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# PIECING TOGETHER THE PUZZLE: ANALYZING THE COLLISION OF THE ACA AND ERISA

Luke Kalamas\*

## I. INTRODUCTION

When the United States House of Representatives finally voted to accept the Senate's amendments to the Patient Protection and Affordable Care Act (hereinafter ACA) in March of 2010, many policy makers were celebrating its passage.<sup>1</sup> At that point in time, the Employee Retirement Income Security Act (hereinafter ERISA) was the only federal source of law covering employer sponsored welfare plans,<sup>2</sup> including health care.<sup>3</sup> The ACA sought to remedy, among other things, the inconsistencies involving the administration of employer sponsored health care plans.<sup>4</sup> However, since its enactment, the ACA has led to some confusion surrounding its intersection with both ERISA and the Internal Revenue Code (hereinafter IRC). This confusion, although beneficial for

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1. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES (Mar. 23, 2010), [http://www.nytimes.com/2010/03/24/health/policy/24health.html?\\_r=0](http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=0).

2. See 29 U.S.C. § 1002(1) (2012) (defining welfare plans as programs that provide individuals benefits such as medical, surgical, or hospital care, disability, or vacation).

3. See, e.g., *id.*

4. See Linda Bergthold, *ACA: Threat to Employer-Sponsored Plans? Kaiser Family Foundation's Larry Levitt Addresses Concerns that Obamacare will Weaken your Employer-Sponsored Health Coverage*, HEALTHINSURANCE.ORG (Feb. 27, 2014), <https://www.healthinsurance.org/blog/2014/02/27/aca-threat-to-employer-sponsored-plans/>.

employee benefits attorneys who are compensated by the hour, may ultimately result in the very thing the ACA sought to remedy: inconsistency.

This paper focuses on addressing the ACA's intersection with ERISA. Due to ERISA's strong preemption provision, for decades it has stood alone regulating employer sponsored health care plans.<sup>5</sup> I argue that although the ACA sought to add uniformity to the world of employer sponsored health care plans, it may have created some confusion as a byproduct. I further argue, however, that some of the ACA's changes will bring much needed reform to employer sponsored health care plans, specifically the new reporting and disclosure requirements. Finally, I argue that although the future of ERISA, the ACA, and the regulation of employer sponsored health care plans seems somewhat uncertain, we have seen an important shift regarding our nation's policy surrounding employment and health care.

Part II of this paper will focus on the history surrounding the regulation of employer sponsored health care plans. This section looks at the Welfare and Pension Plans Disclosure Act (hereinafter WPPDA), ERISA, and the ACA. Part III of this paper will focus on the collision between ERISA and the ACA. Specifically, subsection A will address the potential of an employer staffing down to avoid certain provisions of the ACA. This section will lay out the employer mandate under the ACA, discuss potential ERISA violations for employers staffing down to avoid the ACA, and highlight additional protections added to the Fair Labor Standards Act (hereinafter FLSA).

Subsection B will address the new reporting and disclosure requirements. Specifically, this section will compare the ERISA requirements that formerly applied to all employer sponsored welfare plans, with the new ACA requirements. Subsection C will address the "benefits remedy" for participants or beneficiaries of employer sponsored health care plans. Specifically, this section will compare ERISA's civil enforcement provision for benefit denials with the new independent external review process required by the ACA.

Finally, Part IV of this paper will focus on the future of ERISA, the ACA, and employer sponsored health care plans. This section summarizes my arguments surrounding the intersection of ERISA and the ACA and lays out my vision of what the future of employer sponsored health care plans may look like.

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5. See Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 652 (2014).

## II. HISTORY SURROUNDING THE REGULATION OF EMPLOYER SPONSORED HEALTH CARE PLANS

### *A. Welfare and Pension Plans Disclosure Act (WPPDA)*

Before the enactment of the National Labor Relations Act (hereinafter NLRA) in 1935, very few employers sponsored employee welfare plans.<sup>6</sup> Employers were incentivized to provide pension plans<sup>7</sup> for employees through the Revenue Acts in 1926 and 1928.<sup>8</sup> However, similar provisions for welfare plans were nonexistent.<sup>9</sup> After both the enactment of the NLRA and the industrial boom following World War II, employer sponsored welfare plans became the norm.<sup>10</sup> In response to the prevalence of employer sponsored pension and welfare plans, the WPPDA was enacted in 1958.<sup>11</sup>

In terms of actually regulating welfare plans, the WPPDA did very little. The WPPDA merely required a very limited form of reporting to the Department of Labor (hereinafter DOL) and similarly limited disclosure to plan participants.<sup>12</sup> Congress did amend the WPPDA in 1962 to grant some restricted investigatory and enforcement abilities to the DOL,<sup>13</sup> however, it would be some time before a comprehensive regulatory regime covered employer sponsored health care plans.<sup>14</sup>

### *B. Employee Retirement Income Security Act (ERISA)*

Although Congress enacted ERISA in 1974, the struggle to draft such a complicated and comprehensive bill began over a decade earlier.<sup>15</sup> The federal government was not the only regime that began regulating employer sponsored pension and welfare plans during the

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6. See *History of Pension Plans*, EMP. BENEFIT RESEARCH INST. (Mar. 1998), <http://www.ebri.org/publications/facts/index.cfm?fa=0398afact>.

7. 29 U.S.C. § 1002(2)(A) (2012) (defining pension plans as programs that provide employees benefits such as retirement income).

8. COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW 3 (West, 4th ed. 2014).

9. See *id.*

10. *Id.* at 5.

11. *Id.*

12. *Id.*

13. *Id.*

14. See *id.* at 6.

15. See *id.* (explaining that the effort to enact a comprehensive employee benefit regulation started in 1963).

1950s.<sup>16</sup> Insurance commissioners in an increasing number of states began to enact legislation governing certain aspects of pension and welfare plans.<sup>17</sup> Additionally, courts began to recognize the commissioners' authority to regulate employer sponsored plans.<sup>18</sup> For example, in *State v. Monsanto Co.*, the Missouri Supreme Court held that an employer sponsored, self-insured, health care plan was not "insurance business" and therefore was not subject to applicable state laws regulating the business of insurance.<sup>19</sup>

In order to promote uniformity among the states and protect employee participants and beneficiaries, Congress began to work on drafting and enacting a comprehensive bill that would regulate pension and welfare benefit plans.<sup>20</sup> Finally, in 1973, legislation was introduced that would eventually flourish into ERISA.<sup>21</sup> Although ERISA provided a meaningful expansion in the regulation of pension plans, it again failed to explicitly regulate welfare plans other than reporting and disclosure, fiduciary requirements, civil remedies, and state law preemption.<sup>22</sup> Meanwhile, Congress had sought to completely regulate pension plans by providing for minimum vesting, benefit accrual, funding, and eligibility standards.<sup>23</sup> Other than some minor amendments in 1980,<sup>24</sup> it would be another three decades before welfare plans would finally see some meaningful regulation.<sup>25</sup>

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16. *Id.* at 5.

17. *Id.*

18. *Id.*

19. *State ex rel. Farmer v. Monsanto Co.*, 517 S.W.2d 129, 131-32 (Mo. 1974).

20. MEDILL, *supra* note 8, at 6.

21. *Id.*

22. *See id.* at 71-72.

23. *See id.* at 6.

24. In 1986, Congress, through the passage of COBRA, amended ERISA to provide limited continuation of group health care coverage for terminated employees. *COBRA Continuation Health Coverage*, U.S. DEP'T OF LABOR, [http://www.dol.gov/ebsa/faqs/faq\\_compliance\\_cobra.html](http://www.dol.gov/ebsa/faqs/faq_compliance_cobra.html) (last visited Apr. 12, 2016).

25. *See Health Care Arrangements Established by State and Local Governments for Non-Governmental Employees*, U.S. DEP'T OF LABOR, <http://www.dol.gov/ebsa/regs/unifiedagenda/ebsafall2009/1210-AB34fs.html> (last visited Apr. 9, 2016).

### C. Patient Protection and Affordable Care Act (ACA)

President Obama ran in 2008 on a promise to bring comprehensive reform to health care in the United States.<sup>26</sup> Although most of his speeches on the subject revolved around affordability, when the ACA was finally enacted in 2010 it brought a breath of fresh air to the regulation of welfare plans. The ACA, being a federal statute, was able to regulate welfare plans in a way the states never could, due to ERISA's broad preemption provision.<sup>27</sup>

There were, however, some problems with the passage of the ACA.<sup>28</sup> Due to the beast that is the political process, the idea for health care reform went in neat and concise, only to come out with the appearance of "Frankenstein's monster." Backroom deals such as the "Louisiana Purchase"<sup>29</sup> and the "Cornhusker Kickback"<sup>30</sup> also plagued its passage. However, in the end the bill was passed on March 21, 2010 and signed into law two days later.<sup>31</sup>

The main reforms to the regulation of welfare plans brought on by the ACA involve the new and progressive reporting and disclosure requirements and the new benefits remedy.<sup>32</sup> While these reforms were much needed, there are other provisions of the ACA that may collide with ERISA as well, such as the employer mandate and regulation of

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26. See *Obama Spells out Plans for Change*, CNN, <http://www.cnn.com/2008/POLITICS/08/29/obama.promises/index.html?iref=mpstoryview> (last visited Apr. 9, 2016).

27. 29 U.S.C. § 1144(a) (2012) (stating that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .").

28. See Avik S.A. Roy, *The New Louisiana Purchase: Obamacare's \$4.3 Billion Boondoggle*, THE ATLANTIC (Mar. 6, 2012), <http://www.theatlantic.com/business/archive/2012/03/the-new-louisiana-purchase-obamacares-43-billion-boondoggle/254003/>.

29. *Id.* The "Louisiana Purchase" in this context refers to a specific provision in the Senate version of the ACA that was added to get the vote of Senator Mary Landrieu. *Id.* The provision gave \$200 million in additional federal subsidies to Louisiana's Medicaid program. *Id.*

30. Jordan Fabian, *Obama Healthcare Plan Nixes Ben Nelson's 'Cornhusker Kickback' Deal*, THE HILL (Feb. 22, 2010), <http://thehill.com/blogs/blog-briefing-room/news/82621-obama-healthcare-plan-nixes-ben-nelsons-cornhusker-kickback-deal>. The "Cornhusker Kickback" in this context refers to a specific provision in the Senate version of the ACA that was added to get the vote of Senator Ben Nelson. *Id.* This provision guaranteed that the federal government would pay, until the end of time, any additional costs to the State of Nebraska created by the expansion in Medicaid coverage. *Id.*

31. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

32. Penny Wofford, *ACA Reporting Requirements: Tips for What's Ahead in 2016*, SOCIETY FOR HUMAN RESOURCE MANAGEMENT (Oct. 1, 2015), <http://www.shrm.org/hrdisciplines/benefits/articles/pages/aca-reporting-tips.aspx#sthash.rebOuZ00.dpuf>.

self-insured welfare plans. For the remainder of this paper I will analyze each of the abovementioned provisions of both the ACA and ERISA and discuss their potential points of collision.

### III. THE COLLISION OF ERISA AND THE ACA

#### *A. Staffing Down to Avoid the Employer Mandate*

The first area of potential collision between ERISA and the ACA is the “employer mandate” and ERISA section 510.<sup>33</sup> While this potential collision takes some imagination, it is not the product of far-fetched hypotheticals. Under the ACA, the employer mandate (which will be discussed in full detail in the sections below) only applies to employers with a certain number of full-time employees.<sup>34</sup> Therefore, the knee-jerk reaction for an employer on the border may be to reduce this number, or “staff down.” However, ERISA section 510 protects employees from, among other things, employer actions that interfere with their attaining rights under a benefit plan.<sup>35</sup> This is the basic argument: an employer’s decision to staff down, in order to avoid the employer mandate, may expose it to liability for a violation of ERISA section 510 for interfering with the employee’s attainment of rights under the employer sponsored health care plan. In order to fully develop this argument I will address both the employer mandate under IRC section 4980H<sup>36</sup> and ERISA section 510, in greater detail.

#### 1. The Employer Mandate [IRC Section 4980H]

The ACA’s employer mandate requires certain “large employers”<sup>37</sup> to offer “minimum essential coverage”<sup>38</sup> to “full-time employees.”<sup>39</sup>

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33. See 29 U.S.C. § 1140 (2012). Additionally, in the body of this Article provisions of the ACA, FLSA, IRC, and ERISA will be referred to by their statute sections, however the footnotes will contain the corresponding United States Code sections.

34. See 26 U.S.C. § 4980H(c)(2)(A) (2012).

35. See 29 U.S.C. § 1140.

36. See 26 U.S.C. § 4980H(c)(2)(A).

37. Large employers are defined under 26 U.S.C. § 4980H(c)(2)(A) as an employer who employs, on average in a calendar year, fifty or more full-time, or full-time equivalent, employees. *Id.*

38. Minimum essential coverage is defined under 26 U.S.C. § 5000A(f)(2) as coverage under any plan that provides for more than just “excepted benefits.” See 26 U.S.C. § 5000A(f)(2) (2012). Excepted benefits, under 42 U.S.C. §§ 300gg—91(c)(1)-(4), include things such as disability income insurance, worker’s compensation, long-term care insurance, insurance coverage for a specific disease, or dental/vision insurance. See 42 U.S.C. §§ 300gg-91(c)(1)-(4).

Under the ACA, a full-time employee is any individual “employed on average at least 30 hours of service per week.”<sup>40</sup> When determining whether an employer qualifies as large, the statute takes into account not only actual full-time employees but full-time equivalent employees as well.<sup>41</sup> Therefore, in order to calculate whether an employer meets large employer status, you must do the following: (1) calculate the number of actual full-time employees for a given month; (2) calculate the number of hours worked by part-time employees, per month, and divide that number by one hundred and twenty (to account for thirty hours per week, for four weeks) to determine the number of full-time equivalent employees; (3) add the number of actual employees and full-time equivalent employees; and (4) do this for each month, add the totals together, and divide by twelve.<sup>42</sup> After completing this equation, if the total is fifty or higher, then the employer meets large employer status and is subject to the employer mandate.<sup>43</sup>

The employer mandate itself is made up of two sections. These sections are IRC section 4980H(a),<sup>44</sup> also known as the “play or pay penalty,” and IRC section 4980H(b),<sup>45</sup> also known as the “free rider penalty.”<sup>46</sup>

#### a. Play or Pay Penalty [IRC Section 4980H(a)]

The play or pay portion of the employer mandate is fairly similar to the individual mandate. IRC section 4980H(a) states:

If—

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, *and*

(2) *at least one full-time employee* of the applicable large employer [qualifies and] has enrolled . . . for such month in a qualified health

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39. 26 U.S.C. § 4980H(c)(4)(A).

40. *Id.*

41. MEDILL, *supra* note 8, at 373-74.

42. *Id.* at 374.

43. *See id.*

44. 26 U.S.C. § 4980H(a) (2012).

45. 26 U.S.C. § 4980H(b) (2012).

46. MEDILL, *supra* note 8, at 374.

plan [offered through an Exchange] with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount [defined under Section 4980H(c)(1) as 1/12 of \$2,000, or \$2,000 on an annual basis] and the *number of individuals employed by the employer as full-time employees* during such month.<sup>47</sup>

Essentially, the play or pay penalty requires large employers to offer full-time employees minimum essential coverage through a sponsored group health plan or pay a penalty (where other certain conditions are met as well).<sup>48</sup>

IRC section 4980H(a) does, however, have some additional complexities. For example, even though the calculation for large employer status includes hours worked by part-time employees, the play or pay provision only requires the employer to offer coverage to full-time employees.<sup>49</sup> Additionally, in terms of triggering the penalty, the employee applying for coverage through an exchange, and qualifying for a premium tax credit,<sup>50</sup> must be a full-time employee.<sup>51</sup> Also, in terms of assessing the penalty, the statute calculates based on the total number of full-time employees, even though it takes just one full-time employee's activity to trigger it.<sup>52</sup> More importantly, for this penalty calculation the statute expressly states that the first thirty full-time employees are *not* to be counted.<sup>53</sup>

Finally, under IRC section 4980H(a) a large employer is only required to offer coverage to full-time employees and their dependents, not necessarily their spouses.<sup>54</sup> Although dependent coverage does not make up a major portion of the analysis under the play or pay provision, it will factor in much more under the second section of the employer mandate, the free rider penalty.<sup>55</sup>

47. 26 U.S.C. § 4980H(a) (2012) (emphasis added).

48. *Id.*

49. MEDILL, *supra* note 8, at 375.

50. *Id.* Premium tax credits under 26 U.S.C. § 36B are determined on the basis of income. 26 U.S.C. § 36B(b)(2)(B)(ii) (2012).

51. MEDILL, *supra* note 8, at 375.

52. *Id.*

53. 26 U.S.C. § 4980H(c)(2)(D) (2013).

54. MEDILL, *supra* note 8, at 376.

55. *Id.*

## b. Free Rider Penalty [IRC Section 4980H(b)]

The free rider portion of the employer mandate, unlike the play or pay provision, deals with employers who do in fact offer full-time employees the opportunity to enroll in an employer sponsored health care plan. IRC section 4980H(b) states:

If—

(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer [qualify and are] *enrolled for such month in a qualified health plan [offered through an Exchange]* with respect to which an *applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,*

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to 1/12 of \$3,000 [or \$3,000 on an annual basis].<sup>56</sup>

The free rider provision of the employer mandate seeks to ensure that employers offer enrollment in sponsored health care plans that is in fact affordable.<sup>57</sup> If an employer were to offer coverage to full-time employees (meeting the “play or pay” provision requirements) at an unaffordable price, and the employee would fare better purchasing coverage through the exchange system utilizing a premium tax credit, then the employer would be “free riding” on the exchange system.<sup>58</sup>

The key to IRC section 4980H(b) is the full-time employee’s eligibility for a premium assistance tax credit, notwithstanding the employer offering coverage. The free rider provision’s penalty is triggered only when a full-time employee acquires coverage through an exchange *and* qualifies for a premium assistance tax credit.<sup>59</sup> Under

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56. 26 U.S.C. § 4980H(b)(1) (2012) (emphasis added).

57. See MEDILL, *supra* note 8, at 378.

58. *Id.*

59. *Id.*

IRC § 36B(c)(2)(C)(i)-(ii), an employee who is offered coverage under an employer sponsored health care plan, but decides to purchase coverage on an exchange system,

is *not* eligible for a premium assistance tax credit if: (1) the employer's plan has an actuarial minimum value of at least 60% (as measured by federal regulations); and (2) the employee's share of the premium for *self-only coverage* under the employer's plan does not exceed 9.5% of the employee's *household income*.<sup>60</sup>

Additionally, the affordability of the plan only relates to the employee coverage, *not* dependent coverage.<sup>61</sup>

Finally, the actual penalty associated with IRC section 4980H(b) is limited.<sup>62</sup> A free rider penalty is limited to the maximum play or pay penalty and includes a reduction for the first thirty full-time employees as well.<sup>63</sup>

## 2. Interference with Protected Rights [ERISA Section 510]

ERISA section 510 was initially designed by Congress to protect employee's rights under the new vesting and benefit accrual rules.<sup>64</sup> As the Sixth Circuit stated in *West v. Butler*, "[t]he legislative history reveals that the prohibitions were aimed primarily at preventing unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining vested pension rights."<sup>65</sup> However, section 510 protects an employee's rights connected to welfare benefit plans as well.<sup>66</sup>

ERISA section 510 offers several key protections. As the Seventh Circuit described in *Teumer v. General Motors Corp.*:

Section 510 protects workers against several distinct abuses: the disruption of employment privileges to *prevent* (i.e. interfere with) the vesting or enjoyment of benefit rights—the wrong alleged in this case; the disruption of employment privileges to *punish* (i.e. retaliate for) the exercise of benefit rights; and the disruption of employment privileges

60. *Id.* (citing 26 U.S.C. § 36B(c)(2)(C)(i)-(ii) (2012)).

61. *Id.* at 379 (citing 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(2) (2014)).

62. *Id.* (citing 26 U.S.C. § 4980H(c)(2)(D)(i)).

63. 26 U.S.C. § 4980H(c)(2)(D)(i).

64. MEDILL, *supra* note 8, at 734.

65. *West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

66. *See Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 514-15 (1997).

to prevent or punish the giving of testimony in any proceeding relating to ERISA or a sister act.<sup>67</sup>

The relevant protection that I will address in this paper is “the disruption of employment privileges to prevent . . . the vesting or enjoyment of benefit rights” under an employee benefit plan.<sup>68</sup> In the sections to follow, I will address the elements of a claim under section 510 generally, discuss its application to health care plans before the enactment of the ACA, and discuss its potential use in the current legal climate, specifically in regards to employer staffing down to avoid the aforementioned employer mandate.

#### a. Elements of Section 510

In order “to establish a violation of ERISA [s]ection 510, the plaintiff must prove that the defendant intended acted with the specific intent to interfere with rights protected under [s]ection 510.”<sup>69</sup> While direct evidence showing a discriminatory intent is preferred, it is often unavailable.<sup>70</sup> Therefore, most circuits in the United States have adopted the burden-shifting framework from *McDonnell Douglas Corp. v. Green*,<sup>71</sup> a seminal case for proving employment discrimination with circumstantial proof.<sup>72</sup> The *McDonnell Douglas* burden-shifting framework has been articulated as follows:

First, the plaintiff has the burden of proving by the preponderance of the evidence a prima facie case of discrimination. Second, if the plaintiff succeeds in proving the prima facie case, the burden shifts to the defendant “to *articulate* some *legitimate, nondiscriminatory reason* for the employee’s rejection. . . .” Third, should the defendant carry this burden, the plaintiff must then have an opportunity to prove by a preponderance of the evidence that the legitimate reasons offered by the defendant were not its true reasons, but were a *pretext* for

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67. *Teumer v. Gen. Motors Corp.*, 34 F.3d 542, 547 (7th Cir. 1994).

68. *Id.*

69. *MEDILL*, *supra* note 8, at 735.

70. *Id.*

71. *See McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973).

72. *See Dister v. Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988) (showing a court applying the *McDonnell Douglas* burden-shifting framework to a claim under ERISA § 510); Abigail Rubenstein, *Burden-Shifting Test Alive And Well Despite 7th Circ. Slam*, LAW360 (Feb. 27, 2012, 9:01 PM), <http://www.law360.com/articles/310354/burden-shifting-test-alive-and-well-despite-7th-circ-slam> (listing a number of circuit courts that still embrace the framework’s application).

*discrimination.*<sup>73</sup>

There are a number of important intricacies that have been developed within the framework since 1973. First and foremost, the plaintiff's initial burden in proving a *prima facie* case has been described as by the courts as a *de minimis* burden.<sup>74</sup> At this initial stage the plaintiff is required to simply establish "that the employer's actions give rise to an inference of discriminatory intent under [s]ection 510."<sup>75</sup>

Additionally, if the plaintiff does meet this initial burden, the employer's burden to then "articulate some legitimate, nondiscriminatory reason" is one of production, not persuasion.<sup>76</sup> Finally, although the defendant may have its burden of *producing* a legitimate nondiscriminatory reason, the plaintiff always retains the ultimate burden of *persuading* the trier of fact that an unlawful discriminatory motive is the real reason.<sup>77</sup> This persuasion takes place in one of two ways: "either directly by persuading the court that a discriminatory reason more likely motivated the employer or indirectly by showing that the employer's proffered explanation is unworthy of credence."<sup>78</sup>

Now that I have addressed, generally, the elements of a claim under ERISA section 510, in the following section I will discuss its application with respect to employer sponsored health care plans before March 2010.<sup>79</sup>

#### b. ERISA Section 510 and Health Care Plans (Pre-ACA)

Before the enactment of the ACA in March 2010, section 510 claims concerning employer sponsored health care plans were extremely difficult to bring in most circumstances.<sup>80</sup> Although the Supreme Court

73. *Dister*, 859 F.2d at 1111 (emphasis added) (quoting *Tex. Dep't of Cmty. Affairs v. Burdine*, 450 U.S. 248, 252-53 (1981)).

74. *E.g., id.* at 1114.

75. *MEDILL*, *supra* note 8, at 735.

76. *See Burdine*, 450 U.S. at 254 (discussing the plaintiff's burden of *persuasion* and the defendant's burden of *production*).

77. *See id.* at 256 (discussing the plaintiff's ultimate burden of persuading by a preponderance of the evidence).

78. *Id.* (citing *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 804-05 (1973)).

79. As was previously discussed, the ACA was passed by Congress and signed into law by President Obama in March 2010. *See supra* text accompanying note 1.

80. *West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980) (arising from the difficulty of bringing these claims, the Congressional intent behind section 510 was to make bringing actions against employers that fire or harass employees to prevent them from collecting vested rights easier to bring).

held, as previously mentioned, that section 510 applied to welfare benefit plans as well as pension benefit plans,<sup>81</sup> the Circuits were quick to clarify this holding.<sup>82</sup>

In *McGann v. H & H Music Co.*, the Fifth Circuit held that although section 510 applied to welfare benefit plans, employers could amend or rescind plan provisions, even in a clearly discriminatory manner, so long as the plan itself contains an express termination or amendment procedure.<sup>83</sup> The Court reasoned that because there are no statutory provisions regarding vesting of welfare benefit plans, and the plan itself contained a clause stating “[t]he [p]lan Sponsor may terminate or amend the [p]lan at any time or terminate any benefit under the [p]lan at any time,” there was no *promised benefit*.<sup>84</sup> The Court ultimately held that without a promised benefit there could be no “right to which [McGann] may become entitled under the plan”<sup>85</sup> and therefore no deprivation of such a right.<sup>86</sup>

Although section 510 claims failed to see much success in terms of challenging or preventing health care plan amendments, they did prove useful in challenging terminations or other employee discipline.<sup>87</sup> Some courts have even found *per se* violations of section 510.<sup>88</sup> For example, in *Lessard v. Applied Risk Management*, the Ninth Circuit held that both an employer and successor violated section 510 when entering into a contract that, on its face, discriminated against employees on disability or medical leave.<sup>89</sup>

In *Lessard*, the employer entered into an agreement with a successor for a sale of its business.<sup>90</sup> Part of the agreement, which required the employer to continue funding the disability and health care

81. *Inter-Modal Rail Emps. Ass’n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 514-15 (1996).

82. *See, e.g., Lessard v. Applied Risk Mgmt.*, 307 F.3d 1020, 1026 (9th Cir. 2002); *McGann v. H & H Music Co.*, 946 F.2d 401, 405 (5th Cir. 1991).

83. *See McGann*, 946 F.2d at 405 (finding that although the plan was amended to reduce coverage for a specific treatment, AIDS, and McGann was the only individual filing claims pursuant to such treatment, because the plan contained a termination or amendment provision there was no “promised benefit” for which that McGann was deprived).

84. *Id.*; *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143 (1990) (stating “Congress viewed [section 510] as a crucial part of ERISA because, without it, employers would be able to circumvent the provision of promised benefits.”).

85. *McGann*, 946 F.2d at 403 (citing 29 U.S.C. § 1140 (2012)).

86. *Id.* at 408.

87. *See Lessard*, 307 F.3d at 1026 (listing previous Ninth Circuit decisions to show that section 510 claims proved useful in challenging terminations or other employee discipline).

88. *Id.* at 1025-26.

89. *Id.*

90. *Id.* at 1022.

plan through its termination, also required the successor to employ all employees who were actively at work on the date of the sale, or who were employed but absent on the sale date due to a *non-medical reason*.<sup>91</sup> The Court ultimately held that “section 510 is violated when an employer selects for presumptive termination and denial of benefits specifically those employees presently on medical or disability leave.”<sup>92</sup> The Court reasoned that

[d]efendants here would have been permitted . . . to transfer all former [employees] to [the successor] subject to a reduction in benefits *for all employees*; but they were not permitted to exclude a select group of employees from immediate transfer because they were not “at work” on the day of transfer for health-related reasons.<sup>93</sup>

Additionally, some circuits have held that an employee may articulate a claim under section 510 for being discharged on the basis of his or her spouse’s claim under the employer sponsored health plan.<sup>94</sup> Some circuits have also held that, in terms of a claim under section 510, it is not necessary that the benefits under the health care plan be vested, but only that the reason for discharge was to interfere with the attainment of them.<sup>95</sup> Across the circuits the message has been loud and clear: to be successful in bringing section 510 claims in connection with an employer sponsored health care plan, the individual must have been disciplined or terminated and the claim may not stem from an amendment or modification of the plan itself.<sup>96</sup>

### c. ERISA Section 510 and Health Care Plans (Post-ACA)

After the enactment of the ACA in March 2010, the potential for ERISA section 510 claims in connection with employer sponsored health care plans increased immensely.<sup>97</sup> The ACA has not only

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91. *Id.*

92. *Id.* at 1026.

93. *Id.*

94. *E.g.*, *Fitzgerald v. Codex Corp.*, 882 F.2d 586, 589-90 (1st Cir. 1989).

95. *See, e.g.*, *Seaman v. Arvida Realty Sales*, 985 F.2d 543, 546 (11th Cir. 1993) (“[t]he validity of a § 510 claim does not hinge upon whether the benefits involved are vested but upon the purpose of the discharge.”).

96. *See, e.g.*, *McGann v. H & H Music Co.*, 946 F.2d 401, 407-08 (5th Cir. 1991); *Deeming v. Am. Standard, Inc.*, 905 F.2d 1124, 1127 (7th Cir. 1990); *Aronson v. Servus Rubber, Div. of Chromalloy*, 730 F.2d 12, 16 (1st Cir. 1984); *West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

97. *See* Ryan P. Moulder, *How the ACA, ERISA §510, and FLSA §18C Interact*, MOULDER LAW, <http://moulderlaw.com/how-the-aca-erisa-510-and-flsa-18c-interact/> (last visited Apr. 10,

required large employers to offer affordable coverage, it has regulated the content of that coverage as well.<sup>98</sup> For example, under the ACA, most employer sponsored health care plans, with few exceptions,<sup>99</sup> are required to provide coverage for the “ten essential health benefits,” which include: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services; (6) prescription drug coverage; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision.<sup>100</sup> Moreover, “[a]s of January 1, 2014, all non-grandfathered insured group health plans sold in the small employer market must provide the complete range of ten essential health benefits *without any lifetime or annual limitations*.<sup>101</sup> Although this requirement does not apply to plans with grandfathered status,<sup>102</sup> it shows just how uniform employer sponsored health care plans will soon become.

The entrenchment of mandated uniform employer sponsored health care plans will, according to some practitioners in the field, lead to a new class of ERISA section 510 cases.<sup>103</sup> Specifically, it has been recognized that employers’ decisions to staff down to avoid the ACA’s employer mandate could lead to section 510 claims.<sup>104</sup> In theory, employers may elect to reduce the number of full-time employees, or employees they have altogether, to avoid the ACA’s employer mandate.<sup>105</sup> However, because reducing employee hours to avoid the employer mandate would deny former “full-time” employees the ability to obtain health care coverage through an employer sponsored plan, there may be an argument that this decision was undertaken to deny

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2016).

98. 26 U.S.C. § 5000A(f) (2012).

99. Self-insured health care plans (where the employer uses company assets to pay for medical costs, instead of purchasing a health insurance policy from an insurance company) and plans sold on the large employer market (for employers with more than one hundred employees) are exempt from this requirement. *Id.*

100. 42 U.S.C. § 18022(b)(1) (2012).

101. MEDILL, *supra* note 8, at 368 (emphasis added).

102. *Id.* Grandfathered status, which will be addressed more fully in the “Benefits remedy” section of this paper, works to exempt plans from some requirements under the ACA. *Id.* at 371.

103. Adam C. Solander & Kara M. Maciel, *Where ERISA and the Affordable Care Act Collide*, LAW360 (Dec. 5, 2013, 3:48 PM), <http://www.law360.com/articles/489190/where-erisa-and-the-affordable-care-act-collide>.

104. *Id.*

105. *Id.*

benefits that the employees would have been entitled to.<sup>106</sup>

While the potential liability of employers for electing to staff down in order to avoid the employer mandate is uncertain, the remedies available for a section 510 violation are not. ERISA has three main civil remedy sections: 502(a)(1)(B); 502(a)(2); and 502(a)(3). ERISA section 502, in relevant part, states:

A civil action may be brought—

by a participant or beneficiary—

...

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section [409] . . . ;

(3) by a participant, beneficiary, or a fiduciary (A) to enjoin any act or practice which violates any provision of this [title] or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of this title or terms of the plan.<sup>107</sup>

It has long been held that the appropriate civil remedy section to redress a violation of section 510 is section 502(a)(3).<sup>108</sup> ERISA section 502(a)(1)(B) only applies when plaintiffs seek to redress benefit or claim denials under a plan<sup>109</sup> and section 502(a)(2) involves only fiduciary breaches<sup>110</sup> and does not authorize individual relief.<sup>111</sup> Therefore, any relief for a section 510 violation must be “appropriate equitable relief.”<sup>112</sup>

106. *Id.*

107. 29 U.S.C. § 1132(a)(1)-(3) (2012) (emphasis added).

108. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (quoting *Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

109. See *MEDILL*, *supra* note 8, at 613.

110. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 142 (1984); 29 U.S.C. § 1132(a)(2) refers only to 29 U.S.C. § 1109, which is titled “Liability for breach of fiduciary duty.” 29 U.S.C. § 1132(a)(2); 29 U.S.C. § 1109.

111. See *Russell*, 473 U.S. at 142 n.9.

112. 29 U.S.C. § 1132(a)(3)(B).

For quite some time plaintiffs bringing section 510 claims were allowed to seek reinstatement, back pay, and front pay as they were considered appropriate equitable relief available under section 502(a)(3).<sup>113</sup> However, since the Supreme Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson* pointed to the possibility that back pay and front pay may not be appropriate equitable relief under section 502(a)(3),<sup>114</sup> courts have been reluctant to grant it.<sup>115</sup> The Court's decision in *Cigna Corp. v. Amara*,<sup>116</sup> however, may bring new hope to those seeking relief for section 510 claims.

In *Cigna*, the Court held that although section 502(a)(1)(B) did not authorize *reformation* or *surcharge*, section 502(a)(3) may.<sup>117</sup> In reference to the remedies of reformation (altering the plan itself) and surcharge (monetary relief for losses stemming from a breach of fiduciary duty) granted by the trial court, the Court stated, "contrary to the District Court's fears, the types of remedies the court entered here fall within the scope of the term 'appropriate equitable relief' in section 502(a)(3)."<sup>118</sup> Although this was in reference to a breach of fiduciary duty,<sup>119</sup> the expansion of equitable remedies available under section 502(a)(3) will be an important piece of any potential section 510 claims for employers staffing down to avoid the ACA's employer mandate. Finally, there may be one last remedy available to employees who are faced with employer staffing down to avoid the ACA's employer mandate.<sup>120</sup> However, this provision lies not in ERISA, but the FLSA.

### 3. Other Protections for Employees [FLSA Section 18C]

FLSA section 18C was added in conjunction with the ACA to enforce its provisions.<sup>121</sup> Section 18C provides, in relevant part:

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113. See *Schwartz v. Gregori*, 45 F.3d 1017, 1020 (6th Cir. 1995).

114. See *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204, 218-21 (2002).

115. See, e.g., *Millsap v. McDonnell Douglas Corp.*, 368 F.3d 1246, 1260 (10th Cir. 2004) (citing *Russell*, 473 U.S. at 147) (holding back pay was unavailable under section 502(a)(3)); *Serpa v. SBC Telecomms., Inc.*, 318 F. Supp. 2d 865, 873-74 (N.D. Cal. 2004) (citing *Knudson*, 534 U.S. at 213-14) (holding front pay was unavailable under section 502(a)(3)).

116. See *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011).

117. See *id.* at 1878.

118. *Id.* at 1880.

119. See *id.*

120. See *Moulder*, *supra* note 97.

121. See Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1558, 124 Stat. 119, 261 (2010) (codified as 29 U.S.C. § 218c (2012)).

(a) Prohibition.—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—

[(1) *received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act.*<sup>122</sup>

As we recall from the discussion of the free rider penalty, where a full-time employee is eligible for and receives a premium tax credit to purchase coverage on an exchange, the employer is potentially subject to a penalty.<sup>123</sup> Therefore, it is possible to imagine a situation where a full-time employee, who purchases coverage on an exchange receiving a premium assistance tax credit, has his or her hours reduced, or is terminated altogether, in order to avoid the free rider penalty.<sup>124</sup>

Although this remedy has yet to be tested, at least on a large scale, the statute itself refers to the specific complaint procedure to be utilized.<sup>125</sup> More importantly, this remedy is in addition to any other rights granted by statute, including ERISA section 510.<sup>126</sup> While the future of ERISA section 510, FLSA section 18C, and staffing down to avoid the ACA's employer mandate is uncertain, we should anticipate challenges in the very near future.<sup>127</sup>

### B. Reporting and Disclosure Requirements

This section of the paper will discuss the new reporting and disclosure requirements for employer sponsored health care plans. Reporting requirements refer to the plan's responsibility to provide certain information to the government,<sup>128</sup> whereas disclosure requirements refer to the plan's responsibility to provide information to plan participants and beneficiaries.<sup>129</sup> Both pension and welfare benefit plans are covered by some reporting and disclosure requirements, however they are especially important for health care plans, as

122. *Id.* (emphasis added).

123. See MEDILL, *supra* note 8, at 378.

124. See Moulder, *supra* note 97.

125. See 29 U.S.C. § 218c(b); see also 15 U.S.C. § 2087(b)–(d) (2012).

126. See 29 U.S.C. § 218c(b)(2).

127. See Moulder, *supra* note 97.

128. See Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 2717, 124 Stat. 119, 135-36 (2010) (codified as 42 U.S.C. § 300gg-17(a)(2)(A) (2012)).

129. See 29 U.S.C. § 1024(b)(1)(B) (2012).

transparency is vital.<sup>130</sup> In the sections to follow, I will discuss the new reporting and disclosure requirements for employer sponsored group health plans, including the new Department of Health and Human Services (hereinafter HHS) quality of care report and minimum essential coverage reports to the Internal Revenue Service (hereinafter IRS).

### 1. Disclosures to Plan Participants: ACA Section 1001 vs. ERISA Section 104

As health care plans, like all welfare benefit plans, are subject to constant changes and amendments, it is important that both participants and beneficiaries understand the terms of their plan. In order to ensure adequate transparency, ERISA section 104(b) requires, among other things, the administrator of the plan to provide certain documents to plan participants and beneficiaries.<sup>131</sup> These documents include: (1) summary plan description (hereinafter SPD); (2) summary of material modifications (hereinafter SMM); (3) the summary annual report (hereinafter SAR); and (4) “upon request” disclosures.<sup>132</sup>

Each of these documents serves a specific purpose. Both the SPD and SMM are intended to provide participants and beneficiaries with information such as the plan’s benefits, circumstances leading to disqualification or denial of benefits, procedures for filing a claim for benefits, contact information of certain plan fiduciaries, and the DOL office where they may seek help.<sup>133</sup> More importantly, both the SPD and SMM must “be written in a manner calculated to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”<sup>134</sup>

The SAR is intended to provide a simple overview of insurance information, if the welfare benefit plan is insured.<sup>135</sup> Additionally, the SAR may be distributed by electronic sources.<sup>136</sup> Finally, any participant or beneficiary may request documents from the plan

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130. See *id.* § 1024(a)–(b); Justin Giovannelli, Kevin Lucia, & Sarah J. Dash, *The Affordable Care Act’s Disclosure Rules: Can They Improve Coverage, Raise Care Quality, and Cut Costs?*, THE COMMONWEALTH FUND: BLOG (Jan. 15, 2014), <http://www.commonwealthfund.org/publications/blog/2014/jan/insurer-transparency>.

131. See 29 U.S.C. § 1024(b).

132. MEDILL, *supra* note 8, at 70-75.

133. *Id.* at 70-71.

134. See 29 U.S.C. § 1022(a) (2012).

135. See 29 C.F.R. § 2520.104b–10(a) (2015).

136. MEDILL, *supra* note 8, at 73.

administrator, including “the latest updated [SPD], . . . contract, or other instruments under which the plan is established or operated.”<sup>137</sup> Accordingly, these documents, when requested, must be sent to the participant or beneficiary within thirty days.<sup>138</sup> Finally, if the plan administrator fails to send the requested documents within thirty days, the courts have discretion to hold them personally liable for up to one hundred dollars per day.<sup>139</sup>

The aforementioned provisions are the general requirements under ERISA that apply to all welfare benefit plans, including health care plans.<sup>140</sup> However, with the enactment of the ACA, Congress set in place new disclosure requirements that superseded some ERISA provisions.<sup>141</sup> These new disclosure provisions, which will be addressed in the following two sections, include a new time frame for notice of material modifications and an additional summary of plan benefits.<sup>142</sup>

#### a. Material Modifications

Under ERISA section 104(b)(1), plan administrators were required to send SMM’s to participants of an employer sponsored group health plan within sixty days *after* the modification is implemented.<sup>143</sup> This disclosure requirement, although benevolent in its intention, provided little reaction time for participants or beneficiaries.<sup>144</sup> For example, if a health care plan had a large reduction in services offered, the plan administrator would only be required to provide notice within sixty days *after the modification*, leaving the beneficiaries and participants affected no buffer.

Congress addressed this issue, however, with amendments to the Public Health Service Act (PHSA).<sup>145</sup> Under these new amendments to the PHSA, the plan administrators of employer sponsored group health plans are now required to give notice to plan participants no later than sixty days *before* a material modification.<sup>146</sup> This complete switch in the

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137. 29 U.S.C. §1024(b)(4).

138. MEDILL, *supra* note 8, at 75.

139. 29 U.S.C. § 1132(c)(1).

140. *See id.* § 1024(b)(1).

141. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2715, 124 Stat. 119, 134 (2010) (codified as 42 U.S.C. § 300gg-15 (2012)).

142. *Id.*; *see also infra* Sections III.B.1.a, III.B.1.b.

143. *See* 29 U.S.C. § 1024(b)(1)(B) (2012).

144. *See id.*

145. *See* § 2715, 124 Stat. at 134.

146. *Id.*; *see also* 29 C.F.R. § 2590.715-2715(b) (2015).

disclosure requirement for material modification will now allow an adequate buffer for participants and beneficiaries to prepare.<sup>147</sup> In addition to the new disclosure requirements for SMMs, the ACA also brought about additional requirements, such as the HHS summary of benefits coverage.<sup>148</sup>

b. Summary Plan Description (SPD) and the Department of Health and Human Services (HHS) Summary of Benefits and Coverage

Although the SPD requirements under ERISA section 104 are at least somewhat comprehensive, Congress took advantage of the enactment of the ACA to provide for additional disclosure requirements.<sup>149</sup> Under ACA section 1001, in addition to the provision regarding the SMM, plan administrators must now provide a much more in depth summary of plan benefits and coverage, known as the HHS summary of benefits and coverage.<sup>150</sup> The HHS summary must be presented “in a culturally and linguistically appropriate manner.”<sup>151</sup> Additionally, the summary must use “terminology understandable by the average plan enrollee. . . .”<sup>152</sup>

The HHS summary itself is required to contain the following information:

- Uniform definitions of insurance and medical terms;
- A description of the scope of coverage and any participant cost-sharing requirements for each category of essential health benefits or other benefits provided under the plan;
- Exceptions, reductions and limitations in coverage;
- Provisions describing the terms and conditions for renewability and continuation of coverage;
- Illustrations of coverage under common benefits scenarios;

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147. See generally 29 C.F.R. § 2590.715-2715(b) (2012) (displaying the new disclosure requirement when material modifications to group health plans occur).

148. See 29 C.F.R. §§ 2590.715-2715(a)(1).

149. See *id.*

150. *Id.*

151. 29 C.F.R. §§ 2590.715-2715(a)(5).

152. 29 C.F.R. §§ 2590.715-2715(a)(3).

- A statement concerning whether the plan meets the federal standard for minimum individual coverage required for individuals beginning in 2014 under the ACA;
- A warning that the HHS summary of benefits and coverage is only an outline and that the participant should consult the actual plan or policy language;
- A web site address where the actual plan or policy language may be found; and
- A contact number that participants in the plan may call for additional information.<sup>153</sup>

Additionally, the HHS summary must be no more than four pages and must be written in at least twelve-point font.<sup>154</sup> It is important to remember, as well, that the HHS summary does not replace the SPD but merely adds to it.<sup>155</sup>

Although the ERISA disclosure requirements were fairly helpful, it appears that the new ACA requirements will help even more so.<sup>156</sup> The more information that a participant or beneficiary receives about his or her plan, the better. This is especially so in light of the fact that SPDs are crucial, as most plan documents are verbose and confusing to the average individual.

## 2. Reporting to Federal Agencies

In addition to new disclosure requirements concerning the plan administrator's duty to provide information to participants and beneficiaries, the enactment of the ACA brought on new reporting requirements, which include the HHS quality of care report<sup>157</sup> and the minimum essential coverage reports to the IRS.<sup>158</sup>

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153. 29 C.F.R. §§ 2590.715-2715(a)(2)(i)(A)-(L).

154. 29 C.F.R. §§ 2590.715-2715(a)(3).

155. See 29 C.F.R. § 2520.104b-3.

156. See Penny C. Wofford, *ACA Reporting Requirements: Tips for What's Ahead in 2016*, SHRM (Oct. 1, 2015), <http://www.shrm.org/hrdisciplines/benefits/articles/pages/aca-reporting-tips.aspx>.

157. See *infra* Section III.B.2.a.

158. See *infra* Section III.B.2.b.

### a. HHS Quality of Care Report

Under the ACA, employer sponsored group health plans are now required to provide annual reports to the HHS.<sup>159</sup> All group health plans are required to submit a quality of care report detailing whether the plan:

- Improved health outcomes through activities such as quality reporting, case management, care coordination, and chronic disease management;
- Implemented activities to prevent hospital readmission, improve patient safety, and reduce medical services; and
- Implemented wellness and health promotion activities.<sup>160</sup>

In addition to reporting this information to HHS, the plan administrator must also make copies available to plan participants.<sup>161</sup> Additionally, non-grandfathered plans must report to HHS and make public information regarding, among other things, the policies and practices of paying claims, enrollment and disenrollment information, denying claims, and rating practices.<sup>162</sup>

### b. Minimum Essential Coverage Reports to the IRS

The final reporting requirement under the ACA is the minimal essential coverage report.<sup>163</sup> Under the ACA, employers who sponsor health care plans providing minimum essential coverage to their employees must submit reports containing employee and plan premium information to the IRS.<sup>164</sup> Additionally, the employers who sponsor health care plans must continue to submit the cost of coverage for each enrolled employee to the IRS.<sup>165</sup> Although the Treasury Department has just initiated enforcement of these reporting requirements with complete compliance required in 2016,<sup>166</sup> it appears that the ACA is attempting to add a layer to the reporting and disclosure requirements for health care

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159. See 45 C.F.R. § 158.150.

160. *Id.*

161. See 45 C.F.R. § 156.220(a)–(b).

162. *Id.*

163. See MEDILL, *supra* note 8, at 84.

164. *Id.*

165. *Id.*

166. *Id.*

plans that has yet to be seen.

### C. “Benefits Remedy”

The final collision between ERISA and the ACA that this paper focuses on is the “benefits remedy.” Under ERISA, both participants and beneficiaries of an employer sponsored health care plan had to utilize section 502(a)(1)(B) to challenge their benefit and claims denials.<sup>167</sup> However, with the enactment of the ACA, most participants and beneficiaries now have the option to elect for an independent external review of their benefit and claims denials.<sup>168</sup> In the following sections I will discuss both of these remedy provisions in full detail.

#### 1. ERISA Section 502(a)(1)(B)

ERISA section 502(a)(1)(B) is often called the “benefits remedy” provision,<sup>169</sup> as it is used by litigants to review disputes over benefit claims under employer sponsored welfare benefit plans.<sup>170</sup> Specifically, section 502(a)(1)(B) allows either participants or beneficiaries to bring a civil action in order to “*recover benefits due to [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan.*”<sup>171</sup> There are no specific elements of a section 502(a)(1)(B) claim, as they are based on contractual disputes.<sup>172</sup> However, there are some court-created obstacles that each plaintiff will have to jump over in order to assert a viable cause of action.<sup>173</sup> These hurdles will be addressed in the following section.

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167. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989).

168. 29 C.F.R. § 2590.715-2719(d) (2015).

169. Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 657 (2014) (quoting Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 453, n.151 (2010)).

170. See 29 U.S.C. § 1002(1) (2012); Peter K. Stris, *ERISA Remedies, Welfare Benefits and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 393 (2009).

171. 29 U.S.C. § 1132(a)(1)(B) (emphasis added).

172. See *id.* § 1132.

173. See *Firestone*, 489 U.S. at 108 (contemplating the appropriate standard of review in actions arising under § 1132(a)(1)); see also *Diaz v. United Agric. Emp’t. Welfare Benefit Plan & Tr.*, 50 F.3d 1478, 1482 (9th Cir. 1995) (holding that federal courts have the authority to enforce the exhaustion doctrine and generally do so as a matter of policy).

## a. Litigating Section 502(a)(1)(B)

## i. Administrative Exhaustion

The first and most problematic hurdle for plaintiffs who bring a section 502(a)(1)(B) claim is the “administrative exhaustion” requirement.<sup>174</sup> Under ERISA section 503, every employer sponsored benefit plan, including health care plans, must provide an internal claims procedure.<sup>175</sup> Section 503 states:

[i]n accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a *full and fair review by the appropriate named fiduciary of the decision denying the claim.*<sup>176</sup>

Due to this provision requiring an internal appeals process, most courts require participants and beneficiaries to exhaust their administrative appeals before filing a section 502(a)(1)(B) claim.<sup>177</sup> Although this requirement is not explicit in the statute, many courts have deemed it necessary.<sup>178</sup> As the Ninth Circuit stated in *Diaz v. United Agricultural Employee Welfare Benefit Plan & Trust*, “[a]lthough not explicitly set out in the statute, the exhaustion doctrine is consistent with ERISA’s background, structure and legislative history. . . . Consequently the federal courts have the authority to enforce the exhaustion requirement in suits under ERISA, and as a matter of sound policy they should usually do so.”<sup>179</sup>

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174. See 29 U.S.C. § 1133.

175. *Id.*

176. *Id.* (emphasis added).

177. See, e.g., *Kinhead v. Southwestern Bell Corp. Sickness & Accident Disability Benefit Plan*, 111 F.3d 67, 68 (8th Cir. 1997); *Diaz*, 50 F.3d at 1483 (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)).

178. See, e.g., *Wert v. Liberty Life Assur. Co. of Bos.*, 447 F.3d 1060, 1063 (8th Cir. 2006); *Watts v. Bellsouth Telecomm., Inc.*, 316 F.3d 1203, 1207 (11th Cir. 2003); *Diaz*, 50 F.3d at 1483 (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)).

179. *Diaz*, 50 F.3d at 1483.

There are, however, several exceptions to the exhaustion requirement that have been recognized by a number of the Circuits, including situations in which a plan's appeal process has been removed,<sup>180</sup> there is immediate danger of "life-threatening" harm,<sup>181</sup> pursuing the administrative appeals process would be done in futility,<sup>182</sup> there is no meaningful access to an appeals process,<sup>183</sup> and the appeals process was reasonably interpreted as optional.<sup>184</sup> Although these exceptions are available, the general rule of thumb is that the individual must have exhausted his or her internal appeals process before filing in federal court.<sup>185</sup>

## ii. Judicial Review

Once the plaintiff has met this administrative exhaustion requirement and filed a claim under section 502(a)(1)(B), however, they must next encounter the hurdle of judicial review.<sup>186</sup> The question of what standard to apply when reviewing a benefits claim denial first arose in *Firestone Tire & Rubber Co. v. Bruch*, where the Supreme Court held that "a denial of benefits challenged under [section] 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary *discretionary authority* to determine eligibility for benefits or to construe the terms of the plan."<sup>187</sup> Courts began recognizing what is known as "*Firestone* language" in their ERISA plan decisions. For example, in order to guarantee abuse of discretion review, as opposed to *de novo* review, the Seventh Circuit drafted the following "safe harbor" language for employers to implement: "[b]enefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."<sup>188</sup>

This *Firestone* language, however, did not end the issues concerning judicial review of benefits claims denials. The Supreme Court again addressed the issue in *Metropolitan Life Insurance Co. v.*

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180. See *Lee v. Cal. Butchers' Pension Tr. Fund*, 154 F.3d 1075, 1080 (9th Cir. 1998).

181. See *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 962 (8th Cir. 1995).

182. See *McGraw v. Prudential Ins. Co.*, 137 F.3d 1253, 1264 (10th Cir. 1998).

183. See *Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 403 (7th Cir. 1996).

184. See *Watts*, 316 F.3d at 1207.

185. See Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1167 n.436 (2001).

186. See *id.* at 1167-68 (discussing the differing judicial standards of review in ERISA litigation after filing a section 502(a)(1)(B) claim).

187. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (emphasis added).

188. See *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000).

*Glenn*, this time in reference to an implied conflict of interest where insured plans authorized the insurance companies to determine whether or not to pay benefits under the plan.<sup>189</sup> In *Glenn*, the Court held that although abuse of discretion was the proper standard of review, due to the plan's language granting discretionary authority, it is proper to take into consideration a conflict of interest when determining whether or not there was an abuse of discretion.<sup>190</sup> This was another blow to plans that wished to retain complete discretion in their claim for benefits determinations. Moreover, many states have since passed legislation prohibiting health care insurance policies from containing *Firestone* language, in an attempt to preserve de novo review of claims for benefits.<sup>191</sup>

### iii. Remedies Available

Although it appears that judicial review may, in most instances, benefit plaintiffs, there are other issues with regards to litigating section 502(a)(1)(B) claims, such as whether an adequate remedy will be available.<sup>192</sup> Under section 502(a)(1)(B), courts are generally restricted to ordering that the plan provide benefits for the participant or beneficiary, in accordance with the terms of the plan.<sup>193</sup> For health care plans, where a plaintiff has already received the medical treatment, the proper remedy would simply be reimbursement for out-of-pocket costs.<sup>194</sup> Finally, courts may provide other limited remedies, such as prejudgment interest.<sup>195</sup>

Where the medical procedure or benefit has not been provided, however, the court may only order the plan to "provide the benefit that is due in accordance with the terms of the plan."<sup>196</sup> This is often the case with employer sponsored health care plans, as they often require the plan to "preapprove" the medical treatment.<sup>197</sup> Therefore, a problem that often arises with section 502(a)(1)(B) claims for benefits under an employer sponsored health care plan is that the participant or beneficiary may be either deceased or no longer an appropriate candidate for the

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189. See *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008).

190. *Id.* at 115 (quoting *Firestone*, 489 U.S. at 115).

191. *MEDILL*, *supra* note 8, at 643.

192. *Id.* at 649.

193. *Id.*

194. *Id.*

195. See, e.g., *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 819-20 (7th Cir. 2002).

196. *MEDILL*, *supra* note 8, at 649.

197. *Id.*

procedure.<sup>198</sup> Finally, if the plaintiff has suffered damages due to the original denial of benefits by the plan administrator, they are again unable to fully recover under section 502(a)(1)(B), as it does not authorize compensatory damages.<sup>199</sup>

#### b. Additional Problems: Vesting for Health Care Plans

Finally, there are some additional problems with enforcing benefits under health care plans. Unlike pension benefit plans, welfare benefit plans have no statutory vesting schedule.<sup>200</sup> In fact, under the “settlor function doctrine” employers are generally authorized to modify or completely eliminate welfare benefit plans, including health care plans.<sup>201</sup> However, ERISA section 402(b)(3) does require every employee benefit plan, including welfare benefit plans, to “provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan. . . .”<sup>202</sup>

Although section 402(b)(3) requires an amendment procedure, the courts have been more than generous in finding them, even when the procedure is not clear.<sup>203</sup> For example, in *Curtiss-Wright Corp. v. Schoonejongen* the Supreme Court held that a clause stating “[t]he Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan” satisfied the requirements set out in section 402(b)(3).<sup>204</sup> In its holding the Court recognized that section 402(b)(3) requires two specific procedures: one for *amending* the plan and one for *identifying someone* who is given authority to amend the plan.<sup>205</sup> The Court summarily found that the “company” was properly identified as the “someone” authorized to amend the plan.<sup>206</sup> Finally, the Court found that the reservation clause also met the second requirement, as it held “the literal terms of § 402(b)(3) are ultimately indifferent to the level of detail in an amendment procedure. . . . The provision requires only that there be an

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198. *Id.*

199. *See* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985).

200. *See* Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995); Am. Fed’n of Grain Millers v. Int’l Multifoods Corp., 116 F.3d 976, 979 (1997).

201. *See* Schoonejongen, 514 U.S. at 78.

202. 29 U.S.C. § 1102(b)(3) (2012) (emphasis added).

203. *See* Schoonejongen, 514 U.S. at 81.

204. *Id.* at 76.

205. *Id.* at 78.

206. *Id.* at 75.

amendment procedure, which here there is.”<sup>207</sup>

*Schoonejongen* turned out to be the seminal case for both the settlor function doctrine and the “reservation of rights clause” amendment procedure.<sup>208</sup> The Court’s decision has made it almost impossible to assert a vested right to benefits under an employer sponsored health care plan.<sup>209</sup> However, courts have since found vested rights to welfare plan benefits based on contract principles, specifically that benefits vest when a medical condition arises that is covered under the plan.<sup>210</sup> Additionally, the enactment of the ACA has forced the hands of most large employers to both offer employer sponsored health care plans and ensure the plans contain certain benefits.<sup>211</sup>

## 2. Independent External Review

The final section of this paper discusses the other “benefits remedy,” independent external review. Independent external review is similar to another layer of internal review, except the individual reviewing the claim denial is a third-party.<sup>212</sup> It is also somewhat similar to arbitration in that it is the resolution of a private dispute between two parties, in a private forum, that is much more cost effective than court.<sup>213</sup> Although external review was around before the ACA, its enactment greatly expanded its availability.<sup>214</sup> The external review process, both before and after the enactment of the ACA, will be discussed in the following two sections.

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207. *Id.* at 80.

208. *Id.* As of April 24, 2016, a key cite search shows that *Schoonejongen* has been cited in over 645 subsequent decisions. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73: *Citing Decisions*, LEXIS ADVANCE, <https://advance.lexis.com/shepards/shepardspreview/?pdmfid=1000516&crd=649431ca-3947-4f78-9ecb-b07f4392a2dd&pdshepid=urn%3AcontentItem%3A7XWN-0261-2NSF-C3WP-00000-00&pdshepcat=citingref&action=sheppreview&ecomp=-9pfpk&prid=469e5e49-20d8-4cc7-a8c9-ea80088744c3> (last visited Apr. 24, 2016).

209. Richard L. Kaplan et. al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL’Y, L. & ETHICS 287, 303 (2009).

210. See, e.g., *Wheeler v. Dynamic Eng’g*, 62 F.3d 634, 638 (4th Cir. 1995) (stating that the court chose to interpret the ERISA plan under ordinary contract law).

211. See MEDILL, *supra* note 8, at 374-75.

212. Roy F. Harmon, *An Assessment of New Appeals and External Review Processes – ERISA Claimants Get “Some Kind of A Hearing,”* 56 S.D. L. REV. 408, 440, 451 (2011).

213. *Id.* at 440.

214. See *id.* at 423.

## a. External Review (Pre-ACA)

Since its birth, ERISA's preemption clause has been interpreted by the courts as extremely broad.<sup>215</sup> For example, in *FMC Corp. v. Holliday*, the Supreme Court stated "[t]he preemption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA."<sup>216</sup> For this reason, state laws that "relate to" an employee benefit plan have been held to be preempted by ERISA again and again; this includes alternate remedial provisions.<sup>217</sup>

In 2002, however, the Supreme Court carved out a new exception: the independent external review process.<sup>218</sup> In *Rush Prudential HMO, Inc. v. Moran*, the Court held that although a state-operated independent external review process "related to" an employee benefit plan governed by ERISA, it was nonetheless saved by ERISA's "savings clause," which allows states to pass statutes that regulate, among other things, insurance.<sup>219</sup> The Court further reasoned that the external review process in question did not add a legal cause of action to be brought in court, but rather provided for something similar to the internal appeals process already mandated by ERISA section 503.<sup>220</sup>

After the Court's decision in *Moran*, more and more states began to enact independent external review systems.<sup>221</sup> Although these external review systems became somewhat popular, they did not exist in every state.<sup>222</sup> Moreover, they did not apply to self-insured plans.<sup>223</sup> For this reason, Congress, as it did with many other issues, took advantage of the ACA's enactment to expand the remedy of independent external review for benefit claims denials.<sup>224</sup> This expansion will be addressed in the

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215. See *id.* at 416 (stating that the Supreme Court gave ample boundaries to ERISA domain).

216. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

217. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987), wherein the Supreme Court stated,

[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's [section] 502(a) to [section] 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under [section] 502(a) could be supplemented or supplanted by varying state laws.

218. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386-87 (2002), *overruled in part* by *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003).

219. *Id.* at 387.

220. *Id.* at 386-87.

221. *MEDILL*, *supra* note 8, at 371.

222. *Id.*

223. *Id.*

224. *Id.*

following section.

#### b. External Review (Post-ACA)

In the post-ACA era, independent external review is available in every state to all participants and beneficiaries of non-grandfathered plans, which includes self-insured plans.<sup>225</sup> The specific section of the ACA that created this expansion, section 2719, states, in relevant part:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or insurer shall, at a minimum—

(4) provide an external review process for such plans and issuers that, *at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act* promulgated by the National Association of Insurance Commissioners and is *binding on such plans*.<sup>226</sup>

Under the ACA's external review process, a plan beneficiary or participant may elect to have an independent review organization (hereinafter "IRO") review the plan administrator's claim denial.<sup>227</sup> Before the individual can elect this remedy, however, he or she must first exhaust the plan's internal appeal process, similar to the exhaustion requirement for section 502(a)(1)(B) claims.<sup>228</sup> Once a "final adverse determination" has been made, the individual may file a request for an independent external review, which must be made with the state's insurance commissioner.<sup>229</sup> Under regulations promulgated by the Secretary of HHS, only decisions concerning medical judgment or a rescission of coverage are reviewable by the IRO.<sup>230</sup>

If a claim is reviewable by the IRO, the independent reviewer of the claim denial must "[b]e an expert in the treatment of the covered person's medical condition that is the subject of the external

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225. *Id.*

226. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2719, 124 Stat. 119, 138 (2010) (emphasis added) (codified as amended at 42 U.S.C. § 300gg-19 (2012)).

227. MEDILL, *supra* note 8, at 372.

228. UNIF. HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 7(A) (NAT'L ASS'N OF INS. COMM'RS 2010).

229. *Id.* § 8(A)(1).

230. 29 C.F.R. §§ 2590.715-2719(d)(1)(ii)(A)-(B) (2015).

review. . . .”<sup>231</sup> During the external review, the participant may submit additional evidence not previously considered by the plan administrator.<sup>232</sup> Finally, the independent reviewer, when making a determination, reviews the plan administrator’s decision *de novo*<sup>233</sup> and the reviewer’s determination is binding on the plan administrator.<sup>234</sup>

The independent external review process is meant to be a cost effective alternative to lengthy and often inefficient litigation.<sup>235</sup> Like all remedial options, however, there are some drawbacks to the new independent review process. For example, independent reviewers, much like arbitrators, are not required to explain their decision making process to the public.<sup>236</sup> Additionally, it is unclear whether or not the external review process is now a prerequisite to filing in federal court, or if the external review bars a subsequent action under ERISA altogether.<sup>237</sup> It may take the courts some time to flesh this problem out.

#### IV. FUTURE OF ERISA, THE ACA, AND REGULATION OF EMPLOYER SPONSORED HEALTH CARE PLANS

This paper was intended to do three things. First and foremost, my intention was to present some of the major provisions of the ACA, in terms of their impact on longstanding ERISA sections, and address their advantages/disadvantages. Although I was only able to briefly address it in my paper, ERISA’s broad preemption clause has led to very few significant state and local regulations that touch employer sponsored health care plans.<sup>238</sup> This has led to, for the most part, a steadfast and

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231. UNIF. HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 13(B)(1).

232. MEDILL, *supra* note 8, at 372.

233. U.S. DEP’T OF LABOR, TECHNICAL RELEASE 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, at 5 (2010), <http://www.dol.gov/ebsa/pdf/acatechnicalrelease2010-01.pdf>.

234. UNIF. HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 11(A).

235. *Preserving the Integrity and Viability of Independent Medical Review*, NAT’L ASS’N INDEP. REV. ORG., at 1, [http://nairo.org/site/1920nair/nairo\\_white\\_paper\\_042007.pdf](http://nairo.org/site/1920nair/nairo_white_paper_042007.pdf) (last visited Mar. 7, 2016).

236. Katherine T. Vukadin, NYU REVIEW OF EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION § 15.03 (Matthew Bender & Co., Inc. 2014).

237. *See, e.g.,* Goldman v. BCBSM Foundation, 841 F. Supp. 2d 1021, 1026 (E.D. Mich. 2012) (“It does not appear that the new external review process *must* be completed before an individual has the right to sue under ERISA.”).

238. Patricia A. Butler, *ERISA Implications for Employer Pay or Play Coverage Laws*, CAL. HEALTH CARE FOUND., at 1 (Mar. 2005), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20E/PDF%20ERISAPayPlayImplications.pdf>.

uniform federal common law in terms of litigation surrounding employer sponsored health care plans.<sup>239</sup> However, ERISA's preemption is often a double-edged sword; it will preempt state causes of action without providing adequate remedies under the act itself,<sup>240</sup> as was discussed under the section regarding section 502(a)(1)(B) remedies.<sup>241</sup> Therefore, it is my opinion that expansion of the independent external review process, although it has its drawbacks, is a step in the right direction.

Additionally, the new reporting and disclosure requirements are a significant step in the right direction as well. The idea that participants and beneficiaries could, prior to the ACA, have their coverage rescinded without notice until sixty days after the fact<sup>242</sup> is outrageous. While both Congress and the courts have stressed the importance of allowing employers to amend or rescind welfare benefit plans, for the most part, as they see fit,<sup>243</sup> it would seem equally important that we charge employers and plan administrators with the duty of providing at least a courtesy notice when eliminating benefits. Although welfare plans have not been the subject of substantial regulation, from the WPPDA through ERISA, they have been subject to reporting and disclosure requirements.<sup>244</sup> The ACA's new provisions on reporting and disclosure are the *exact* requirements we have needed.

Second, this paper was intended to address potential issues based on employer activity, likely to occur in the face of the ACA's employer mandate, and how that activity may implicate provisions under ERISA, specifically section 510. Although the logic behind the argument for liability is sound, it presupposes the employer activity. At the end of the day, each employer's decision on whether or not to reduce staff will be based upon a cost benefit analysis comparing potential liability under ERISA with potential liability under the ACA.<sup>245</sup> My guess is that this

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239. William Sage, *Nothing (Still) Matters: ERISA Preemption Returns to the Supreme Court*, HEALTH AFFAIRS BLOG (Dec. 7, 2015), <http://healthaffairs.org/blog/2015/12/07/nothing-still-matters-erisa-preemption-returns-to-the-supreme-court/>.

240. *Id.*

241. *See infra* Section III.C.1.a.iii.

242. Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8677 (Feb. 14, 2012) (to be codified 45 C.F.R. pt. 147).

243. Andrew M. Kramer, Evan Miller & Richard F. Shaw, *Retiree Health Benefits: Legal Developments in a Changing Global Economy*, at 3 n.1 (2008), [http://www.jonesday.com/files/Publication/b862f89d-f5f8-445f-8344-aa037c82b669/Presentation/PublicationAttachment/008b578a-4949-4371-b8e3-f557edc34941/JD\\_~4294925.pdf](http://www.jonesday.com/files/Publication/b862f89d-f5f8-445f-8344-aa037c82b669/Presentation/PublicationAttachment/008b578a-4949-4371-b8e3-f557edc34941/JD_~4294925.pdf) (quoting *Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997)).

244. *See infra* Section III.B.

245. *See* Kevin LaCroix, *ACA Employer Mandates and Potential Liability Issues*, THE D&O

issue will arrive before the courts fairly quickly. However, similar to many aspects of employee benefit law, it will probably take the courts a while to fully resolve it. The ACA's employer mandate, specifically the penalty calculation, is fairly new and still somewhat confusing.<sup>246</sup> Until its application is worked out through litigation, it is hard to say exactly what employers will actually do in terms of staffing down.

Finally, this paper was intended to address the future of ERISA, the ACA, and employer sponsored health care plans. Although the ACA has been the center of partisan bickering since its enactment in 2010,<sup>247</sup> its actual provisions seem fairly moderate. For example, the employer mandate sets out a prescription that some critics claim will kill small business.<sup>248</sup> However, the penalty provision discounts the first thirty full-time employees, leaving many small businesses completely unscathed.<sup>249</sup> This paper is not meant to comment on the policy decisions behind the ACA one way or another. The ACA's enactment does lead me to one conclusion, however: Employers will most likely be the primary sources of health care for individuals, for the foreseeable future.

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DIARY (Dec. 15, 2014), <http://www.dandodiary.com/2014/12/articles/affordable-care-act/aca-employer-mandates-and-potential-liability-issues/>.

246. See *Obamacare Employer Mandate*, OBAMACARE.NET, <https://obamacare.net/obamacare-employer-mandate/> (last updated Oct. 30, 2015).

247. David Morgan, *Top U.S. Health Adviser Wants End to Partisan Fighting Over Obamacare*, BUSINESS INSIDER (Sept. 8, 2014, 4:50 PM), <http://www.businessinsider.com/r-top-us-health-adviser-wants-end-to-partisan-fighting-over-obamacare-2014-9>.

248. See SEAN LOWRY & JANE GRAVELLE, CONG. RESEARCH SERV., R43181, THE AFFORDABLE CARE ACT AND SMALL BUSINESS: ECONOMIC ISSUES 11-12 (2015), <https://www.fas.org/sgp/crs/misc/R43181.pdf>.

249. *Obamacare Employer Mandate*, *supra* note 246.