentive based only on the total cost of self-only coverage. The final GINA rule permits an additional 30 percent (of self-only coverage cost) incentive for a covered spouse versus the Tri-Agency Regulations, which base the calculation on the total cost of coverage for the individual and any spouse and dependents to whom the wellness programs are available where family or dependent coverage is selected.

TAKEAWAYS: Employers should now evaluate their wellness programs against the conflicting ACA and ADA/GINA rules to ensure that the monetary incentives comply with the more stringent standards under the ADA and GINA. If a plan currently offers the 50 percent incentive for tobacco cessation, it may be time to reevaluate that as well.

NOTEWORTHY RECENT DECISIONS

Santana-Diaz v. Metropolitan Life Insurance Co.: Informing Participants of Plan Limitations on Period to Bring Suit

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

Three Circuits have now determined that a plan limitation regarding the time period to bring a civil lawsuit in federal court related to a benefit claim must be set forth not only in the plan documents, but also in the benefit claim denial letter. The First Circuit Court of Appeals, in *Santana-Diaz v. Metropolitan Life Insurance Company*, No. 15-1273 (1st Cir. March 14, 2016), is the most recent court to drive home the importance of inclusion of such limitation periods in the claim denial letters (following decisions in the Court of Appeals for the Third Circuit (*Mirza v. Insurance Administrator of America, Inc.*, 800 F.3d 129 (3d Cir 2015) and Sixth Circuit (*Moyer v. Metropolitan Life Ins. Co.*, 762 F. 3d 503 (6th Cir. 2014)).

The U.S. Supreme Court found in *Heimeschoff v. Hartford Life & Acc. Inc. Co.*, 134 S. Ct. 604 (2013) that it is permissible for benefit plans to impose reasonable time limits on the filing of benefit claim suits. The subsequent cases *Moyer, Mirza and Santana-Diaz* found that under the plain language of the labor regulations, the plan's contractually-based time limit for filing a civil action must be explained in the plan documents and claim denial letters in addition to the required statement regarding a claimant's right to bring a civil action. A plan administrator's failure to inform claimants of the plan's time limit renders the plan limitation period inapplicable and violates the regulations. The courts left open the question as to whether a forum state's statute of limitations for bringing a suit must be included in the denial letters where the plan does not contain its own contractual limitations.

TAKEAWAYS: Ensure that any plan limitations period for filing a suit is set forth in the plan documents, and the claim denial letters, and ensure that any third party claims administrator who issues claim denial letters also tailors the letters to include the plan's particular limitation period.

Supreme Court Sets Its Sights On Who Can Sue: Risks to Derisking

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

Two cases decided by the United States Supreme Court in May 2016 addressed the issue of standing, that is, who can sue over an alleged violation of the law. The first of these cases involved the Fair Credit Reporting Act (FCRA); the second teed up the issue under ERISA. These decisions raise a critical issue for employers considering annuity purchases as a method of derisking their defined benefit plans.

Spokeo, Inc. v. Robins

In *Spokeo, Inc. v. Robins,* 135 S. Ct. 1892 (2015), an individual claimed to be aggrieved by inaccurate information on Spokeo's "people search engine," an aggregating site that purports to gather and provide information from a wide range of online databases. The suit failed in the trial court because the judge concluded that the plaintiff had not showed "injury in fact," part of the requirement of "standing," the doctrine by which courts sort out who may and may not go forward with a lawsuit in federal court. The appellate court said the case could proceed, because the plaintiff's contention that his statutory right to accuracy under the FCRA sufficiently described an injury.

The Supreme Court decided somewhere in between the holdings of the two lower courts. The injury-in-fact requirement, according to the Court, requires a plaintiff to show that he or she suffered an invasion of a legally protected interest that is concrete and particularized and actual or imminent, not merely conjectural or hypothetical. Concreteness means that the injury must actually exist; particularization means the plaintiff must be affected by the injury in a personal and individual way.

Within this framework, a statutory violation sometimes may be enough to create an injury-in-fact, and allow a plaintiff to go forward with a suit. But such violations do not always grant that right. A concrete and particularized injury still must correlate with the claimed violation of the statute. A "bare procedural violation," for example, would not be enough to confer a right to bring suit, and a violation of a statute that does not cause harm, or carry any material risk of harm, also would be insufficient.

Pundt v. Verizon

Several days after deciding Spokeo, the Court acted on a petition filed in *Pundt v. Verizon Communications, Inc.*, a case known in the lower court as *Lee v. Verizon Communications, Inc.*, 623 Fed. Appx. 132 (5th Cir. 2015), and vacated the decision previously entered in Verizon's favor, sending it back for reconsideration in light of what the Court said in *Spokeo*.

In *Pundt*, Verizon engaged in an annuity transaction, transferring 45% of its defined benefit pension plan participants out of the plan to annuities purchased with plan assets. The transferred participants who sued ended up failing on the merits of their claim. The non-transferred participants, however, suffered dismissal due to a lack of standing, the issue arising in *Spokeo*.

The non-transferred participants complained that Verizon used plan assets to pay approximately $1 billion in fees and expenses involved in the annuity transaction, and that this represented an illegal use of plan assets. The Fifth Circuit found they lacked standing to prosecute the suit because participants in a defined benefit plan have no ownership interest in the assets of a plan. They only may claim a right to collect the benefit due under the terms of the plan. While the complaint alleged that the plan would be significantly underfunded after the transaction, the court said the risk of future problems with benefit payment did not represent an injury that could confer a right to sue. Additionally, the Fifth Circuit refused to allow the injury-in-fact to arise out of the plaintiffs' claim that a statutory violation automatically represented an injury.

The Supreme Court's action in *Pundt* allows the non-transferee participants to raise renewed arguments that they suffered a concrete and particularized injury. In all likelihood, the "statutory violation" theory will continue to fail. The key question to be answered will lie in how much "risk" of a harm resulting from plan underfunding will be required to confer a right to sue. This will involve flushing out what *Spokeo* meant when it referred to a "material risk" of harm that can give standing to sue. If plan participants can prove that a plan transaction is likely to lead to insolvency, the courts may deem this a material risk of harm.

TAKEAWAYS:

- Bare accusations of statutory violations probably are not a basis for a lawsuit.
- Risk-based injuries may have a place in conferring standing.
- The opinion in *Pundt* upon reconsideration will clarify how far risk-based injuries will go in providing standing to sue for defined benefit plan participants

Ninth Circuit Kicks Participation Burdens to ERISA Plan Managers

By Adam C. Solander, Member of the Firm in the Health Care and Life Sciences practice, and **Cassandra Labbees**, Associate in the Employee Benefits practice

In *Estate of Barton v. ADT Security Services Pension Plan*, No. 13-56379 (9th Cir. April 21, 2016), the Ninth Circuit held that if the person bringing a case (the "claimant") successfully makes an initial argument that he is entitled to plan benefits (known as a "prima facie" case), the burden of proof shifts to plan fiduciaries to determine whether or not he worked enough hours for a participating employer to collect a pension.

Barton, the claimant, worked for the American District Telegraph Company ("ADT"), the defendant in this case, and/or its affiliates from November 1967 until he resigned in September 1986. Barton also worked for a moving company and served in the Marine Reserve for parts of that period. ADT denied Barton's claims for benefits, stating that he failed to demonstrate "continuous employment" under the plans. The Ninth Circuit, reversing the district court's decision, stated that the lower court incorrectly placed the burden of proof on Barton. Ordinarily the claimant bears the burden of showing he has a right to ERISA benefits, but only when the claimant has at least equal or better access to evidence to prove he is entitled to benefits. In situations where the defendant controls the information that determines entitlement, thus leaving the claimant without a way of establishing his burden of proof, the burden shifts to the defendant. To require a claimant to prove hours worked over the course of two decades is unreasonable and inconsistent with the goals of ERISA. Citing *Anderson v. Mt. Clements Pottery Co.*, 328 U.S. 680 (1946), the court stated that an employer has a duty to maintain relevant records. To make a prima facie case for plan benefits, the plaintiff need not have all the relevant information, but only needs to show some objective evidence of prior employment, such as W-2 statements, Social Security records, income tax returns and pay stubs.

TAKEAWAYS: Employers should carefully retain all relevant records for all past and present employees regarding benefits in order to substantiate any claim for benefits if the need arises.

Second Circuit Rejects Doctrine of "Substantial Compliance" with DOL's Claims Processing Regulations

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

The Second Circuit recently held that a plan's failure to follow the Department of Labor's (DOL) detailed regulations regarding benefit claims processing and appeals will result in a forfeiture of the deferential review despite discretionary authority having been granted. *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016). The Second Circuit thus departed from the "substantial compliance" doctrine, which says that when the plan and the claimant engage in a good faith exchange of information on claims, denials and appeals, non-material violations of deadlines or other procedural irregularities will not entitle the claimant to *de novo* review.

The regulations, found at 29 C.F.R. 2560.503-1, mandate a plethora of processes and procedures plans must establish and follow. The Second Circuit applied the regulations strictly, and gave decisive weight to the DOL's "preamble" to the regulations, which states that any decision departing from the regulations should not be entitled

to judicial deference, even though the regulations themselves do not contain any such provision. Perhaps mindful of (but not mentioning) the Supreme Court's "rejection" of the "one-strike-and-you're out" approach in *Conkright v. Frommert,* 559 U.S. 506 (2010), the Second Circuit held that a plan that proves it has established procedures "in full conformity" with the regulations *and* can show that its failure to comply with the regulations was both inadvertent and harmless, can preserve the deferential review.

TAKEAWAYS: Because *de novo* review both imposes a greater burden on plans to justify benefit denials, and allows claimants, in the discretion of the trial court, to admit evidence beyond the administrative record, plan and claims administrators should ensure (and importantly, document for litigation purposes) that their claims review/appeal procedures fully comply with the regulations, as well as new regulations issued under the Affordable Care Act. Such procedures should be followed as close to the letter as reasonably possible, despite the burden some claimant's counsel, anticipating litigation, will impose for tactical reasons during the appeal stage. At all times, claims should be governed by the principle that claimants are entitled to a transparent process, so that any deviations from the process can reasonably be found to be inadvertent and without any substantial prejudice to the claimant.

About Epstein Becker Green

Epstein Becker & Green, P.C., is a national law firm with a primary focus on health care and life sciences; employment, labor, and workforce management; and litigation and business disputes.

About ERIC

The only national association advocating solely for the employee benefit and compensation interests of America's largest employers.

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

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