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General Employee Benefits

Fifth Circuit Vacates DOL Fiduciary Rule

On March 15, the U.S. Court of Appeals for the Fifth Circuit vacated the U.S. Department of Labor's ("DOL") fiduciary rule, holding that the rule conflicts with the Employee Retirement Income Security Act ("ERISA"). Currently, ERISA and its regulations limit fiduciary status to parties who render investment advice for a fee to parties who render individualized investment advice "on a regular basis" that is the "primary basis" for investment decisions. The new fiduciary rule eliminates the "regular basis" and "primary basis" criteria, and imposes new "impartial conduct standards" and other requirements previously inapplicable to investment advisors.

In *Chamber of Commerce v. U.S. Dep't of Labor*, the Fifth Circuit held that ERISA's statutory text incorporates the common law rule that fiduciary status requires a special relationship of trust and confidence between the fiduciary and the investing party. The Fifth Circuit went on to state that, by attempting to broadly expand the definition of "fiduciary" to include persons such as stockbrokers and insurance agents, the new fiduciary rule "fatally conflicts with the statutory text" of ERISA and the common law rule by eliminating the "regular basis" and "primary basis" criteria. The Fifth Circuit also noted that, even if the new fiduciary rule did not conflict with the statutory text of ERISA, the rule would nevertheless fail to meet the reasonableness requirements for administrative action under the Administrative Procedures Act and the U.S. Supreme Court's *Chevron* ruling. The Fifth Circuit found the rule unreasonable for several reasons, including it being illogical and inconsistent, and infringing on "SEC turf" in a manner that undercuts the Dodd Frank Act.

Fifth Circuit Will Apply De Novo Review to Benefit Denials Based on Factual Determinations

The U.S. Court of Appeals for the Fifth Circuit has held that it will now review an ERISA plan administrator's benefit denials based on factual determinations under the *de novo* standard of review, rather than the more deferential "abuse of discretion" standard. In *Ariana M. v. Humana Health Plan of Tex., Inc.*, a covered dependent under an employer sponsored group health plan received treatment

for an eating disorder at a provider facility. The plan covered partial hospitalization for mental health treatments that were medically necessary. The plan administrator approved coverage for a certain period of time, but then determined the benefit was no longer medically necessary.

In her lawsuit, the claimant asserted the Fifth Circuit should review the plan administrator's determination *de novo* because the plan's discretionary authority language was unenforceable under a state law banning discretionary clauses for insurers. The plan administrator agreed not to rely on the plan language, but invoked the deferential abuse of discretion standard of review regarding the factual medical necessity determination. The Fifth Circuit noted several U.S. Supreme Court rulings on standards of review, finding that the Court refers to benefit determinations and denials without distinguishing between legal and factual decisions. The Fifth Circuit also noted the Court's strong interest in uniformity for ERISA plans.

Previously, the Fifth Circuit had applied the deferential arbitrary and capricious review standard to factual determinations, while reserving the stricter *de novo* standard to review plan interpretations. The Fifth Circuit's decision overrules long standing precedent and resolves a circuit split that had developed between the Fifth Circuit and eight other circuit courts.

IRS Revises 2018 Benefit Limits Under Tax Cuts and Jobs Act

The Internal Revenue Service ("IRS") issued Revenue Procedure 2018 18, announcing several revised 2018 benefit limits and thresholds to reflect certain changes prescribed under the Tax Cuts and Jobs Act (the "Act"). Key changes include:

- HSAs. Annual health savings account ("HSA") contribution limits for individuals with family high deductible health plan ("HDHP") coverage have been lowered to $6,850 from $6,900. HSA contribution limits for individuals with self only HDHP coverage remain unchanged. Minimum annual deductibles and out of pocket maximums for self only and family HDHP coverage amounts also remain unchanged.

- Adoption Assistance Exclusion and Adoption Credit. The maximum amount that may be excluded from an employee's gross income under an employer provided adoption assistance program and maximum credit for the adoption of a child have been reduced to $13,810 (down from $13,840). The exclusion and credit will also begin to be phased out for individuals with a

modified adjusted gross income ("AGI") of over $207,140 (down from $207,580), and will be entirely phased out for individuals with a modified AGI of over $247,140 (down from $247,580).

- Small Business Health Care Tax Credit. The average annual wage at which the tax credit begins to phase out for eligible small employers has been reduced to $26,600 (from $26,700). The maximum average annual wage for small employers to be eligible for the credit has been reduced to $53,200 (from $53,400).

- Archer MSAs. For Archer MSA compatible high deductible coverage, for self only coverage, the out of pocket maximum has been lowered to $4,550 (from $4,600). For family coverage, the minimum annual deductible has been lowered to $4,550 (from $4,600).

Other 2018 limits and thresholds, including limits for salary reduction contributions to health flexible spending accounts (FSAs), qualified transportation fringe benefits, and qualified small employer health reimbursement arrangements (QSEHRAs) remain unchanged. The IRS also announced that the Act will not affect 2018 dollar limits applicable to qualified retirement plans.

Retirement Plan Developments

Seventh Circuit Joins in Holding ERISA Does Not Preempt State Slayer Statutes

The U.S. Court of Appeals for the Seventh Circuit held that ERISA does not preempt an Illinois state law preventing murderers from receiving benefits from their victims by treating the murderers as having predeceased their victims (generally known as a "slayer" statute). In *Laborers' Pension Fund v. Miscevic*, a woman killed her husband who had earned a vested benefit under a pension plan that provided survivor benefits if the participant died prior to the commencement of benefits. Both the wife and the couple's child (through a guardian) sought to recover a survivor benefit: the child's guardian argued that the state's slayer statute prevented the wife from receiving the benefit, while the wife argued that ERISA preempted the state statute. In making its decision, the Seventh Circuit looked to the U.S. Supreme Court's decision in *Egelhoff v. Egelhoff*, wherein the Court noted that slayer statutes had a "long historical pedigree predating ERISA" and that their underlying purpose is well established and predates ERISA. In *Miscevic*, the Seventh Circuit found in favor of the guardian, noting that the wife

had failed to demonstrate that Congress had intended ERISA to contravene the well established principle underlying slayer statutes and intended for an individual to receive benefits after murdering a participant.

Southern District of New York Disallows "Segal Blend" in Calculating Withdrawal Liability

The U.S. District Court for the Southern District of New York held that the use of the "Segal Blend" to calculate a company's withdrawal liability when it withdrew from a multiemployer pension plan violated ERISA. The "Segal Blend" is a proprietary method used by the Segal Company to value a multiemployer plan's unfunded vested benefits to calculate withdrawal liability. In *The New York Times Co. v. Newspapers & Mail Deliverers' Publishers' Pension Fund*, the plaintiff argued that using the Segal Blend violated ERISA, which requires that actuarial assumptions and methods used to calculate withdrawal liability be reasonable in the aggregate and "offer the actuary's best estimate of anticipated experience under the plan." The court agreed with the plaintiff, noting that the pension funds' actuary testified that the Segal Blend's funding rate was lower than the actuary's best estimate of anticipated plan experience in the long term.

IRS Announces Retroactive Reduction in Determination Letter Fee for Terminating Plans

The IRS issued Revenue Procedure 2018 19, which announced that the user fee for determination letters for terminating retirement plans has been reduced to $2,300 (from $3,000) effective January 2, 2018. The reduction reverses an increase in the Form 5310 user fee, which appeared in Revenue Procedure 2018 4, and applicants who paid the higher user fee will receive a refund. No explanation was given for the retroactive reduction.

Health and Welfare Plan Developments

Eastern District of Wisconsin Rules on Scope of Essential Health Benefits for Annual Dollar Limit Purposes

The U.S. District Court for the Eastern District of Wisconsin determined that a group health plan insurer did not violate the Affordable Care Act's ("ACA") prohibition on annual dollar limits for essential health benefits in 2013 by imposing a limit on dialysis benefits. Under the ACA, group health plans and insurers are not permitted to impose annual dollar limits on "essential health benefits" for individuals, effective for plan years beginning January 1, 2014,

following a three year approach to phase out annual dollar limits. In 2013, the maximum limit for essential health benefits for each insured individual was $2 million. Under joint regulations, states were required to adopt a benchmark plan to define which benefits would be considered "essential health benefits" effective for 2014.

In *Fresenius Medical Care Midwest Dialysis LLC v. Humana Ins. Co.*, Fresenius, a dialysis provider, opposed Humana's $30,000 annual limit on dialysis benefits in 2013, arguing that dialysis was an essential health benefit under the broader category of "chronic disease management." In its review, the district court noted that the ACA's statutory definition of "essential health benefits" lists 10 general categories, but leaves the scope of coverage within these categories to be defined by the Secretary of Health and Human Services. Therefore, because the Secretary had not specifically stated that dialysis was an essential health benefit, the court determined it could not conclude otherwise and held that Humana's $30,000 annual limit was permissible.

Second Circuit Holds Title VII Protections Extend to Sexual Orientation Discrimination

The U.S. Court of Appeals for the Second Circuit has held that Title VII of the Civil Rights Act of 1964 prohibits discrimination based on sexual orientation, in addition to previously established protected classes of race, color, religion, sex or national origin. In *Zarda v. Altitude Express*, a gay employee, who was fired from his job after telling a client he was gay, filed a discrimination charge with the Equal Employment Opportunity Commission ("EEOC") and also sued his former employer under both New York state law (which explicitly prohibits discrimination based on sexual orientation) and Title VII. Overruling prior precedents, the Second Circuit concluded that Title VII's prohibition of sex discrimination extends to discrimination based on sexual orientation. Although the Second Circuit noted that Congress was likely not concerned with sexual orientation discrimination when it enacted Title VII, it nevertheless explained that sexual orientation discrimination is a subset of sex discrimination for three reasons. First, sexual orientation discrimination is defined by an individual's sex in relation to the sex to which an individual is attracted, making discrimination impossible unless an employer takes an employee's sex into account. Second, sexual orientation discrimination is rooted in sex based stereotypes about how members of a particular sex should act or behave. Third, sexual orientation discrimination is associational discrimination because an action motivated by the employer's opposition to the association between members of particular sexes is

discrimination based on the basis of sex. The Second Circuit is the second U.S. Court of Appeals to find that sexual orientation discrimination is a protected subclass of sex discrimination, following the Seventh Circuit's 2017 decision on similar grounds in *Hively v. Ivy Tech Cmty. College.*

IRS Releases Sample Notice of Employer Shared Responsibility Liability

The IRS released sample Notice CP 220J (the "Notice") that will be used to notify applicable large employers ("ALEs") that the IRS has charged an employer shared responsibility payment, which is the Internal Revenue Code 4980 penalty that may be assessed if an ALE fails to offer adequate health coverage to full time employees and their dependents. The release of the sample Notice follows the release of Forms 14764 and 14765, which ALEs can use to communicate with the IRS and change information reported on Form 1095 C to potentially reduce or eliminate any penalty or liability. The sample Notice provides summary information about any penalty, including circumstances that could trigger liability, as well as a description of steps the ALE can take to challenge the penalty. The sample Notice also includes a reminder that any penalty is not deductible for federal income tax purposes. The IRS noted that it would review information submitted by ALEs and contact them, or would send nonresponding ALEs a Notice and demand for the proposed penalty.

IRS Clarifies Male Sterilization or Contraceptives Not Preventive Care for HDHP Purposes

In IRS Notice 2018 12, the IRS clarified that health plans covering male sterilization or male contraceptives, either with or without a deductible, under the statutory minimum deductible for HDHPs do not qualify as HDHPs under current guidance for HSAs. Under current guidance, individuals may make or receive HSA contributions only if they are covered by a qualified HDHP and have no other disqualifying coverage. Generally, an HDHP may not provide benefits until its minimum deductible is satisfied, although it may provide preventive care benefits, either with or without a deductible, below the statutory minimum requirement. To qualify as preventive care, benefits must be defined as such under the Social Security Act ("SSA") or in IRS or Treasury Department guidance.

The IRS noted that some states have recently adopted laws requiring health insurance policies to cover male sterilization or contraceptives without cost sharing. However, despite the fact that these benefits are required under state law, plans that provide these benefits before the HDHP minimum deductible

is satisfied will not be considered HDHPs under federal law. Consequently, individuals covered by such plans will be ineligible to make or receive HSA contributions because these benefits are not considered preventive care under the SSA or under IRS or Treasury Department guidance. Finally, the IRS noted that these benefits are not required to be covered without cost sharing under health care reform. The IRS provided transition relief for periods before 2020, during which time individuals will not be treated as failing to qualify as eligible for an HSA merely because they are or were covered by an insurance policy that is not an HDHP solely because it provides male sterilization or contraceptive benefits, either with or without a deductible, below the HDHP statutory minimum.

Anthem Settles Autism Treatment Class Action for $1.6 Million

Anthem Insurance Companies Inc. agreed to pay over $1.6 million to end claims that it violated federal law by placing limits on coverage of therapy treatments for children with autism disorders. The proposed settlement would end a class action lawsuit stemming from allegations that Anthem had violated the Mental Health Parity and Addiction Equity Act by limiting coverage for a 13 year old boy's autism treatment to 20 hours per week. Under the settlement, Anthem also agreed to stop using guidelines that base coverage of applied behavioral analysis therapy for autism solely on an individual's age. Individual payments to class members would range from $2.02 to over $36,000.

Upcoming Compliance Deadlines and Reminders

Upcoming Retirement Plan Compliance Deadlines and Reminders

1. **Quarterly Benefit Statements.** For defined contribution plans that permit participants to direct investments, the deadline for distributing first quarter benefit statements is May 15, 2018.

2. **Annual Funding Notice.** Calendar year defined benefit pension plans with over 100 participants must provide the annual funding notice to required recipients by April 30, 2018 (*e.*, within 120 days of the end of the plan year). Defined benefit pension plans with 100 or fewer participants generally have until the Form 5500 filing deadline to provide the annual funding notice.

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