U.S. Legal Update

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Overview

• **Part 1 – Three Interesting Developments**
• Part 2 - Ten Tips to Avoiding Litigation and Other Recent Cases and Trends
• Part 3 – Other Selected United States Supreme Court Cases
Part 1 - Three Developments

• Three important and interesting developments
  – Deference to Agency Decisions –
    • Kisor v. Wilkie
  – ACA Challenges
  – Corporate Governance
Part 2 - Guiding Principles: The D’s and Illustrative Cases

• D’s to Remember:
  – Dignity
  – **Discretion**
  – Diversity
  – Disclosure
  – Due Diligence
  – **Due Process**
  – Documentation

• D’s to Avoid:
  – **Delay**
  – **Discrimination**
  – Deceit
Part 3 – Supreme Court Cases

• US Supreme Court cases which will be noted only in passing are:
  – ADEA/Age Discrimination –
    • Mount Lemmon Fire District v. Guido – 11/6/2018
  – Arbitration and Arbitrability –
    • Henry Schein v. Archer and White Sales – 1/08/2019
    • New Prime Inc. v. Oliveira – 1/15/2019
Part 3 – Supreme Court Cases

- **Compensation taxable under the RRTA**
- **Medicare Reimbursement**
- **Social Security – Final decision (5/28/2019)**
  - Smith v. Berryhill
Part 1 - Three Developments

• Three important and interesting developments
  – Deference to Agency Decisions –
    • Kisor v. Wilkie
  – ACA Challenges
  – Corporate Governance
Kisor v. Wilkie

- Deference to Agency Interpretations
- Most important Supreme Court case this term for the benefits world

A Vietnam War veteran sought disability benefits in 1982 from the Department of Veteran Affairs (VA) alleging that he had developed PTSD as a result of his participation in a military action called Operation Harvest Moon.

The VA’s evaluating psychiatrist noted that Kisor’s involvement in that battle, but found that he did not suffer from PTSD. He was denied benefits.

In 2006, 24 years later, he sought to reopen his claim.

The VA agreed he was eligible for benefits based on a new psychiatric report, but only from the date of his filing to reopen, not retroactively to the date of his first application.
The Board of Veterans’ Appeals affirmed that timing decision based on its interpretation of an agency rule.

Under the VA regulation, the VA could grant retroactive benefits if it found there were “relevant official service department records” that it had not considered in its initial denial. (emphasis added)

The Board acknowledged that Kisor had come up with two new service records, both confirming his participation in Operation Harvest Moon.

Kiser had argued that to count as “relevant”, a service record need only relate to some criterion for obtaining disability benefits; he said it did not need to counter the basis of the prior denial.
The Board, however, found that those records were not “relevant” because they did not go to the reason for the denial, namely that Kisor did not have PTSD. There was no dispute as to whether or not he had engaged in combat.

The Court of Appeals for Veterans Claims affirmed for the same reason.

The Court of Appeals for the Federal Circuit affirmed, but did so by granting deference to the VA’s interpretation of its own rule, rather than its own interpretation.
• The court found that the language of the VA rule was ambiguous and that either reading was reasonable.
• It therefore applied the so-called Auer deference doctrine.
• This doctrine is based on the presumption that Congress intended for courts to defer to agencies when they interpret their own ambiguous rules, the concept being that agencies that promulgate a rule are very likely in the best position to reconstruct its original meaning.
Kisor v. Wilkie

- In this 5-4 decision, the Supreme Court upheld the use of the *Auer* deference doctrine to administrative agencies when regulations are reasonably ambiguous.
- Although it upheld *Auer*, it seriously limited its use through the creation of a three step test:
  - First, a court must determine that the rule at issue is genuinely ambiguous, which is done through the court exhausting all “traditional tools” of construction;
  - Next, the agency’s interpretation of its genuinely ambiguous regulation must be reasonable; and
Finally, the court must determine if the character and circumstances of the agency interpretation is entitled to controlling weight. This entails the following:

- The regulatory interpretation must first be the agency’s official position on an issue, rather than a mere “ad hoc statement” that does not reflect the views of the agency;
- Second, the agency must bring some type of administrative knowledge and experience to its interpretation; and
- Lastly, the agency’s reading of the ambiguous rule must reflect “fair and considered judgment.”

“Delay”
Kisor v. Wilkie

• **Takeaways:**
  – Although not an “ERISA” case, there was much concern that this case could have resulted in the “total upheaval” of the retirement plan regulatory system established by the DOL.
  – Although the Auer deference doctrine survived, it was a close call, shows the split on the court, and may encourage lower courts to grant less deference to agencies than they might otherwise have done.
  – The Court may be forced to revisit the issue in the next year or two.

• “Delay”
Part 1 - Three Developments

• Three important and interesting developments
  – Deference to Agency Decisions –
    • Kisor v. Wilkie
  – ACA Challenges/Status
  – Corporate Governance
Status of the ACA

- Texas v. U.S.
- Maryland v. U.S.
- Moda Health Plus, Inc. v. U.S.
- New Mexico Health Connections v. U.S. Dep’t of Health and Human Services
- Contraception Mandate
- Grandfathered Group Health Plans
- Proposed Legislation
- Health Care and the Election
Bonus Cases

- Association Health Plans
  - New York v. U.S. Dep’t of Labor
- Drug Marketing
  - Merck & Co, Inc. v. United States Department of Health and Human Services
Status of the ACA

• **Tax Cuts and Jobs Act of 2017 ("TCJA")**
  – Eliminated the tax penalty imposed on individuals without minimum essential health coverage
    • Applied beginning on January 1, 2019
    • Essentially eliminated the individual mandate
    • Did not affect the employer mandate but opened the door for questions on the ACA’s constitutionality more broadly
Status of the ACA, cont’d

- *Texas v. United States*
  - States claimed that TCJA’s elimination of the ACA tax penalty rendered the individual mandate unconstitutional
  - Also argued that the rest of the ACA must be unconstitutional, because it is not severable from the individual mandate
Status of the ACA, cont’d

• *Texas v. United States*
  – December 14, 2018, District Court for Northern District of Texas rules that the individual mandate is unconstitutional and cannot be severed from the remainder of the ACA, rendering the entire law invalid
  – December 30, 2018, the court stays implementation of its ruling during appeal of the decision
  • “because many everyday Americans would otherwise face great uncertainty during the pendency of appeal”
Status of the ACA, cont’d

- *Texas v. United States*
  - January 7, 2019, appeal filed to the Fifth Circuit
  - March 25, 2019, Department of Justice files formal position supporting district court’s ruling
    - Position means that DOJ supports repeal of the entire ACA
  - April 10, 2019, Fifth Circuit granted an unopposed motion to expedite the appeal
  - Oral arguments were heard in July
Status of the ACA, cont’d

• *Maryland v. United States*
  – Maryland sued the government seeking a declaration upholding the constitutionality and enforceability of the Affordable Care Act
  – District Court of Maryland dismissed the case, because Maryland lacked standing
    • The court found that there was no “substantial or certainly impending risk that the Trump Administration will cease enforcement of part or all of the ACA.”
    • Court left open the possibility that the claim can be brought in the future when non-enforcement of the ACA “moves from the speculative to the concrete”
Status of the ACA, cont’d

• Risk Corridors Program
  – *Moda Health Plan, Inc. v. United States*
    • June 14, 2018, Federal Circuit Court of Appeals determined government is not required to pay insurers the full amount of money owed to them through the risk corridors program
    • Insurers petitioned in February, 2019 for review in the Supreme Court
Status of the ACA

• Risk Adjustment Program
  – New Mexico Health Connections v. U.S. Dep’t of Health and Human Services
    • District Court determined that DHHS’ risk adjustment methodology was arbitrary and capricious
    • Appeal has been filed in the 10th Circuit Court of Appeals
Status of the ACA, cont’d

• Risk Adjustment Program
  – Centers for Medicare and Medicaid Services issued two final rules providing additional explanation for the use of a statewide average premium and why the program is operated in a budget-neutral manner for the 2017 and 2018 benefit years
Status of the ACA, cont’d

• Cost-Sharing Reduction Payments
  – The government halted cost-sharing reduction payments in October, 2017
    • The decision was made after the House of Representatives sued the Secretary of Treasury and HHS alleging that the payments violated the Constitution, because the ACA did not appropriate money to the program
  – States then sued the President to require the continuation of cost-sharing reduction payments, but their claims were dismissed
Status of the ACA, cont’d

- **Cost-Sharing Reduction Payments**
  - Insurers have sued the federal government to recover cost-sharing reduction payments
    - Insurers have had success in these actions to recover unpaid reimbursements in the U.S. Court of Federal Claims
      - Including a claim by Common Ground Healthcare Cooperative on behalf of itself and a class of insurers on February 15, 2019
      - Cases brought by Community Health Choice, Montana Health Co-Op, and Sanford Health Plan have been appealed to the Federal Circuit
Status of the ACA, cont’d

• Contraception Mandate
  – November 15, 2018 – 2 Final Rules regarding Moral & Religious Exemptions and Accommodations
    • Finalized interim rules issued in October, 2017
    • Expanded exemptions for religious beliefs or “sincerely held moral objections” to coverage of contraception
    • Includes non-profit organization plan sponsors, for-profit entities that are not publicly traded, higher education institutions, health insurance issuers that are otherwise exempt, and individuals with respect to their own coverage
    • Moral exemption does NOT extend to non-federal governmental entities
    • Effective as of January 14, 2019
Contraception Mandate

- Federal judges issue injunctions preventing implementation of the final rules
  - Just before the anticipated effective date of the Final Rules regarding Moral and Religious Exemptions and Accommodations
  - Judge in Pennsylvania issued a nationwide injunction
  - Appeals have been filed in both cases

- The Women’s Health Amendment, enacted under the Affordable Care Act (the “ACA”), requires preventive healthcare coverage, which includes contraceptives.
- Certain religious employers are exempt from providing such coverage directly and are no longer responsible for said coverage.
  - The accommodation process, however, allows for an employee to receive preventative coverage, but through a third party rather than the religious employer.
Pennsylvania v. United States, --- F.3d ----, 2019 WL 3057657. cont’d

• The Trump administration sought to extend the rule to include for-profit entities whose owners objected to contraceptive coverage based on religious or moral beliefs, and to eliminate the accommodation process as well.
• After Pennsylvania and New Jersey sought to enjoin the enforcement of these interim final rules ("IFRs"), the district court granted that request.
• The United States Court of Appeals for the Third Circuit (the “Court”) upheld the judgment of the district court.
• The Court first confirmed that the states had standing to bring suit because the injury of having to pay for more preventative healthcare measures when employers will not is traceable to the IFR and will be fixed through a favorable judicial decision.
• The Court found that all the district court’s rulings were within their discretion.
Pennsylvania v. United States, --- F.3d ----, 2019 WL 3057657. cont’d

• States were likely to succeed on claim because:
  – Procedural deficit: the Government failed to show they had good cause or an exemption to explain why it disregarded the notice and comment requirement.
  – Substantive deficit: the IFRs and Final Rules were enacted “in excess of statutory jurisdiction, authority, or limitations,” making them not in line with the law and therefore an abuse of discretion.
• Because of the large, undue burden that would befall employees, a nationwide injunction was the most appropriate form of equitable relief.
• Time will tell if this case is heard by the Supreme Court.
Grandfathered Group Health Plans and Insurance Coverage

- February 25, 2019, Treasury, DHHS, and DOL request information regarding grandfathered group health plans and insurance coverage
- Goal is to better understand challenges faced in avoiding loss of grandfathered status and to determine ways to help preserve grandfathered status
ACA

• **Takeaways:**
  – The Supreme Court may ultimately determine whether or not the ACA remains good law.
  – The election may have a major effect on what happens.
  – The push-pull and politics are playing out in other related areas such as association health plans.
ERISA’s purpose is “to protect the interests of participants in employee benefit plans and their beneficiaries.”

The ACA absorbs key ERISA definitions into its statutory scheme, most notably, the definitions of employers and employees.

Under ERISA and the ACA, the Department of Labor (DOL) has allowed certain association health plans (AHPs) to qualify as a single ERISA employee benefit plan, as long as the AHP met specific criteria.
New York v. U.S. Dept of Labor

- These “bona fide associations” could only sponsor an AHP under ERISA if the association displayed “employer-like characteristics,” determined through a three step test.
  - First: “whether the group or association was a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits,” known as the purpose requirement;
  - Second: the employers must “share some commonality and genuine organizational relationship unrelated to the provision of benefits,” called the commonality of interest requirement; and
  - Lastly: the employers must “either directly or indirectly exercise control over the program, both in form and substance,” named the control requirement.
New York v. U.S. Dept of Labor

• Under the Final Rule, both the purpose and commonality of interest requirements are relaxed, making it easier to qualify as a bona fide association.
  – The purpose requirement allows the association’s primary purpose to be to offer and provide health coverage, so long as it contains “at least one substantial business purpose unrelated to the provision of health care.”
  – The commonality of interest requirement provides that geography alone is sufficient to meet the criteria, although the trade or industry of the companies may differ.
New York v. U.S. Dept of Labor

• The District Court for D.C. ruled the Final Rule fails to carry out Congress’s intent in enacting ERISA by interpreting the definition of employer “beyond what ERISA’s text and purpose will bear.”

• The DOL’s interpretation of employer was unreasonable because the test used to determine eligibility was unduly expansive
  – The purpose test “failed to set meaningful limits on the character and activities of an association,” and
  – The commonality of interest test “improperly expands ERISA’s scope” by allowing geography to act as a proxy for common interest; and
  – The control test is only relevant if “employer members’ interests are already aligned,” which may not be the case under the standard set by the Final Rule.
New York v. U.S. Dept of Labor

• Finally, the court noted that the expansion of employers under the Final Rule to include “working owners without employees” is unreasonable, and runs contrary to the aims of ERISA.

• The statute’s text “clearly anticipates a relationship between two parties,” and requires the condition of employees, making the Final Rule’s expansive reach clearly fall outside ERISA’s set restrictions.

• United States Department of Health and Human Services ("HHS") created a rule that required drug manufacturers to disclose a list price—also known as the *wholesale acquisition price*—for a thirty-day supply of their drugs in any television advertisement ("WAC Disclosure Rule")

• HHS cited the Social Security Act ("SSA") as the statutory source of its rule-making authority.

• Plaintiffs brought suit against HHS to vacate the WAC Disclosure Rule, alleging that HHS lacked the statutory authority to enact the WAC Disclosure Rule
Merck & Co, Inc v. United States Department of Health and Human Services

• Under the Chevron Test, the court looked for Congress implicitly approving HHS to enact the WAC Disclosure Rule. The court did so by analyzing the SSA’s statutory text, other statutes, and the scope of the statutory provision cited by HHS.
  - **Statutory Text Analysis:** In its textual analysis, the court found that while HHS has broad power to regulate federal public health insurance programs, the WAC Disclosure Rule attempts to regulate “the conduct of market actors that are not direct participants in the Medicare or Medicaid programs.”
  - **Other Statutes Analysis:** The Court found that because Congress has deliberately legislated on drug marketing before (with the FDCA) and because the SSA contains no provision about drug marketing, Congress did not intend for the SSA to be used to regulate drug marketing.
  - **Scope Analysis:** Because the pharmaceutical industry is such a profound portion on the nation’s economy, Congress would not have authorized such a broad regulatory power based solely on general rulemaking authority under the SSA.
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- **Scope Analysis:** Because the pharmaceutical industry is such a profound portion on the nation’s economy, Congress would not have authorized such a broad regulatory power based solely on general rulemaking authority under the SSA.
Merck & Co, Inc v. United States Department of Health and Human Services

• **Takeaway:** The court found the administration exceeded its regulatory authority when it attempted to require drug manufacturers to list the prices of their prescription drugs in television advertisements.
Part 1 - Three Developments

- Three important and interesting developments
  - Deference to Agency Decisions –
    - Kisor v. Wilkie
  - ACA Challenges
  - Corporate Governance
Corporate Governance


- Business Roundtable Statement on the Purpose of a Corporation – August 2019

- Query how will these developments affect the development of fiduciary/trust law for benefit plans?
Overview

• Part 1 – Three Interesting Developments
• **Part 2 - Ten Tips to Avoiding Litigation and Other Recent Cases and Trends**
• Part 3 – Other Selected United States Supreme Court Cases
The Guiding Principles: The D’s

- D’s to Remember:
  - Dignity
  - Discretion
  - Diversity
  - Disclosure
  - Due Diligence
  - Due Process
  - Documentation

- D’s to Avoid:
  - Delay
  - Discrimination
  - Deceit
"Don't look at this as a demotion, look at it as the stripping away of your last shred of dignity."
Dignity

- Treat employees with courtesy and respect.
- Listen carefully.
- Be as responsive as possible.
- Practice the Golden Rule.
Discretion

- Retain Discretion,
- But Exercise It
- Consistently!

“...But I do exercise. I exercise discretion.”
Discretion

• Make sure plan and SPD’s and other benefit communications provide discretion to the employer/administrator
  – to construe, interpret and apply terms and to resolve ambiguities;
  – to amend or change those policies/handbooks/plans at any time.
Discretion

- Exercise discretion reasonably and consistently.
  - Provide adequate notice/avoid retroactive amendments whenever possible.
- Still must comply with the law, the plan and the SPD.
- Examples:
  - Rittinger v. Healthy Alliance Life Insurance Company
  - See also Tedesco under Due Process and Fessenden under Delay

Anthem denied preauthorization for both the surgery and the follow-up surgery based on plan language explicitly stating that the plan did not cover bariatric surgery.

Rittinger appealed, emphasizing that she suffered from excessive nausea and vomiting and therefore came within an exception to the bariatric surgery exclusion.
The exception stated that the exclusion did not apply to certain conditions including but not limited to excessive nausea/vomiting.

She provided records showing
- She suffered from GERD and esophagitis
- GERD/esophagitis is linked to nausea and vomiting, and
- She underwent surgery to address these problems.

The second level Grievance Advisory Panel convened by Anthem affirmed the denial.
The plan document granted the plan administrator discretion to apply plan provisions and interpret the plan.

Thus under the **Firestone** rule, the administrator’s decision should be upheld unless arbitrary and capricious or an abuse of discretion.
Rittinger v. Healthy Alliance Life Ins. Co.

- The court found that it could not determine that the administrator’s interpretation “was so off-kilter as to be an abuse of discretion”.
- In support it cited two parts of the record:
  - The medical records up to the time of the surgery did not reflect treatment for nausea and vomiting
  - Her preauthorization request was for “morbid obesity” and was coded for obesity “due to excess calories” rather than indicating nausea or vomiting
Rittinger v. Healthy Alliance Life Ins. Co.

• **Takeaways:**
  – If the plan document invests the plan administrator with discretion, courts will defer to the administrator’s decision and apply an abuse of discretion standard.
  – To ensure receipt of the “benefit of the doubt” from the courts, make sure your plan language provides for that discretion.
  – If you do not, a *de novo* standard will apply which means that the plan administrator’s decision is much more likely to be overturned.
Diversity

"Actually, the hardest thing about diversity isn't finding and hiring different people."

"It's training them to think and act like us."
## Diversity

- Age
- Gender
- Ethnic background
- Race
- Religion
- National origin
- Disability
- Color
- Gender identity
- Sexual orientation
- Military service or Veteran status
- Genetic Information
Diversity

- Cultural competency is the watchword.
- Be sensitive to people’s varying backgrounds and special needs.
- Develop a communication style that works for you and then adapt as needed to each individual’s needs.
- Create an atmosphere of dignity and respect where each person feels that their contributions are valued and where diversity is celebrated.
- Be alert to possible accommodations that may be needed.
Disclosure/Communication/Loose Lips
Sink Ships

- Jander offers a rare victory for plaintiffs suing their fiduciaries in a stock drop case.
- Larry Jander participated in an IBM 401(k) plan that was invested in an IBM stock fund and suffered losses resulting from IBM market share declines.
- He and others brought a class action suit against the IBM plan fiduciaries (“Defendants”) claiming a breach of their ERISA duty of prudence.
- ERISA requires fiduciaries of retirement plans to manage the plans’ assets prudently.
Jander v. Ret. Plans Comm. of IBM

• Jander claimed that duty had been breached because
  – the company’s troubled microelectronics division was overvalued,
  – the fiduciaries failed to disclose that inflated stock price, and
  – this failure artificially inflated IBM’s stock price, harming the ESOP’s members.

• The Second Circuit found that a prudent fiduciary could not have been able to conclude that the corrective disclosures suggested by the plaintiffs would do more harm than good.
Jander v. Ret. Plans Comm. of IBM

• The court looked at the 2014 Fifth Third Bancorp v. Dudenhoeffer ("Dudenhoeffer") case in which the Supreme Court dismantled the presumption of prudence in favor of ESOP fiduciaries while also imposing a heightened pleading standard in stock-drop lawsuits.

• The Second Circuit found Dudenhoeffer to be internally inconsistent, but did not decide which degree of prudence ought to be followed, but found that, even under a more restrictive interpretation of Dudenhoeffer and other rulings, Jander’s disclosure claim stood muster and demonstrated plausibility.

• It therefore reversed the district court’s dismissal.
Jander v. Ret. Plans Comm. of IBM

• **Takeaway:**
  – *Jander* potentially opens the door for other stock drop cases to survive the defendant fiduciaries’ motion to dismiss.
  – The Supreme Court has taken *Jander* on appeal, which may result in more clarity.
Disclosure/Loose Lips

- Use all available communications opportunities and frame communications so that they will be most likely to be understood by all.
- Avoid legal or highly technical language.
- And always remember: Loose lips sink ships!
Disclosure/Loose Lips

- Cases this year include:
"Benson is conscientious to a fault..."
Due Diligence

• Due diligence means doing your homework.
• Investigate thoroughly: don’t rely on stereotypes, hearsay, or assumptions.
• Due diligence is important in all aspects of plan design and administration from development of the SPD and the ensuring of consistent treatment, to the adoption of an investment policy and the careful selection of investments and the regular review and monitoring of same.
Due Diligence

• Stay current and get appropriate advice before taking the action
  – Retain appropriate expertise if you are not adequately qualified.
  – Remember to monitor the professionals that you do select; sift all recommendations with an eye to practicalities, financial and legal ramifications and public perception.
  – Document your process and why you made the decisions you did.
Due Diligence

- Brotherstone v. Putnam Investments
- Ramsey v. Commissioner of the Internal Revenue Service
Brotherston v. Putnam Investments, LLC, 907 F.3d 17 (1st Cir. 2018).

• Two former employees who had participated in their employer’s 401(k) plan brought this case, alleging that the employer and other named plan fiduciaries had breached their duties and engaged in prohibited transactions under ERISA.
  – The employer’s investment options included all its own mutual funds, despite those investments not necessarily being prudent options.
  – Plaintiffs claimed that the structured fees and rebates in the plan were unreasonable and treated other investors better than the plan participants.
Brotherston v. Putnam Investments

- The district court found that the plaintiffs failed to prove that any lack of care in selecting the plan’s investment options resulted in a loss, and the manner in which the defendant transacted with the plan was neither unreasonable nor less advantageous than the manner in which it dealt with other investors.
- The First Circuit, finding errors of law in these rulings, vacated the judgment in part and remanded it to the trial court for further proceedings.
Brotherston v. Putnam Investments

• The 1st Circuit, joining the 4th, 5th, and 8th circuits, stated that once a plaintiff demonstrates the existence of a fiduciary breach and a loss to the plan, the burden shifts to the fiduciary to demonstrate that the breach did not cause the loss.
• Putnam filed for certiorari on 1/11/2019.
• Takeaway:
  – Due to a split among the various circuit courts on this issue, with the 6th, 9th, 10th and 11th going the other way, this decision or its subject matter may find its way into the Supreme Court of the United States in the near future.
Ramsay v. Commissioner of Internal Revenue, 732 Fed.Appx.307 (5th Cir. 7/23/2018)(per curiam)

- Ramsey submitted a 2011 tax return that included $891 in imputed income from a life insurance policy provided by his employer.
- The IRS sent him a notice of deficiency regarding capital gains and dividends.
- Ramsey filed a petition with the Tax Court.
- He also resubmitted his 2011 taxes, with the previously unreported capital gains and dividends, but omitting the $891 for the life insurance premiums that he had previously reported.
Ramsay v. Commissioner of Internal Revenue

• Ramsay argued
  – that the life insurance premiums should not be included in his gross income because he had neither requested coverage nor did he desire it.
  – that he had persuaded the IRS in 2010 to exclude the same insurance premiums from his W-2.

• The Tax Court looked at his first tax submission for 2011 which included the life insurance premiums.
  – Because the policy was in effect, the court found that this original admission could not be overcome.
• The Tax Court denied his argument that simply because he had been excused from paying taxes the previous year, he should continue to be excused.

• It found that “each tax year stands alone”: Acceptance of a position by the IRS for one year is not controlling in a later year.

• The Tax Court also stated that the IRS is not required to accept and process his second amended return as “an amended return is a creature of administrative origin and grace.”
Ramsay v. Commissioner of Internal Revenue,

• **Takeaways** (despite the case not constituting “precedent”):
  – Exercise due diligence in your original filings.
  – The IRS is not required to accept and process amended returns.
  – Acceptance or rejection of an amended tax return is solely within the discretion of the Commissioner.
  – Each tax year stands alone - Acceptance of a position by the IRS for one year is not controlling in a later year
Due Process
Due Process

- Develop sound policies and procedures and adhere to them.
- Beware of overly complicated processes.
- Usually, processes should be in writing or otherwise clearly published.
- Importance of both procedural and substantive due process.
- This year’s examples: Sweda, Tedesco
  See also Fessenden under Delay and Peterson under Documentation.
**Sweda v. Univ. of Pennsylvania, 923 F.3d 320 (3d Cir. May 2, 2019)**

- There are multiple instances of university employees suing their retirement plan fiduciaries for breach of prudence under ERISA.
- **Sweda** develops a legal standard for evaluating the plausibility of a plaintiff’s pleadings:
  - First, the Third Circuit dropped the anti-trust law required by **Twombly**.
  - Second, the Third Circuit did not use the **Renfro** rule that providing retirement plan participants “with a range of available investment options” will allow fiduciaries to escape liability.
Sweda v. Univ. of Pennsylvania

- Third, it developed its own **Sweda Rule** where a court ought to assess the “fiduciary’s performance by looking at process rather than results, ‘focusing on a fiduciary's conduct in arriving at [a] ... decision ... and asking whether a fiduciary employed the appropriate methods to investigate and determine the merits of a particular investment.’”
Sweda v. Univ. of Pennsylvania

• By evaluating the allegations in the most favorable light towards the plaintiffs, the Third Circuit found that the Plaintiff’s plausibly alleged the Defendant Fiduciary’s breach. This means that the Plaintiffs survived the motion to dismiss and can go to trial.

• The dissenting opinions warns that broadening the plausibility of the pleadings will result in more costly and length litigation.

- Wendy Tedesco, mother of two and part-time medical assistant suffered from a severe case of OCD and other mental illness.
- She received treatment from several health care providers including a psychiatrist and a licensed social worker.
- The IBEW Ins. Fund retained a board-certified psychiatrist through Corporate Care Management to review her claims.
Tedesco v. IBEW Local 1249 Ins. Fund

• The reviewer, without speaking with the psychiatrist, found
  – Her visits with the psychiatrist were medically necessary but only once a week for 13-20 weeks, monthly thereafter for 3-6 months
  – Her visits with the social worker were not medically necessary
• She appealed. On appeal she was approved for
  – Two psychiatrist visits a week for 16 weeks with later evaluation
  – No visits with the social worker despite the record reflecting the efficacy of the types of treatment he was providing.
Tedesco v. IBEW Local 1249 Ins. Fund,

- She sued. The case ultimately went to the 2d Circuit which remanded the denial based its 2016 case Halo v. Yale Health.
- Halo held that a plan’s failure to comply with DOL claim procedure regulations will result in de novo review unless the plan can show its failure was “inadvertent and harmless”.
The court upheld the administrator's findings and denied her request for attorney's fees.

The Second Circuit stated that

– obtaining some degree of success on the merits must be considered in awarding fees, but here
– The trial court failed to consider the five part Chambless test.
Tedesco v. IBEW Local 1249 Ins. Fund,

- The Chambless factors are:
  - The degree of the offending party’s culpability or bad faith
  - The ability of the offending party to satisfy an award of attorney’s fees
  - Whether an award of fees would deter other persons from acting similarly under like circumstances
  - The relative merits of the parties’ positions, and
  - Whether the action conferred a common benefit on a group of pension plan participants specifically looking at the fund’s degree of culpability.
On remand the trial court granted her fees due to the level of culpability of the Fund combined with her partial success on the merits.

She had sought over half a million dollars but the Fund argued she lost “90% of the action.”

After taking a number of factors into consideration, she was granted $127,612.97 in attorneys fees and the full amount of her requested costs.
**Tedesco v. IBEW Local 1249 Ins. Fund,**

- **Takeaways:**
  - A plan’s failure to comply with DOL claims regulations will result in a *de novo* review unless the failure is “inadvertent and harmless.”
  - Plaintiffs shall be awarded attorney’s fees if they find “some success”.
  - This does not mean they need be the prevailing party, but they do need to show more than a “purely procedural victory”.
  - The five-factor *Chambless* test is used to determine fees.
I had no choice, his documentation was weak.
The reasons for good documentation are many, not the least of which is that judges, juries, arbitrators, and administrative agencies expect it.

- Know the difference between good and bad documentation.
- Don’t promise more documentation then you can deliver.
- Document facts rather than conclusions.
- See Peterson under Due Process.
Peterson v. UnitedHealth Group Inc.,
913 F.3d 769 (8th Cir. 1/15/2019)

• Plaintiffs, Dr. Peterson and Riverview Health Institute, sued on behalf of patients and others similarly situated challenging United’s cross-plan offsetting practice.

• Cross-plan offsetting occurs when an administrator determines it has overpaid an out-of-network provider when completing a payment for one patient, and then, when another patient utilizes the same provider, the administrator pays a portion of the bill, claiming that the rest was paid by the debt the provider created by not refunding the alleged overpayment from the first patient.
Peterson v. UnitedHealth Group

- Defendant, United, claimed that Dr. Peterson and Riverview Health Insurance were not able to act as representatives in their lawsuit because Dr. Peterson had a conflict of interest that he didn’t disclose and United’s plans had a provision that prohibited assignments.
- The district court dismissed these claims and held that cross-plan offsetting was not a reasonable interpretation of the plan documents.
- The Eighth Circuit affirmed.
Peterson v. UnitedHealth Group

- The court noted that two points were key to its analysis.
- First, all of the plans explicitly authorize same-plan offsetting but none of them “even come close to authorizing cross-plan offsetting”.
- It found that remaining effectively silent on cross-plan offsetting in the plan documents does not grant the TPA authority to engage in the practice.
- The court noted that such a practice would conflict with ERISA’s requirement that every plan must be established and maintained pursuant to a written instrument.
Peterson v. UnitedHealth Group

- Second, the court found that the practice of cross-plan offsetting is in tension with the requirements of ERISA.
- The court determined that it was not necessary to determine whether cross-plan offsetting necessarily violates ERISA, but “at the very least it approaches the line of what is permissible”.
- It was concerned that cross-plan offsetting created a tension with ERISA’s requirement that these administrators act in a manner that works in their beneficiaries’ best interest.
- This practice can lead to patients paying out of pocket because the provider needs to recuperate the cost that the administrator didn’t pay by claiming it was a debt that needed to be paid back.
Peterson v. UnitedHealth Group

• United has filed for a petition for *certiorari* with the Supreme Court.

• **Takeaways:**
  – The validity of cross-plan offsets is up in the air.
  – If you intend to use them pending more certainty
    • Spell it out in the plan document and SPD
    • Adopt a solid written procedure that ensures that decisions are made in the best interest of each plan and its participants and well-documented.
Delay
## Delay

- Act/Respond as promptly as possible under the circumstances.
- Always adhere to any time limits set forth in your plan documents, SPD, CBA, or other relevant source.
- Document agreements to extend timelines.
- Investigations should be as prompt as possible under the circumstances.
- Keep employees informed of need for additional time.
Delay

• Be proactive – try to anticipate potential issues and plan your strategy ahead of time so that you can respond quickly.

• Example? Kiser, Fessenden, Arkun
Don Fessenden was a Software Engineer Manager for Oracle USA until 2008 when he stopped working due to fatigue and severe, chronic migraine headaches.

He applied and was approved for short-term disability benefits through Oracle’s group insurance plan.

He received benefits through May 11, 2008.

Oracle terminated him shortly thereafter.

In March 2014, he submitted a claim to Reliance for LTD benefits dating back to his last day of work in 2008.
• To support his Chronic Fatigue Syndrome diagnosis, he supplied medical records from 2006 to 2014 and statements from multiple doctors.
• Reliance denied his claim, emphasizing the difficulties involved in reviewing a six year old claim.
• The denial was thorough and included the reasons for the denial, how to request review and the timeline for appeals.
• Fessenden submitted his request for review with additional medical records and physicians’ statements, but sent it to an address different from the one in the instructions.
Reliance confirmed receipt on May 8, 2015.
On June 17, it notified Fessenden it needed an additional 45 days to make its determination.
On August 19, after those 45 days had passed but before receiving a final decision from Reliance, Fessenden sued.
Eight days later, on August 27, Reliance entered its final decision denying the LTD claim.
The parties disagreed about how late Reliance was in responding, but they agreed its final decision missed the deadline.

- Normally the claimant is expected to wait for a final decision or exhaust his appeal rights before filing suit.
- The court however found that when a plan administrator fails to follow required procedures (e.g., deadlines for issuing decisions), the claimant will be considered to have exhausted administrative remedies available under the plan.
- This means that the claimant can seek judicial review even if the plan’s internal process has not run its course.
The court also noted that the absence of a final decision affects the standard of review.

Normally if the plan invests the administrator with discretionary authority to determine eligibility for benefits, its decision is reviewed under an arbitrary and capricious standard.

- This standard means the court defer to the administrator's exercise of discretion.

This court found that there is no exercise of discretion to defer to when there is no final decision, hence the court will review the matter de novo.

- The court recognized that Reliance did eventually issue a final decision but it was late.
- The court opined that the absence of a final decision affects the standard of review.
- Normally if the plan invests the administrator with discretionary authority to determine eligibility for benefits, its decision is reviewed under an arbitrary and capricious standard.
  - This standard means the court defer to the administrator's exercise of discretion.
- This court found that there is no exercise of discretion to defer to when there is no final decision, hence the court will review the matter *de novo.*

- Reliance argued that it was only a little bit late, and that a late decision is different from a case in which an administrator fails to render a decision at all.
- It thus suggested that the court should excuse its untimeliness under the doctrine of “substantial compliance”.
  - Under that doctrine, if the administrator has substantially complied with its duties but has violated a technical rule, the court will still give the administrator the benefit of deferential review under the arbitrary and capricious standard rather than applying a *de novo* review.

- Fessenden argued that the substantial compliance doctrine, as a common law (judge-made) rule, cannot override DOL regulations and argued that the 2002 changes to the claims procedure regulations were intended to eliminate judicial deference in the absence of the mandated procedural protections.
- The court decided not to decide whether to overturn the substantial compliance doctrine, because even if it remains valid, it does not apply to the violations of regulatory deadlines.

• The court found that because the administrator lacks discretion to take longer than the regulations allow, its tardy decision is not entitled to deference.

• The court also found that applying the substantial compliance doctrine to “blown deadlines” was incompatible with the doctrine itself.

• It also rejected Reliance’s argument that even if that were so, a plan administrator could change the standard of review with a “late-breaking” decision, noting that a contrary rule could allow claimants to be “sandbagged”.

7A-110

• **Takeaways:**
  – The split in Circuits with the 3rd, 9th and 10th Circuits taking a different view means this issue could end up at the US Supreme Court.
  – Until then, administrators should make sure to comply with all procedural requirements or risk application of a *de novo* standard of review, at least in the 7th Circuit (Illinois, Indiana, and Wisconsin)
Sulyma v. Intel Corp. Investment Policy Committee, 909 F.3d 1069 (9th Cir. 11/28/2018)

- ERISA creates a three-year limitations period on suing based on fiduciary breach.
- The statute says that the plaintiff cannot bring a claim of breach forward “three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation“.
- The Sixth Circuit has held actual knowledge to be the same as constructive knowledge.
- The Ninth Circuit diverges here and held that the defendant must show that the plaintiff was actually aware of the nature of the alleged breach more than three years before the plaintiff’s action is filed.
• **Takeaways:**
  – Plaintiff’s should make sure to file claims timely.
  – Plans should not assume that constructive knowledge will trigger the three-year limitations period on suing based on fiduciary breach; actual knowledge of the breach is required at least in the 9th Circuit.
  – The split in the circuits makes this another area to watch as the issue could go to the Supreme Court.
Delta and their pilots had a benefit plan that was terminated when Delta filed for bankruptcy.

Title IV of ERISA created PBGC “to ensure that employees and their beneficiaries would not be completely deprived of anticipated retirement benefits by the termination of pension plans before sufficient funds have been accumulated in the plans.”

In accordance with that mission, the PBGC collects premiums from plan sponsors like Delta and guarantees certain benefits to plan participants even if a plan terminates without enough money to pay its ongoing obligations.
Lewis v. Pension Benefit Guaranty Corporation, 912 F.3d 605 (D.C. Cir. 12/21/2018)

- The pilots sued PBGC for violations of the Administrative Procedure Act, and alleged that the PBGC breached its fiduciary duty as a statutory trustee in various ways, claiming that this allowed the PBGC to control the Plan’s assets for a longer time period and collect investment returns instead of timely paying the pilots their benefits.
- Pilots asserted that their returns should reflect the increase in value that the assets of the plan accrued since the plan was terminated.
- The D.C. Circuit Court referenced 29 U.S.C. §1344(c) which states that if after a plan is terminated the assets increase or decrease in value, it is up to the corporation to absorb those costs.
Lewis v. Pension Benefit Guaranty Corporation, 912 F.3d 605 (D.C. Cir. 12/21/2018)

• The court held that disgorgement was not an available equitable remedy for alleged breach of fiduciary duty by PBGC to recover post-termination increases in the value of pension plan assets.

• Takeaway: The Supreme Court has declined to take this case (6/17/2019). Participants with similar concerns may need to find other avenues of redress, for example, more timely injunctive relief.
Susan Arkun, a former tax attorney became disabled in January 1999 with a chronic persistent motion sickness that left her unable to perform her occupation. Unum ultimately found her disabled under the group long-term disability policy but in 2004 notified her that her LTD benefits would be terminated. They also notified her of the 3 year time limitations period. She appealed 2 weeks later but only completed her appeal in October 2008. Six months later Unum denied the appeal (March 20, 2009) and notified her of the right to seek judicial review. On October 22, 2015, she sued.
Arkun v. Unum Group,

• ERISA does not specify when lawsuits must be filed to recover benefits due under a plan.
• In Heimeshoff v. Hartford Life (2013), the Supreme Court ruled that such suits would be time-barred if not filed within the time period set by the plan as long as the plan provision is reasonable.
• Here the plan set a limit of 3 years after proof of loss is due or received, whichever is earlier.
• Arkun, who had submitted proof of loss by 10/6/2008 had until 10/6/2011 to file.
Arkun v. Unum Group,

- The court noted that even if the New York 6 year statute had been applied, she would still be time barred as the suit was not filed until 10/22/2016, more than 6 years after the notice of final denial on 3/20/2009 and more than 4 years after the plan’s limitation had run.
- The court found she had not shown either that the plan’s limitation period was unreasonably short nor was there a controlling statute that would prevent the period from going into effect.
Arkun v. Unum Group,

• Takeaways:
  – ERISA itself does not specify when lawsuits must be filed to recover benefits due under a plan.
  – The Supreme Court has ruled that such suits will be time-barred if not filed within the limitations period set by the plan as long as the plan provision is reasonable.
  – Set a reasonable time limit and put it in the plan and the SPD.
  – Make sure to communicate the time limitation at all relevant times, for example, with the notice of denial.
"Why me and not you?"
Discrimination

- Avoid illegal discrimination or the appearance of it.
  - Remember that under some laws, an intent to discriminate is not necessary if there is an adverse disparate impact on a protected class.
- Consistency is perhaps the single most important guiding principle in handling workplace issues.
Discrimination

• This consistency should include:
  – Consistency with the plan/SPD/policy and how it has been previously interpreted and applied to other employees.
  – Consistency among departments, divisions, locations, and supervisors.
  – Internal consistency vis-à-vis the employee.
• Example under the ACA: Doe v. BCBS of Tennessee
John Doe is HIV-positive and takes Genvoya for his condition.

BC of TN requires those needing specialty medicines, usually high-cost medicines for chronic and serious diseases, to purchase by mail-order or from a specialty pharmacy network if they want to pay the lower in network prices.

Hence Doe can fill his Genvoya Rx only through mail order or by picking it up at certain brick-and-mortar pharmacies.
**Doe v. BlueCross of Tennessee**

- If he uses the specialty pharmacy network, his co-pay for the month is $120; if he uses his local pharmacy, BC will not cover it at all. Doe would then have to pay thousands of dollars per month.
- Do preferred interacting with his regular pharmacists who knew his medical history and could spot the effects of harmful drug interactions.
- He also was concerned that medicine deliveries to this house might compromise his privacy or risk heat damage to the medicine.
Doe v. BlueCross of Tennessee

- Doe asked BC for a waiver of the specialty pharmacy requirement. BC denied his request.
- Doe filed a class action against BC alleging that it discriminated against him and other HIV-positive beneficiaries in violation of the ACA and the ADA and that it violated the insurance contract.
Doe v. BlueCross of Tennessee

• The ACA provides that
  – an individual “shall not, on the ground prohibited under
    • title VI of the Civil Rights Act of 1964,
    • title IX of the Education Amendments of 1972,
    • the Age Discrimination Act of 1975, or
    • section 504 of the Rehabilitation Act of 1973,
  – be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance.
Doe v. BlueCross of Tennessee

- Doe argued that he could choose which of the standards in the 4 incorporated laws applies. The 6th Circuit disagreed.
- It did agree that Doe has a private right of action under the ACA; however the action must fall under the legal standards under each of the 4 incorporated laws.
- It rejected the HIHS position which interpreted Sec. 1557 of the ACA as authorizing claims of disparate impact on the basis of any of the criteria enumerated in the legislation.
Doe v. BlueCross of Tennessee

- Note the related HHS 5/24/2019 proposed rule changes.
- The court also decided the only one of the discrimination laws that could apply to Doe was the Rehabilitation Act.
- Significantly it went on to conclude, contrary to the rulings of 2 other circuits (the 7th and the 10th), that disparate impact claims are not available under the Rehabilitation Act.
Doe v. BlueCross of Tennessee

- Doe’s ADA claim of discrimination in public accommodation, the local pharmacy, also lost.
  - Title III of the ADA prohibits decimation in the enjoyment of public accommodations by any person who owns, leases (or leases to), or operates a place of public accommodation.
  - BC does not own, lease or operate the local pharmacy, hence the claim fails.
- Doe makes the connection between the BC specialty medications program and his diminished access. But the court read that as targeting BC’s operation of the plan, not its control over his pharmacy.
Doe v. BlueCross of Tennessee

- Doe’s final claim that BC breached its contract with him by violating its implied duty of good faith and fair dealing also failed.
  - There is such a duty under Tennessee law.
  - But the court found that the failure of his ACA and ADA claims dooms the argument.
Doe v. BlueCross of Tennessee

• **Takeaways:**
  – There appears to be a private right of action under the non-discrimination provisions of the ACA. Note, however, HHS 5/24/2019 proposed rule changes which scale back the availability of ACA impact discrimination claims.
  – The split in the Circuit makes it likely the issue of the availability of disparate impact claims under the Rehabilitation Act will go up to the Supreme Court.
Deceit
Deceit

- It is better to say nothing than to lie.
- Using a false reason for a job action can cause an inference of discrimination.
• Johnston v. Prudential Ins. Co, (8th Cir. 2/25/2019)
• The Depot Inc. v. Caring for Montanans, Inc. (9th Cir. 2/6/2019)
Overview

- Part 1 – Three Interesting Developments
- Part 2 - Ten Tips to Avoiding Litigation and Other Recent Cases and Trends
- Part 3 – Other Selected United States Supreme Court Cases
Part 3 – Supreme Court Cases

• US Supreme Court cases which will be noted only in passing are:
  – **ADEA/Age Discrimination** –
    • Mount Lemmon Fire District v. Guido – 11/6/2018
  – **Arbitration and Arbitrability** –
    • Henry Schein v. Archer and White Sales – 1/08/2019
    • New Prime Inc. v. Oliveira – 1/15/2019
Part 3 – Supreme Court Cases

– Compensation taxable under the RRTA
  • BNSF Railway Co. v. Loos - (3/4/2019)

– Medicare Reimbursement
  • Azar, Secy of HHS v. Allina Health Services (6/3/2019)

  • Smith v. Berryhill
Mount Lemmon Fire District v. Guido, 139 S. Ct. 22 (Nov. 6, 2018).

• Issue: Whether the Age Discrimination in Employment Act (ADEA) specification of a twenty-employee minimum, as applied to private employers, applies to political subdivisions of a state.

• Holding: The Court unanimously held that the ADEA applies to ALL political subdivisions of a state, regardless of the number of their employees, based on the plain language of the statute.

• Takeaway: Clarifies ambiguity in statute for state and local governments.
• **Issue:** Whether under the FAA the “wholly groundless” exception allows a court to decide the issue of arbitrability where the parties’ agreement provides the arbitrator the authority to do so.

• **Holding:** The “wholly groundless” exception is inconsistent with the FAA. Arbitration is a matter of contract. Where the contract delegates the question of arbitrability to an arbitrator, a court may not override the contract, even if the court thinks that the arbitrability claim is wholly groundless.

• **Takeaway:** Another victory for arbitration proponents
New Prime Inc. v. Oliveira, 139 S. Ct 532 (1/15/2019).

- In January 2019, the Supreme Court unanimously affirmed that before enforcing an agreement to arbitrate, the trial court (not the arbitrator) must determine whether the arbitration agreement is covered by the FAA and not otherwise excluded, e.g., certain transportation workers.
- The Court also concluded that based on the legal meaning of terms in 1925 (when the FAA was enacted), those “contracts of employment” excluded under the Act include both employment and independent contractor agreements.
- Takeaway: In upholding arbitration exclusion, rare victory for arbitration opponents
In Lamps Plus, Inc., the Court overturned a decision by that ordered class arbitration where an agreement was ambiguous regarding class-action arbitration.

Lamps Plus, Inc. was initially filed as a class action against Lamps Plus for negligence, invasion of privacy, and breach of contract due to alleged privacy breach by one of its employees—Frank Varela—on behalf of a putative class of employees whose information was disclosed in the scam.

Ninth Circuit found that the district court was correct in finding it ambiguous, and California law construes the ambiguity of a contract against its drafter. Based on these conclusions, the Ninth Circuit affirmed the district court’s decision to compel class arbitration.
Lamps Plus, Inc. v. Varela

- **Supreme Court Decision:** Majority opinion explained how class arbitration is a fundamental change to individual arbitration because it “sacrifices the principal advantage of arbitration” and “greatly increases risks to defendants.”
  - Under the FAA, an ambiguous agreement cannot “provide the necessary ‘contractual basis’ for compelling arbitration.”
  - A court cannot “infer consent to participate in class arbitration absent an affirmative ‘contractual basis for concluding that the parties agreed to do so.’”
  - Although there is a California law that construes the ambiguity of a contract against its drafter, that policy argument “cannot substitute for the requisite affirmative ‘contractual basis for concluding that the party[ies] agreed to [class arbitration].’”
  - The Court reversed the Ninth Circuit’s decision and remanded the case of further proceedings.

- **Dissenting Opinions:** The four Dissenting opinions responded to the Majority’s decision by raising concerns about how the Court’s decision will further the power imbalance that powerful economic entities have over employees and consumers.
Loos was injured on the job due to BNSF Railway’s (Defendant) negligence.

He was awarded compensation for his injuries and the wages he would lose while away from work.

BNSF claimed a right to offset the compensation awarded to Loos because the portion paid for lost wages was equivalent to wages that were subject to employment taxes.

The District Court and Eighth Circuit Court disagreed.
• The Supreme Court reversed the lower courts ruling, holding that a railroad’s payment to an employee for working time lost due to an on-the-job injury is taxable “compensation” under the Railroad Retirement Tax Act (RRTA), citing Nierotko and Quality Stores.

• Gorsuch’s dissent emphasized the issue that BNSF’s negligence caused the injury in the first place and Loos shouldn’t have to suffer an offset to his compensation in light of that.

- Under Medicare Part A, medical institutions that serve a disproportionate number of low-income individuals are entitled to financial reimbursements.
- These reimbursements are calculated based on the fraction of patients served under Medical Part A ("Medicare Fraction").
  - The fraction's denominator is the amount of time spent by hospitals serving patients receiving benefits under Medicare Part A.
  - The numerator represents the amount of time spent caring for Part A eligible patients who were also eligible for income support payments under the Social Security Act.
  - Under the Medicare Fraction, the larger the fraction equates to the larger HHS reimbursement payment to a hospital.
Azar, Sec’y of HHS v. Allina Health Services

- In 2014, HHS made the decision to include Medicare Part C participants in the Medicare Fractions. It made this decision by posting the 2012 Medicare Fractions online, and explained that the fractions included Part C participants.
- Plaintiff hospitals sued HHS because they saw their Medicare reimbursement decrease as a result of the inclusion of Medicare Part C participants in the Medicare Fraction.
Azar, Sec’y of HHS v. Allina Health Services

- Procedurally, the Medicare Act requires the HHS to provide public notice and a 60-day public comment period (“notice-and-comment rule”) for any policy that establishes or changes a substantive legal standard governing the federal payment of services.
- In a 7-1 ruling, the Court found that the HHS policy to amounted to a substantive legal standard, and therefore, the proper notice-and-comment rule ought to have been followed.
- “Due Process”

- Justice Sotomayor wrote this unanimous opinion, reversing the judgment of the U.S. Court of Appeals for the Sixth Circuit.
- Holding: a dismissal by the Social Security Administration’s (“SSA”) Appeals Council because of untimely filing after a hearing by an administrative law judge (“ALJ”) on the merits constitutes a final decision within the meaning of §405(g) of the Social Security Act (the “Act”).
- To obtain judicial review from a federal court, a claimant must proceed through a four step process.
  - First: seek a determination as to his eligibility.
  - Second: seek reconsideration of that determination.
  - Third: request a hearing from an ALJ.
  - Finally: seek review of the ALJ’s decision by the Appeals Counsel.
Smith v. Berryhill

• If a claimant has proceeded through these steps on the merits, he is entitled to judicial review under §405(g).
• Dismissals are “binding and not subject to further review by the SSA,” and denote a “terminal event,” which is in line with the text of the Act.
• The statutory context states an action is final under the statute if it both marks the end of an agency’s decision-making process, and is one from which “legal consequence will flow.”
• This decision, as noted by the Court, “hardly knocks loose a line of dominoes,” highlighting that not much will change following this ruling.
Questions?