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WHAT'S INSIDE

TAFT-HARTLEY REPORT

J&K Scores Huge Victory for Multiemployer Pension Funds Seeking to Collect Withdrawal Liability from Successors

On June 24, 2016, the Seventh Circuit reversed a federal district court's opinion which held that J&K's client, the Automobile Mechanics' Local No. 701 Union and Industry Pension Fund ("Pension Fund"), could not prevail on its successor liability claims against a successor company.[1] In reversing the opinion, the Seventh Circuit held that notice to a successor of the predecessor's obligation to contribute to a multiemployer defined benefit pension fund was sufficient to satisfy the notice element in successor liability claims.

Hannah Maritime Company ("HMC") was signatory to a collective bargaining agreement with Local 701 that required it to contribute to the Pension Fund. HMC was owned by Donald Hannah. In 2008, HMC sold its unencumbered assets to Full Circle Group, a company started by Donald Hannah's son. When HMC transferred its assets which resulted in a cessation of its covered operations, it sustained a complete withdrawal from the Pension Fund.

According to the employees of HMC, nothing changed when Full Circle Group took over HMC's covered operations. Prior to the closing of the agreement in which the assets were transferred, Full Circle Group was aware of HMC's obligation to contribute to the Pension Fund. Additionally, HMC continued to pay wages to and contributions on behalf of Full Circle Group's employees even though Full Circle Group was allegedly their employer. Furthermore, the only money ever transferred from Full Circle Group to HMC was for the sole benefit of Full Circle Group. As such, the Pension Fund asserted claims for successor liability against Full Circle Group.

In order to prevail on successor liability claims, the charging party must prove two elements: (1) continuity of operations and (2) the successor's pre-acquisition notice of the liability. In its motion for summary judgment, Full Circle Group argued that it could not be liable because the withdrawal liability had not been assessed at the time of the asset transfer and Full Circle Group was not aware of HMC's potential withdrawal liability. The district court agreed with Full Circle Group.

[1] *Board of Trustees of the Autom v. Full Circle Group, Inc., et al*, 7th Cir., No. 15-2497, 6/24/16.

On appeal, the Pension Fund argued that knowledge of the obligation to contribute to the Pension Fund alone satisfied the notice element in successor liability claims. The Seventh Circuit agreed with the Pension Fund's position and held that Full Circle Group's knowledge that HMC had obligations to the Pension Fund put Full Circle Group "on notice that there was a possibility of such liability" such that the notice element was satisfied. In so doing, the Seventh Circuit stated that "[a] lack of familiarity with the concept of withdrawal liability cannot be an excuse." Prior to the Seventh Circuit's ruling, several district courts had essentially eliminated the ability to prevail on successor liability claims in the withdrawal liability context because withdrawal liability is not due until after the sale closes. Thanks to this opinion, that is no longer the case.

The case has been remanded back to the district court for trial on the continuity of operations element.

Phase 2 of OCR's HIPAA Audit Program is Upon Us

As part of its ongoing efforts to examine compliance with the HIPAA Privacy, Security and Breach Notification Rules, the Health and Human Services Office for Civil Rights ("OCR") announced on March 21, 2016 that it has officially begun its next phase of audits of covered entities and their business associates. In its 2016 Phase 2 HIPAA Audit Program, OCR will review the policies and procedures adopted and utilized by covered entities and their business associates to meet selected standards and implementation requirements of the Privacy, Security, and Breach Notification Rules.[2] Unlike the pilot audits during 2011 and 2012 ("Phase 1 Audits"), which concentrated on covered entities, the Phase 2 audits will cover both covered entities and business associates. The primary focus of the Phase 2 Audit Program will be the deficiencies uncovered during the Phase 1 audits, including: failure to conduct periodic security risk assessments, missing, outdated or deficient privacy/security policies and controls; and inadequate HIPAA training.[3]

What did OCR discover from its audits during Phase 1? During the Phase 1 Audits, OCR audited 115 covered entities and of those entities, only 11% were determined to be 100% compliant.[4] More than 60% of the findings were Security Standard violations. Moreover, greater than 39% of the findings related to Privacy standards were attributed to a lack of awareness of the applicable Privacy Standard rules.[5]

For its Phase 2 Audits, OCR randomly selected a pool of 550-900 covered entities and will issue a mandatory pre-audit screening survey to the pool of covered entities this summer. OCR will notify the entities randomly selected via email. The survey is part of the agency's verification process and concerns organization size, location, services and contact information, including identification of any business associates. If an entity does not respond to OCR's request to verify its information or pre-audit questionnaire, it will use publically available information about the entity to create its audit subject pool. Once it receives responses on the survey, OCR will select approximately 350 covered entities, including 232 health care providers, 109 health plans and 9 health care clearinghouses, for Phase 2 Audits.[6]

After selected entities are notified of their participation, OCR will begin a round of desk audits for covered entities, followed by a round of desk audits for business associates. OCR has stated that it plans to complete all desk audits by the end of December 2016. It is important to note that entities selected for a desk audit may still be subject to a subsequent onsite audit.[7]

Because OCR randomly selects the covered entities via email, notifications may be incorrectly classified as spam. OCR indicated that it expects covered entities to regularly check their junk or spam folders for emails from OCR.

OCR has stated that during its investigation it will be looking at risk analyses and risk management, notices of privacy practices and access and response to requests for access, and content timeliness of notifications.[8] The goal of the audits, according to OCR, is to enhance industry awareness of compliance obligations and enable OCR to better target technical assistance regarding problems identified

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[2] *OCR Launches Phase 1 of HIPAA Audit Program*, HHS.gov.
[3] Snyder, Barley. HIPAA Phase 2 Audits Begin: What Are the Risks? Lexology.com,April7,2016;http://www.lexology.com/library/detail.aspx?g=815244a6-83f3-4f77-85d2-6004b9248c0e.
[4] Gottlieb, Daniel F. *OCR to Begin Phase 2 of HIPAA Program*. McDermottWill&Emery,July29,2014;https://www.mwe.com/en/thought-leadership/publications/2014/07/ocr-to-begin-phase-2-of-hipaa-audit-program.
[5] *Id.*
[6] *Id.*
[7] Fanshawe, Frank J. and Damian J. Privitera. *Phase 2 HIPAA Audits Are Under War: Are You Prepared? Wilson Elser.* http://www.wilsonelser.com/news_and_insights/client_alerts/2601-phase_2_hipaa_audits_are_under_way_are_you. March 31, 2016.
[8] Bowman, Dan. *OCR Launches Phase 2 of HIPAA Audit Program*. FierceHealthIT.com. March 21, 2016.

through the audits. With the information learned from the audits, OCR hopes to develop tools and guidance to assist the industry in compliance self-evaluation and in preventing breaches.

If you have any questions about the OCR Phase 2 Audits, please contact our office.

The New DOL Persuader Rule and the Challenges It Faces

In March 2016, the Department of Labor ("DOL") finalized the new "persuader rule", which replaces fifty years of precedent under the Labor Management Reporting and Disclosure Act ("LMRDA").[9] The new rule, which was scheduled to become effective on July 1, 2016, requires employers to report "any actions, conduct or communications that are undertaken to – explicitly or implicitly, directly or indirectly – affect an employee's decision regarding his or her representation or collective bargaining rights."[10] The rule alters the previous rule under the LMRDA which allowed employers to hire consultants and lawyers for such matters without disclosing such information so long as the employer was free to accept or reject the advice and as long as the lawyer or consultant did not directly communicate with the employees.[11] The new rule broadens the communications that must be disclosed.

Three lawsuits were filed in federal district courts in Texas, Michigan and Wisconsin alleging that the rule violates employers' rights under the constitution and violates attorney-client confidentiality. Ten states subsequently intervened in the Texas lawsuit, taking the position that the new rule violates their right to regulate the legal profession. Since the rule requires full disclosure of communications, even indirect communications, it includes communications between employers and attorneys. "While legal advice is still exempt under the rule, it is only exempt as long as there is no underlying purpose to persuade."[12] As a result, attorney communications with an employer in which the object is to persuade employees relating to their rights to collectively bargain are subject to disclosure.

On June 27, 2016, the United States District Court for the Northern District of Texas issued a nationwide preliminary injunction against the rule.[13] As a result of the preliminary injunction, the DOL has stated that employers and their consultants and law firms should continue to use the pre-2016 rule until further notice from the DOL. There is no trial currently set in the Texas matter, and as a result, it may be a while before the fate of the new rule is determined.

Departments Issue New Summary of Benefits and Coverage Templates

On April 6, 2016, the Departments of Health and Human Services ("HHS"), Labor, and Treasury (the "Departments") issued final changes to the Summary of Benefits and Coverage ("SBC") template and Uniform Glossary. The Departments also released updated instruction guides, a final coverage example calculator and calculator instructions.

Health plans and issuers must use the new SBC template and accompanying documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017. For plans and issuers that do not use an open enrollment period, the new SBC template and accompanying documents must be used beginning on the first day of the first plan year that begins on or after April 1, 2017.

The new SBC template adds a helpful explanation of the SBC on the first page and directs participants where to find more information. The Departments also created space on the new SBC template by rearranging and deleting informational material that is not required by the statute. The new template also adds disclosure language about minimum essential coverage and minimum value standards.

The revised template also includes an additional coverage example for a participant's costs relating to a simple foot fracture with an emergency room visit. The current SBC template only provides two coverage examples regarding cost sharing for maternity and diabetes.

The Departments also updated the Uniform Glossary that must accompany the SBC. Specifically, the Departments revised a few of the existing definitions in addition to adding new definitions, such as "claim," "cost sharing" and "specialty drug."

Depending on a plan's start date, health plans and issuers should be prepared to provide new SBC templates by the effective date. This means that health plans and issuers should carefully review the revised templates and accompanying documents for compliance. Please contact our office for further information.

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[9] Murphy, James and Topolski, Douglas, Welcome to the Jungle: Trade Associations and Reportable Persuader Activity, JDSupra, website (June 13, 2016)

[10] Wheeler, Lydia, DOL Issues Union Persuader Rule, The Hill, website.

[11] Bultman, Matthew, DOL Fights Biz Groups' Bid to Block 'Persuader' Rule, LAW360, website (May 18, 2016).

[12] "Persuader Rule" Important Update, LEXOLOGY, website (June 13, 2016)

[13] Update on the U.S. Department of Labor Persuader Rule Reporting Requirements, THE NATIONAL LAW REVIEW (July 14, 2016), http://www.natlawreview.com/article/update-us-department-labor-persuader-rule-reporting-requirements

Second Circuit Emphasizes the Importance of Following DOL Claims-Procedure Regulations

The Second Circuit has now weighed in on the importance of following DOL guidelines in processing benefits claims, finding that failure to follow DOL procedures in denying such claims will likely result in an unfavorable standard of judicial review.[14] This holding represents a significant shift in law, as the Second Circuit also rejected the more plan-friendly substantial compliance doctrine, which would excuse a plan's failure to follow DOL claims-procedure regulations if it otherwise "substantially complied" with DOL requirements.[15]

In this case, a Participant in the Yale Health Plan ("Plan") pursued medical treatment with out-of-network doctors. As such, the Plan would only cover treatment if the Participant's condition was considered an emergency or urgent condition, or if the treatment was pre-approved by the Plan's Care Coordination Department.[16] When the Plan denied the Participant's claims for coverage, she filed a lawsuit alleging that the Plan had failed to follow the appropriate DOL regulations.[17] Specifically, she alleged that the Plan failed to provide her with (1) the specific reason for denial, (2) a reference to governing Plan provisions, (3) information necessary to perfect her claims and an explanation as to why that information was necessary, and (4) a description of the Plan's review procedures.[18]

The District Court evaluated the Plan's actions under the substantial compliance doctrine, finding that while the Plan's communications "were not ideal, the substance and timing of its denials of [the Participant's] claims were sufficient . . . ."[19] The Second Circuit Court of Appeals, however, strongly disagreed. In reversing the District Court, the Second Circuit made the following observations: (1) a key component of ERISA is to provide adequate notice in writing of claims denials, (2) ERISA requires that plans afford reasonable opportunity for review of those denials, and (3) plans often fail to follow minimum standards of procedural fairness.[20] The court also declared that "a [plan's] decision [to deny a benefits claim] made in the absence of the mandated procedural protections *should not be entitled to any judicial deference*."[21] When a claim is not entitled to any judicial deference, reversal is much more likely.

While this case only governs entities falling within the Second Circuit's jurisdiction, this decision marks a shift in federal jurisprudence that may very well expand to other circuits. Its significance is twofold. First, reversal becomes more likely because judges will not give deference to a plan's decision-making process or good faith intentions. In fact, the only way a plan could benefit from a more favorable standard of review is if "the plan has otherwise established procedures in full conformity with the [DOL] regulation and can show that its failure to comply with the claims- procedure regulation in the processing of a particular claim was inadvertent *and* harmless."[22] Second, participants and their attorneys are now more likely to scrutinize a plan's claims procedures and, upon denial of a claim, argue that violations were intentional, caused harm and accordingly do not warrant judicial deference. As such, plan administrators should carefully review their claims-procedure processes, as full compliance is now even more important should a participant choose to challenge a denial in federal court.

Private Equity Funds Held Liable for Portfolio Company's Withdrawal Liability

Under the MPPAA, in order to impose withdrawal liability on an organization other than the withdrawing employer, the organization must be (1) a "trade or business," and (2) under "common control" with the obligated organization.[23] In 2013, the First Circuit held that private equity funds could be considered "trades and businesses" for the purposes of withdrawal liability, adopting the "investment plus" approach set forth by the PBGC.[24] Under the "investment plus" approach, a "trade or business" can arise from an investment for profit plus some additional activity that amounts to more than that of a passive investor. In *Sun Capital Partners III, LP*, the First Circuit found it persuasive that one of the private equity fund's general partners had an extensive role in managing the withdrawing employer's operations, and that management fees, paid by the withdrawing employer to the general partner, and were credited against the general partner's overall compensation from the private equity fund. The First Circuit then remanded the case back to the district court to determine whether the two private equity funds at

[14] *Halo v. Yale Health Plan, No. 14-4055, 2016 U.S. App. LEXIS 6659, at *42 (2d Cir. Apr. 12, 2016).*
[15] *Id. at *7.*
[16] *Id. at *4-5.*
[17] *Id. at *5.*
[18] *Id. at *5-6.*
[19] *Id. at *8.*
[20] *Id. at *9-23.*
[21] *Id. at *23 (emphasis in original).*
[22] *Id. at *35 (emphasis in original).*
[23] *29 U.S.C. § 1301(b)(1)*
[24] *Sun Capital Partners III, LP v. New England Teamsters & Trucking Indus. Pension Fund, 724 F.3d 129 (1st Cir. 2013).*

issue were also under "common control" with the withdrawing employer and therefore jointly liable for its $4.5 million withdrawal liability.[25]

In March 2016, on remand from the First Circuit, the District of Massachusetts expanded the appellate court's original holding and found that private equity funds can now be considered to be in "common control" with a withdrawing employer despite not independently meeting the threshold requirement of owning 80% of the withdrawing employer. The district court found that the two private equity funds at issue, who split their ownership stake in the withdrawing employer, one owning 70% and the other 30%, made "a conscious decision . . . so that neither would be exposed to withdrawal liability if [the withdrawing employer] failed."[26] The district court observed that, despite explicitly disclaiming any intent to form a partnership or joint venture, the private equity funds had taken joint activity in co-investing in the withdrawing employer and other companies using the same organizational structure.[27] As a result, the district court held that the two private equity funds together constituted a partnership-in-fact under common control with the withdrawing employer and were therefore jointly and severally liable for the employer's withdrawal.[28] Thus, once secure in their status as passive investors, private equity funds now face many unanswered questions and an increased threat of liability in the wake of this line of cases.

Supreme Court Holds that ERISA Preempts State Healthcare Databases

In April of this year, the Supreme Court struck down a Vermont statute that required "all payers" (healthcare providers, insurers, facilities, and governmental agencies) to report healthcare information to the State of Vermont, holding that ERISA preempted the statute. In doing so, the Supreme Court reinforced ERISA's broad preemptive scope. The decision stands to put an end to all-payer claims databases that have been established, or are in the process of being established, in 16 states.[29]

The Supreme Court's ruling in *Gobeille v. Liberty Mutual Ins. Co.* addresses the implementation of all-inclusive, state-run healthcare databases developed to collect healthcare data on members, subscribers, and policyholders.[30] The Vermont statute required a broad spectrum of information to be turned over to the database, including healthcare costs, quality, utilization patterns, and access to care. States like Vermont have implemented all-payer claims databases as a resource for consumers and purchasers of services so that they can weigh prices and quality in making informed healthcare decisions.

In *Gobeille*, Liberty Mutual Insurance Company ("Liberty Mutual") filed suit in the District Court of Vermont when Vermont issued a subpoena ordering its third-party administrator, Blue Cross Blue Shield of Massachusetts, Inc. ("Blue Cross") to transmit all of its Vermont member files on member eligibility, medical claims, and pharmacy claims for inclusion in their state database. Liberty Mutual is the fiduciary and plan administrator to its health plan, which qualifies as an "employee welfare benefit plan" under ERISA. Liberty Mutual instructed Blue Cross not to comply with Vermont's subpoena, fearing that disclosing such confidential medical information may violate its fiduciary duties.

On certiorari, the Supreme Court ruled against Mr. Alfred Gobeille in his capacity as Chair of the Vermont Green Mountain Care Board, holding that ERISA preempted the Vermont statute, as the statute's reporting requirements overlapped with those central to ERISA's design, "which is to provide a single uniform national scheme for the administration of ERISA plans without interference from the laws of the several States even when those laws, to a large extent, impose parallel requirements."[31] The Supreme Court further explained that ERISA broadly preempts state laws requiring health plans to report information, even if the state laws are only in addition to ERISA reporting requirements. The Supreme Court's finding that the Vermont statute intruded upon ERISA plan reporting, disclosure, and recordkeeping requirements will halt similar legislation concerning all-payer claims databases in other states. The *Gobeille* holding stands as good news to self-funded plan sponsors, fiduciaries, and third-party administrators, who no longer need to worry about complying with burdensome, costly, and conflicting state reporting requirements in the future.[32]

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[25] *Id.*
[26] *Sun Capital Partners III, LP v. New Eng. Teamsters & Trucking Indus. Pension Fund, No. 10-10921-DPW, 2016 U.S. Dist. LEXIS 40254 at *40 (D. Mass. Mar. 28, 2016).*
[27] *Id.*
[28] *Id.*
[29] *All-Payer Claims Database Council. "Interactive State Report Map." https://www.apcdcouncil.org/state/map.*
[30] *Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936 (2016).*
[31] *Id. 947.*
[32] *Bloomberg BNA. "View From Proskauer: ERISA Preemption After Gobeille v. Liberty Mutual Ins. Co." http://benefits.bna.com.*

Treasury Issues MPRA Regulations and Rejects Central States Application

The Multiemployer Pension Reform Act of 2014 ("MPRA") established new procedures that apply to severely underfunded multiemployer pension plans.

Generally, a plan is classified as in "critical and declining" status if it is projected to be insolvent in the next fifteen to twenty years. A plan that is certified as "critical and declining" can apply to the Treasury Department to suspend or reduce benefits indefinitely if such cuts are reasonably expected to save the plan from insolvency.

In 2015, the Treasury issued temporary regulations[i] so that affected plans could apply to suspend benefits while the Treasury received comments and prepared to issue permanent regulations. On April 26, 2016, the Treasury issued final regulations and Revenue Procedure 2016-27. The final regulations closely follow the proposed regulations.

On September 25, 2015, the Central States Southeast and Southwest Areas Pension Plan ("Central States") was the first plan to apply to suspend benefits under the temporary regulations. In its application to the Treasury, Central States stated that it is projected to be insolvent in ten years.

On May 6, 2016, the Treasury rejected the Central States application to suspend benefits. The Treasury gave three reasons: (1) the participant notices were not understandable to the average participant; (2) the proposed benefit suspensions were not equitably distributed; and (3) the suspension was not reasonably estimated to avoid insolvency because of unreasonable assumptions regarding investment return and the entry age for new participants.

The Treasury found that that the assumed 7.5% investment assumption was too optimistic given current economic data and Central States' negative cash flow. Also, the Treasury found that the assumed entry age of 32 did not take into account the recent demographic mix of new entrants, which would have a negative effect on near-term cash flows.

Thomas Nyhan, the Executive Director for Central States, in a letter to participants, stated that due to the passage of time, Central States can no longer develop a suspension plan that complies with MPRA and thus there will be no new rescue plan. Nyhan stated that if the Treasury had identified its concerns during the review process, Central States could have taken action to remedy the defects in a timely manner. At this point Central States is anticipating insolvency within ten years and sees legislative action as the only alternative.

The insolvency of Central States also calls into question whether the Pension Benefit Guarantee Corporation ("PBGC") will be able to fulfill the guarantee it provides to insolvent multiemployer plans. For a participant with 35 years of service and an earned benefit of $2,000 per month, the PBGC guarantee level is $1,251 per month.

However, PBGC projects that it has a 90% likelihood of being insolvent by 2025. If the PBGC's cash balance is depleted, the agency would have to rely solely on the annual insurance premium receipts. The United States Government Accountability Office estimates that the benefits paid by PBGC would be reduced to less than 10% of the PBGC guarantee level. In the above example, a retiree who once received a monthly pension of $2,000 and whose pension was reduced to $1,251 under the PBGC guarantee, would see the monthly pension income reduced to less than $125 or less than $1,500 per year.

Accordingly, the effect of Central States' anticipated insolvency will have repercussions for the PBGC and multiemployer plans in general. The PBGC premium for 2016 is $27 per participant. If nothing else, there will be increased pressure to increase the level of PBGC premiums for all multiemployer plans.

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[i] *A total of seven plans have applied to suspend benefits as of this writing: (1) Central States, Rosemont, IL, on September 25, 2015 and rejected on May 6, 2016; (2) Teamsters Local 469 Pension Plan, Hazlet, NJ, on December 28, 2015 which was later withdrawn and resubmitted on March 31, 2016; (3) Road Carriers Local 707 Pension Fund, Hempstead, NY, on March 15, 2016 and rejected on June 24, 2016; (4) Iron Workers Local 16, Baltimore, MD, on March 26, 2016 and still in review; (5) Bricklayers & Allied Craftsmen Local No. 7 Pension Plan, Akron, OH, on June 28, 2016 and still in review; (6) Iron Workers Local 17 Pension Fund, Cleveland, OH, on July 29, 2016 and still in review; and (7) Bricklayers and Allied Craftworkers Local 5 New York Pension Plan on August 4, 2016 and still in review.*

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