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Employee Benefits for Employers

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Arbitration of ERISA Claims: Yes, You Can!*

I. Introduction.

ERISA neither expressly nor impliedly prohibits mandatory arbitration of claims.[1] Numerous courts that have analyzed the purpose of both ERISA and the Federal Arbitration Act ("FAA") have held that ERISA claims are arbitrable.[2] And while the Supreme Court has not spoken directly to the issue, the Court's pro-arbitration jurisprudence under the FAA[3] – culminating with several decisions approving the inclusion of class action waivers in arbitration agreements[4] – strongly suggests that it would sanction the inclusion of ERISA claims in an arbitration agreement.

Moreover, courts applying the recent Supreme Court decisions involving mandatory arbitration agreements have affirmed the use of class waivers in a variety of federal statutory contexts, including ERISA.[5] As a result, more and more employers are implementing broad arbitration clauses with class action waivers.[6]

The endorsement of arbitration of ERISA claims means that employers may want to consider implementing a mandatory arbitration policy that covers *all* workplace-related causes of action, including ERISA claims. This article does not provide in depth coverage of the advantages and risks of including ERISA claims in an arbitration program, but highlights some of the key issues.[7] Before deciding to implement a mandatory arbitration policy prohibiting class-based litigation of all potential claims (including claims that could be brought under ERISA), employers should consider whether the program is appropriate for their organization and should determine whether the benefits of such program outweigh any potential costs associated with its drafting, corporate rollout, and enforcement.

II. Implementing a Mandatory Arbitration Policy Prohibiting Class-Based Dispute Resolution: Some Pros and Cons.

Advantages. There are many advantages for employers who adopt a mandatory arbitration program that prohibits class litigation. When deciding whether to implement an "all claims" arbitration agreement, perhaps the biggest consideration is the ability to require that any future ERISA *class* claims could be included within the scope of the arbitration agreement. In today's litigious environment, most sizable companies are at risk for class actions, including ERISA class actions. When ERISA fiduciary breach claims are involved, damages are often alleged to be tens or hundreds of millions.

Likewise, the private nature of the proceedings and the confidential negotiation and resolution of arbitration can help minimize a potential public devaluation of the corporate brand. Experienced arbitrators can also be an advantage. When an ERISA claim is brought in federal court, there is a relatively high likelihood that the district judge does not have expertise in ERISA. By contrast, today most large arbitration associations have a roster of experienced ERISA arbitrators.

Other considerations are costs and likelihood of success. For instance, a 2011 Cornell University study found that employers win more often in arbitration than litigation, and that arbitration often results in lower awards for employees.[8] In short, arbitration, with its greater procedural and evidentiary flexibility, *may* provide a speedier, cheaper, more efficient, and more advantageous resolution to disputes.

Risks. Arbitration is not without its drawbacks. Rarely is an arbitration award vacated. The FAA provides

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for appellate review in very limited circumstances (e.g., fraud, partiality, arbitrator exceeds scope of authority), and those appeals are largely confined to challenges regarding the general fairness of the arbitration process itself (unless, as discussed below, the agreement provides otherwise).

Moreover, the arbitrator's interpretation of the arbitration agreement, even if erroneous, is afforded great deference by federal courts.[9] Mandatory arbitration of benefits claims under ERISA does present unique challenges. For instance, the notice and disclosure process required by ERISA, and the management of workforce perceptions may present employers with complications during the rollout and implementation of the mandatory arbitration program which includes benefits claims.

If an employer does decide to include ERISA claims within its arbitration program, as will be discussed below, there are drafting suggestions and other communicative strategies that can be used to maximize the full benefit and utility of the program, minimize any negative potentialities, and safeguard against challenges to enforcement after the policy has been implemented.

III. Special Considerations When Drafting, Implementing, and Enforcing a Mandatory Arbitration Policy That Includes Causes of Action under ERISA.

Clarity, fairness, and transparency are hallmarks of an effectively drafted and implemented mandatory arbitration program. Employers will benefit from keeping these general principles front and center during all phases of the rollout of the program. The incorporation of ERISA claims into the arbitration agreement does require special care and consideration when crafting and implementing the program. Below is a non-exclusive list of some of the more important considerations.

a. Application of General Contract Principles and Other Drafting Considerations.

As the Supreme Court has made abundantly clear, it is essential that the arbitration agreement contains the basic attributes and threshold requirements of a valid contract: consideration, mutual assent, and definiteness of terms. To stave off challenges to contract formation, it is critical that assent is evidenced by written acknowledgment that the employee understands and accepts the terms of the agreement. It is also wise to include severability and choice of forum clauses, and to incorporate into the agreement an appellate arbitration procedure to protect against the limited appellate review under the FAA.

b. Defining the Scope of the Agreement and the Powers and Duties of the Arbitrator.

Consider specifying in the agreement that the arbitrator, not the court, decides any and all questions of enforceability/arbitrability, with one exception: the class waiver. To take advantage of the Supreme Court's pro-class action waiver jurisprudence, reserve review of any challenge to the class action waiver to the court. In this way, the company has a right of appeal if the district court invalidates the waiver/finds that silence means plaintiffs can proceed as a class.

Similarly, to get maximum value from the mandatory arbitration program, employers must clearly delineate the scope of the agreement by specifying what types of claims will be subject to arbitration. A good rule of thumb: broad provisions are best (e.g., "all claims of whatever nature arising out of or related to the employee's employment.")

Be sure to identify the parties that will be subject to and bound by the arbitration agreement. To avoid the *Oxford Health Care v. Sutter* scenario (Justice Scalia: "[t]he arbitrator's construction holds, however good, bad, or ugly") where the arbitrator was free to interpret the agreement to allow for class arbitration, explicitly and unequivocally mandate in the agreement that the dispute must be arbitrated on an individualized basis. Additionally, employers will need to assess and evaluate corporate culture when deciding whether the mandatory arbitration program will include all employees or only newly hired employees and/or new plan participants.

Regardless of the arbitrator's working knowledge of ERISA, the agreement nevertheless should limit the scope of the arbitrator's review on a denial of benefits claim to the facts contained in the administrative record, as would be the case in federal court after the exhaustion of administrative remedies. Employers define the scope of

the arbitrator's review by including language that the arbitrary and capricious standard applies to claims for wrongful denial of benefits[10] (whether under an ERISA-governed plan or otherwise).[11]

c. Incorporating the Mandatory Arbitration Program into the Plan.

Aside from the contractual requirements of any enforceable arbitration agreement, ERISA requires employers and other plan fiduciaries notify and inform participants and beneficiaries about their benefits, rights, and obligations under the benefit plans in which they participate. Thus, unlike the arbitration of either commercial or traditional workplace disputes, where the operative provisions can be contained within the four corners of one controlling document, the implementation and rollout of a mandatory arbitration program that includes ERISA causes of action requires reference in plan documents to ensure a court will find the agreement to arbitrate ERISA causes of action enforceable. The main vehicle for informing participants and beneficiaries of these requisite features under the plan is the summary plan description (the "SPD"). DOL regulations require certain information to be contained in the SPD, much of which is information to assist participants and beneficiaries recover benefits or enforce or clarify rights under the plan.[12] Therefore, it is critical that there is a uniformity and clarity of intention between and among the arbitration agreement, the plan, and the relevant notice, namely the SPD, provided to plan participants and beneficiaries.

Thus, when drafting a mandatory arbitration program that includes fiduciary breach and other statutory claims under ERISA and as well as claims for benefits,[13] reference to the arbitration program must be included not only in the relevant agreement[14] but also in the plan documents, preferably in the rights and claims procedures sections of the plan and the SPD.

Likewise, the terms of the arbitration agreement should be specifically incorporated by reference into the plan and the SPD, and remain consistent throughout all of the relevant and operative documents. Inconsistencies or ambiguities between and among the documents may render them unenforceable.

If substantive changes are later made to the arbitration agreement/program, such changes may need to be reflected in the plan documents and a summary of material modifications may need to be provided to plan participants informing them of any changes to the program.

To avoid any possible gaps in coverage (i.e., during the time of execution of the agreement and the time the employee becomes eligible to participate in the plans), the arbitration clause should specifically reference that it applies to any claims which may arise out of plans to which the employee may be eligible.

d. ERISA-Governed Benefits Claims and DOL Regulations.

Fiduciary breach claims and actions for equitable relief under ERISA §§ 502(a)(2) and (a)(3) respectively, COBRA litigation, and other statutory claims under ERISA, e.g., Section 510 suits to redress discrimination, retaliation, and coercive interference, Section 515 actions for delinquent contributions under § 502(g)(2) and Section 4301 actions for withdrawal liability payments (which is mandatorily arbitrated under § 4221(a)(1) anyway) can be subject to mandatory arbitration. Claims for benefits under ERISA, too, can be arbitrated, but the DOL has adopted regulations that limit the use of mandatory arbitration of claims involving group health and disability plans.[15] To be clear, all benefit claims, ERISA-governed or otherwise, can be arbitrated, but adverse benefit claimants under group health and disability plans cannot be prevented from suing thereafter.[16]

Employers with self-insured health or disability plans should be mindful of these regulations when crafting arbitration agreements and claims procedures under the benefits plan, and may consider carving out such claims from the scope of the agreement. For instance, the relevant arbitration provision could be drafted to draw a distinction between the claims for group health and disability benefits, and arbitration with respect to any other types of benefit-related claims, including those that can be brought under ERISA.

e. Insured Plans.

A final note about insured plans is worth mentioning. Employers routinely provide welfare benefits like health, disability, and life insurance

by purchasing group insurance coverage. More often than not, benefit claims under such plans are administered by the carrier, not the employer. If the employer is named in a wrongful denial of benefits claim under ERISA Section 502(a)(1)(B) arising out of one of these insured benefits, the employer typically can tender the claim to the insurance carrier as claims administrator of the claims, and remove itself from the litigation. To deal with this issue in an arbitration agreement, the employer can include language in all operative documents excluding claims for benefits which are insured and for which the employer does not serve as claims administrator. Any tag along claims against the employer, like a penalty or breach of fiduciary duty claim, will keep the employer in the dispute, but such claims would still be subject to mandatory arbitration.

IV. Conclusion.

These drafting considerations are all designed to maximize the benefit of the program and fend off any challenges to it. However, the culture, business considerations, and plans for each employer are unique. Therefore, we strongly recommend you consult with counsel when deciding whether arbitration of ERISA claims is right for you.

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ENDNOTES:

1 Department of Labor ("DOL") regulations provide a limited qualification related to administrative review of health and disability benefit claims, as will be discussed below.

2 *See, e.g., Comer v. Micor, Inc.*, 436 F.3d 1098, 1100 (9th Cir. 2006) (explaining that the Ninth Circuit Court of Appeals had "expressed skepticism about the arbitrability of ERISA claims ... but those doubts seem to have been put to rest by the Supreme Court's opinions...."); *Williams v. Imhoff*, 203 F.3d 758, 767 (10th Cir. 2000) (holding "that Congress did not intend to prohibit arbitration of ERISA claims"); *Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (surveying prior courts and "agree[ing] that Congress did not intend to exempt statutory ERISA claims from the dictates of the Arbitration Act"); *Pritzker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 7 F.3d 1110, 1119 (3d Cir. 1993) (overturning circuit precedent and holding that "agreements to arbitrate statutory ERISA claims under the FAA may be enforceable."); *Arnulfo P. Sulit, Inc. v. Dean Witter Reynolds, Inc.*, 847 F.2d 475, 478-79 (8th Cir. 1988) (similar); *Smith v. Aegon Companies Pension Plan*, 769 F.3d 922 (6th Cir. 2014) (recognizing that the Sixth Circuit "ha[d] previously upheld the validity of mandatory arbitration clauses in ERISA plans" in *Simon v. Pfizer Inc.*, 398 F.3d 765 (6th Cir. 2005)); *Challenger v. Local Union No. 1*, 619 F.2d 645 (7th Cir. 1980) (arbitration clauses upheld in ERISA-based litigation outside of FAA context); *Hornsby v. Macon County Greyhound Park, Inc.*, 2012 U.S. Dist. LEXIS 81552 (M.D. Ala. 2012) ("The court finds these decisions persuasive, and there is no need to repeat the now well-established reasons for holding that ERISA claims may be subject to arbitration. Thus, having carefully examined this body of law and the rationale of each decision, and while neither the Supreme Court nor Eleventh Circuit has explicitly ruled upon the issue of whether ERISA claims are subject to arbitration, this court holds that Congress did not intend to prohibit arbitration for ERISA claims."); *Hendricks v. UBS Fin. Servs., Inc.*, 546 Fed. Appx. 514 (5th Cir. 2013) (compelling arbitration of ERISA claims). The Eleventh Circuit's decision in *Caley v. Gulfstream Aero. Corp.*, 428 F.3d 1359 (11th Cir. 2005) suggests that it would uphold the mandatory arbitration of ERISA claims under the FAA, as that case included ERISA claims, but they were not included in the dispute resolution policy at issue.

3 *Moses H. Cone Memorial Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1 (1983) (Section 2 of the FAA is a congressional declaration of a liberal federal policy favoring arbitration agreements); *Dean Witter Reynolds Inc. v. Byrd*, 470 U.S. 213 (1985) (FAA requires rigorous enforcement of agreements to arbitrate); *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614 (1985) (No presumption under FAA against arbitration of federal statutory claims); see also *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220 (1987); *Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477 (1989).

4 *Stolt-Nielsen S.A. v. AnimalFeeds Corp.*, 559 U.S.662 (2010) (under FAA a party may not be compelled to submit to class arbitration without a contractual basis for concluding that the party agreed to do so); *AT&T Mobility LLC v. Concepcion*, 131 S. Ct. 1740 (2011) (FAA preempts state law given the strong federal policy favoring arbitration and enforcement of arbitration agreements); *Oxford Health Care v. Sutter*, 133 S. Ct. 2064 (2013) (arbitrator awards are upheld so long as the arbitrator's determination is based on construction of the arbitration agreement, even if interpretation is erroneous); *American Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2304 (2013) (unless there is a contrary congressional command, class action waivers will be upheld even if pursuing such claims would be prohibitively expensive).

5 *Sutherland v. Ernst & Young, LLP*, 2013 U.S. App. LEXIS 16513 (2d Cir. 2013) (FLSA); *Parisi v. Goldman, Sachs & Co.*, 710 F.3d 483 (2d Cir. 2013) (Title VII); *D.R. Horton v. NLRB*, 737 F.3d 344 (5th Cir. 2013) (NLRA); *Luchini v. Carmax, Inc.*, 2012 U.S. Dist. LEXIS 102198 (E.D. Cal. 2012) (court dismissed without prejudice plaintiff's collective and representative claims where plaintiff failed to provide authority for a nonwaivable right to bring a class or collective action under FLSA and ERISA). *See also Hornsby v. Macon County Greyhound Park, Inc.*, 2012 U.S. Dist. LEXIS 81552 (M.D. Al. 2012) (holding that silence on class in an arbitration agreement meant that Plaintiffs could not proceed as a class).

6 According to 2015 survey by the law firm Carlton Fields Jorden Burt, since the Supreme Court's decision in *AT&T Mobility LLC v. Concepcion* in 2011, "the use of arbitration clauses to address class actions has continued to rise" with "the percentage of companies that address class actions in their arbitration clauses ... more than doubl[ing] (from 21.4 to 45.8 percent), with most of those companies now using clauses that explicitly preclude class actions."

7 For comprehensive treatment of the pros and cons of including ERISA claims in an arbitration program, see the forthcoming article from Jackson Lewis.

8 *See* Alexander J.S. Colvin, *An Empirical Study of Employment Arbitration: Case Outcomes and Processes*, 8 J. Empirical Legal Stud. 1 (2011).

9 *Sutter*, 133 S. Ct. at 2071("The arbitrator's construction [of the agreement] holds, however good, bad, or ugly").

10 Again, as discussed below, there are special considerations for health and disability claims only.

11 Reminder to employers and plan sponsors: the plan should unequivocally confer discretion on the plan administrator to interpret the plan and make benefit determinations thereunder, whether or not they have adopted a mandatory arbitration program. Failure to do so may result with the arbitrator requesting not only additional documents that were not part of the administrative record but also the having of a hearing and the calling of witnesses to supplement the record.

12 *See* 29 C.F.R. § 2520.102-3.

13 Our reference to benefit claims includes claims under non-ERISA governed benefits plans, such as many short term disability plans. Both types of claims should be subject to mandatory arbitration and the prohibition of class-based litigation.

14 Arbitration provisions may be included in employment agreements, but they can also come in the form of stand-alone agreements.

15 29 C.F.R. § 2560.503-1(c).

16 29 C.F.R. § 2560.503-1(c)(4)(i) and (ii).

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Insight...

ACA Reporting Guidance Updates

Clarifying a number of issues that have confounded practitioners advising clients on compliance with the Affordable Care Act, the IRS recently published Instructions for the Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns (Form 1094-C) and Employer-Provided Health Insurance Offer and Coverage (Form 1095-C).[1]

Clarification of Treatment on Unpaid Leaves of Absence

IRS regulations provide that, in certain circumstances, an employee with a break in service during which no hours of service are earned must be treated as a continuing employee – rather than a new hire – upon earning eligible service again for purposes of certain rules issued under Internal Revenue Code Section 4980H. These regulations *do not* impact whether the individual was an employee during the break in service; the Instructions clarify that an individual should only be treated as an employee during a break in service for purposes of reporting *if the individual remained an employee during that period* (and had not terminated employment with the employer). Thus, according to the Instructions, an employee on unpaid leave *during a break in service* would be treated as an employee for reporting purposes *during the break in service*, while a former employee whose employment had been terminated during the break in service would not be treated as an employee for reporting purposes.

Thus, employers should carefully consider whether an employee should be terminated, rather than going on an unpaid leave, where a termination would not violate applicable law. An individual who is not terminated must be reported as an employee on Forms 1094-C and 1095-C, potentially exposing the employer to a Section 4980H penalty if such employee is not offered affordable health coverage. Of course, employers should consider all laws, including applicable discrimination laws, when terminating an employee.

Multiemployer Plan Issues

According to the "Interim Guidance Regarding Multiemployer Arrangements" in the preamble to the 4980H Regulations, an employer is treated as offering health coverage to an employee if the employer is required by a collective bargaining agreement or related participation agreement to make contributions for that employee to a multiemployer plan offering coverage to eligible individuals that is affordable and provides minimum value, and that also offers health coverage to those individuals' dependents.

According to the Instructions, employers who are required to contribute to such a multiemployer plan by a collective bargaining agreement or related participation agreement will report that they are entitled to deemed offer relief for 2015 by using Code 2E on line 16 of the Form 1095-C. Under prior guidance, it was unclear how an employer would report *the actual* insurance offered to an employee (on line 14) where the employer did not have such information (in many cases, only the multiemployer plan itself has this information).

Addressing this potential "lack of data" issue, the Instructions provide that *for 2015 reporting*, an employer relying on the multiemployer arrangement interim guidance should enter Code 1H (employee was not offered any health coverage or employee was offered coverage that is not minimum essential coverage) on line 14 for any month for which the employer enters code 2E on line 16. This means that for 2015, the employer should use Code 1H *regardless of whether the employee was eligible for coverage under the multiemployer plan.* In practice, this means that the employer does not need information from the multiemployer plan regarding which employees were actually enrolled in the multiemployer plan in 2015.

However, for 2016 and later years this special reporting rule may not be available. Thus, when negotiating collective bargaining and related agreements, employers should still request language requiring the multiemployer plan to provide any information the employer deems necessary for the completion of Forms 1094-C and 1095-C.

COBRA Coordination Issues

The Instructions explain how to report offers of COBRA coverage. Specifically, an offer of COBRA continuation coverage made to a *former employee* upon

termination of employment is reported as an offer of coverage using the appropriate indicator Code *only if the former employee enrolls in the coverage.* If the former employee does not enroll in the coverage, the code for no offer of coverage should be entered for any month for which the offer of COBRA continuation coverage applies.

Alternatively, an offer of COBRA continuation coverage that is made to an active employee (because, for example, the employee experienced a reduction in the employee's hours that resulted in the employee no longer being eligible for coverage under the plan) is reported in the same manner and using the same code as an offer of that type of coverage to any other active employee.

ACA Affordability Concerns

An "applicable large employer" may be subject to a penalty if the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, but one or more full-time employees obtains a subsidy on an exchange because the employer's coverage was not *affordable* or does not provide minimum value (Section 4980H(b) liability).

What does "affordable" mean?

Affordable means that an employee's required contribution for the lowest-cost individual coverage under his or her employer's plan does not exceed 9.5 percent (indexed as provided in applicable regulations) of the employee's household income.

Since employers usually do not have household-income information of their employees, the 4980H Regulations provide three separate safe harbors under which an employer may determine affordability based on information that is readily available to the employer. These include (1) the Form W-2 wages safe harbor, (2) the rate of pay safe harbor, and (3) the federal poverty line safe harbor. For example, if an employer uses the Form W-2 safe harbor, health coverage will be deemed affordable for Section 4980H(b) liability purposes if an employee's required contribution for the lowest-cost individual coverage under the plan is no more than $190 per month and his Form W-2 compensation is $2,000 per month ($190 is 9.5% of $2,000).

However, informal discussions with IRS representatives suggest that this opt-out amount must be counted as part of the employee contribution, if the employer also offers employees an "opt-out" payment for those who decline coverage. Using the previous example, if the employer offers employees a $100 per month opt-out payment, the employee contribution for the lowest-cost individual coverage under the plan would be deemed to be $290 per month, rendering the insurance unaffordable under the Form W-2 safe harbor test ($290 is 15.5% of $2,000).

While the IRS has not provided formal guidance, the informal position described above is consistent with the final regulations relating to the requirement to maintain minimum essential coverage (79 Fed. Reg. 70,468 (Nov. 26, 2014)); it also makes sense from an economic standpoint as the opt-out is an additional cost borne by an employee who elects coverage and forgoes the opt-out payment. The IRS has also stated informally that it may treat similar cash payments to Service Contract Act and Davis-Bacon Act employees differently.

On these issues, employers should proceed with caution until formal guidance is issued.

Reporting Penalties

Employers who fail to complete and file or furnish Forms 1094-C and 1095-C properly may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. The penalties for returns required to be made and statements required to be furnished after December 31, 2015, were recently increased pursuant to Trade Preferences Extension Act of 2015, as follows:

- The penalty for failure to file an information return generally will be $250 for each return for which such failure occurs (with a maximum of $3,000,000).
- The penalty for failure to provide a correct payee statement will be $250 for each statement with respect to which such failure occurs (with a maximum of $3,000,000).
- Special rules apply that decrease the penalties in the case of certain errors that are promptly corrected.
- Other special rules apply that increase the penalties if there is intentional disregard of the reporting requirements.

For 2015 reporting, the IRS will not impose penalties for certain reporting failures if the filer can show that it made good-faith efforts to comply with the information reporting requirements.

Note that these reporting penalties are separate from the penalties that may apply under Code Section 4980H in the event an applicable large employer fails to offer coverage or offers inadequate coverage – *i.e.*, coverage that is not affordable and/or does not provide minimum value – to its full-time employees and their dependents. Thus, an applicable large employer who fails to offer affordable, minimum value coverage to its full time employees and fails to file/furnish Forms 1094-C and 1095-C may be subject to both Section 4980H and reporting penalties.

ACA Cadillac Tax Update

Effective for tax years after December 31, 2017 Code Section 4980I – the so-called "Cadillac Tax" – will impose a tax on high-cost employer-sponsored health coverage. If the aggregate cost of employer-sponsored coverage (referred to as "applicable coverage") exceeds an annually adjusted statutory dollar limit, the excess cost above the statutory limit (referred to as the "excess benefit") will be subject to a 40% nondeductible excise tax.

Notice 2015-16

In February 2015, the IRS and Treasury Department issued Notice 2015-16, which discussed numerous approaches being considered for Section 4980I proposed regulations. Notice 2015-16 generally concerned: (a) the definition of applicable coverage; (b) how the cost of applicable coverage might be determined; and (c) how the dollar limit might apply to the cost of applicable coverage in determining the excess benefit subject to the excise tax. The highlights of Notice 2015-16 include:

Definition of Applicable Coverage

Generally, applicable coverage is broadly defined as any coverage – whether paid for by the employer or the employee – under any group coverage made available by an employer to an employee or former employee. Applicable coverage, however, excludes "excepted benefits" – *i.e.*, benefits that are generally exempt from the requirements of the ACA and the Health Insurance Portability and Accountability Act – such as accident-only coverage and long-term care coverage.

Cost of Applicable Coverage

Generally, the cost of applicable coverage will be determined in accordance with rules similar to those that apply in determining COBRA premiums, which are based on the average cost of providing coverage under a plan to similarly situated non-COBRA beneficiaries. For purposes of calculating average cost, similarly situated employees would be determined by: (a) aggregating employees based on the benefits package in which they are enrolled (*i.e.*, high-option enrollees grouped together, standard-cost enrollees grouped together, and the like); (b) mandatorily disaggregating employees based on type of coverage (*i.e.*, self-only coverage or other-than-self-only coverage); and (c) permissively disaggregating employees based on broad standards (*i.e.*, job category or collective bargaining status) or specific standards (*i.e.*, current employees, former employees, or number of family members enrolled in coverage).

Application of Dollar Limit

Currently, the self-only coverage dollar limit for 2018 is $10,200 and the other-than-self-only dollar limit is $27,500. The applicable dollar limit – which is subject to adjustment based on age and gender characteristics and demographic factors – includes both employer-paid and employee-paid premiums and contributions. After 2018, a cost-of-living adjustment will apply to the dollar limit.

Notice 2015-52

In July 2015, the IRS and the Treasury Department issued Notice 2015-52, which supplements Notice 2015-16 by discussing additional approaches being considered for Section 4980I proposed regulations. Notice 2015-52 generally concerns: (a) who is liable for the tax; (b) the application of employer aggregation rules; and (c) the determination of the cost of applicable coverage.

Liability for the Tax

In general, the coverage provider is liable for the tax. The identity of the coverage provider depends on the type of plan at issue. For an insured plan, the provider is the insurer; for an HSA or an Archer MSA, the employer is the provider.

For other types of applicable coverage, the provider is the "the person who administers the plan benefits," although this term is not otherwise defined. The proposed regulations may define "the person who administers the plan" as the person or entity responsible for day-to-day administration of the plan (typically the third-party administrator of a self-insured plan) or, in the alternative, as the person or entity with ultimate authority or responsibility for administering plan benefits (typically the employer).

The sponsoring employer is required to calculate the Cadillac Tax that applies for each employee and, thereafter, notify each coverage provider and the IRS concerning the amount of excise tax the coverage provider owes on its share of the excess benefit.

Employer Aggregation Rules

Section 4980I provides that all members of a controlled group are treated as a single employer. This creates special issues regarding how to identify the applicable coverage; the relevant employees for age, gender, and high-risk profession adjustments to the applicable dollar limits; the employer responsible for calculating and reporting the excess benefit; and the employer liable for any penalty for improper calculation of the tax. Future guidance may clarify this issue.

Determining the Cost of Applicable Coverage

As noted above, the cost of applicable coverage is determined using rules similar to those that apply in calculating COBRA premiums. Many plans, however, will face timing issues in calculating the cost of applicable coverage. For example, self-insured plans may need to wait for the expiration of a run-out period before the actual cost of coverage can be determined and experience-rated insured plans may need to reflect subsequent period premium discounts back to original coverage periods. For account-based plans with employee contributions that often fluctuate monthly (such as HSAs, MSAs, and FSAs) a safe-harbor method to determine cost is being considered under which total annual employee contributions would be allocated on a pro-rata basis over the plan year, without regard to when contributions are actually made. Safe-harbor treatment is also being considered for FSAs with unused balance carry-forward features, pursuant to which employee annual salary reductions would be included in the cost of applicable coverage only in the year the salary reductions occur, without regard to any carry-forward that happens.

For ongoing coverage of ACA requirements, and corresponding regulatory activity, see the Jackson Lewis Benefits Law Advisor (http://www.benefitslawadvisor.com/).

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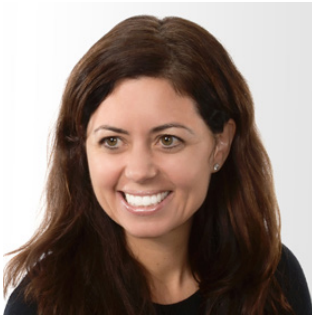
ENDNOTES:

1 The Instructions were published on September 16, 2015.

Featured Attorney: Joy Napier-Joyce (Baltimore)



Joy Napier-Joyce, the Office Managing Shareholder of our Baltimore office and the leader of Employee Benefits Practice Group, represents clients in all aspects of benefits compliance and administration. After graduating from Boston University School of Law, Ms. Napier-Joyce began her career with a Boston firm and gravitated almost immediately to employee benefits law.

After two years in Boston, she took her growing benefits practice to Baltimore, her hometown, while her husband earned his MBA at the University of Maryland. As benefits law evolved through the technology boom, the rise of stock option litigation, new IRS regulation of deferred compensation, and the enactment of the Affordable Care Act, Ms. Napier-Joyce's practice evolved with it. These days, she frequently advises clients on the Affordable Care Act, qualified retirement plans, and executive compensation matters.

Ms. Napier-Joyce joined Jackson Lewis in 2011. The combination of her expertise and the firm's client base offered her the perfect opportunity to focus on providing in-depth counseling to her clients. "For a benefits lawyer, it was a natural, symbiotic relationship," she recalled.

Contributing Editor Bill Payne recently caught up with Ms. Napier-Joyce to learn more about her and her employee benefits work.

What do you wish that everyone knew about ERISA?

I don't want people to be afraid of benefits. It's really not that bad. There's a rhyme and reason to ERISA and the tax code. Employers need to take benefits compliance seriously, be proactive, and follow best practices. The rules are real, and they can have a big adverse impact on employers if they are not paying attention.

What attracted you to employee benefits law?

It's not something that you come out of law school knowing how to do, but I actually enjoy the code-centric and regulatory aspects of employee benefits law. I like it when there is an answer — or, at least having some kind of guidepost to rely on. There's a thread that runs through the tax code, a continuum that makes it all fit together: You have to live by the rules, and you generally cannot discriminate.

How do you maintain balance in your hectic life?

I get up and go running at 5:00 a.m.! I like the cathartic aspect of running and clearing my head. I've done several marathons and other races with my friends, but mostly I enjoy running alone. It's about going at my own pace and how I feel on that particular day.

What's something about Joy Napier-Joyce that people might not know?

I'm actually a huge sports fan. I've been collecting Orioles baseball cards since I was kid growing up in Baltimore, and now my kids are really into their hometown teams as well. Even though everyone in Baltimore had a tough time getting over it when the Colts left town, I've become a big Ravens fan, too!

For information on Ms. Napier-Joyce and her practice, please visit http://www.jacksonlewis.com/people/joy-m-napier-joyce.

Cases and Regulations...

- **De-Risking: Fifth Circuit Upholds the Right to Annuitize.** In *Lee v. Verizon Communications, Inc.*, 2015 U.S. App. LEXIS 14588 (5th Cir. Tex. Aug. 17, 2015), Verizon retirees brought class-action claims under ERISA after Verizon "de-risked" its defined-benefit plan by transferring certain pension liabilities to a third-party annuity provider. The district court certified classes both for "transferees," whose pension payments were transferred in the annuity transaction, and "non-transferees," whose pension liabilities remained with Verizon. In upholding the district court's dismissal, the Fifth Circuit held (among other things) that the annuity purchase was a settlor function, and thus not subject to review under ERISA's fiduciary provisions. The court also held that the non-transferee class lacked Article III standing, because they had suffered no "injury in-fact."

- **Supreme Court to Consider ERISA Pre-emption.** On June 29, 2015, the Supreme Court granted certiorari in *Gobeille v. Liberty Mutual Insurance Co.*, No. 14-181. The central question in *Gobeille* is whether ERISA pre-empts a Vermont statute that requires "health insurers" to report on a wide array of claims data with a Vermont state agency, which purports to use the data to guide state healthcare policy. A split panel of the U.S. Court of Appeals for the Second Circuit, in New York, held that ERISA pre-empted the statute, noting that reporting was a "core ERISA function shielded from potentially inconsistent and burdensome state regulation." In doing so, the court characterized the Vermont reporting requirement as "burdensome, time-consuming, and risky."

- **ERISA Coverage for Severance Plans.** In *Okun v. Montefiore Medical Center*, Dkt. No. 13-3928-cv (2d Cir. July 17, 2015), a physician claimed that his termination "for cause" was a pretext for prohibited interference with his right to receive severance benefits. The district court dismissed the case for lack of subject-matter jurisdiction, holding that the severance policy at issue did not constitute a "plan" under ERISA. The Second Circuit held that the severance program "represents a multi-decade commitment to provide severance benefits to a broad class of employees under a wide variety of circumstances and requires an individualized review whether certain covered employees are terminated," and as such, was an ERISA plan. The action was remanded to the district court for further proceedings.

- **ERISA Section 510 & the Affordable Care Act.** An employee has filed class-action claims under ERISA Section 510, alleging that her work hours were reduced with the specific intent of interfering with her entitlement to health insurance benefits required under the Affordable Care Act. *Marin, et al. v. Dave & Buster's, Inc., et al.*, No. 15-cv-3608 (S.D.N.Y., complaint filed May 8, 2015). In a case that will be watched closely by employers and practitioners, the lawsuit seeks plaintiff's reinstatement to full-time employment, restoration of her right to coverage under the employer's medical plan, and restitution for lost wages and benefits. As of this report, the court has not ruled on the defendants' motion to dismiss, filed on July 31, 2015.

- **Regulation of Investment Advisors under ERISA.** This spring, the Department of Labor re-proposed a controversial regulation that would classify most brokers, registered investment advisors, and insurance agents working with retirement accounts in 401(k) plans and individual retirement accounts as ERISA fiduciaries. The new regulation is a much narrower version of a 2010 proposal, which addressed a much wider array of plan service providers, and which was eventually withdrawn under heavy political pressure. The new proposal requires that advice from covered providers be based solely by the client's best interests, and prohibits advice tainted by conflicts of interest. Critics of the rule argue that it will significantly raise regulatory and liability costs for brokers, and limit access to investment advice for working and middle-income Americans. Proponents believe that it will protect those same individuals from the backdoor payments and hidden fees and can result from bad investment advice. The comment period for the proposed rule ended on July 21, 2015; public hearings began on August 10.

Media...

- **Joy Napier-Joyce** comments on the U.S. Supreme Court's *King v. Burwell* decision in *Law 360*'s "Attorneys React To Supreme Court's ACA Save." (http://www.law360.com/articles/672421/attorneys-react-to-supreme-court-s-aca-save)

- **Joe Lazzarotti** was quoted in *Employee Benefit News*' "How The Gay Marriage Ruling Impacts Group Benefits" (http://ebn.benefitnews.com/news/employer-strategies/how-the-gay-marriage-ruling-impacts-group-benefits-2747089-1.html)

- *Human Resource Executive Online* quotes **Joy Napier-Joyce** on the U.S. Supreme Court's *King v. Burwell*: "King v. Burwell: Now the Work Must Continue" (http://www.hreonline.com/HRE/view/story.jhtml?id=534358915)

- **Collin O'Connor Udell** wrote "Parsing ERISA's Equitable Remedies Provision," published in the *Connecticut Law Tribune* (http://www.ctlawtribune.com/id=1202724505105/Parsing-ERISAs-Equitable-Remedies-Provision#ixzz3YorBJEN4)

- **Stephanie Zorn** authored "ACA Cadillac Tax: Cruising Toward Proposed Regulations," published in *Primary Opinion* (https://www.primaryopinion.com/articles/aca-cadillac-tax-cruising-toward-proposed-regulations)

Honors...

Attorneys Recognized in *The Best Lawyers in America*© 2016

Jackson Lewis is pleased to announce 137 of the firm's attorneys have been named to the 2016 edition of *Best Lawyers*. The firm's presence in this prestigious publication has grown steadily each year, with the number of attorneys listed more than tripling since the 2010 edition.

We congratulate the following Jackson Lewis Employee Benefits group attorneys named to the 2016 *Best Lawyers in America* list:

- David E. Block
- Pedro P. Forment
- Brian P. Goldstein
- Jay Adams Knight
- Randal M. Limbeck
- Joy M. Napier-Joyce
- Andrew C. Pickett
- Mark S. Ross
- Charles F. Seemann, III
- Stephen M. Silvestri
- René E. Thorne

UPCOMING SEMINARS

SEPTEMBER

- ***Retirement Plan Best Practices in 2015 for Government Contractors***, Attorney Jewell Lim Esposito, Virginia (9/30)

OCTOBER

- ***The Affordable Care Act – It's Here to Stay, So Get Used to It***, Attorney Randal Limbeck at Jackson Lewis, Minnesota (10/1)
- ***ESOP Current Events***, Attorney Brian Goldstein at the National Center for Employee Ownership, Georgia (10/6)
- ***Protecting Yourself From Legal Problems: Audits, Lawsuits & Insurance Issues***, Attorney Brian Goldstein at the National Center for Employee Ownership, Georgia (10/6)
- ***What You Need to Know About ERISA: A Comprehensive Overview***, Attorney Charles Seemann at Bloomberg BNA, New York (10/8 – 10/9)
- ***Healthcare Summit/Complying with the Affordable Care Act***, Attorney Melissa Ostrower at the Queens Chamber of Commerce, New York (10/12)
- ***ACA Compliance Issues Heading into 2016***, Attorney Joy Napier-Joyce at Jackson Lewis, New Hampshire (10/15)
- ***Emerging Trends in ERISA Class Actions***, Attorney René E. Thorne at the American Conference Institute ERISA Litigation, New York (10/26)
- ***Class Action Summit***, Attorney Charles Seemann at Jackson Lewis, Florida (10/27)
- ***ERISA Class Actions***, Attorney René E. Thorne at Jackson Lewis, Florida (10/27)
- ***Best Practices for Boards: Selection, Pay and Function***, Attorney Brian Goldstein at the National Center for Employee Ownership, Missouri (10/28)
- ***How Do the Recent US Supreme Court Decisions Impact My Benefit Plans?***, Attorney Natalie Nathanson at Jackson Lewis, Illinois (10/28)
- ***Cost-Saving Trends for Dispute Resolution***, Attorney René E. Thorne at the Women Influence & Power in Law Conference, Washington, D.C. (10/28 – 10/30)

NOVEMBER

- ***ERISA Class Actions***, Attorney René E. Thorne at Jackson Lewis, Illinois (11/10)
- ***Class Action Summit***, Attorney Charles Seemann at Jackson Lewis, Illinois (11/10 – 11/11)
- ***The Affordable Care Act: Managing Employee Benefit Compliance and Minimizing Risk***, Attorney Joy Napier-Joyce at the American Conference Institute (ACI), New York (11/17 – 11/18)
- ***Are Employee Life Insurance Benefit Plans Worth the Risk of Litigation After CIGNA Corp. v. Amara?***, Attorney Robert Wood at the Bloomberg-BNA Compensation Planning Journal Advisory Board Meeting, New York (11/19)

JACKSON LEWIS' EMPLOYMENT CLASS ACTION SUMMIT

– October 27, 2015 –

Seminole Hard Rock Hotel & Casino Hollywood
Hollywood, Florida

Presented by leading attorneys with a wide range of class action expertise, this full-day program will dive into key strategies for defending and avoiding class actions and discuss new trends and challenges facing employers.

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For more on this and other events, please visit http://www.jacksonlewis.com/events.

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