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The Universal Misery of Health Care Policy

By David E. Morse

First, the good news. If someone had to choose a time in history or a place in the universe to have a life-threatening illness or injury treated, it would be right now and in the United States. But the nation's world-class medical care is delivered by a system combining the worst aspects of socialized medicine and the free market, resulting in a health care system that is expensive, inadequate and understaffed. Patients and providers are miserable; we are overdue for a rewrite.

The major concern with government-run single payer systems is access to care. Patients in countries such as the United Kingdom and Canada have long waits to see a provider, get routine testing and non-emergency surgery. Without free-market profit incentives, the thinking goes, underpaid doctors and other providers lack the incentive to hustle and innovate while government red tape makes everything that much harder. There is also a shortage of professionals as young adults gravitate towards higher paying careers. However, in the United States we have . . . a shortage of health care professionals, long wait times, and a byzantine bureaucracy. And that is in the big cities; folks in rural America have it worse.

Without a single payer, hospitals are combining to have the heft to cover overhead and negotiate with large health insurers, which in turn need to grow larger (and acquire providers), all causing physicians groups to merge to better deal with the hospital chains and insurers, in a cycle of continuing *biggerness*. But size does not seem to matter, because we have the most expensive health care of any wealthy country with rather mediocre outcomes as measured by life expectancy, infant mortality and similar markers.

The U.S. health care system has managed to turn bureaucracy into an art form. Go for a checkup and watch your doctor spend most of his or her time typing into a computer. To make an appointment for a checkup one needs patience and, perhaps, a master's in computer science. Or consider the no-win electronic maze to get a provider to answer a question – frustrating and time consuming for both patient and provider (who does not even get paid for answering).

With miracle meds and life-changing treatments emerging from new and (very) expensive technology, the failures of the U.S. system are becoming more apparent and alarming.

And what are our leaders on both sides of the aisle doing? They are engaged in culture wars arguing over anything to do with sex, what type of care should be mandated or forbidden and who should (must)

pay for what. Health outcomes, patients' own decision-making and medical science all take a back seat to gathering "likes" and campaign contributions.

POSSIBLE SOLUTIONS

Granted the health care system is huge and complicated and, as several presidents have found, a fix will not come easily. But to do nothing is to guarantee higher and higher costs with poorer and poorer outcomes. As complicated as delivering health care is, here are a few places to start looking for solutions:

1. Insurance is about risk pooling and everybody should be in the pool. The M-word has become toxic, but coverage mandates are fair because otherwise someone who decides not to buy coverage still receives care when he or she is wheeled into the emergency room after some catastrophe forcing the insured to cover the $1 million hospital bill through higher premiums. People who can afford insurance should pay full freight; those who can only afford a portion, should pay that amount; those with little to nothing, should get it for free. Whether employers subsidize their workers' premiums should be left to the employment market to decide. Premiums should be age-based, so the young do not subsidize the older population.

2. Medical and nursing students should receive tuition refunds or loan forgiveness, provided they serve where needed for a minimum number of years.

3. Practitioners (not academics, techies or regulators) should be tasked with redesigning the billing and recordkeeping system to something useful and usable.

4. Hospitals and providers should have one visible fee schedule for all users. Like an airline, it is OK if they charge extra for "extra leg room" as long as the important stuff – the actual care – is the same for all. It is also OK to charge medical tourists more.

5. Tax breaks should be the same for everyone and not dependent on the vagaries of whether they receive employer-paid coverage or have access to a company-run spending account.

6. The hardest challenge will be solving how to develop and pay for new bespoke drugs and treatments. Human life is priceless,

but can we afford million dollar cures for every known disease? There must be a way to effectively target our research spending on cures that will do the most good (not make the most money), avoid wasteful development of duplicate (but patentable) cures, and reward success yet still control costs. Put research scientists in a room to figure out what motivates them (I have a feeling it is not just money) and to develop a system to effectively spend available research dollars. And make sure patients in other countries pay the same amount as Americans for care that is developed in the United States.

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The views set forth herein are the personal views of the author and do not necessarily reflect those of the law firm with which he is associated.

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U.S. Department of Labor Finalizes Major Changes to Its Fiduciary Investment Advice Rule

By Katherine B. Kohn, Edward C. Redder, David Uhlendorff, Brian L. Gaj and Dominic DeMatties

In this article, the authors examine the final "Retirement Security Rule" published recently by the U.S. Department of Labor amending the existing rule defining when a person is an investment advice fiduciary under the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code.

The U.S. Department of Labor (DOL) has published its final "Retirement Security Rule" (the Final Rule)[1] that amends the existing rule defining when a person is an investment advice fiduciary under the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (the Code). The DOL simultaneously published amendments to various prohibited transaction exemptions (PTEs or exemptions) intended to narrow and harmonize the exemptions available to address conflicts of interest with respect to investment advice.

As discussed in this article, the Final Rule and amendments to exemptions significantly expand who may be considered an investment advice fiduciary under ERISA and the Code and can impose new and expanded requirements on investment firms and professionals that rely on exemptions in their work with retirement investors. While the Final Rule was anticipated to be similar to the proposed rule and exemption amendments issued on October 31, 2023, the DOL made adjustments to the proposed rules based on comments from stakeholders.

BACKGROUND

ERISA imposes significant fiduciary obligations on individuals responsible for operating and managing a wide range of workplace employee benefit plans, including retirement plans (e.g., 401(k) plans

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and tax-qualified defined benefit plans). Among other obligations, ERISA fiduciaries must act solely in the interest of plan participants and beneficiaries for the exclusive purpose of providing benefits to them and paying reasonable plan expenses, act in accordance with a prudent person standard, follow the governing plan documents unless contrary to ERISA, and diversify plan assets to minimize the risk of large losses unless it is clearly prudent not to do so. The consequences of breaching those fiduciary duties can be significant, including disgorgement of profits and restoration of plan losses.

ERISA and parallel provisions of the Code (with respect to which DOL has interpretive authority) also prohibit certain conduct by those dealing with many workplace retirement plans and certain retirement and investment accounts (e.g., individual retirement accounts (IRAs) and health savings accounts (HSAs)), including certain conflicts of interest involving fiduciaries of plans and covered accounts. Violation of these rules can result in "prohibited transactions," which can lead to significant liability and imposition of excise taxes.

ERISA broadly defines the term "fiduciary" including by reference to a functional test: a person is a fiduciary to the extent he or she engages in certain conduct (or has the authority to do so), including a person who provides investment advice for a fee, direct or indirect, with respect to moneys or property of a plan. In 1975, the DOL adopted a rule defining when a person is a fiduciary as a result of providing investment advice to a plan (the Five-Part Test). Under the Five-Part Test, a person is considered to provide investment advice if that person:

- Renders advice to the plan as to the value of securities or other property or makes recommendations as to the advisability of investing in, purchasing, or selling securities or other property;
- On a regular basis;
- Pursuant to a mutual agreement, arrangement, or understanding with the plan or plan fiduciary;
- For which the advice will serve as a primary basis for investment decisions with respect to the plan; and
- For which the advice will be individualized based on the particular needs of the plan.

As discussed below, the Final Rule replaces the Five-Part Test with a construct that, in the view of the DOL, "appropriately defines an

investment advice fiduciary to comport with reasonable investor expectations of trust and confidence."

THE FINAL RULE

The Final Rule replaces the Five-Part Test with a less rigid three-part test designed to impose fiduciary status in circumstances when investors "can and should reasonably place trust and confidence in the financial services provider."

Who Is an Investment Fiduciary?

Under the Final Rule, a person is an investment fiduciary under ERISA and the Code if the person:

1. Makes a recommendation of any securities transaction or other investment transaction or any investment strategy involving securities or other investment property to a retirement investor;

2. Either:

    a. Directly or indirectly makes professional investment recommendations to investors on a regular basis as part of their business and the recommendation is provided under circumstances that would indicate to a reasonable investor in like circumstances that the recommendation:

        i. Is based on a review of the retirement investor's particular needs or individual circumstances,

        ii. Reflects the application of professional or expert judgment to the retirement investor's particular needs or individual circumstances, and

        iii. May be relied upon by the retirement investor as intended to advance the retirement investor's best interest; or

    b. Represents or acknowledges that they are acting as a fiduciary under Title I of ERISA (applicable to employer-sponsored plans), Title II of ERISA (applicable to employer-sponsored plans, IRAs and other covered accounts), or both, with respect to the recommendation; and

3. Receives a fee or other compensation in connection with or as a result of the recommendation, directly or indirectly.

What Is a "Recommendation"?

Investment advice must include a "recommendation." Like the Proposed Rule, the Final Rule does not explicitly define what constitutes a "recommendation." However, the preamble to the Final Rule (the Preamble) notes that the determination is based on all the facts and circumstances, including whether the communication can reasonably be viewed as a call to action. Further, the Preamble states that the DOL will interpret and construe the term consistent with the interpretation of the U.S. Securities and Exchange Commission (SEC) under Regulation Best Interest, an SEC rule governing the conduct of broker-dealers. The Preamble also offers that:

- The more individualized a communication, the more likely it will be considered a recommendation;
- A communication to a group can be a recommendation; and
- Not all actions of affiliates will be considered in the determination; rather, the determination will consider actions taken "through or together with" the affiliate (or other party).

Although interesting from a transparency perspective as a view into DOL's thinking, it is worth noting that Preamble statements do not have the same effect as regulatory provisions.

To Whom Must the Recommendation Be Made?

A recommendation is not investment advice unless it is directed to a "Retirement Investor," defined under the Final Rule as a plan, plan participant or beneficiary, IRA, IRA owner or beneficiary, plan fiduciary (other than a person who is a plan fiduciary solely as a result of the provision of investment advice), or IRA fiduciary with respect to an IRA. The DOL rejected requests for exceptions or limitations for sophisticated advice recipients, noting that the criteria suggested by various commenters failed to reliably identify whether an advice recipient was, in fact, sophisticated. Informally, individuals at DOL have publicly stated that providing exceptions and limitations could make the rule more susceptible to successful challenges in court.

The Final Rule also clarifies that when advice is rendered to a plan or IRA fiduciary, the focus is on the "particular needs or individual circumstances" of the plan or IRA and not the fiduciary. The DOL also rejected blanket exclusions for health and welfare plans and HSAs but noted in the Preamble that many common structures likely would not rise to the level of covered recommendations (e.g., identification of investment alternatives using objective third-party criteria to assist plan sponsors in their selection and monitoring of investments).

What Must Be the Subject of the Recommendation?

A recommendation to a retirement investor is not investment advice unless it relates to:

- *Investment of Securities or Investment Property*. Recommendations regarding whether to buy, hold, or sell securities or other investment property, or investment strategy, including after a rollover, transfer, or distribution from a plan or IRA. The Final Rule includes coverage of investment strategies to make clear that it covers certain recommendations regardless of whether the recommendations refer to particular securities or investment property. For example, investment strategies will be interpreted broadly to include recommendations for using a bond ladder, day trading or margin strategy, and other strategies.

  Note that the term "investment property" is intended to capture investments made by plans and IRAs that are not securities, such as real estate investments, but explicitly does not include health or disability insurance policies, term life policies, or other policies or property that do not contain an investment component.

- *Investment Management*. Recommendations regarding "the management of securities or other investment property," including recommendations on investment policies, portfolio composition, selection of investment advice or investment management services, account arrangements, and proxy voting. For example, a recommendation to move from a commission-based account to an advisory fee-based account would be a covered recommendation.

  The DOL's focus on the selection of *other* persons to provide advice or management services was intentional: it is intended

to exclude communications marketing one's own advisory or management services (so-called "hire me" communications). The DOL cautioned, however, that marketing communications that rise to the level of a covered recommendation and that satisfy the other requirements of the Final Rule would be investment advice, and, thus, fiduciary in nature. Simply put, the mere fact that a recommendation may come in the form of or be combined with marketing materials does not shield the recommendation from coverage under the Final Rule.

- *Rollovers, Transfers, or Distributions.* As with previous attempts to revise the Five-Part Test, the Final Rule targets rollover and distribution advice to participants and beneficiaries and provides that such recommendations – even without advice on how to invest assets following the rollover or distribution – are considered investment advice. The Preamble provides that "[d]ecisions to take a benefit distribution or engage in a rollover transaction are among the most, if not the most, important financial decisions that plan participants and beneficiaries, and IRA owners and beneficiaries are called upon to make." The DOL reasons that a recommendation to take a distribution or rollover from a plan or IRA and invest assets generally would require an evaluation of how the option compares to leaving the assets in the plan or IRA. The DOL also noted that the analysis does not turn on whether it is coupled with a change in investments: "The recommendation not to hold an asset in the plan, even if the intention is to hold essentially the same asset outside the plan, is still an investment recommendation." Finally, the DOL views recommendations on how securities or other investment property should be invested after a rollover, transfer or distribution from a plan or IRA to include an implicit rollover recommendation and would be a covered recommendation.

In What Context Must The Investment Advice Be Provided?

The DOL is clear that a person should be subject to ERISA's fiduciary duties when the person provides investment advice under circumstances in which a reasonable retirement investor would place their trust and confidence in the advice provider as acting in the retirement investor's best interest. Under the Final Rule, a person providing a covered recommendation will always be an investment advice fiduciary if they represent – in writing or otherwise – that they are acting

as a fiduciary under Title I and/or Title II of ERISA with respect to the recommendation.

However, even absent an acknowledgment of fiduciary status, the Final Rule provides that a person may be an investment advice fiduciary with respect to a recommendation if they satisfy the facts and circumstances test by:

- Either directly or indirectly making professional investment recommendations to investors;
- On a regular basis as part of their business; and
- The recommendation is made under circumstances that would indicate to a reasonable investor in like circumstances that the recommendation:
    - Is based on a review of the retirement investor's particular needs or individual circumstances,
    - Reflects the application of professional or expert judgment to the retirement investor's particular needs or individual circumstances; and
    - May be relied upon by the retirement investor as intended to advance the retirement investor's best interest.

This is intended to be an objective standard, based on the expectations of a reasonable investor in like circumstances. The Final Rule provides that written disclaimers of fiduciary status or the conditions of the facts and circumstances test will not control if they are inconsistent with the advice provider's oral or written communications, marketing materials, applicable state or federal law (such as the Advisers Act), or other interactions with the retirement investor. In other words, an advice provider cannot engage in activities that create a legitimate expectation that the advice provider is in a position of trust and at the same time disclaim such status. The Preamble also highlights that, in determining whether the standard is met:

- Express representation by the advice provider that the components have been satisfied is not required;
- Absent unusual circumstances, if the advice provider has investment discretion over the assets that are the subject of a recommendation, the test would be satisfied;

- Use of titles (e.g., "financial consultant" or "wealth manager"), credentials or marketing slogans are relevant but generally not determinative; and

- Gathering a retirement investor's personal and financial information is indicative that the advice is individualized.

Notably, the Final Rule eliminates the Five-Part Test's "regular basis prong" and instead focuses on whether the person makes professional investment recommendations to investors on a regular basis as part of their business. As such, the focus shifts from the particular relationship to the advice provider's business and considers the person providing advice, including the person's firm and its employees, agents and representatives. Eliminating the "regular basis prong" also results in the possible coverage of one-time advice, further evidencing the DOL's intent of capturing one-time rollover advice.

To address concerns that marketing communications, investment education, and routine communications from human resources or similar employees could be found to be investment advice subject to fiduciary duties, the Final Rule makes clear that:

- Sales pitches and the provision of investment education would not be considered investment advice so long as neither the facts and circumstances test is satisfied nor a fiduciary acknowledgment is provided (e.g., a statement that "you'll love the return on X stock in your retirement plan, let me tell you about it," without more, would not result in fiduciary status), and

- An advice provider must make professional investment recommendations. Therefore, routine communications from a non-professional would not be subject to fiduciary duties.

What Is Considered a Direct or Indirect Fee or Other Compensation?

According to the Final Rule, a person provides investment advice for a fee or other compensation, direct or indirect if:

> The person (or any affiliate) receives any explicit fee or compensation, from any source, for the investment advice or the person (or any affiliate) receives any other fee or other compensation, from any source, in connection with or as a result of the recommended

> purchase, sale, or holding of a security or other investment property or the provision of investment advice, including, though not limited to, commissions, loads, finder's fees, revenue sharing payments, shareholder servicing fees, marketing or distribution fees, mark-ups or markdowns, underwriting compensation, payments to brokerage firms in return for shelf space, recruitment compensation paid in connection with transfers of accounts to a registered representative's new broker-dealer firm, expense reimbursements, gifts and gratuities, or other non-cash compensation. A fee or compensation is paid "in connection with or as a result of" such transaction or service if the fee or compensation would not have been paid but for the recommended transaction or the provision of advice, including if eligibility for or the amount of the fee or compensation is based in whole or in part on the recommended transaction or the provision of investment advice.

While this definition is broad, it is not all-encompassing. Specifically, there must be a connection between transaction-based compensation and the recommendation. In other words, compensation is paid in connection with or as a result of a recommendation only if it would not have been paid but for the recommended transaction, or if eligibility for, or the amount of, the fee or compensation is based on the recommended transaction.

APPLICATION TO CERTAIN COMMON CIRCUMSTANCES

The Preamble also addresses a variety of common circumstances raised by various commenters, including the application of the Final Rule to platform providers (i.e., entities that offer a platform or selection of investment options to participant-directed individual account plans from which plan fiduciaries select options that will be available to participants), pooled employer plans, investment information and education, call centers, swaps and security-based swaps, and valuation services.

The DOL refrained from providing special exceptions or exemptions to platform providers, pooled employer plans (and more specifically, pooled plan providers), and call center employees and instead reiterated that communications would be evaluated based on the general standards of the Final Rule. However, the DOL noted that platform providers that merely identify investment alternatives using objective third-party criteria without additional screening or recommendation would not be providing covered recommendations. Further, a provider generally does not make a covered recommendation merely by offering a preset list of investments.

With respect to investment information and education, the DOL confirmed that providing investment information and education such as those described in Investment Bulletin 96-1 and the "Investment Education" provision in the 2016 Final Rule[2] without more would not result in the provision of investment advice. The DOL also noted that providing information found in the IRS safe harbor Code Section 402(f) notice would also not result in the provision of investment advice.

Provision of mandated disclosures related to swaps and security-based swaps without more would not result in the provision of investment advice. As in previous attempts to revise the Five-Part Test, the Final Rule excludes valuation services from coverage.

AMENDMENTS TO PROHIBITED TRANSACTION EXEMPTIONS

Contemporaneous with the issuance of the Final Rule, the DOL also amended several existing Exemptions: PTEs 2020-02, 84-24, 75-1, 77-4, 80-83, 83-1, and 86-128. The amendments make clarifying changes to the exemptions and require investment advice fiduciaries who will receive otherwise prohibited compensation to satisfy, among other requirements, the impartial conduct standards of PTE 2020-02 or PTE 84-24. A subsequent bulletin will discuss the Exemptions in greater detail.

EFFECTIVE DATE

The Final Rule and amended Exemptions are effective September 23, 2024. However, the requirements of amended PTEs 2020-02 and 84-24, other than the impartial conduct standards and acknowledgment of fiduciary status, are delayed until September 23, 2025.

IN SUMMARY

In summary, the following groups, among others, could be impacted by the Final Rule and related exemptions) amendments:

- Pension consultants;
- Robo-advisors;
- Insurance agents and brokers;

- Investment company principal underwriters;
- Retirement plan fiduciaries;
- Insurance companies;
- Registered investment advisors;
- Banks and credit unions;
- Investment professionals; and
- Financial advisors.

The Final Rule and related PTE amendments change many of the rules regarding these groups' interactions with plans, plan participants and beneficiaries, IRA owners, and the like, including subjecting people who were not previously considered investment advice fiduciaries to fiduciary standards under ERISA.

LOOKING AHEAD

The Final Rule marks a significant shift away from the rigid Five-Part Test and instead focuses on the expectations of a hypothetical reasonable investor in like circumstances. Based on the breadth and substance of comments submitted in response to the proposed rule, as well as the legal challenges to past attempts by the DOL to revise the Five-Part Test, future legal challenges are expected. However, given the announced effective date, investment professionals and financial institutions should review their current offerings and service models to ensure that they either do not result in the provision of investment advice under the Final Rule or that they comply with the fiduciary standards and prohibited transaction provisions of ERISA and the Code, as applicable. Likewise, workplace retirement plan fiduciaries should consider the services provided by plan service providers and assess how the Final Rule may alter the services provided (or how the services are provided).

NOTES

1. 89 FR 32122.
2. 81 FR 20946.

When Does a Corporate Transaction Trigger a 401(k) Participant's Right to a Distribution?

By Emily Pellegrini

In this article, the author explains when employees of a company that sponsors a 401(k) plan can receive their money when their company is sold.

It is widely predicted that the rate of merger and acquisition activity in corporate America will continue to rise throughout the remainder of this year. Often, considerations relating to a seller's qualified plans are treated as an afterthought when structuring a transaction. However, leaders of selling entities that sponsor 401(k) plans may find themselves hearing the same question over and over from employees – "when can I get my money?" To accurately answer that question – and to avoid potentially costly operation errors – sponsors of 401(k) plans that intend to participate in corporate transactions should be well versed in the applicable distribution rules under the Internal Revenue Code (the Code) and how they apply to various transaction scenarios. This article focuses on the rules applicable to 401(k) plans, although much of the guidance discussed is applicable to 403(b) and 457(b) plans as well.

WHAT IS A SEVERANCE OF EMPLOYMENT?

401(k) plans may only permit distribution of a participant's elective deferrals upon the occurrence of certain events. Amidst a corporate transaction, the permissible distribution event most likely to occur is known as a severance of employment. 401(k) plans are not required to permit distributions upon a severance of employment, but the vast majority do.

While some plans use the "severance of employment" language when listing permissible distribution events, others often substitute more commonplace language, saying that a participant is permitted to receive a distribution upon "termination of employment." Replacing the phrase "severance of employment" with simplified language such

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as "termination of employment" is not necessarily a compliance issue for plans.

However, plan sponsors should be aware that the phrase "severance of employment" is a term of art with a very specific meaning, and that meaning is not a perfect match to what the average employee would consider a "termination of employment." This means that when considering whether a corporate transaction will result in participants becoming entitled to a plan distribution, plan sponsors should not simply assume that a change in a participant's common law employer will entitle the participant to a distribution.

It is important to note that the phrase "severance of employment" and the phrase "separation from service" are distinct concepts under the Code with separate definitions. It is possible for a participant to experience one of these events but not the other. Prior to 2002, "separation from service" was listed as a distributable 401(k) event in place of "severance from employment." The "same desk rule" that is sometimes discussed regarding issues relating to vesting and service crediting is tied to "separation from service" – not "severance of employment." Confusingly, the "separation from service" concept still exists in the Code, and is a standard used to determine whether a participant qualifies for exceptions to the premature distribution penalties.

Under current guidance, a participant experiences a "severance of employment" when the participant is no longer working for the employer who maintains the plan. The seemingly straightforward definition can quickly become complicated to apply for a couple of reasons.

First, for qualified plan purposes, the Internal Revenue Service (IRS) considers groups of related companies with common ownership (commonly referred to as "control groups" or "affiliated service groups") to be a single employer even when the underlying companies are distinct legal entities.

Second, corporate transactions often result in changes to qualified plans, including plan spinoffs, plan mergers and changes in the plan sponsor. This makes applying the rule a challenge.

According to the IRS, the main factor that determines whether a participant will experience a severance of employment as a result of a corporate transaction is the structure of the transaction. IRS guidance generally addresses two types of corporate transactions: asset sales and stock sales.

ASSET SALES

Generally, asset sales involve one company acquiring the business assets of another company. In situations where the buyer will purchase

substantially all the seller's assets it is common for the buyer to agree to hire some, or all, of the seller's workforce.

If a seller maintains a 401(k) plan for its employees and some, or all, of the seller's employees are hired by the buyer as a result of the sale, then those employees will generally experience a severance from employment. This means that, assuming the seller's plan permits distributions upon a severance from employment, the affected employees will be eligible to request a distribution once they are hired by the buyer. The affected employees may elect to roll over their distribution into the buyer's 401(k).

However, employees who go to work for the buyer following an asset sale will not experience a severance from employment if the buyer "continues" the seller's 401(k) plan. A buyer is treated as "continuing" the seller's plan if it: (1) adopts the seller's plan as the new plan sponsor, or (2) assets from the seller's plan are directly transferred via a trustee-to-trustee transfer to a plan maintained by the buyer.

STOCK SALES

In a stock sale, the buyer purchases stock of the selling company from the owner of the selling company and after the transaction owns all or a portion of the selling business entity.

Generally, participants will not have a severance from employment simply because all, or a portion of the stock of their employer, is sold.

However, there can be certain stock sale structures that trigger a severance of employment even if the employee does not have a change in their common law employer. This will typically arise in the stock sale of a subsidiary and, while the analysis can be quite complex, one factor that must be true for there to be a severance of employment for plan purposes is that subsidiary is no longer a participating employer in the 401(k) plan.

APPLYING COOKIE CUTTER GUIDANCE TO COMPLICATED REALITIES

The existing guidance on how the severance of employment rules apply to corporate transactions is very limited. The sum total of guidance from the IRS includes some passing references in the 401(k) regulations, a General Counsel Memorandum from 1990 and a 2002 Notice. In addition to the scarce number of guiding documents, the scope of existing guidance is limited as well. The commentary the IRS has provided to date generally addresses sales involving a buyer

purchasing 100 percent of a buyer's assets or stock. In reality, the structure of corporate transactions is often far more nuanced.

Therefore, when it comes to determining whether participants will experience a severance of employment and be entitled to a 401(k) distribution as a result of a corporate transaction, there may not always be a clear answer. While the stakes may seem low, this confusion can quickly spiral into costly issues for plan sponsors – participants denied a distribution could bring legal action, while impermissibly allowing participants to receive a distribution can create plan qualification issues subject to review by the IRS.

For this reason, plan sponsors involved in a corporate transaction work should closely with their attorneys to determine how to best apply existing guidance to their unique situations.

Insurance Reimbursement Complications in the Age of Remote Patient Monitoring

By Abbye E. Alexander, Christopher J. Tellner and Henry Norwood

In this article, the authors discuss how the use of Intraoperative neurophysiological monitoring (IONM) – the practice of remote electronic monitoring of a patient during a surgical procedure – has led to complications regarding processing reimbursements for IONM services by health insurers; look at the details regarding the issues that are considered when processing these claims; and explain what nuances insurance providers and healthcare providers should be aware of when handling such claims.

The now commonplace practice of Intraoperative neurophysiological monitoring (IONM) – the electronic monitoring of a patient's nervous system while the patient undergoes a surgical procedure – has birthed a host of questions surrounding the processing of insurance claims for such services by providers, including how to code such claims, how to process such claims when more than one person is being monitored by the same remote servicer at a time, what standards of care are required for processing these claim codes, etc. While ambiguity remains until the courts bring further procedural clarity for such claims, healthcare and insurance providers can gain an understanding of best practices to minimize complications when handling these nuanced claims.

INTRAOPERATIVE NEUROPHYSIOLOGICAL MONITORING

IONM is the electronic monitoring of a patient's nervous system while the patient undergoes a surgical procedure. IONM is utilized to prevent life-threatening injury during surgery such as paralysis and death where the patient's nervous system could be harmed. IONM can immediately identify changes in the brain, spinal cord, and peripheral

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nerve function of a patient, potentially providing early warning signals if the patient's nervous system is at risk. One or more physicians oversee IONM and this oversight can take place either in the operating room (OR) or remotely via live feed outside of the OR.

When IONM is performed remotely without in-person continuous physician oversight, reimbursement for IONM services by health insurers had been a contested issue between IONM providers and health insurers, resulting in the creation of new insurance claim codes. Complicating the issue though is the practice of remotely overseeing multiple patients simultaneously. This results in a higher number of claims submitted for the same time period. From the insurer's perspective, this practice strains the level of care the provider can deliver. From the provider's perspective, this practice allows more patients to receive IONM care.

REIMBURSEMENT FOR REMOTE IONM

The remote IONM problem has been addressed in the public health insurance realm. The Centers for Medicare and Medicaid Services (CMS) established a separate CPT code for IONM services reimbursable through a public insurance program. Private insurers do not benefit from the CMS CPT code, but instead must rely on other sources of authority to dispute multiple, concurrent, remote IONM claims.

CPT codes for IONM services are divided into two separate categories: (1) the time component, and (2) base codes. Prior to January 1, 2013, the universal code for the time component was CPT 95920, established by the American Medical Association (AMA). CPT 95920 was removed from Jan. 1, 2013 on and was replaced by two new codes applicable to private insurers and an additional new code created by CMS afterward. Time component codes currently accepted by insurers include HCPCS G0453, CPT 95940, and CPT 95941. These CPT codes allow the provider or facility to bill for time spent performing the appropriate IONM service.

CPT Code 95940 is designated for exclusive, continuous, one-on-one monitoring in the OR, according to AMA guidance. Private insurers accept CPT code 95940 with the requirement that no other cases can be monitored at the same time. CPT 95940 cannot be submitted unless there is a record in the OR log documenting the IONM physician's attendance in the OR.

CPT Code 95941 is specified for continuous IONM from outside the OR, remotely or near the OR, or for monitoring more than one surgery while in the OR. Private insurers generally accept CPT 95941. CPT 95941 cannot be used unless there is documentation of real-time, continuous interpretation by the IONM physician and communication

by the physician of that interpretation to the operator of the IONM equipment in the OR. This CPT Code raises the question as to whether multiple patients can be monitored concurrently and be submitted to private insurers for payment. Private insurers may argue, relying on the CMS guidance underlying HCPCS G0453 and the AMA guidance underlying CPT Codes 95940 and the former 95920, that providers should only be able to submit a single monitoring claim at a time.

HCPCS G0453 is specified for continuous IONM monitoring from outside the operating room, remotely or nearby. Insurers that require G0453 include Medicare, Worker's Compensation, and certain HMOs. G0453 cannot be used unless there is documentation of real-time, continuous interpretation by the IONM physician and communication by the physician of that interpretation to the operator of the IONM equipment in the OR. Medicare created HCPCS G0453 to be used in place of CPT 95941 because Medicare does not allow a physician to bill for multiple, concurrent surgeries for overlapping periods of time, requiring the undivided attention of the monitoring physician to a single patient.

Prior to 2013, when all payers, including Medicare, accepted CPT 95920 for both in-person and remote monitoring, Medicare rules still only allowed the use of CPT 95920 once per hour, even if multiple patients were monitored simultaneously. In other words, under the prior CPT code, Medicare still only allowed remote monitoring of one surgery at a time. Since the adoption of HCPCS G0453 by Medicare, Worker's Compensation carriers have also mandated the use of HCPCS G0453 and have adopted Medicare's rules associated with this code.

SOLELY DEDICATED AND AVAILABLE TO INTERVENE

Reimbursement for these CPT codes requires that the monitoring physician provided continuous, real-time monitoring of the IONM feedback throughout the surgery. CPT introductory language and AMA coding guidance is clear that in order to bill these codes (95940, 95941, or G0453) the service must be performed by a monitoring professional who is solely dedicated to performing IONM and is available to intervene at all times during the surgery as necessary. The monitoring professional may not provide any other activities aside from IONM during the same period of time billed for monitoring.

The tension arises when the questions is asked whether an IONM provider can be solely dedicated to and available to intervene in a specific patient's procedure if that provider is monitoring multiple patients at the same time. Providers generally take the position that multiple patients may be monitored without compromising the availability to intervene. Insurers have pushed back on this, contending

a one-patient-at-a-time approach is needed and only reimbursing a single claim for payment at a time.

The concern that practitioners may bill for monitoring more than one beneficiary for the same work during the same period of time was a primary purpose behind the creation of HCPCS code G0453 (continuous IONM, from outside the operating room, with attention directed exclusively to one patient). HCPCS code G0453 may be billed only for undivided attention by the monitoring physician to a single patient, not for simultaneous attention by the monitoring physician to more than one patient. CMS noted the threats of abuse when allowing a provider to bill for the simultaneous remote monitoring of patients and other federal health programs have agreed with this view.

The preface language of CPT 95941 permits providers to bill for overlapping IONM services provided to multiple patients at the same time. When monitoring more than one procedure, there must be the immediate ability to transfer the patient monitoring to another monitoring professional during the surgical procedure should that professional's exclusive attention be required for another procedure. The number of cases monitored at any one time should not exceed the requirements for providing adequate attention to each patient.

CONTRACTING AROUND THE ISSUE

Some insurers have included provisions in contracts with in-network providers imposing limits on the number of overlapping IONM cases that can be provided and billed. This practice would not limit the number of patients insured by different insurers that a provider can monitor. For example, if an IONM provider simultaneously monitored three patients who are covered by three different insurers, each insurer would only receive one claim even though the provider monitored three patients at the same time. Contracting around the issue also does not address out-of-network providers who would not be subject to any IONM limitation provision.

THE OUTLOOK FOR INSURERS AND PROVIDERS

Until the IONM issue is addressed by courts, providers will continue submitting multiple, concurrent claims for remote IONM services and many insurers will attempt to limit the number of simultaneous, reimbursable claims. Provisions in provider agreements clarifying the number of overlapping claims an insurer will reimburse may provide an understanding between the provider and payer and avoid disputes down the road. On the other hand, overlapping claims submitted by

out-of-network providers remains a legal blind spot with insurers referencing the stance of CMS and providers noting the absence of any clear restriction on the number of patients a provider may simultaneously monitor. Insurers should expect that simultaneous IONM claims will be submitted and providers should be aware they may face resistance to payment.

Undue Influence Claims Under ERISA

By Barry L. Salkin

In this article, the author analyzes undue influence claims under the Employee Retirement Income Security Act of 1974.

The Employee Retirement Income Security Act of 1974 (ERISA) does not expressly address the circumstances, if any, in which a non-beneficiary[1] may avoid the payment of benefits to a named beneficiary. When ERISA is silent, courts must develop federal common law,[2] including the scenario in which ERISA preempts a state statute, as will be discussed below, but it itself is silent on the relevant issues.[3]

However, because there is no established body of federal common law to apply to improperly designated beneficiaries,[4] in cases dealing with fraud, duress, forgery, competence (mental capacity) undue influence,[5] a type of fraud,[6] federal courts look to state law principles for guidance.[7] Thus, even if a federal court acknowledges that federal common law controls, a federal court may resort to state law principles of undue influence,[8] although, at least in theory, that is inconsistent with having a uniform set of rules governing ERISA matters.[9] Additionally, while the relief available under ERISA may differ from that afforded by state law, the elements of any federal ERISA claim parallel those of a state law undue influence claim.[10]

However, while district courts frequently look to a state's laws of undue influence, the U.S. Court of Appeals for the Sixth Circuit in *Tinsley v. General Motors Corp.*[11] provided guidance for a federal common law of undue influence.[12] The court began by stating that, "Since ERISA does not contain any provisions regulating the problems of beneficiary designations that are forged, the result of undue influence,or otherwise improperly procured, it appears that federal common law must apply to[these]claims. Furthermore, because there is no established common law . . . dealing with forgery and undue influence in the designation of beneficiaries, [courts often] look to state law principles for guidance."[13]

The Sixth Circuit then set forth some general principles regarding undue influence. It indicated that undue influence is generally defined as influence that is sufficient to overpower volition, destroy free

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agency, and impel the grantor to act against the grantor's inclination and free will."[14] A showing of mere motive or opportunity to exercise excessive control over another is not sufficient to make out a claim of undue influence. Rather, the influence must actually be exerted either prior to or at the time of execution of the relevant document.[15]

FACTORS

The Sixth Circuit then listed a series of factors that courts have looked to[16] when determining whether undue influence has been exerted in a particular case:

(i) The physical and mental condition of the benefactor;

(ii) Whether the benefactor was given any disinterested advice with respect to the disputed transaction;

(iii) The unnaturalness of the gift;

(iv) The beneficiary's role in procuring the benefit and the beneficiary's possession of the document conferring the benefit;

(v) Coercive or threatening acts on the part of the beneficiary;

(vi) Control of the benefactor's financial affairs by the beneficiary; and

(vii) The nature and length of the relationship between the beneficiary and benefactor.[17]

It concluded by stating that the determination of undue influence was fact intensive,[18] and may need to be proven by circumstantial evidence.[19] A plan's committee may address issues of undue influence.[20]

Courts have set forth different formulae for establishing an undue influence claim. One secondary source lists the requirements as:

(i) A person who is susceptible to influence;

(ii) An opportunity to exert undue influence;

(iii) A disposition to exert undue influence; and

(iv) A result indicating undue influence.[21]

By way of comparison, under Alabama law,[22] a plaintiff seeking to establish undue influence must show that:

(i) A confidential relationship existed between a favored beneficiary and the testator;

(ii) Influence of or for the beneficiary was dominant and controlling in that relationship; and

(iii) There was undue activity on the part of the dominant party in procuring the execution of the document.

In Virginia, establishing undue influence requires "prima facie evidence of great weakness of mind and grossly inadequate consideration of suspicious circumstances, or the existence of a fiduciary or confidential relationship.[23]

Under Indiana law, "under the common law, when transactions occur between a dominant and subordinate party, which benefit the dominant party, the law imposes a presumption that the transaction was the result of undue influence exerted by the dominant party, constructively fraudulent and therefore void."[24] This type of relationship would include fiduciary relationships but be more expansive.

BURDEN OF PERSUASION

Procedurally, in a dispute over the validity of a facially valid change in beneficiary form, the burden of persuasion rests on the party seeking to set aside the document.[25] However, beyond that point, the federal common law of undue influence is silent. For example, New York, while the burden of proof is generally on the party contesting the designation of beneficiary, the burden can shift to the proponent of the designation if "the facts prompt suspicion that undue influence was indeed exerted, such as when a confidential or fiduciary relationship between the decedent and the designated beneficiary."[26] Whether the burden shifts is a factual determination. Federal common law accords documents which are valid on their face a presumption of validity against attacks based on undue influence.[27] Were it otherwise, ERISA administrators would be unable to safely rely on the paperwork they receive on a daily basis without undertaking a thorough and impracticable investigation.[28]

However, as the district court noted in *Franklin v. Gibson*,[29] "In the Restatement of Trusts, nearly every reference excluding extrinsic evidence or discussing the parol evidence rule includes the exceptions of " fraud, duress, undue influence or mistake." As an illustration,

Section 21, comment a of the Restatement (Third) of Trusts states that, "Under the parol evidence rule, where the manifestation of the settlor's intention is integrated in a writing, that is, if a written instrument is adopted by the settlor as the complete expression of the settlor's intention, extrinsic evidence is not admissible to contradict or vary the terms of that instrument in the absence of fraud, duress, mistake, or other grounds for reformation or rescission."[30] With respect to statutes of limitations with respect to undue influence claims, in *Elliott and Barton v. Mitsubishi Cement Corp.*,[31] the district court found that an undue influence claim was an action based on a rescission of a contract in writing that accrued when the contract was negotiated and signed and subject to California's four year statute of limitations on such claims.

ERISA PREEMPTION

Although there are some contrary holdings,[32] the great majority of cases hold that state law claims of undue influence with respect to ERISA plans[33] are preempted by ERISA.[34] That a counterclaim involves a dispute over a change of beneficiary form in no way defeats ERISA preemption.[35]

Undue influence may be an equitable defense, but a district court found no support for the proposition that considerations of undue influence and misrepresentations took the case outside of ERISA.[36] Some courts have held that a plan committee should have jurisdiction to determine if a beneficiary designation resulted from undue influence, and, if it fails to do so, but instead interpleads the case into district court, the standard of judicial review is de novo.[37] The issue arises because of the Supreme Court's decision in *Kennedy* that a plan administrator's obligation is simply to apply the terms of a plan. Some decisions have held based on *Kennedy*, that a plan administrator could rely upon a beneficiary designation in circumstances that suggested that the designation was the result of undue influence.

In *Dunlop v. Ormet Corp.*[38] the district court stated that "under *Kennedy*, if the plan sets forth procedures that comply with ERISA's requirements, and if the plan administrator follows those procedures, no duty may be imposed upon the plan administrator to examine external documents, which could create ambiguities concerning the dispensation of benefits."[39]

In *Young v. Anderson*,[40] the U.S. District Court for the Eastern District of Michigan voiced a similar sentiment, explaining that, "Here, the relevant plan document, the application, clearly designated Anderson as the beneficiary. There is nothing in the document to indicate any error

of any kind. Ford is therefore entitled to rely on the application. Ford's decision to pay Anderson is correct under the plan document rule."[41]

In *Dahl v. Aerospace Employees*,[42] the U.S. District Court for the Eastern District of Virginia followed *Kennedy* in holding that there was no federal common law fraud exception. Courts in the Eleventh Circuit follow *Metropolitan Life & Annuity Company of Connecticut v. Akpela*,[43] in which the court held that "as mandated by the Supreme Court in *Kennedy* that a party who is not a named beneficiary of an ERISA plan may not sue the plan for any plan benefit."[44]

Therefore, in *In re Hendricks III*,[45] the court found *Tinsley v. General Motors*, a pre-*Kennedy* case, not to be persuasive."

In contrast, cases that continue to apply *Tinsley v. General Motors* after *Kennedy*[46] such as *Metropolitan Life Insurance Co. v. Smith Howell*, rely upon the position that an undue influence challenge is a challenge to the validity of a plan document, although arguably that position is stronger with respect to a forgery claim, because to comply with the terms of a plan, presumably the plan administrator needs to determine if the beneficiary designation form was executed by the plan participant or a third party. In an undue influence challenge, the beneficiary designation form will be executed by the plan participant, and the issue is whether the designation was effectively made by a third party.

NOTES

1. Manning v. Hayes, 212 F.3d 866 (5th Cir. 2000), cert. den. 532 U.S. 941 (2001); Washington v. Ganaway, 2008 WL 2604816 (N.D. Tex. July 2, 2008), Tinsley v. General Motors Corp., 227 F. 3d 700 (6th Cir. 2000); Phoenix Mutual Life Insurance Co. v. Adams, 30 F. 3d 554, 562 (4th Cir. 1994) ("ERISA is silent as to any provision regarding the change in beneficiaries"); Sun Trust Bank v. Aetna Life Ins. Co., 251 F. Supp. 2d 1282, 1292 (E.D. Va. 2003); Guardian Life Ins. Co. v. Bowes, 2012 WL 1378556 (W.D.Va. Apr. 20, 2012); Franklin v. Gibson, 38 F. Supp. 2d 590 (M.D. Tex. 1999) ("There is no mention in ERISA of how a plan administrator should deal with fraud, forgery, or mistake in a change of beneficiary form"); Metropolitan Life Ins. Co. v. Johnson, 297 F. 3d 558, 564 (7th Cir. 2002) ("ERISA does not contain any provision governing disputes between claimants as to plan proceeds or address whether an insured has effectively changed a beneficiary designation. Prudential Ins. Co. v. Schmid, 337 F. Supp. 2d 325, 329 (D. Mass. 2004), quoted in Metropolitan Life Ins. Co. v. Giscombe, 2022 WL 2467066 (E.D.N.Y. Jan. 21, 2022) ("The statute contains no specific provision for the settlement of disputes between claimants"); Gratz v. Gratz, 2020 WL 6164307 (M.D. Pa. Sept. 18, 2020) ("ERISA provides no explicit text defining undue influence claims"); Mohammed v. Kerr, 53 F. 3d 911, 913 (8th Cir. 1995); Lyman Lumber Co. v. Hill, 877 F. 2d 692 (8th Cir. 1989); Equitable Life Ins. Co. of the United States v. Chrysler, 66 F. 3d 944 (8th Cir. 1995). One commentator believes that the courts have not stated properly the issue that ERISA does not address. Albert Feuer, in "Who Is Entitled to Survivor Benefits from ERISA Plans?" 40 John Marshall Law Rev. 917, 1022 (2007) (hereinafter, Feuer, "Who is Entitled?"), would frame the statutory omission as "ERISA does not set

forth the conditions a beneficiary designation must fulfill to satisfy the requirement that an ERISA plan be established and maintained pursuant to a written agreement."

2. Thomason v. Aetna Life Ins. Co., 9 F. 3d 645, 647 (7th Cir. 1993); Phoenix Mutual Life Ins. Co. v. Adams, supra, n. 1; Sun Trust Bank v. Aetna Life Ins. Co., supra, n. 1; Krishna v. Colgate Palmolive Co., 7 F. 3d 11 (2d Cir. 1993), cited in Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1; Hartford Life & Accident Ins. Co. v. Kowalski, 654 F. Supp. 3d 884 (N.D. Cal. 2023) (The elements of undue influence are determined by federal common law.) See also Albert Feuer, "Determining the Death Beneficiary under an ERISA Plan and the Rights of Such a beneficiary," 54 Tax Management Memorandum 323 (August 26, 2013). ("Federal common law rather than state common law determines how the doctrines of fraud, undue influence, capacity to make designations apply to beneficiary designation."). The authority of the federal courts to promulgate federal common law is very limited. Rodriguez v. FDIC, 140 S. Ct. 713 (Feb. 25, 2020). Courts must be conscientious to fashion federal common law only when it is necessary to effectuate the purposes of ERISA. Provident Life & Accident Ins. Co. v. Waller, 906 F. 2d 985, 992 (4th Cir. 1990) Cf. Jenkins v. Montgomery Industries, Inc., 77 F. 3d 740, 744 (4th Cir. 1996) (Courts considering ERISA regulated plans often apply general principles of contract law, insurance law, or trust law that do not conflict with the Congressional purpose of enacting ERISA) and Mohammed v. Kerr, 53 F. 3d 911, 913(8th Cir. 1985) (Courts "may look to state law for guidance in developing federal common law, but it is inappropriate to apply state law if it conflicts with ERISA or its underlying policies"). As is the case with many federal statutes, several policies are reflected. In Kennedy v. Plan Administrator for Dupont Savings & Investment Plan, 555 U.S. 285, 301 (2009), the Supreme Court noted three important ERISA objectives: (i) simple administration of plans;(ii) avoiding double liability for plan administrators; and (iii) ensuring that plan beneficiaries receive benefits promptly. Addressing difficult issues such as undue influence is certainly on the surface inconsistent with all of these Congressional objectives. However, a federal common law of undue influence is arguably consistent with ERISA's purposes. See, for example, American International Life Insurance Company of New York v. Vasquez, 2003 WL 548738 at *5 (S.D.N.Y. Feb. 23, 2003) ("[k]eeping in mind that one of the primary purposes of ERISA is to promote the interests of employees and their beneficiaries, courts have customarily used evidence of the insured's intent to establish the primary beneficiary."). Further, while an important policy objective of ERISA is strict adherence to the plan document, applying doctrines such as the undue influence doctrine is not inconsistent with that policy where the improper procurement of a beneficiary designation would call into question the validity of the plan document itself. Metropolitan Life Insurance Co. v. McCloskey, 36 EBC 2755 (N.D. Ohio 2005). Cf. Lincoln v. National Life Ins. Co. v. Ridgway, 2018 WL 883881 (W.D. Wash. Feb. 14, 2018) (Because the interpleader action came to the court on the basis of federal question jurisdiction, federal law governs the question of undue influence).

3. Connecticut General Life Insurance Co. v. Mitchell, 1995 WL 469714 at *7 (S.D.N.Y. August 8, 1995); Aetna Life Insurance Co. v. Frank, 592 F. Supp. 3d. 317 (S.D.N.Y. 2022); McClure v. Life Insurance Co. of North America, 84 F. 3d 1129,1133 (9th Cir. 1996); Emard v. Hughes Aircraft Co., 153 F. 3d 949, fn. 3 (9th Cir. 1998).

4. American United Life Ins. Co. v. Arthur, 2016 WL 165034 at *2 (W.D.N.C. Jan. 14, 2016); Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1; Tinsley v. General Motors Corp., supra, n. 1.

5. While issues relating to undue influence generally arise in connection with beneficiary designations [See, for example, Salkin, "Challenges to Beneficiary Designations under ERISA," 27 Benefits Law Journal No.2, Summer 2014], undue influence challenges are made in other contexts as well. See, for example, Sharer v. Siemens Corp.,

2007 WL 1006681 (W.D. Penn. March 29, 2007), in which the district court stated that in determining whether a waiver is made knowingly and willfully, a court may consider the possibility of undue influence; Cuchara v. Gai-Tronics Corp., 129 Fed. Appx. 728 (3rd Cir. 2005) (whether a release was the result of fraud or undue influence); Jakimas v. Hoffman LaRoche, 485 F. 3d 770 (3d Cir. 2007) (same); Schatter v. United States, 746 F. 3d 319 (6th Cir. 1984) (whether settlement agreement was the product of undue influence); United States v. Woods, 554 F. 3d 611 (6th Cir. 2011) (whether a plea agreement was the result of undue influence). One of the bases for reformation of a contract is undue influence. Hackett v. PBGC, 486 F. Supp. 1357 (D. Md. 1980). Additionally, in the law of trusts, a court may reform a trust to the extent that it was procured by wrongful conduct such as undue influence, duress or fraud. See Restatement (Third) of Trusts Section 12.62, cmt. a (2003), and Restatement (Third) of Property (Wills and Other Donative Transfers) Section 8.3, both quoted in Skinner v. Northrop Grumman Retirement Plan, 2012 WL 887600 (9th Cir. 2012).

6. Guardian Life Ins. Co. v. Bowes, supra, n. 1; Davis v. Davis, 2017 WL 3820962 (M.D. Ala. Aug. 31, 2017); Sun Life Assurance Co. v. Tinsley, 2007 WL 1052485 (W.D. Va. Apr. 4, 2007); Davis v. Adelphi Communications Corp., 475 F. Supp. 2d 600 (N.D. Va. 2007). As a species of fraud, the party making the challenge on undue influence grounds may need to establish it case by clear and convincing evidence. Cf. In Connecticut, when a person alleged to have exerted undue influence is not in a fiduciary relationship with the other party. The standard is clear and convincing evidence, discussed in Wisconsin Province of the Society of Jesus v. Cassem, 486 F. Supp. 3d 527 (D. Conn. 2020). In Davis v. Davis, supra, the U.S. District Court for the Middle District of Alabama did not decide whether the relevant standard is clear and convincing evidence or preponderance of the evidence).

7. American United Life Ins. Co. v. Arthur, supra, n. 3; Tinsley v. General Motors Corp., supra, n. 1; Sun Life Assurance Co. v. Horn, 2018 WL 704867 (D. Md. Feb. 5,2018); Horton v. Reliance Standard Life Ins. Co., 141 F. 3d 1038, 1041 (11th Cir. 1998) (acknowledging that in an ERISA action, when crafting a body of common law, federal courts may look to state courts as a model because of the states' greater experience in interpreting insurance contracts and resolving coverage disputes); Metropolitan Life Ins. Co. v. Kelly, 2017 WL 3085519 (E.D. Mich. July 17, 2017) (in the "absence of established federal common law in this Circuit dealing with the issues of undue influence or competence, it is proper to look to state law principles for guidance."); Johnson v. American United Life Ins. Co., 716 F. 3d 813, 819 (4th Cir. 2013) ("although courts apply federal common law rules of contract interpretation when construing a policy governed by ERISA, we look to principles of state common law to guide our analysis."); Herndon v. Dupont, 145 F. 3d 1331, 1333 (6th Cir. 1998), quoted in Franklin v. Gibson, 38 F. Supp. 2d 590 (M.D. Tenn. 1999) ("In order to ascertain the applicable law, we look to either the statutory language or finding no answer there, to federal common law which, if not clear, may draw guidance from analogous state law."); Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1 (Courts have also referenced state law when ERISA policies are challenged on the basis of forgery, undue influence, and mental incapacity). Whether state law is binding or merely instructive will not be relevant if both approaches produce the same result. Metropolitan Life Ins. Co. v. Smith Howell, 2020 WL 974893 (W.D.N.C. Feb. 28, 2020), fn.1. There are alternative sources of federal common law, such as the Restatements. See, e.g., Gamewell Mfg., Inc. v. HVAC Supply, Inc., 715 F. 2d, 112 (4th Cir. 1983) and Reid v. IBM Corp., 1997 WL 357 (S.D.N.Y. 1999).

8. Davis v. Davis, supra, n. 6 (applying Alabama law of undue influence); Woolf v. Wiggington, 659 Fed. App'x 526 (10th Cir. August 31, 2016) (applying Utah law of undue influence); Metropolitan Life Ins. Co. v. Austin & Brown, 2015 WL 7770659 (E.D.

Mich. December 3, 2015) (Applying Michigan law of undue influence); Metropolitan Life Ins. Co. v. Kelly, supra, n. 7 (same); Sun Life Assurance Co. of Canada (U.S.) v. Gruber, 2007 WL 4457771 at *14 (S.D.N.Y. Dec. 14, 2007) (applying New York law); Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1 (same); Harmon v. Harmon, 962 F. Supp. 2d 873(S.D. Tex. 2013) (Applying Texas Law of undue influence); Davis v. Adelphia Communications Corp., 475 F. Supp. 2d 600 (W.D. Va. 2007); Wisconsin Province of the Society of Jesus v. Cassem, 486 F. Supp. 3d 527 (D. Conn. 2020); (Applying Connecticut law of undue influence). Cf. Ivie v. Ivie, 2018 WL 8333539 (S.D. Ind. Feb. 13, 2018) (Applying Indiana law of undue influence with no discussion of federal common law) and Metropolitan Life Ins. Co. v. Yeary, 208 F. 3d 214 (6th Cir. 2000) (applying Ohio law of undue influence where issue of ERISA preemption not raised at district court level). Of course, even if state substantive law applies, an undue influence claim will be dismissed if it does not comply with FRCP Rule 56. See, Schreffler v. Metropolitan Life Ins. Co., 2006 WL 1127096, 37 EBC 2115 (D. Ariz. Apr. 25, 2006) (Claim of undue influence dismissed because unsupported by evidence in the form of an affidavit and based on his personal knowledge).

9. See, Egelhoff v. Egelhoff, 532 U.S. 141,148 (2001) ("One of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits"); Phoenix Mutual Life Ins. Co. v. Adams, supra, n. 1 ("federal common law [on ERISA] should be consistent across the Circuits."); Metropolitan Life Ins. Co. v. McCloskey, 36 EBC 2755 (N.D. Ohio 2005) (finding federal common law on the basis of the law of a single state would be inconsistent with ERISA's clear intent that ERISA be a uniform federal scheme across the country). Alliant Techsystems, Inc. v. Marks, Civ. No. 04-0539 [JRT/FIN] (D. Minn. March 31, 2008) (Applying the standard for determining undue influence in the Eighth Circuit based upon the law of most states (preponderance of the evidence), rather than the clear and convincing evidence of the forum state, Minnesota). Cf. Sarabeth A. Raybo, "Divorcees Turn Around in Their Graves as Ex-Spouses Cash In: Codified Constructive Trusts Ensure An Equitable Result Regarding ERISA Covered Employee Benefit Plans," 106 Michigan Law Review 373, 386 (November 2007) (hereinafter Raybo, "Divorcees") ("federal common law should not be a backdoor vehicle for implementing state law.") and Patrick L. Vasey, "R.I.P.: The Federal Common Law Waiver Approach to Retirement Plan Death Benefit Payments Rests in Peace after Kennedy v. Plan Administrator for Dupont Savings and Investment Plan, 497 F. 3d 426 (5th Cir. 2007), aff'd 129 S. Ct. 865 (2009)," 88 Nebraska Law Rev. 205, 219-220 (2009) ("An even more troubling aspect of the federal common law waiver approach is the courts' use of state law just held preempted. . . . This blatantly and inappropriately undermines the ERISA express preemption provision, producing the same result as if state law was never preempted.").

10. Gratz v. Gratz, supra, n. 1.

11. Supra, n. 1. For articles discussing Tinsley v. General Motors, see Feuer, "Who is Entitled," supra, n. 11; Raybo, "Divorcees," supra, n. 9; David Pratt, "Marriage, Divorce, Death, and ERISA," 31 Quinnipiac Probate Law Journal 100,163-164 (2018); Jeaneen Johnson & Colleen K. O'Brien, "Beneficiary Designations-Show Me the Money"; and Stephen M. Schatz, Stephen L. Cotter, and Bradley S. Wolff, "Insurance," 56 Mercer Law Rev. 259, 280 (2004).

12. Washington v. Ganaway, supra, n. 1 (The federal common law of undue influence, while not necessarily clear, begins with the Sixth Circuit case of Tinsley v. General Motors). Tinsley was followed in United Food and Commercial Workers Union Employer Pension Fund v. Rubber Associates, 812 F. 3d 521, 527 (6th Cir. 2016); Board of Trustees of Plumbers v. B & B Mech. Serv., 813 F. 3d 603, 608 (6th Cir, 2015);

DiGeronimo Aggregates LLP v. Zemla, 763 F. 3d 506 (6th Cir. 2014); and Metropolitan Life Ins. Co. v. McGhee, 2016 WL 4031347 (W.D. Tenn. July 26, 2016) (2016).

13. Supra, n. 1, at 704.

14. That standard is identical to the Michigan state law standard. Metropolitan Life Ins. Co. v. Kelly, supra, n. 7. The law in other jurisdictions is very similar in nature. For example, in Connecticut, under Pickman v. Pickman, 6 Conn. App. 271, 275 (1986), quoted in Wisconsin Province of the Society of Jesus v. Cassem, supra, n. 6 "Undue influence is the exercising of sufficient control over a person whose acts are brought into question in an attempt to destroy his free agency and constrain him to do something other than he would do under normal control." Under Tennessee law, quoted in Metropolitan Life Insurance Company v. McGhee, supra, n. 12), undue influence is "exerting enough influence or pressure to break down a person's will power ad to overcome a person's free agency or free will so that the person is unable to keep from doing what he or she otherwise would not have done." Minnesota law finds undue influence when "the will of the person exercising[the influence] is substituted for the will of the testator whereby the resulting written testament represents the intent and purpose of that person and not the will of the testator, In re: Estate of Opsahl, 448 N.W. 2d 96, 100 (Minn. Ct. App. 1989), quoted in Alliant Techsystems, Inc. v. Marks, supra, n. 9, with the district court commenting that the definition used by the Minnesota courts is "virtually identical" to the definition used by the federal circuit courts of appeals. Under New York Law quoted in Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1, in which the bar for establishing undue influence is high [Metropolitan Life Ins. Co. v. Bradway, 2011 WL 723579 at 85 (S.D.N.Y. Feb. 24, 2011)] a party alleging undue influence must show "that the influence exercised amounted to a moral coercion which restrained independent action and destroyed free agency or which, by importunity which could not be resisted, constrained the [victim] to do that which was against his free will and desire, but which he was unable to refuse or too weak to resist." In Washington v. Ganaway, supra, n. 1, the district court stated in a footnote that the elements of a claim for undue influence under Texas Law are not a significant departure from the elements of a claim for undue influence developed by the Sixth Circuit. Under Texas Law, as set forth in Rothermel v. Duncan, 369 S.W. 2d 917, 922 (Tex. 1963), to establish a claim for undue influence, a plaintiff must prove: (i) the existence and assertion of an influence; (ii) the effective operation of such influence so as to subvert or overpower the person's mind when executing the document; and (iii) the person would not have executed the document but for such influence. In Indiana, undue influence can be established by the particular facts of a case showing an imposition of power by one party to deprive the other party of the exercise of free will. Ivie v. Ivie, supra, n. 8.

15. A party asserting an undue influence challenge must show undue influence was exerted at the time that the beneficiary designation was made. Hartford Life & Accident Insurance Co. v. Kowalski, supra, n. 2; Metropolitan Life Ins. Co. v. Galicia, 2021 WL 5083439 at *4 (C.D. Cal. Nov. 1, 2021).

16. The factors were based largely on cases from state courts in the Sixth Circuit, Michigan, Ohio, and Tennessee. Similarly, in Alliant Techsystems, Inc. v. Marks, supra, n. 9, the standards were based upon all of the states in the Eighth Circuit, rather than simply Minnesota.

17. Supra, n. 1, at 704.

18. Sun Life Assurance Co. v. Tinsley, supra, n. 6; Guardian Life Insurance Co. v. Bowes, supra, n. 1; Alliant Techsystems, Inc. v. Marks, 465 F. 3d 864 (8th Cir. 2012); Hartford Life and Accident Insurance Co. v. Kowalski, 654 F. Supp. 3d 854 (N.D. Cal.

2023); Metropolitan Life Ins. Co. v. Austin and Brown, 2015 WL 7770659 (E.D. Mich. December 3, 2015) and 2015 WL 8279329 (E.D. Mich. Dec. 8, 2015); Metropolitan Life Insurance Company v. Little, 2021 WL 23603963 (N.D. Ohio August 13, 2021); Metropolitan Life Ins. Co. v. Hoenstine, 2017 WL 40363019 (E.D. Mich. Sept. 13, 2017); Plan Administration of the Chevron Corporation Retirement Restoration Plan v. Minvielle, 2024 WL 536277 (N.D. Cal. Feb. 9, 2024). Therefore, while in general ERISA claims can be resolved on motions for summary judgment [Sun Life Assurance Co. of Canada v. Gruber, supra, n 8], summary judgment is generally inappropriate when determining whether a decedent intended to effect a beneficiary change. Hartford Life Ins. Co. v. Einhorn, 497 F. Supp. 2d 398 (E.D.N.Y. 2007); Metropolitan Life Insurance Co. v. Giscombe, supra, n. 1 (same); Krishna v. Colgate Palmolive Co., supra, n. 1 (summary judgment is "notoriously inappropriate for determinations of claims in which issues of intent, good faith, and other subjective feelings play dominant roles."); Metropolitan Life Ins. Co. v. Davis, 2010 WL 3941449 at *19 (E.D. Mich. Oct. 6, 2010) (Because fact issues existed regarding undue influence, a bench trial was necessary). For an illustrative case in which there were sufficient issues of fact to avoid summary judgment, see Washington v. Ganaway, supra, n. 1.

19. Under Connecticut law, circumstantial evidence may be used to establish undue influence. Tyler v. Tyler, 151 Conn. Ap. 98, 93 A.3d 1179 (2017), cited in Wisconsin Province of the Society of Jesus v. Cassem, supra, n. 6. See also, Sun Life Assurance Co. v. Tinsley, supra, n. 6.

20. Trustees of the Electricians Salary Deferral Plan v. Wright, 688 F. 3d 922 (8th Cir. 2012); Clark v. Board of Trustees SS Trade Association Benefits Trust Fund, 896 F. 2d. 1366 (4th Cir. 1990).

21. 25 Am Jur. 397-398, Duress and Undue Influence, Section 36, quoted in Wisconsin Province of the Society of Jesus v. Cassem, supra, n. 6. The formulation of the undue influence doctrine under the Restatement (Second) of Trusts requires the "unfair persuasion of a person who, because of his relation to the victim, is justifiably assumed at the time to be one who will not act in a manner inconsistent with the victim's welfare."

22. Furrow v. Hilton, 135 So. 3d 350, 353-354 (Ala. 2008), cited in Davis v. Davis, supra, n. 6.

23. Davis v. Adelphi Communications Corp., supra, n. 6. See also, Sealez v. Beazley Ins. Co., Inc., 2016 WL 4392624 (S.D. Miss. Aug. 16, 2016) (A presumption of undue influence arises in transactions between parties in a fiduciary relationship, such as an attorney client relationship).

24. Nichols v. Estate of Tyler, 910 NE 2d 221, 228 (Ind. Ct. App. 2009), quoted in Ivie v. Ivie, supra, n. 8.

25. Guardian Life Ins. Co. of America v. Bowes, supra, n. 1; Davis v. Davis, supra, n. 6.

26. Sun Life Assurance Co. of Canada v. Gruber, supra, n. 8; Metropolitan Life Ins. Co. v. Giscombe, supra, n. 1. Similarly, and solely for purposes of illustration, and not to suggest what the federal common law of undue influence procedure should be, undue Alabama law, if the challenger to the designation establishes the three requirements for undue influence, then the proponent must then rebut the presumption of undue influence by showing that the "transaction was fair, just and equitable in every respect." Davis v. Davis, supra, n. 6.

27. Rice v. Office of Service Members Group Life Insurance, 260 F. 3d 1240 (10th Cir. 2001); Sun Life Assurance Co. v. Tinsley, supra, n. 6; Davis v. Davis, supra, n. 6.

28. Rice v. Office of Service Members Group Life Insurance, supra, n. 27.

29. Supra, n. 1.

30. Ibid.

31. 2008 WL 11338619 (C.D. Cal. May 15, 2008).

32. Metropolitan Life Ins. v. Galicia, supra, n. 15 (Claims for fraud, undue influence, and incapacity under state law are not preempted by ERISA); Dahood v. Noyd, 2006 WL 8435816 (D. Mont. Oct. 10, 2006) (Claims based on undue influence are not preempted by ERISA because "relevant state law applicable to these claims does not act immediately and exclusively on an ERISA plan, nor is any ERISA plan essential to the operation of the state law."); Dish Network Corp. on behalf of Dish Network Corp. 401(k) Plan v. Pompa, 2020 WL 2513671(E.D. Cal. Oct. 3, 2020) (If ERISA preempted such challenges, "there would be no recourse for fraudulent beneficiary designations in ERISA governed plans as ERISA is silent as to the procedures related to beneficiary changes."). Cf. Hartford Life Insurance Co. v. Kowalski, supra, n. 2 ("both parties appear to presume that an undue influence claim is cognizable under ERISA, but it is unclear if that is the case.").

33. Jacques v. Jacques, 2016 WL 7034513 (M.D. Fla. Dec. 1, 2016) (Undue influence is preempted with respect to policies that are ERISA plans, but state law undue influence claims apply to policies that are not ERISA plans.) Individual retirement accounts are generally not subject to ERISA, so state law applies to undue influence claims. Harbrorson v. Sheive, 2004 WL 627939 (W.D. N.Y. 2004).

34. Schrefflen v. Metropolitan Life Ins. Co., supra, n. 8 (holding ERISA preempts Arizona community property law and stating it is "well settled law" that state law claims of undue influence would be preempted by ERISA."); Metropolitan Life Ins. Co. v. Hoenstine, supra, n. 18 ("Questions regarding competing claimants to proceeds of life insurance policies due to alleged forgeries on the beneficiary designation form or any alleged exercise of undue influence are preempted by ERISA."); Anthem Life Ins. Co. v. Olguin, 2007 WL 2904223 at *4 (E.D. Cal. Oct. 3, 2007); Metropolitan Life Ins. Co. v. Pettit, 164 F. 3d 857, 864 (4th Cir. 1998); Davis v. Adelphi Communications, Corp., supra, n. 6; Clark v. Board of Trustees SS Trade Association Benefit Trust, supra, n. 19 ("There is little doubt that state law causes of action for improper execution of a change of beneficiary and undue influence are preempted by ERISA."); Gratz v. Gratz, supra, n. 1; Tinsley v. General Motors Corp., supra, n. 1; Hendricks v. Birdou, 2020 WL 9439391 (M.D. Fla. Sept. 8, 2020); Variety Childrens Hospital v. Century Medical Health Plan, Inc., 57 F. 3d 1040 (11th Cir. 1995); Estate of Neidich v. Neidich, 2002 WL 31014831 (S.D.N.Y. Sept. 6, 2002); Raff v. Travelers Insurance Co., 1996 WL 137310 (S.D.N.Y. 1996). In SunLife Insurance Co. v. Tinsley, supra, n. 6, the district court considered whether the exception to ERISA preemption for laws regulating insurance might apply and concluded that it did not. The court explained that rules governing a change in beneficiary have no effect upon risk-spreading and are not limited to the insurance industry. Rather, the laws of undue influence are predominantly drawn from the law of wills.

35. Unum Life Insurance Co. of America v. Burton, 2005 U.S. Dist. 41153, 2005 WL 3185413(M.D. Fla. Nov. 29, 2005); Liberty Life Assurance Company of Boston v. Kennedy, 228 F. Supp. 2d 1367(N.D. Ga. 2002), aff'd 358 F. 3d 1295(11th Cir. 2004); Aetna Life Ins. Co. v. Bayonna, 223 F. 3d 1030 (9th Cir. 2000).

36. Advisory Committee of the MTS Systems Corporation Retirement Savings Plan and Trust v. Nelson, 2021 WL 26469129 (D. Minn. Feb. 19, 2021), relying upon Trustees of Electricians Salary Deferral Plan v. Wright, supra, n. 19 (holding an abuse of discretion standard applicable) with respect to undue influence and mental capacity challenges).

37. Alliant Techsystems, Inc., v, Marks, supra., n. 18.

38. 2009 U.S. Dist. LEXIS 22346 (N.D. W.Va. March 19, 2009). Dunlop was followed in Boyd v. Metropolitan Life Ins. Co., 2010 WL 11530911 (D.S.C. June 15, 2010).

39. Ibid, discussed in Pratt, "Marriage, Divorce, Death, and ERISA," supra, n. 11, p. 165.

40. 2009 U.S. Dist. LEXIS 35458 (E.D. Mich. April 27, 2009).

41. Ibid, discussed in Pratt, "Marriage, Divorce, Death, and ERISA," supra, n. 11, p. 165.

42. 2015 WL 6604799 (E.D. Va. October 25, 2015).

43. 886 F. 3d 998 (11th Cir. 2018).

44. Ibid. at 1107.

45. 2020 WL 9439374 (M.D. Fla. Nov. 2, 2020).

46. Supra, n. 9.

A Regulation Wellspring

By Karen R. McLeese

A wellspring of regulations is flooding the Federal Register and hence our inboxes. Could it be that it is an election year or a race to outrun the Congressional Review Act? These are matters for others to discern. What is for certain is a rush of regulation issuances and a seemingly unending race to the courthouse to challenge those regulations is in full swing. This column highlights some of the guidance impacting employee benefit plans.

FIDUCIARY INVESTMENT ADVICE FINAL RULE ISSUED

The Department of Labor (DOL) issued its final rule[1] related to investment advice. Plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) must comply with ERISA's fiduciary standards. Providing investment advice for a fee is a fiduciary act. These regulations clarify when an investment professional is acting in a fiduciary capacity.

The fiduciary standard applies to a financial advisor if the individual makes an investment recommendation to an investor, the investment recommendation is made for a fee or other compensation, the financial advisor holds himself or herself out as a trusted advisor by:

- Stating it is a fiduciary; or
- Making recommendations in a way that would indicate to an investor that he or she is a trusted advisor making individualized recommendations based on the investor's best interests.

Notably these regulations include in the definition of fiduciary one time advice such as advice provided to an individual relating to a distribution from a 401k plan as long as the criteria described above are met.

A plan fiduciary is required to comply with the care, prudence, and loyalty required of an ERISA fiduciary. This means the individual must

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avoid any misleading statements about conflicts of interest, fees or investments and any fee or other compensation must be reasonable.

The regulations clarify that the fiduciary rules would not apply to investment education or investment information, for example offered by an human resources department to plan participants. Further, the rules would not apply to a sales pitch when investment advice is not given, the salesperson recommends a product, does not suggest fiduciary status and the circumstances do not indicate that a reasonable person would assume it is receiving advice specific to his or her circumstances or that it is advancing his or her best interests.

The first legal challenge to these regulations was filed against the Department of Labor (DOL) on May 2, 2024, in *Federation of Americans for Consumer Choice, Inc., et al. v. United States Department of Labor, et al.*, plaintiffs allege that the regulations in the final rule would result in compliance burdens and the inability to make commissions. Plaintiffs further allege that the DOL is violating the Administrative Procedure Act by abusing its authority and that the rule is in conflict with ERISA and the Internal Revenue Code. Plaintiffs are seeking an injunction to prevent the implementation of the final rule and are asking the court to vacate the package completely.

These regulations are to take effect on September 23, 2024, with a one-year delay for certain prohibited transaction provisions.

SECTION 1557 FINAL RULE

On April 26, 2024, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS) issued a final rule under Section 1557 of the Affordable Care Act (ACA) that aims to address inequity across health care. This section of the ACA is the anti-discrimination section of the law. Individuals cannot be discriminated against or prohibited from participating in health-related programs or denied health coverage on the basis of race, color, national origin, sex, age, or disability.

The rule applies to health programs or activities that receive HHS funding or that are administered by HHS. These are defined broadly to include health insurers, including third-party administration services and pharmacy benefit manager services receiving federal financial assistance. These rules apply to all activities of the entity. While the rules do not directly apply to group health plans and employers sponsoring group health plans as these entities often do not receive federal financial assistance. These types of entities might be impacted to the extent that the insurer, third-party administrator, PBM, or others are subject to the rules.

The final rule,[2] published on May 6, 2024, effective sixty days later on July 5, 2024, aims to broadly address inequity across health care and underscores the importance of not discriminating based on sex, which is defined broadly to include gender identity and sexual orientation.

HIPAA PRIVACY REGULATIONS

In an effort to ensure patients can receive appropriate reproductive health care as well as to ensure provider-patient confidentiality, the Department of Health and Human Services (HHS) has issued regulations[3] specifically protecting certain information. Notably these rules limit the use and disclosure of certain information.

The final rule requires a health care provider, health plan or their business associates to obtain a signed attestation that certain requests for information related to reproductive health care are not for prohibited purposes. The attestation requirement will apply in certain instances, including for:

(1) Law enforcement purposes;

(2) Judicial and administrative proceedings;

(3) Health oversight activities; or

(4) Disclosures to coroners and medical examiners.

The final rule includes required elements for the attestation and HHS will publish model attestation language before the compliance date of the final rule.

In addition, these same entities are required to modify their Notice of Privacy Practices (NPP) to reflect the changes to reproductive health care privacy. The NPP should be updated to include a description and example of the Prohibited Purposes with enough detail, so it is easy to understand the prohibition and the types of uses and disclosures of PHI that require an attestation.

The final rule went into effect on June 25, 2024, and the date for compliance is currently set for December 22, 2024. However, the requirements for the NPP go into effect on February 16, 2026.

ASSOCIATION HEALTH PLANS BACK TO THE FUTURE

A 2018 rule that expanded the definition of association health plans (AHPs), has been rescinded. As a reminder, AHPs exist when two or

more unrelated employers participate in a single plan. If two or more unrelated employers participate in a welfare benefit plan a multiple employer welfare arrangement (MEWA) is established.

As background, the 2018 final rule was adopted on June 21, 2018, many of the criteria in that rule were weaker than previous guidance in order to grow formation of AHPs. The 2018 rule was fraught with legal challenges.

The final rule[4] published on April 30, 2024, withdraws the 2018 regulations in their entirety and returns to the pre-2018 standards for AHPS. These standards are intended to ensure compliance with ERISA. Under these standards, a facts and circumstances approach is used to determine if a group or association of employers is a bona fide employer group or association capable of sponsoring an ERISA plan on behalf of its employer members. There are three general criteria:

1. Whether the entity has business or organizational purpose and function unrelated to the provision of benefits;

2. Whether the employers share a commonality and genuine organizational relationship unrelated to the provision of benefits; and

3. Whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.

States can regulate these AHPs known as MEWAs. As a reminder, any welfare benefit plan providing health coverage to employees of two or more employers who are not part of a control group of businesses, is required to file an annual Form M-1 report.

READY, SET PWFA

On April 15, 2024, the U.S. Equal Employment Opportunity Commission (EEOC) issued its final rule[5] to implement the Pregnant Workers Fairness Act (PWFA).[6] The PWFA, took effect on June 27, 2023, and requires covered employers to provide reasonable accommodations to the known limitations of an employee for pregnancy, childbirth, or related medical conditions, unless the accommodation would impose an undue hardship. The PWFA generally applies to public and private employers employing fifteen or more employees.

Like the Americans with Disabilities Act (ADA),[7] the PWFA defines a qualified employee as an employee or applicant who, with or without reasonable accommodation, can perform the essential functions of a job. Unlike the ADA, an individual may still be qualified under the

PWFA even if they cannot perform one or more of the essential job functions as long as they are or are expected to be able to perform the essential functions in the near future (generally within 40 weeks for pregnant employees though a different timeframe might apply in certain circumstances) and that the inability to perform the essential function(s) can be reasonably accommodated.

The PWFA builds on existing pregnancy-related protections under Title VII[8] and the ADA.

Key points of consideration in the final rule include:

- Reasonable Accommodations;
- Predictable Assessments;
- Limitations and Medical Conditions;
- Communicating Accommodation Requests;
- Supporting Documentation; and
- Undue Hardship.

For a more detailed summary of the requirements see "What You Should Know About the Pregnant Workers Fairness Act."[9]

On April 25, 2024, a group of states filed a lawsuit in the U.S. District Court for the Eastern District of Arkansas, marking the first challenge to the PWFA for including abortion as a "related medical condition." In the lawsuit, *States of Tennessee, et al., v. Equal Employment Opportunity Commission*,[10] plaintiffs list five causes of action and ask the Court to enjoin the implementation of the final regulation pending final ruling. The plaintiffs allege that the EEOC exceeded its authority by including abortion in the PWFA.

The final rule, published in the Federal Register on April 19, 2024, is expected to become effective on June 18, 2024, pending litigation. In the meantime, employers should review policies and procedures to ensure compliance with the PWFA. As a reminder, be sure to post the most current Know Your Rights poster.

FTC ISSUES FINAL RULE BANNING NON-COMPETE AGREEMENTS

The Federal Trade Commission (FTC) issued regulations[11] effectively prohibiting most non-compete agreements. The rule will also prevent the enforcement of existing non-competes except as provided below.

When and if the rule goes into effect, businesses will be prohibited from entering into, or attempting to enter into, a non-compete agreement. Most non-compete agreements already in place will not be enforceable. The final rule defines non-compete clauses to include other types of restrictive language, including:

- Overly broad confidentiality and nondisclosure agreements;
- Overly broad coworker non-solicitation agreements;
- Training repayment agreements; and
- Overly broad customer non-solicitation agreements.

There are several exceptions in the new rule:

- Senior Executives
    - Any non-compete entered into with a senior executive before the effective date of the rule will remain in place.
    - Senior executive is narrowly defined to include an annual compensation in the prior year greater than $151,164.
    - The individual must hold a position that includes policy-making authority.
- Sale of a Business
    - The rule will not apply to non-competes that were entered into pursuant to a sale of the business, ownership interest in the business
- The law also provides for an exclusion or prior causes of action and a good faith standard.

The final rule is already facing legal challenges. In *Ryan, LLC, v. Federal Trade Commission,* plaintiffs are challenging the FTC's non-compete ruling. Ryan alleges that the FTC's action imposes a burden on businesses and that the rule would upend companies' IP protections and talent development and retention. The complaint alleges that the FTC lacks the authority to prohibit non-compete agreements. It also argues that the FTC itself is unconstitutionally structured.

In *Chamber of Commerce, et al. v. Federal Trade Commission, et al.*, plaintiffs seek to strike down the FTC's rule on non-compete

agreements. Plaintiffs allege the FTC lacks the authority to adopt such sweeping rules and state that the FTC does not have the power to enact rules that determine what type of conduct is anticompetitive.

The final rule is expected to go into effect in 120 days from May 5, 2024, or on September 2, 2024. This date may be delayed pending this and other potential litigation.

FLSA SALARY TEST REVISED

On April 23, the U.S. Department of Labor (DOL) issued its final rule[12] regarding the salary threshold for overtime exemptions under the Fair Labor Standards Act (FLSA). The final rule, "Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales and Computer Employees" makes changes to salary requirements for highly compensated employees (HCEs) and exempt employees and extends overtime protections.

The FLSA defines exempt and non-exempt status for employees. Individuals classified as non-exempt are entitled to time and a half for hours worked over forty per week. To determine exempt status there is a duties test, unchanged by these regulations, and a salary test. These regulations changed the salary test as described below and apply it to an escalator every three years.

The standard salary level will increase in two phases from $684 per week ($35,568 per year) to:

- July 1, 2024: $844 per week ($43,888 annually); and
- Jan. 1, 2025: $1,128 per week ($58,656 annually).

The highly compensated exemption annual compensation level will increase from $107,432 per year to:

- July 1, 2024: $132,964 per year; and
- Jan. 1, 2025: $151,164 per year.

The salary thresholds will be updated every three years beginning July 1, 2027. The Final Rule is expected to go into effect on July 1, 2024.

CONCLUSION

The landscape continues to evolve, making it important to stay current with the ever-changing rules impacting employee benefits.

NOTES

1. 81 F.R. 321229 (April 25, 2024) (to be codified at 29 C.F.R. § 2510) (effective September 23, 2024), at https://www.federalregister.gov/documents/2024/04/25/2024-08065/retirement-security-rule-definition-of-an-investment-advice-fiduciary.

2. 89 F.R. 37522 published to the Federal Register on May 6, 2024; (to be codified at 42 C.F. R. Parts 438, 440, 457, and 460 and 45 C.F.R. § Parts 80, 84, 92, 47, 155, and 156) (effectivedate July 5, 2024); at https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities.

3. 89 F.R. 32976 (April 26, 2024) to be codified at 45 C.F.R. § 160 and 164 on June 25, 2024; at https://www.federalregister.gov/documents/2024/04/26/2024-08503/hipaa-privacy-rule-to-support-reproductive-health-care-privacy.

4. 89 F.R. 34106 (April 30, 2024) (to be codified to 29 C.F.R. § 2510) (effective July 1, 2024), at https://www.federalregister.gov/documents/2024/04/30/2024-08985/definition-of-employer-association-health-plans.

5. 29 F.R. 29096 (April 19, 2024) (to be codified to 29 C.F.R. § 1636) (effective June 18, 2024), at https://www.federalregister.gov/documents/2024/04/19/2024-07527/implementation-of-the-pregnant-workers-fairness-act.

6. https://www.federalregister.gov/documents/2024/04/19/2024-07527/implementation-of-the-pregnant-workers-fairness-act.

7. 42 U.S.C. § 12101 (2008).

8. 42 U.S.C. § 2000e, as amended.

9. What You Should Know About the Pregnant Workers Fairness Act | U.S. Equal Employment Opportunity Commission, at https://www.eeoc.gov/wysk/what-you-should-know-about-pregnant-workers-fairness-act.

10. States of Tennessee, et al., v. Equal Employment Opportunity Commission, Case No. 2:24-cv-84-DPM (E.D. Ark.).

11. Non-Compete Clause Rule (proposed April 23, 2024) (to be codified to 16 C.F.R. §§ 910 and 912) (scheduled to be published to the Federal Register on May 5, 2024) (becomes effective September 2, 2024), at https://www.federalregister.gov/documents/2024/05/07/2024-09171/non-compete-clause-rule.

12. 89 F.R. 32842 (published April 26, 2024) (to be codified to 29 C.F.R. § 541) (effective July 1, 2024 and January 1, 2025), at https://www.federalregister.gov/documents/2024/04/26/2024-08038/defining-and-delimiting-the-exemptions-for-executive-administrative-professional-outside-sales-and.

"Painting with Half a Palette": Creating Caste Within the Populace

By Diane M. Soubly

> Of course, a judge must consult the text and understand the text as limiting or helping to explain the scope of the statutory phrase. But I have learned over and over again that textualism is but one interpretive tool among many. And I fear that the enthusiasm for widespread adoption of more purely textual or linguistic approaches to interpretation means that other equally or more important tools will be set aside. It is as if an artist were to try to paint with only half a palette.
>
> – Retired Justice Stephen Breyer
> Preface, *Reading the Constitution: Why I Chose Pragmatism over Textualism*,[1] 2024

In his latest book, one that he dedicates to his former colleagues and intends for the general public, retired Justice Stephen Breyer attempts to explain the divisions on the U.S. Supreme Court as apolitical, perhaps to shore up the Court's flagging reputation with the public. In significant high-profile cases affecting people's daily lives and involving statutory and constitutional interpretation, Justice Breyer prefers, to no Court watcher's surprise, the lens of pragmatism. He decries the "current enthusiasm" for a form of originalism that ignores purpose and context in favor of "phrases describing the world rather than as words that perform (often technical) legal functions."[2]

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In his preface, the retired justice observes that "[t]hose following a textualist or originalist view of the interpretation" informed "by the Constitution's Founders or by their contemporaries" often ask "closely related questions," such as what the terms of the statute or the Constitution literally mean, what their original authors linguistically meant, and what "the public took the words to mean at the time Congress enacted the states or the states adopted the Constitution."[3] That reductive view of a static constitution conflicts with Justice Breyer's 42 years of federal judicial experience, including more than a quarter century on the Supreme Court. In his view, when judges adhere to the current brand of originalism/textualism to the exclusion of other interpretative tools, they stray from the rule of law. The highly controversial *Dobbs v. Jackson Women's Health Organization* decision[4] resonates throughout Justice Breyer's book as a cautionary tale, an opinion "paint[ed] with half a palette" whose intended or unintended consequences will take years to unravel.

As employee benefits practitioners who consult their advance sheets know, in the past two months (at this writing in early May) the issuance of significant agency guidance and regulations, judicial decisions, and the filing of new litigation relating to employee health care plans has accelerated. In the current election cycle, the enforced return of second-class citizenship for pregnant persons, in the guise of protecting "children" not yet born alive, has created a caste within the populace, as politicians of all stripes have politicized employee benefits as they did in 2022. The constraints visited upon pregnant persons, with their attendant dangers to maternal and infant health and survival, will bedevil easy resolution.

This column explores two recently issued Final Rules that raise the following conundrums for employee benefits practitioners, concerns exacerbated by litigation or the threat of litigation:

- Whether to administer group health plans to reimburse costs and expenses for reproductive health care, including pregnancy, childbirth, or pregnancy-related conditions, consistent with the Pregnancy Discrimination Act of 1978 (PDA) (amending Title VII of the Civil Rights Act of 1964) (Title VII) and the Pregnant Workers Fairness Act of 2022 (PWFA) and as permitted under federal agency guidance; and

- Whether to resist attorney general or prosecutor demands, through subpoenas or discovery requests, for the protected health information (PHI) of targeted employees who seek

pregnancy termination, contraceptives, or IVF in states where such terminations remain legal, as required under the recently issued Health Insurance Portability and Accountability Act (HIPAA) Final Rule supporting reproductive health care.

I. ADMINISTERING GROUP HEALTH PLANS TO REIMBURSE REPRODUCTIVE HEALTH CARE COSTS AND EXPENSES

As several states consider bans on reproductive health care before and during the 2024 general election, employee benefits practitioners may not yet have fully grasped the determined discrimination afoot against, and the lack of humane care for, living female patients, in particular lower income women in underserved populations. Hardly had the ink dried on the final EEOC PWFA Guidance when 17 states filed a lawsuit to kill it in an Arkansas federal district court. This section first analyzes an ill-received 1976 Supreme Court decision that Congress quickly reversed in 1978 by adopting the PDA, a predecessor statute to the PWFA. Then this section details the impact of *Dobbs* and state health care bans on the maternity care deserts and maternity and infant mortality rates. Finally, the section discusses the claims in the new lawsuit filed on April 25, 2024, in Arkansas seeking to invalidate the Final EEOC PWFA Guidance.[5]

A. An Earlier Supreme Court Decision Denying Reproductive Health Care Reversed by The Pregnancy Discrimination Act

In 2022, the PWFA replicated certain language in the PDA of 1978, an act that had reversed *General Electric Co. v. Gilbert* (*Gilbert*),[6] a class action and another Supreme Court decision that the public viewed as dubious.

Gilbert lacked a majority (i.e., 5 of 9 justices). Only a plurality approved the lead opinion, called the "Opinion of the Court," so named because 6 of the 9 justices concurred in the disposition of the case. Offering different rationales underpinning their votes, Justices Stewart and Blackmun concurred separately only in the result. Each disapproved the analysis of the plurality opinion, drafted by Justice Rehnquist and signed by Chief Justice Burger and Justices Powell and White. The author will refer to the lead opinion as "the *Gilbert* plurality opinion."

Gilbert issued on December 7, 1976. Justice Brennan authored a dissent joined by Justice Marshall. True to form, Justice Stevens dissented in a separate opinion.

1. Earlier Decisions Pre-Dating Gilbert

Two earlier decisions of then recent memory employed various theories to protect women from discrimination based on sex stereotypes.

In 1971, in *Phillips v. Martin Marietta Corporation*,[7] in a per curiam (i.e., unauthored) opinion, the Burger Court reversed the U.S. Court of Appeals for the Fifth Circuit, which had affirmed summary judgment for the employer because 75% or more of the employees the company hired were women, even though Martin Marietta refused to give employment applications to women, like Ida Phillips, who forthrightly answered questions that she had pre-school age children, a question never propounded to male applicants. The school board's hiring process thus incorporated the sexual stereotype (a/k/a "sex-plus" discrimination, although some early women advocates disliked that term) that women, and not men, shouldered the childcare responsibilities for pre-school age children. The justices on the Court at that time included Chief Justice Burger and Justices Black, Douglas, Harlan, Brennan, Stewart, White, Marshall, and Blackmun.

On January 21, 1974, in *Cleveland Board of Education v. LaFleur*,[8] fewer than ten months before the *Gilbert* plurality opinion would not even acknowledge that General Electric Company had severed Gilbert from employment because of her pregnancy, the Burger Court found in a pair of consolidated cases from two federal circuits that school board rules violated the Fourteenth Amendment.

Court watchers may remember that, by 1974, Justice Powell had replaced Justice Black, who retired from the Court on September 17, 1971, and died eight days later; and Justice Rehnquist had replaced Justice John Marshall Harlan II, (the grandson of the great dissenter in *Plessy v. Ferguson*). Justice Harlan had retired from the Court on September 23, 1971, and passed away from spinal cancer on December 29th of that year.[9] (Note: for those employee benefits practitioners who have forgotten the finer points of nominations for the Supreme Court, the president nominates persons either for associate justice or for chief justice. Not until 1986 did President Reagan nominate Associate Justice Rehnquist as chief justice to succeed Chief Justice Burger. In 2005, President George W. Bush had planned to nominate District of Columbia Circuit Judge John Roberts as an associate justice but instead nominated him as chief justice upon the death of Chief Justice Rehnquist at the beginning of the 2005-2006 term.)

In the 7-2 majority opinion in *LaFleur* (with Justices Rehnquist and Burger in dissent), employing reasoning that employee benefits practitioners designing or defending public sector health care plans should find instructive, Justice Stewart found that the school board rules mandating that pregnant teachers take disability leave without pay starting at the end of the fourth or fifth month of their pregnancies (Cleveland school board, and Chesterfield county school board, respectively) and violated the Due Process Clause of the Fourteenth Amendment of the federal Constitution. The school boards attempted to defend the rules as benevolent:

> Secondly, the school boards seek to justify their maternity rules by arguing that at least some teachers become physically incapable of adequately performing certain of their duties during the latter part of pregnancy. By keeping the pregnant teacher out of the classroom during these final months, the maternity leave rules are said to protect the health of the teacher and her unborn child, while at the same time assuring that students have a physically capable instructor in the classroom at all times."[10]

Justice Stewart displayed a healthy skepticism of justifications for the school boards' forced disability leave rule in a lively footnote 9 of the majority opinion:

> The records in these cases suggest that the maternity leave regulations may have originally been inspired by other, less weighty, considerations. For example, Dr. Mark C. Schinnerer, who served as Superintendent of Schools in Cleveland at the time the leave rule was adopted, testified in the District Court that the rule had been adopted in part to save pregnant teachers from embarrassment at the hands of giggling schoolchildren; the cutoff date at the end of the fourth month was chosen because this was when the teacher "began to show." Similarly, at least several members of the Chesterfield County School Board thought a mandatory leave rule was justified in order to insulate schoolchildren from the sight of conspicuously pregnant women. One member of the school board thought that it was "not good for the school system" for students to view pregnant teachers, "because some of the kids say, my teacher swallowed a water melon [sic], things like that." . . . The school boards have not contended in this Court that these considerations can serve as a legitimate basis for a rule requiring pregnant women to leave work; we thus note the comments only to illustrate the possible role of outmoded taboos in the adoption of the rules. Cf. Green v. Waterford Board of Education, 473 F.2d

> [629,] 635 [(2d Cir. 1972)] ("Whatever may have been the reaction in Queen Victoria's time, pregnancy is no longer a dirty word").[11]

The Cleveland board of education not only required pregnant teachers to take disability leave without pay five months before their due dates, but it also required that the teachers could not return until the next school semester, and then only if they obtained medical certification of their fitness for work and only if their children borne during the leave had reached three months of age. Under that rule, the Cleveland school board forced women with due dates during the summer to leave in January of one school year and barred their return until January of the following year, when they could seek open positions, assuming that any opened up mid-school year. Reversing and vacating the district court (which had simultaneously tried both cases), a divided Sixth Circuit found that the mandatory leave policy, probably floundering on old taboos and stereotypes, violated the Due Process Clause.

In contrast, the U.S. Court of Appeals for the Fourth Circuit affirmed the district court's ruling in favor of the school board and found no constitutional violation. In that separate case, the Chesterfield County, Virginia school board, whose stereotypic views of pregnant women and schoolchildren appeared in footnote 9 quoted above, required that a pregnant teacher take disability leave without pay at the end of the fifth month of pregnancy. Once no longer pregnant, however, the teacher could return at the beginning of the next semester with medical certification of fitness for work. In other words, the county school board imposed no arbitrary rule requiring that the child borne during the disability leave reach three months of age before allowing the teacher to seek to return to teaching.

In the majority opinion reversing both appellate decisions on the mandatory disability without pay leave policy, Justice Stewart reasoned that both school boards' rules (1) violated the Due Process clause, under which the Court had extended protection to an individual's freedom of personal choice in matters of marriage and family life, and (2) created an unconstitutional irrebuttable presumption that every pregnant teacher became incapable of teaching in the fourth or fifth month of pregnancy. The majority opinion also rejected administrative convenience as a sufficiently important interest for the school board rules. It then rejected the Cleveland school board's policy of no return before the children attained three months because the board had offered no proof of any reasonable business justification for that rule, but the Court found no constitutional violation in the Chesterfield County school board's rule of requiring certification of the teacher's fitness to return to teaching.

As employee benefits practitioners know, that fitness for work certification appears not only in the federal Family and Medical Leave Act (FMLA), but also in many employee health care benefit plans and short-term disability plans that offer at least partial pay (sometimes complemented by additional contributions to a voluntary disability insurance plan by the pregnant employee).

Justice Powell separately concurred on the basis that the mandatory leave policy violated the Equal Protection Clause of the Fourteenth Amendment in the federal Constitution but would not support the irrebuttable presumption analysis arising under the Due Process Clause.

A scant four months after *Cleveland Board of Education v. LaFleur*, the Supreme Court issued *Geduldig v. Aiello*,[12] having presumably reviewed briefs relating to the high expenses and costs associated with even normal pregnancy, childbirth, and pregnancy-related conditions. In *Geduldig*, the Court declined to hold unconstitutional California's decision to exclude pregnancy from its definition of "disability" for purposes of the California disability benefits law. The *Geduldig* decision figures prominently in the plurality opinion in *Gilbert*, as discussed next.

B. The Dubious Gilbert *Plurality Opinion and the Brennan and Stevens Dissents*

In *Gilbert*, the Supreme Court refused to require the General Electric Company disability plan to provide non-occupational sickness and accident disability benefits for pregnant women, whose employment the company severed upon pregnancy, a separation from service that rendered the women ineligible for the nonoccupational disability pay of 60% of their regular straight-time earnings and reimbursement of medical expenses for pregnancy, miscarriage, abortion, childbirth, and pregnancy-related conditions.

1. The Gilbert *Plurality Opinion*

The *Gilbert* plurality opinion viewed pregnancy as "sex-specific" (i.e., only women were capable of becoming pregnant) and as "voluntary" in contrast to "involuntary" diseases covered under the plan. It did not appear to trouble the Court that the company's group health plan (for which the women became ineligible by virtue of their pregnancies) covered far less costly medical procedures "specific to the reproductive systems of men,"[13] such vasectomies, prostate surgery, circumcisions, and (in more modern times) penal implants.

Discussing "sex-specific" or "sex-linked" characteristics, Justice Rehnquist hewed to EEOC guidance issued more contemporaneously

with Title VII and appearing to approve treating pregnancy in disability plans or other benefit plans under the same terms and conditions as all other disabilities. Justice Rehnquist justified his choice by citing the Davis treatise on administrative law, which warned that later guidance often fell victim to political whim. As guidance careens from one presidential administration to another, the principle that Davis articulated in the 1950's might resonate for those employee benefits practitioners nostalgic for simpler times.

Purportedly seeking to avoid political whim, Justice Rehnquist rejected the EEOC position in an amicus brief filed on behalf of the class represented by lead plaintiff Gilbert as "at odds" with the Wage and Hour Administrator's interpretation of Section 703(h) of Title VII and the statute's legislative history and with other EEOC guidance.[14] The Fourth Circuit had accorded "great deference" to the EEOC guidance, while Justice Rehnquist reviewed the statutory delegation to the EEOC and would accord only "Skidmore respect" to guidance from that agency. The guidance at issue treated pregnancy as a temporary disability:

> 29 C.F.R. §§ 1604.10 (1975), which specifies:
>
> (a) A written or unwritten employment policy or practice which excludes from employment applicants or employees because of pregnancy is a prima facie violation of Title VII.
>
> (b) Disabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom are, for all job-related purposes, temporary disabilities and should be treated as such under any health or temporary disability insurance or sick leave plan available in connection with employment. Written and unwritten employment policies and practices involving matters such as the commencement and duration of leave, the availability of extensions, the accrual of seniority and other benefits and privileges, reinstatements, and payment under any health or temporary disability insurance or sick leave plan, formal or informal, shall be applied to disability due to pregnancy or childbirth on the same terms and conditions as they are applied to other temporary disabilities.
>
> (c) Where the termination of an employee who is temporarily disabled is caused by an employment policy under which insufficient or no leave is available, such a termination violates the Act if it has a disparate impact on employees of one sex and is not justified by business necessity.[15]

Next, the *Gilbert* plurality opinion relied upon then Senator Hubert Humphrey's remarks in the legislative record regarding Title VII that "differences in treatment in industrial benefit plans, including earlier retirement operations for women, may continue in operation under this bill, if it becomes law."[16] The senator's remarks may have anticipated the "equal cost" *or* "equal benefit" rule that the AARP would later hammer out with the EEOC.

More likely, those remarks remarked the stubborn stereotype about women's participation in the workforce that prevailed in 1926 when General Electric offered no benefit plan to its female employees, as Justice Brennan footnotes in his dissent in *Gilbert*:

> General Electric's disability program was developed in an earlier era when women openly were presumed to play only a minor and temporary role in the labor force. As originally conceived in 1926, General Electric offered no benefit plan to its female employees because "women did not recognize the responsibilities of life, for they probably were hoping to get married soon and leave the company." App. 858, excerpted from D. Loth. Swope of G.E.: Story of Gerard Swope and General Electric in American Business (1958). It was not until the 1930's and 1940's that the company made female employees eligible to participate in the disability program. *In common with general business practice, however, General Electric continued to pursue a policy of taking pregnancy and other factors into account in order to scale women's wages at two-thirds the level of men's. Id.* at 1002.[17]

(Emphasis added).

This author here pauses to note that the same scale of women's wages in the 1930s and 1940s at two-thirds the level of men's has persisted and actually declined to 59% as of the passage of the federal Equal Pay Act (EPA). Significant gaps in pay and benefits remain, according to the White House June 10, 2023 Fact Sheet issued on the EPA's 60th Anniversary:

> In 1963, women overall were paid only 59 cents for every dollar paid to men. Sixty years later, while we've had some progress in closing the gender pay gap, pay disparities persist. Today, women overall are paid 84 cents to every dollar paid to men – and this gap is even more pronounced for Black women, Native American women, Latinas, many Asian American women, and women with disabilities.
>
> Gender and racial pay gaps reflect a combination of factors that lower women's earnings over a lifetime. Women experience

> outright discrimination[;] and, in 90 percent of occupations, they are paid less than men, on average. *Women are less likely to participate in the workforce, or work as many hours as men, due to time spent on caregiving combined with the lack of affordable child care, paid family and medical leave, paid sick leave, and fair and predictable scheduling. Mothers may experience the compounding effects of discrimination, and lower work hours due to caregiving responsibilities, leading to a parental gender earnings gap, or "motherhood penalty."*
>
> *In fact, a recent published study funded by the U.S. Department of Labor's Women's Bureau found that mothers lose an average of $295,000 in employment-related costs over a lifetime due to providing unpaid care to minor children and older family members. Additionally, differences in jobs held by men and women may contribute to the gender pay gap. Jobs held primarily by women, such as nurses and teachers, tend to be undervalued and have low pay and few benefits. Conversely, women are underrepresented in higher paying jobs, such as engineers and electricians.*
>
> *Pay disparities compound from paycheck to paycheck, resulting in lower annual earnings for women, especially women of color. In turn, lower earnings harm their ability to afford basic necessities like housing and child care and to build and sustain their families' financial security. Also, it impacts their ability to save for an unexpected expense and save for retirement. Over a lifetime, women lose hundreds of thousands of dollars in lost earnings and retirement savings.*[18]

(Emphasis added.)

Practice Pointer: For employee benefits practitioners, the above disparities may inform potential business justifications for including pregnancy, childbirth, and pregnancy-related benefits in health care plans, in order to attract and to retain women workers. In addition, employee benefit designs that incorporate caretaker benefits and that create other means of meeting certain life expenses for children (such as schooling) that mothers currently pay by raiding their retirement savings may also attract and retain women workers to reduce the costs of labor turnover, a "brain drain" of experienced employees, and training new employees. Under such an insurance risk analysis, could plan designers exclude transgender or IVF pregnancies as separate physical conditions unrelated to gender?

The *Gilbert* plurality opinion next addressed whether the class in *Gilbert* had made no showing of a disparate effect under Title VII, a

theory that Justice Rehnquist conceded that the Court has recognized in prior cases. However, following the model of *Geduldig*, the *Gilbert* plurality opinion affirms the district court's findings that (1) the evidence presented simply failed to show that the plan "worked against any definable group or class in terms of the aggregate risk protection derived by that group or class from the program," and (2) the evidence tended to show that the California "plan covered some risks but not others," and Justice Rehnquist repeats his talismanic phrase:

> The "package" going to relevant identifiable we are presently concerned with – General Electric's male and female employees – covers exactly the same categories of risk, and is facially nondiscriminatory in the sense that "[t]here is no risk form which men are protected and women are not. Likewise, there is no risk from which women are protected and mean are not."[19]

Apparently the public, unfamiliar with insurance risk analysis or with the labor and employment lawyer's use of comparators to prove discrimination, invariably voiced their opinion that sex-linked discrimination on the basis of pregnancy *was*, in fact, the very essence of sex discrimination. The dubious reasoning of the *Gilbert* plurality opinion did not resonate with the public, and Congress passed the PDA in direct response to *Gilbert*.

2. The Brennan Dissent

In his *Gilbert* dissent, Justice Brennan detailed the many fatal flaws in reasoning in the majority opinion, two of which this author discusses as particularly pertinent at this moment.

The First Flaw - Plaintiff's "Ineligibility for Disability Plan Benefits": The *Gilbert* plurality opinion cavalierly dismissed one plaintiff's claim for reimbursement of medical expenses on the ground that the plan did not include pregnancy as a covered event, a "fact" that Justice Brennan disputed in footnote 4 of his dissent (joined by Justice Marshall):

> The experience of one of the class plaintiffs is instructive of the reach of the pregnancy exclusion [in the General Electric plan]. On April 5, 1972, she took a pregnancy leave, delivering a stillborn baby some nine days later. Upon her return home, she suffered a blood clot in the lung, a condition unrelated to her pregnancy), and was not re[-]hospitalized. *The company declined her claim for disability payments on the ground that pregnancy severed her eligibility under the plan. See* [the district court's opinion, 375 F.Supp. 367,] 372 [(E.D. Va. 1974)]. Had she been separated from work for

> any other reason – for example, during a work stoppage – the plan would have fully covered the embolism.[20]

Justice Brennan also explained that all six circuit courts of appeals addressing the question of whether a private employer's disability plan that compensates employees for all temporary disabilities save one "affecting exclusively women, pregnancy"[21] had found such employee benefit plan design unconstitutional. He then rebutted the *Gilbert* plurality's stereotypic assumption of pregnancy as a "voluntary" condition rather than a "disability" or a "disease"[22] *and emphasized that the Court of Appeals had correctly found that "other than for childbirth disability, [General Electric] had never construed its plan as eliminating all so-called 'voluntary disabilities,' including sport injuries, attempted suicides, venereal disease, disabilities incurred during the commission of a crime or during a fight, and elective cosmetic surgery. [Gilbert v. General Electric Co., 519 F.2d 661,] at 666 [(9th Cir. 1975)].*"[23] (Emphasis supplied.)

Nor had the General Electric plan, as administered, found "disease" determinative in denying benefits, as Justice Brennan again pointed out in attacking the fallacies of the majority's reasoning. The plan's pregnancy disqualification also "exclude[d] the 10% of pregnancies that end in debilitating miscarriages[,] [citing the district court's opinion] 375 F.Supp.,] at 377, the 10% of cases where pregnancies are complicated by 'diseases' in the intuitive sense of the word, *ibid.*, and cases where women recovering from childbirth are stricken by severe diseases unrelated to pregnancy."[24] At that point, Justice Brennan positioned footnote 4, discussed above.

In this author's opinion, those words of Justice Brennan relating to pregnancy, childbirth, and diseases related to pregnancy appear remarkably prescient of the language in the PDA, i.e., "pregnancy, childbirth, and pregnancy-related conditions," as if Congress, in rejecting the flawed *Gilbert* plurality opinion, had turned to Justice Brennan's better reasoned dissent for guidance in crafting statutory language.

The Second Flaw: The Gilbert *Plurality's Misreading of* Geduldig: The *Gilbert* majority relied heavily upon *Geduldig*, resurrected by the 17 states from several federal circuit courts of appeal suing in Arkansas federal district court – within the Eighth Circuit – to invalidate the PWFA Final Rule as violating the Federal Constitution (discussed below in Part I.E.).

Even as he rejected a sex-specific classification as per se unconstitutional in a state-funded disability pay plan, Justice Rehnquist characterized the 6-3 decision in *Geduldig* decision as "holding that an exclusion of pregnancy from a disability benefits plan providing general coverage is not a gender-based discrimination at all."[25] He then

chastised the Fourth Circuit and other circuit courts for "misreading" the Court's *Geduldig* decision:

> There is no more showing in this case than there was in *Geduldig* that the exclusion of pregnancy benefits is a mere "pretex[t] designed to effect an invidious discrimination against the members of one sex or the other." The Court of Appeals expressed the view that the decision in *Geduldig* had actually turned on whether or not a conceded discrimination was "invidious," but we think that, in so doing, it misread the quoted language from our opinion. *As we noted in that opinion, a distinction which, on its face, is not sex-related might nonetheless violate the Equal Protection Clause if it were in fact a subterfuge to accomplish a forbidden discrimination. But we have here no question of excluding a disease or disability comparable in all other respects to covered diseases or disabilities and yet confined to the members of one race or sex. Pregnancy is, of course, confined to women, but it is in other ways significantly different from the typical covered disease or disability. The District Court found that it is not a "disease" at all, and is often a voluntarily undertaken and desired condition, 375 F. Supp. at 375, 377. We do not therefore infer that the exclusion of pregnancy disability benefits from petitioner's plan is a simple pretext for discriminating against women.* The contrary arguments adopted by the lower courts and expounded by our dissenting Brethren were largely rejected in *Geduldig*.[26]

(Emphasis supplied.)

The *Gilbert* plurality opinion seemingly simultaneously (1) championed pregnancy as a disease or disability so that under an insurance risk analysis excluding the sex-linked condition from coverage did not amount per se sex discrimination, and (2) derogated any view of pregnancy, a much desired condition, as a disability or, worse yet, a disease. The vague and gratuitous final sentence of his analysis seems, in this author's view, a patent attempt to bolster a mere plurality opinion by tying it to *Geduldig's* coattails.

As Justice Brennan notes in his dissent, the *Gilbert* plurality opinion elevates a footnote in *Geduldig*, a case resting on constitutional law principles, to a lens for state statutory interpretation. Calling the state disability system "strikingly similar" to the General Electric private sector plan, Justice Rehnquist noted that California received 1% of an employee's salary up to an annual maximum of a mere $85 to fund its "disability insurance protection system." He then explained that the *Geduldig* Court had rejected the employee's argument that the exclusion of pregnancy constituted "invidious discrimination under the

Equal Protection Clause" on the basis of "an asserted under[-]inclusiveness of the set of risks that the State has selected to insure."[27]

Weakly (in this author's view) attempting to distinguish *Reed v. Reed*[28]and *Frontiero v. Richardson*[29] as cases "involving discrimination based upon gender as such" when the California insurance program "does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition – pregnancy – from the list of compensable disabilities," Justice Rehnquist must admit that (at least at that time in 1974, before recognition of transgender persons who decline FTM gender reconstruction surgery) "it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification like those considered in *Reed* . . . and *Frontiero*."[30]

For Justice Rehnquist, because "normal pregnancy" remains an "objectively identifiable physical condition," the classification at issue merely divided potential insurance recipients into two groups: "pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes." Therefore, he concluded, "even a cursory review" of the paradigm as he devises it, on the basis of pregnancy, seemingly a function only of an insurer's risk analysis using a physical condition that affects only women, shows no invidious intent to discriminate on the basis of gender:

> There is no showing [in the *Geduldig* record] that the selection of the risks insured by the program worked to discriminate against any definable group or class in terms of the aggregate risk protection derived by that group or class from the program. There is no risk from which men are protected and women are not. Likewise, there is no risk from which women are protected and men are not.[31]

In dissent, Justice Brennan highlighted Justice Rehnquist's selective and incomplete analysis of *Geduldig*, an analysis which defied common sense:

> Considered most favorably to the Court's view, *Geduldig* established the proposition that a pregnancy classification standing alone cannot be said to fall into the category of classifications that rest explicitly on "gender as such" [citations omitted]. Beyond that, *Geduldig* offers little analysis helpful to decision of this case. Surely it offends common sense to suggest [citation omitted] that a classification revolving around pregnancy is not, at the minimum, strongly sex related." [citing Justice Powell's concurrence in *Cleveland Board of Education v. LaFleur*] Indeed, even in the insurance context where neutral actuarial principles were found to have provided a legitimate and independent input into the

> decision[-]making process, *Geduldig's* outcome was qualified by the explicit reservation of a case where it could be demonstrated that a pregnancy-centered differentiation is uses as a "mere pretext . . . designed to effect an invidious discrimination against the members of one sex. . . ." [citation omitted]
>
> Thus, *Geduldig* itself obliges the Court to determine whether the exclusion of a sex-linked disability from the universe of compensable disabilities was actually the product of neutral, persuasive actuarial considerations, or rather stemmed from a policy that purposefully downgraded women's role in the labor force.[32]

For Justice Brennan, the *Geduldig* Court had, in 1974, employed a paradigm constitutional analysis (critically different in premises from a statutory analysis looking to purpose and context – Justice Breyer's favored lens of pragmatism, as opposed to the current practice of originalism/textualism). Justice Stewart's majority opinion thus followed the Court's "normal presumption favoring legislative action" and had found no invidious discrimination in the state's fiscal concerns and in its capacity to "effectuate reforms 'one step at a time.'"[33]

Again, in this author's opinion, Justice Brennan's thorough dissection of the flawed reasoning in the *Gilbert* majority explains precisely why the Supreme Court should not now resurrect the infirm summary of the *Geduldig* decision so selectively portrayed in the *Gilbert* plurality opinion, nor credit Justice Rehnquist's patently overreaching attempt to tack the Geduldig majority to the weak Gilbert plurality opinion.

Even if one credited Justice Rehnquist's view that the *Gilbert* plurality rode on *Geduldig's* coattails, then the PDA and the PWFA obliterated both "holdings" as Congress can do when the Supreme Court reasons so poorly and acts so arrogantly that its decisions repulse the public. Just as *Gilbert* weakened confidence in the Court, so *Dobbs* has blackened the current Court, whose reputation has already suffered from political patronage scandals, "leaks" of decisions to donors in advance of their release (e.g., *the Hobby Lobby v. Burwell* case), an anemic Code of Ethics, and failures of justices to recuse themselves in cases critical to democratic principles by the actual, let alone appearance of, conflict of interest (e.g., the emails by Ginny Thomas to her "best friend" (as she constantly calls her husband) during the day of the January 6th insurrection, not to mention her constant emails to the White House Chief of Staff and her presence at the rally from which the attack on the Capitol originated, according to the January 6th Report released by the House).[34]

3. The Stevens Dissent

In his dissent, Justice Stevens refused to apply the constitutional analysis in *Geduldig* to a case involving a federal statute because the burden of establishing a constitutional violation of the Equal Protection Clause "is significantly higher than the burden of proving a violation of a statutory prohibition of discrimination," and because General Electric had not provided any proof of a business justification.[35]

4. Congressional Course Correction

Congress heard the public's displeasure with the dubious *Gilbert* decision. Rejecting the *Gilbert* plurality opinion's faulty reasoning and consignment of women to mere peripheral and temporary members of the labor force, Congress passed the PDA some 22 months later, on Halloween in 1978, in order to reverse *Gilbert*.

An amendment to Title VII, the PDA accords protection to pregnancy, childbirth, and pregnancy-related conditions under private and public sector group health plans, with a delayed effective date for collectively bargained agreements where the parties do not reopen negotiations to account for the PDA during an extant CBA. While the Hyde and Weldon Amendments prohibits the use of certain federal funds to underwrite abortion benefits, the PDA expressly permits, but does not require, employers as plan administrators to reimburse expenses and costs of pregnancy, childbirth, and pregnancy-related conditions in employee benefit plans. Nor does the PDA forbid employers from doing so.

C. The Increase in Pregnancy-Related Deaths Pre- and Post-Dobbs

By various measures, compared to other highly developed nations, the United States continues to lag behind in reducing maternal and infant mortality rates. Even before *Dobbs*, state efforts to defund and to deny state licenses to non-faith-based health care service providers that provided pregnancy termination took hold. *Dobbs* has further emboldened such state conduct, particularly in an era when the Supreme Court majority, as reconstituted by Trump, has rebranded the establishment of religion as "religious liberty" and an "absolute" constitutional right.

The CDC Pregnancy Mortality Surveillance System [PMSS] defines a "pregnancy-related death" as "*a death while pregnant or within 1 year of the end of pregnancy* from any cause related to or aggravated by the pregnancy."[36] To compile PMSS data collection on U.S. maternal

mortality rates, medical epidemiologists review the death records, plus linked birth and fetal death records, from all 50 states, New York City and the District of Columbia. Under that method, as the CDC found, the U.S. maternal mortality rate highest among high-income developed nations, ten times the rate in 2020 in other wealthy developed countries like Australia, Austria, Israel, Japan, Spain (around 2-3% per 100,000 births).[37] Even before *Dobbs*, the 2023 Commonwealth Fund Report (the 2023 CF Report) summarized findings for 2020 showing the U.S. spends more on health care than any other of the 38 member nations of the Organisation [sic] for Economic Cooperation and Development (OECD), all of whom (other than US) guarantee residents governmental health care.[38] According to the 2023 CF Report, "in 2021, 8.6 percent of the U.S. population was uninsured. The U.S. is the only high-income country where a substantial portion of the population lacks any form of health insurance [i.e., governmental [or] public or private]."[39]

Released in late 2021, another Commonwealth Fund "primer" (the 2021 CF Primer) tracked severe maternal morbidity from 2013-2021, defined by the CDC as "unexpected outcomes of labor and delivery that result in significant and unexpected short- and long-term consequences to a woman's health."[40] The 2021 CF Primer concluded that statistics compiled on a population-wide basis did not track "near-miss births" or "serious illnesses that occur during pregnancy, like ectopic pregnancy, and the post-partum period, like cardiomyopathy" from 2013 to the date of the report issued on October 28, 2021.[41] Again, the report found that the U.S. showed the highest rates compared to certain developed countries in the OECD and urged supplementation of the CDC statistics useful for research with procedures useful in real time for hospitals and health care professionals:

> The U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG) have offered detailed recommendations for monitoring and review of severe pregnancy and delivery complications. Both recommend facility-level, multidisciplinary review of all cases using a two-factor scoring system that identifies severe maternal morbidity by: 1) admission to the intensive care unit (ICU) and/or 2) transfusion of four or more units of blood products at any time from conception through 42 days postpartum. The scoring system, developed by Stacie Geller and colleagues, has been validated and can be used in real time in hospital settings, unlike administrative datasets currently used for population-level surveillance. To date, severe maternal morbidity reviews remain rare, having been implemented in individual facilities in California, and Illinois recently piloted a statewide operation through its regionalized

> perinatal system. In the future, severe morbidity reviews may increase as more hospital systems assess their experience with severe morbidity and states expand the scope of their maternal mortality reviews.[42]

Slicing the data in a slightly different fashion and using a more restrictive WHO definition of the relevant post-pregnancy period, the CDC National Vital Statistics System (NVSS) nonetheless identified an uptick in maternal mortality for Black women and for women over 40 post-*Dobbs*. The WHO definition used by NVSS includes "the death of a woman *while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes*."[43] In 2021, under that measure, U.S. maternal mortality deaths, i.e., the number of maternal deaths per 100,000 *live births*, continued to rise and had almost doubled since 2018: from 17.4% in 2018 to 20.1% in 2019 to 23.8% in 2020 to 32.9% in 2021.[44] While the CDC NCHS Health E-Stats show a decrease in the U.S. maternal mortality rate to 22.3 deaths per 100,000 live births, the maternal mortality rate for Black women (49.5 deaths per 100,000 live births) remained significantly higher than rates for White (19.0), Hispanic (16.9), and Asian (13.2) women.[45]

In addition, the rate for maternal mortality varied by age sub-groups; and, although the rate decreased in 2022 from 2021 in all 3 sub-groups (women 18-25, from 20.4 to 14.4; women 26-40, from 31.3 to 21.1; and women over 40, from 138.5 to 87.1), the difference in the maternal mortality rates for women over 40 in both years proved statistically significant.[46] The CDC statistics thus highlight, in advance of the *Dobbs* decision, he disproportionate effect that the *Dobbs* decision would visit upon Black women and older women.

Among the U.S. underserved populations, Black, Hispanic, "Indigenous" (native American and Alaska Native, as well as Native Hawaiian/Pacific Islander) present statistically significant higher maternal mortality rates than non-Hispanic Whites and Asian Americans. The lower rates flow from a combination of factors: lack of prenatal care, post-partum care lacking, and maternity care deserts. Pregnancy-related conditions include post-partum depression, PTSD, clinical depression, paranoia and other emotional or mental health issues; sepsis and loss of limbs or sepsis and coma; preeclampsia; pre-existing conditions exacerbated by pregnancy or pregnancy termination; hysterectomy and post-pregnancy care, including mental health counseling.[47]

The *Dobbs* decision will indeed exacerbate, in many cases cruelly, the dangers that this demographic swath will face, as this author has discussed in prior columns in this journal and here, when governments:

- License and fund only faith-based service providers;
- Criminalize reproductive health care;
- Threaten to prosecute pregnant persons for murder;
- Compel in-person visits for OTC medications so that pregnant persons and their "aiders and abettors" risk identification and loss of protection for their protected health information;
- Arm bounty hunters with incentives to sue health care providers that adhere to the principle to do no harm to the living patient;
- Threaten to criminally prosecute and to disbar attorneys who assist employers that wish to reimburse reproductive health care; and
- Threaten plan sponsors and plan administrators with prosecution and/or civil fines if they include and administer necessary and/or emergency reproductive health care to pregnant persons and reimburse their expenses for procuring such health care under employer-provided welfare benefit plans.

As a 2019 study by the Henry J. Kaiser Family Foundation observed: "Since the 2016 election, state and federal efforts to restrict public funding to Planned Parenthood and other abortion providers and to funnel new federal funds to faith-based providers who oppose contraceptives and abortion have gained traction and begun to shift the family planning landscape across the nation."[48]

Completing the pattern begun in 2016 of polarizing members of the American populace and creating a caste system for minority and pregnant persons and underrepresented populations, a majority of five (sans Chief Justice Roberts) comprised of three Trump appointees in a single term, the Supreme Court reversed *Roe v. Wade* and *Planned Parenthood v. Casey* in June 2022. The Court did so even after (as 61 of the 62 courts addressing purported voter fraud found no election voter fraud, with the outlier resolving the case on procedural grounds) Trump lost the popular vote by some 3 million votes and lost the Electoral College delegate vote. During this election cycle, mere days before submission of this column to the publisher, the presumptive Republican presidential nominee announced at a campaign stop – perhaps as a hint of the Republican platform – that some states will want to criminally prosecute women who have abortion for murder. As discussed below in Part IV, 21 states have introduced "fetal personhood" bills.

After *Dobbs*, the closure of Planned Parenthood and other non-faith-bathed clinics has accelerated and augmented the drive to make reproductive health care coverage inaccessible to Black and older pregnant persons and populations identified as underserved during early years of the COVID-19 pandemic. The 2022 and 2023 March of Dimes Reports reported that increased closures, occurring as state supreme courts and governors and state legislatures overrode majority votes in favor of restoring *Roe/Casey*, created significant maternity care deserts. The Reports define maternity care deserts as "counties with lack of maternity resources, no hospitals or birthing centers offering obstetric care, no OB/GYN providers, and no certified midwives.[49]

Because of such maternity deserts, those who seek elective pregnancy terminations within the windows permitted under state laws now must travel hundreds of miles at a cost they can ill afford, if they can afford it at all, as Professor Caitlyn Myers and her student researchers have captured on dashboard maps, and as the new Florida ban on abortions will complicate.[50] With the new ban reducing the number of states in the South permitting pregnancy termination after six weeks from 3 to 2 (i.e., North Carolina and Virginia), the only route for Floridians, who will find appointments at overbooked clinics out-of-state difficult to schedule and may require that they bypass North Carolina, with its 3-day waiting period (at great expense) for Virginia.

D. The Predecessor Statute for the PWFA: The PDA

1. A Supreme Court Decision After Gilbert *But Before the PDA*

On December 6, 1977, just one day shy of the first anniversary of *Gilbert*, Chief Justice Rehnquist authored the majority decision in *Nashville Gas Co. v. Satty*.[51] There, the Supreme Court found a Title VII violation because the employer forced pregnant women to lose their positions and accumulated seniority (and thus their years of credited service towards their pension benefits) each time that they became pregnant, when they could not restore their benefits unless they successfully bid on other open permanent positions. The chief justice succinctly described the constraints that the company placed on pregnant women:

> Petitioner requires an employee who is about to give birth to take a pregnancy leave of indeterminate length. Such an employee does not accumulate seniority while absent, but instead actually loses

> any job seniority accrued before the leave commenced. Petitioner will not hold the employee's job open for her awaiting her return from pregnancy leave. An employee who wishes to return to work from such leave will be placed in any open position for which she is qualified and for which no individual currently employed is bidding; before such time as a permanent position becomes available, the company attempts to find temporary work for the employee. If and when the employee acquires a permanent position, she regains previously accumulated seniority for purposes of pension, vacation, and the like, but does not regain it for the purpose of bidding on future job openings.[52]

The gas company also refused to pay pregnant women on leave any pay, an issue that the Supreme Court remanded.

Ten months after the *Satty* decision, Congress passed the PDA, and President Carter signed the act into law the same day.

2. Salient Provisions of the PDA

Pertinent to this column, the PDA defines the terms "because of sex" or "on the basis of sex" to express include pregnancy, childbirth, or related medical conditions:

> The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e–2(h) of this title shall be interpreted to permit otherwise.[53]

That sub-section of the PDA does not require, but simply permits an employer to pay for an abortion, unless the life of the mother is endangered or where medical complications have arisen from an abortion:

> This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.*[54]

Whatever faith-based groups attack the PDA or the PWFA on the basis of a comment or two by legislators during the debate on either act, the PDA expressly permits, but does not require employers to provide abortion benefits except under the two conditions above-described.

Of interest to employee benefits practitioners who design plans for religious entities, Title VII § 702(a) exempts "contains an exemption for an employer that is a "religious organization, association, educational institution, or society" carrying on religious duties, and Title VII § 703(e)(2) allows "a qualifying religious organization to assert as a defense to a Title VII claim of discrimination or retaliation that it made the challenged employment decision on the basis of religion."[55]

Of interest to all employee benefits practitioners who design health care plans, Title VII's preemption provision provides a federal law floor, but does not supplant state law that provides protection equal to or greater than Title VII.[56] As discussed in Part I.E. below, ERISA's Federal Law Savings Clause will not save from preemption state laws that frustrate the purpose of ERISA or federal labor law in states that lack state civil rights agencies with work-sharing agreements with the EEOC.

3. Salient Provisions of the PWFA

"Fast forwarding" 45 years, Congress passed the PWFA on December 29, 2022, with an effective date in 180 days; hence, the act took effect on July 27, 2023. On that date, the EEOC immediately accepted charges under the PWFA.

The PWFA tracks the definition of unlawful acts of the PDA, with delineations of "covered employer" unlawful employment practices:

> It shall be an unlawful employment practice for a covered entity to—
>
> (1) not make reasonable accommodations to the known limitations related to the pregnancy, childbirth, or related medical conditions of a qualified employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity;
>
> (2) require a qualified employee affected by pregnancy, childbirth, or related medical conditions to accept an accommodation other than any reasonable accommodation arrived at through the interactive process referred to in section 2000gg(7) of this title [section 102(7)];

> (3) deny employment opportunities to a qualified employee if such denial is based on the need of the covered entity to make reasonable accommodations to the known limitations related to the pregnancy, childbirth, or related medical conditions of the qualified employee;
>
> (4) require a qualified employee to take leave, whether paid or unpaid, if another reasonable accommodation can be provided to the known limitations related to the pregnancy, childbirth, or related medical conditions of the qualified employee; or
>
> (5) take adverse action in terms, conditions, or privileges of employment against a qualified employee on account of the employee requesting or using a reasonable accommodation to the known limitations related to the pregnancy, childbirth, or related medical conditions of the employee.[57]

The Final Rule implementing the PWFA, published in the Federal Register on April 19, 2024, contains the EEOC's position, in the Preamble, that it is appropriate to read the identical language (i.e., "pregnancy, childbirth, or related medical conditions") in the PDA and the PWFA, two statutes with the same purposes, to have the same meaning, even post-*Dobbs*.[58]

The term "covered employer" under the PWFA expressly includes, by cross reference, a "respondent," a covered entity under Title VII, Congress and presidential offices, state employers employing state employees covered under Section 304(a) of the Government Employee Rights Act of 1991 (the GERA), and federal sector agencies with equal employment actions/programs.[59] The PWFA does respect the Title VII exemptions for religious employers.[60]

The term "employee" covered under the PWFA expressly includes "applicant," employees and applicants under Title VII, federal employees and applicants under the Congressional Accountability Act of 1995 and Title 3, state employees covered under Section 304(a) of the GERA, and employees responsible for equal employment actions/programs in federal sector agencies.[61]

The PWFA defines "known limitation" as a "physical or mental condition related to, affected by, or arising out of pregnancy, childbirth, or related medical conditions that the employee or the employee's representative has communicated to the covered entity, whether or not such condition meets the definition of disability" under the Americans with Disabilities Act, as amended.[62]

The act also defines a "qualified employee" as an employee who, with or without reasonable accommodation, cannot perform an

essential function of the job. In a significant difference with the ADA, the PWFA includes within "qualified employee" an employee:

(1) Whose inability to perform an essential job function lasts only for a *temporary* period;

(2) Who can perform the essential job function(s) in the *near future;* and

(3) Whose inability to perform the essential function(s) can be *reasonably accommodated*.[63]

The PWFA does not require an employer- sponsored health plan to pay for or cover "any particular" item, procedure, or treatment: "Nothing in this chapter shall be construed— . . . (2) by regulation or otherwise, to require an employer-sponsored health plan to pay for or cover any particular item, procedure, or treatment or to affect any right or remedy available under any other Federal, State, or local law with respect to any such payment or coverage requirement."[64]

The PWFA expressly provides protection against retaliation against employees, applicants, or former employees for opposing actions made lawful under the act or for filing a charge, testifying, and/or participating in a procedure under the PWFA.[65] The act also expressly adds protection against certain retaliatory actions against "any individual" aiding or encouraging any other individual exercising or seeking to enjoy any right granted by the PWFA:

> It shall be unlawful to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of such individual having exercised or enjoyed, or on account of such individual having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this chapter.[66]

Under both sections, the person retaliated against need not be a "a qualified employee." Sub-section 1 protects any employee, and sub-section 2 protects any "individual." Thus, bystanders (such as coworkers) and third parties (such as clients, customers, or service providers) can bring such retaliation claims.

Perhaps mindful that the Supreme Court had held that Congress had exceeded its authority under the Enabling Clause of the Fourteenth Amendment by extending the RFRA to the states,[67] and that states remained immune from suit under the ADA by plaintiffs other than the federal government unless Congress waived the states' sovereign immunity,[68] the PWFA expressly waives state sovereign immunity:

> A State shall not be immune under the 11th Amendment to the Constitution from an action in a Federal or State court of competent jurisdiction for a violation of this chapter. In any action against a State for a violation of this chapter, remedies(including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in an action against any public or private entity other than a State.[69]

Finally, although the act labels an employer defense a "limitation," the PWFA describes that, in actions where the alleged unlawful employment practice involved a purported reasonable accommodation brought under 1981(a) (a federal cause of action to make or enforce contracts available to those alleging intentional race or sex discrimination), the employer may assert a defense, shoulder the burden of proving its good faith in providing the accommodation, and avoid an award of monetary damages:

> Notwithstanding subsections (a)(3), (b)(3), (c)(3), (d)(3), and (e)(3), if an unlawful employment practice involves the provision of a reasonable accommodation pursuant to this chapter or regulations implementing this chapter, damages may not be awarded under section 1981a of this title [42U.S.C. 1981a] if the covered entity demonstrates good faith efforts, in consultation with the employee with known limitations related to pregnancy, childbirth, or related medical conditions who has informed the covered entity that accommodation is needed, to identify and make a reasonable accommodation that would provide such employee with an equally effective opportunity and would not cause an undue hardship on the operation of the covered entity.[70]

The EEOC has issued two guidances related to the PWFA: the first as an NPRM now published as a Final Rule with modifications after the agency reviewed comments with which it agreed; and the second, published as an Interim Final Rule (IFR) amending EEOC procedures to include PWFA charges and investigations. The IFR, immediately effective on February 14, 2024, remains subject to change pending review of comments filed by April 15, 2024.[71]

4. The Lawsuit Challenging the EEOC Final Rule Implementing the PWFA

On April 25, 2024, led by attorneys in the State of Tennessee Attorney General's Office, 19 states from various federal appellate circuits filed a lawsuit in the Eastern District of Arkansas to challenge

the EEOC Final Rule implementing the PWFA.[72] Not surprisingly, the states attack the inclusion of "abortion rights" in the Final Rule in a five-count complaint.

In an attempt to manufacture standing based on irreparable harm, the States of Tennessee and Arkansas claim that they provide leave or pregnancy-related health care or accommodations to their female employees except for female employees who seek "elective abortions that are illegal under state law," so that the Final Rule is coercive. As irreparable harm, they also claim that, if they succeed in their lawsuit, they cannot recover the monetary costs and expenses incurred while their suit continued towards resolution.

The states may experience difficulty in asserting standing to bring the lawsuit because their own actions in following less than adequate state-law procedures may complicate their ability to demonstrate traceability or redressability under traditional federal rules of constitutional standing.

Should the EEOC counter-sue the plaintiff states under Title VII's preemption clause providing a federal floor for the employee benefits described in the PDA and the PWFA, the agency may also consider an inter-governmental agency strategy of agreeing to permit plan administrators to intervene based on ERISA preemption of state laws that subject a plan fiduciary to conflicting federal and state laws relating to employee health care benefits, i.e., federal laws governing ERISA health care benefits and state laws prohibiting employers from enforcing the terms of their plans or rights under Title I of ERISA.

The plan administrators could argue that the plaintiff states could not avoid preemption under ERISA's Federal Law Savings Clause to save their varied state "civil rights" laws from preemption under the PDA/PWFA as amendments of Title VII. As employee benefits practitioners remember, in *Shaw v. Delta Airlines*,[73] the Supreme Court found the New York disability law saved from preemption under ERISA's Federal Law Savings Clause because the state law helped to enforce Title VII, as amended by the PDA. The 17 states arguably do not help to enforce Title VII because at least one (and sometimes more than one) of those states:

- Lacks a civil rights law enforcing employment discrimination (Alabama, Arkansas (prohibiting only housing description));

- Enforces a restricted civil rights law pertaining only to employment with the state itself (Georgia);

- Fails to defer to the EEOC to investigate Title VII claims and allows state charges to be filed only after the state agency

reviews the charge and permits it to be filed (Tennessee, Indiana, Utah, Missouri, Kansas, and Oklahoma);

- Screens every charge and determines whether an investigation should continue (absent a requested Right to Sue letter) and after investigation may forward the charge "if appropriate" to the EEOC (Iowa);

- Prohibits a person from filing a state charge altogether if the person has filed an EEOC charge (Florida);

- Informs potential complainants that the state agency can take up to one year to finish investigating a complaint (Idaho);

- Provides only a lengthy intake questionnaire that announces it is not a charge form and requires the potential charging party to identify the EEOC as the appropriate agency and to indicate whether a charge has already been filed (South Carolina); or

- Provides an intake questionnaire form that requires filing within 180 days, informs plaintiff that the form is not a charge, and requires claimants to check only one of several designated boxes which do not specify pregnancy with a later reference to undefined "maternity benefits" (South Dakota).[74]

Only Nebraska, North Dakota, and West Virginia appear, on quick review, to investigate charges that violate both state and parts of federal law prohibited under Title VII and the ADA, but the complaint process does not indicate dual filing or investigation pursuant to a work-sharing agreement.[75] Nebraska and West Virginia do not announce a filing period; North Dakota informs potential complainants that the form must be filed within 300 days of the last act of harm.[76]

Even if all 17 states could satisfy standing requirements and avoid ERISA preemption, the PDA and the PWFA both amend Title VII and remain covered under Title VII's preemption provision. Often called a "rachet" provision because it turns only one way, i.e., providing a federal floor for benefits, so that states could provide more, but not less protection than federal law, Title VII's preemption provision provides conflict preemption.[77] As the Supreme Court observed in *California Savings & Loan Ass'n v. Guerra*, the "narrow scope of preemption available under [Title VII, as amended by the PDA] reflects the importance Congress attached to state antidiscrimination laws in achieving Title VII's goals of equal employment opportunity."[78]

Replete with legal allegations, the states' complaint claims irreparable harm because the Final Rule "forces the co-plaintiff States to violate their policies of regulating abortion to protect unborn life" purportedly "enacted by the representatives of its people" and impairs [the states'] interests in protecting their messaging with respect to the primacy of protecting fetal life and the damages caused by abortion.[79] However, the Republican legislatures in Kansas, who politicized constitutional rights yet again for this election cycle, adopted a statute that directly contradicted the majority of the state's voters, who had voted to uphold pregnancy termination rights.[80] In the November 2023 elections, abortion measures cost Republicans several defeats:

> [I]n addition to Ohio approving a ballot measure enshrining abortion protections in the state Constitution and effectively repealing a six-week ban, Virginia rejected Republican Gov. Glenn Youngkin's calls for a 15-week ban and handed Democrats control of the Legislature. Kentucky also reelected pro-abortion rights Gov. Andy Beshear, a Democrat, and Pennsylvania sent an abortion-rights supporter to the state Supreme Court.[81]

Predictions for the upcoming November 2024 election suggest that most of the plaintiff states in the Arkansas case will be acting against the will of the people for political end: Florida, whose 6-week total abortion ban took effect on May 1, 2024, will have abortion on the November 2024 ballot; while efforts to put the "abortion vote" on the ballot remain well underway in Missouri, Iowa, Arkansas, Nebraska, and South Dakota of the co-Plaintiff States, as well as Arizona, Nevada, Montana, and Pennsylvania.[82] By now, Justice Alito's hoped-for response by the people clearly backfired.

Even more concerning, the counts in the states' complaint threatens federalism, especially in Count IV, which contends that the Final Rule violates Article II and the Separation of Powers. According to plaintiffs, Article II vests all of the Executive Power in the president, and "[a]s a corollary" plaintiffs assert that "the Constitution demands that the President maintain the ability 'to remove those who assist him carrying out his duties."[83] Plaintiffs characterize this power as at "at-will removal power" applicable to all "multimember expert agencies" that "wield substantial executive power, so much so that the complaint seeks to restructure the EEOC,"[84] despite the fact that the holdover Republican general counsel refused to resign when Trump lost, as did the Republican EEOC chair, who stayed on as an EEOC Commissioner for 3 more years. In a frightening echo of the sloganeering about the "deep state" by the presumptive Republican nominee in the last two weeks, political scientists are estimating that he would seek to replace 70% of the federal employees.

In a brief overview of the remaining lengthy counts in the complaint, Count I contends that the Final Rule violates the PWFA itself, the long-standing Hyde amendment (designed to limit federal funding (e.g., Medicaid) for abortions of low-income women of color and other underserved populations) and the Weldon Amendment, the "major questions" doctrine reconfigured by the Roberts Supreme Court as reconstituted by Trump, Step 2 of the *Chevron* analysis, and (alternatively) *Chevron* itself – all in violation of the Administrative Procedures Act (APA).[85] As a Fact Sheet from the Guttmacher Institute explains: "The Weldon Amendment and related federal 'refusal of care' policies embolden health insurance plans, health care institutions and medical providers to deny abortion services and coverage, without regard to the impact on patients' rights, health or well-being and often under the rubric of protecting 'conscience' or 'religious freedom.'"[86] In her Fall 2024 column for this journal, this author intends to analyze the interplay, if any, between the Weldon Amendment and the express exemptions in the Final Rule for ACA Section 1557, just published in the Federal Register.

Count II alleges that the Final Rule violates federalism, state sovereignty, and the First Amendment, an assumption proceeding from the non-evident premise that states possess First Amendment Rights, a questionable argument that Alabama State Supreme Chief Justice Ray Moore seems to have lost when the Alabama Court of the Judiciary removed him from office in November 2003 for defying a federal court order to remove the marble monument of the Ten Commandments that he had placed in the Alabama Judicial Building.

Count III alleges that the Final Rule violates the APA because it runs counter to the evidence before the agency, impinges on the co-Plaintiffs' religious freedom, discounts the costs to Tennessee and Arkansas, and runs contrary to the Arkansas constitution."[87]

Count V brings the usual separate count for a declaratory judgment under the federal Declaratory Judgment Act for all of the relief (other than monetary relief) sought in the complaint.[88]

* * * * *

In short, the PWFA Final Rule appears to continue the agency interpretation of the PDA, and the complaint by the 17 states may face the standing issue yet again, given Title VII's religious exemption and given the inability of the plaintiff states to establish administrative costs as a "pocketbook injury" traceable to the federal agency sued (as opposed to Congress that passed the PWFA with rare bilateral support), as Justice Breyer explained in *California v. Texas*.[89]

Most troublingly, Count IV of the complaint incorporates a complete concentration of executive power in the President with no check or balance on his power to remove agency personnel whom he deems disloyal.

As Americans have awakened to the caste system established by *Dobbs,* the will of the people frustrated by the actions of their

representatives will likely drive the vote in the 2024 general election, just as the anger against the *Dobbs* decision drove the vote in 2022.

Until the courts begin to resolve what will probably be another litigation wave from conservative groups attempting to secure an extraterritorial reach for their abortion bans through threats, coercion, and invasion of PHI, however, the caste of second-class citizenship for women will persist.

II. DECLINING TO DISCLOSE PHI OF PREGNANT PERSONS WHO TRAVEL OUT OF STATE FOR PREGNANCY TERMINATION

Not only has the Biden Administration released the Final Rule interpreting the PWFA, but it has also released the 2024 Final HIPAA Privacy Rule To Support Reproductive Health Care Privacy (the 2024 Privacy Rule), issued by the Office for Civil Rights, the Office of the Secretary of Health and Human Services, and the Department of Health and Human Services, and published in the Federal Register on April 26, 2024.[90]

The 2024 Privacy Rule becomes effective on June 25, 2024 (i.e., 60 days after publication), and covered entities of all sizes will have 180 days beyond that effective date to comply with the Privacy Rule's provisions (for a total of 240 days), with the exception of the provisions delineating the requirements for the Notice of Privacy Practices (referenced in the Rule as the NPP or the 2024 Privacy Rule Part 2), which become effective February 16, 2026.[91]

In essence, although the 2024 Privacy Rule delineates permitted uses and disclosure of PHI for public health purposes, the Rule prohibits covered entities and their business associates (and those business associates' contractors) (new in the Final Rule) from using or disclosure of PHI in the face of subpoenas, discovery demands, and other requests that target specific individuals from attorneys general or prosecutors enforcing their states' abortion bans.

The HHS Office of Civil Rights (HHS OCR) evaluated more than 25,000 comments to the Proposed Rule and did make some modifications, as described in the Preamble to the Rule. HHS OCR will enforce the 2024 Privacy Rule.

A. The Basic Purpose of the HIPAA Rule: To Encourage Pregnant Persons to Entrust Health Care Providers With Their PHI

HHS OCR reaffirms that the 2024 Privacy Rule fulfills the basic purpose of the HIPAA Rules on privacy: to increase confidence in the

health care system and to address the "changing legal landscape" after *Dobbs* "that increases the likelihood that an individual's PHI may be disclosed in ways that cause harm to the interests that HIPAA seeks to protect, including the trust of individuals in health care providers and the health care system."[92]

HHS OCR recognizes that, after the *Dobbs* decision overturned *Roe v. Wade*, public officials and legislators have threatened to prosecute pregnant persons and providers and other facilitators of reproductive health care. The agency also recognizes that those threats have created a climate of fear. Moreover, infant and maternal mortality rates have risen since *Dobbs*. As the preamble states:

> The threat that PHI will be disclosed and used to conduct such an investigation against, or to impose liability upon, an individual or another person is likely to chill an individual's willingness to seek lawful health care treatment or to provide full information to their health care providers when obtaining that treatment, and on the willingness of health care providers to provide such care. These developments in the legal environment increase the potential hat use and disclosure of PHI about an individual's reproductive health will undermine access to and the quality of health care generally.
>
> In order to continue to protect privacy in a manner that promotes trust between individuals and health care providers and advances access to, and improves the quality of health care, we [presumably the Department, HHS OCR, and the Office of the Secretary] have determined that the Privacy Rule must be modified to limit the circumstances in which provisions of the Privacy Rule permit the use or disclosure of an individual's PHI about reproductive health care for certain non-health care purposes, where such use or disclosure could be detrimental to privacy of the individual or another person or the individual's trust in their health care providers.[93]

The 2024 Privacy Rule prohibits a regulated entity from using or disclosing an individual's PHI for conducting investigations or imposing liability on any person seeking, obtaining, providing, or facilitating reproductive health care lawful in the state where such health is provided or protected under federal law, including the federal Constitution:

> This final rule prohibits a regulated entity from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil, or administrative investigation into or imposing criminal, civil, or

> administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided, meaning that it is either: (1) lawful under the circumstances in which such health care is provided and in the state in which it is provided; or (2) protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which such health care is provided.[94]

B. Additional Definitions of "Person" and "Reproductive Health Care"

1. "Person"- 45 CFR § 160.103

The 2024 Privacy Rule incorporates 1 U.S.C. § 8 (informally known as the federal Dictionary Act, passed in 1996), in order to define the term "person" in the Act, in keeping with the agency's past practice. After reviewing comments, the Department reiterated that from its first iteration of the HIPAA rules in 2000 (after Congress did not act within 36 months of the passage of HIPAA in 1996 and thereby entrusted the rulemaking to the Department) and through the successive HIPAA and HITECH rules (the HIPAA Rules), the Department has consistently understood that the definitions in 1 U.S.C. 8 listed above include a "natural person," i.e., a living child that is born alive:

> The final rule adopts the proposed clarification of the definition of person, to mean a "natural person (meaning a human being who is born alive, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. Therefore, an "individual," "child"' or "victim" (e.g., a victim of crime under the HIPAA Rules must be a natural person.[95]

The Department footnotes that it makes no comment on "whether any state law confers a particular status upon a fertilized egg, embryo, or fetus."[96] However, 45 CFR §160.103 defines "person," "individual," and "child" as a natural person, a "child born alive."[97] Consistent with that definition, the Final Rule does not include a fertilized egg, fetus, or embryo as "child born alive."[98] The response to comments also clarifies that "[t]he final rule's clarification to define the term 'person' does not affect the ability of a parent to make decisions related to health care for an individual who is an unemancipated minor, and nothing in this rule dictates a standard of care. The application of this definition is limited to the HIPAA Rules."[99]

After reviewing more than 25,000 comments, the Department expressly added the sub-part (2) to the above prohibition and explained that "the Department had always intended" to include the U.S. Constitution to inform the determination of "lawful" reproductive health care:

> Additionally, the final rule modifies the regulatory text in 45 CFR 164.502(a)(5)(iii)(B)(*2*) to include an express reference to the U.S. Constitution as a source of Federal law for determining whether reproductive health care is lawful under the circumstances in which such health care is provided. The Department has always intended to include the U.S. Constitution as a source of Federal law, and the final regulatory text now explicitly reflects this. The regulatory text also makes clear that the U.S. Constitution is not the sole source of Federal law and that Federal statutes, regulations, and policies may be the relevant legal authority for determining whether the reproductive health care is protected, required, or authorized under Federal law. This final rule in no way supersedes applicable state law pertaining to the lawfulness of reproductive health care.[100]

2. "Reproductive Health Care"- Including Contraceptive, Prescribed or OTC

Section 160.103 of the HIPAA Rules defines "health care" as "care, services, or supplies related to the health of an individual." The definition "clarifies that the term 'includes but is not limited to' several identified types of care, services, and procedures265 and includes examples such as therapeutic, rehabilitative, or maintenance care, as well as sale or dispensing of drugs or devices."[101]

As some comments requested, the 2024 Privacy Rule now contains a new definition of, and a non-exhaustive list of, "reproductive health care."[102] That list includes some forms of care still protected under the federal Constitution, such as contraception.[103]

Consistent with its clarified definition of "lawful" reproductive health care, the Department also elaborated:

> Consistent with the definition of "health care" in the HIPAA Rules, the proposed definition of "reproductive health care" would have applied broadly and included not only reproductive health care and services furnished by a health care provider and supplies furnished in accordance with a prescription, but also care, services, or supplies furnished by other persons and non-prescription supplies purchased in connection with an individual's reproductive

> health. The Department proposed to use the term 'reproductive health care' rather than 'reproductive health services' to ensure that the term was interpreted broadly to capture all health care that could be furnished to address reproductive health, including the provision of medications and devices, whether prescription or over-the-counter.[104]

Last July, the FDA approved the first non-prescription OTC contraceptive,[105] and 29 states have passed laws that allow pharmacists to prescribe contraceptive care such as birth control pills or patches.[106] Retailers may sell and deliver OTC contraceptives intrastate without a prescription, but only in states where pregnancy termination remains legal. As this column went to press, 19 states completely ban or heavily restrict telehealth prescription for "medication abortion" and 14 states require "the physical presence of the prescribing clinician to receive the mediation."[107]

In the Summer 2023 issue of this journal, this author chronicled the many cases across the country challenging medication abortions and OTC contraceptives. Just last week, the justices heard oral argument in *Alliance for Hippocratic Medicine v. FDA*, a case challenging the FDA's very ability to authorize the conditions under which medications that safely and effectively induce pregnancy termination. In an amicus brief filed on behalf of medical association, the American Medical Association and the American College of Obstetricians and Gynecologists urged the Court to reverse the Fifth Circuit's ruling because it reinstates out-of-date restrictions on mifepristone:

> The Fifth Circuit's ruling is complex. If that decision is allowed to go into effect, the FDA's approval of mifepristone will stand, and the generic version of the pill will remain available under the same restrictions as brand-name Mifeprex. However, the Fifth Circuit's decision would turn back the clock and reinstate restrictions on mifepristone that were in effect prior to a 2016 risk evaluation and mitigation strategy issued by the FDA. This would change which health care professionals are able to prescribe the drug, reinstate the in-person dispensing requirement, and limit use of mifepristone to seven weeks of gestation. It would also presumably require a patient to submit to two more visits to their health care professional and possibly alter the recommended dosage prescribed to patients.
>
> Reimposing these outdated restrictions is completely unnecessary and not reflective of decades of data proving that mifepristone is safe and effective and that risk evaluation and mitigation strategies for mifepristone do not improve patient outcomes or safety.

> Additionally, these changes would result in increased delays in care for most patients and a complete loss of access to mifepristone for many others.[108]

3. Business Associates

HHS and OCR did agree with comments that, just like hospitals and health care providers and health care clearing houses, business associates should review the attestations that must accompany requests for the protected health information (PHI) of pregnant persons who seek reproductive health care. All of those entities must reasonably determine if a request falls within lawful disclosure.

4. Use and Disclosure Permitted Only for Public Health Purposes and Not for Targeted Investigations

The Department states that it always intended, and has now clarified in the 2024 Privacy Rule, that reproductive health care privacy rights under HIPAA may justify rejecting disclosure requests or subpoenas in connection with criminal, civil, and agency investigations. Such investigations target specific individuals for prosecution, rather than seeking information for public health purposes:

> The Department concludes that neither section 1178(b) nor the Privacy Rule's permissions to use and disclose PHI for the "public health" activities of surveillance, investigation, or intervention include conducting criminal, civil, or administrative investigations into, or imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating health care, including reproductive health care, nor do they include the identification of any person for such purposes. Such actions are not public health activities. . . . Public health surveillance, investigations, or interventions ensure the health of the community as a whole by addressing ongoing or prospective population-level issues such as the spread of communicable diseases, even where they involve interventions involving specific individuals. Such surveillance systems provide the necessary data to examine and potentially develop interventions to improve the public's health, such as providing education or resources to support individuals' access to health care and improve health outcomes and are not affected by this final rule. . . .
>
> By contrast, efforts to conduct criminal, civil, and administrative investigations or impose criminal, civil, and administrative liability on any person for the mere act of seeking, obtaining, providing,

> or facilitating health care generally target specific persons for particular conduct; they are not designed to address population-level health concerns and are not limited to information authorized to be collected by a public health or similar government authority for a public health activity. Thus, the exceptions in section 1178(b) for "public health" investigations, interventions, or surveillance do not limit the Department's ability to prohibit uses or disclosures of PHI for other purposes, such as judicial and administrative proceedings or law enforcement purposes.[109]

Examples of reasonable requests include seeking PHI without individual identifiers for public health purposes such as disease control and for bringing to justice health care providers and others who submit false claims for payment with federal Medicare funds. Most significantly, to protect pregnant persons, covered entities reviewing PHI requests can determine whether "the circumstances" show that the request is lawful by looking to the law of the state where the reproductive health care occurs, typically in states where such health care is legal:

> The Department is retaining the proposed framework for identifying the circumstances in which reproductive health care is lawful, and thus the prohibition applies. However, we are modifying the regulatory text of the Rule of Applicability to clarify its conditions. As revised, the regulatory text combines the first and third conditions of the Rule of Applicability into a revised 45 CFR 164.502(a)(5)(iii)(B)(*1*) that focuses on whether the reproductive health care at issue is lawful under the circumstances in which such health care is provided. Under the revised condition, the circumstances in which the prohibition applies are determined by the law of the state in which the health care is provided.[110]

After reviewing comments submitted insisting that the Proposed Rule did not respect state law bans, the Department reiterated that the HIPAA Rules contain privacy protections to increase trust by individuals that the health care they receive, including reproductive health care, will not result in the release of their PHI to any entity for purposes other than the purposes permitted by the HIPAA Rules. Therefore, the Department identified "efforts to conduct criminal, civil, and administrative investigations or impose criminal, civil, and administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating health care general target specific persons for particular conduct." Those efforts do not fall within public health investigations.

However, as to requiring individual authorizations to release PHI (apart from the required Notice requirements), after reviewing

comments, the Department did not require that covered entities follow specific written authorizations for disclosures by individuals. However, it noted that state laws requiring such authorizations provide greater privacy protection and are not federally preempted.[111]

The Department also cautioned that its authority did not extend beyond the covered entities identified in HIPAA: "We also clarify that because HIPAA only authorizes the Department to protect IIHI used or disclosed by covered entities and their business associates, we are not able to regulate information that individuals themselves store and share using consumer health apps."[112] The Biden Administration has previously cautioned that HIPAA does not protect the specific IIHI shared by consumers on such apps.

5. Adding a Regulatory Presumption of Lawfulness of the Reproductive Health Received

The Department has added a "regulatory presumption" of lawfulness of the reproductive health care received, measured by the law of the state in which the health care is performed, upon which covered entities may rely in determining whether to respond to a request for PHI/Individually Identifiable Health Information (IIHI):

> Considering the many comments expressing concern about the burden associated with, the difficulty of, or the liability that could attach when someone other than the person who provided the health care must determine whether the underlying reproductive health care is lawful, the Department is adding a regulatory presumption in the final rule. . . .
>
> [T]he regulatory presumption in 45 CFR 164.502(a)(5)(iii)(C) will permit a regulated entity receiving a PHI request that may be subject to the prohibition to presume the reproductive health care at issue was lawful under the circumstances in which such health care was provided when provided by a person other than the regulated entity receiving the request. The presumption includes a knowledge requirement such that the regulated entity must not have actual knowledge that the reproductive health care was unlawful under the circumstances in which such health care was provided or factual information supplied by the person requesting the use or disclosure of PHI that demonstrates to the regulated entity a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which such health care was provided.[113]

The Department intends the attestation requirement to reduce the investigation burden on covered entities and employs this rebuttable

presumption for that purpose, with the burden of rebutting the presumption on the individual, public official, or entity seeking the PHI to demonstrate that the information is sought for a health care purpose.

6. The Attestation Requirement

Under the Final Rule, as modified, covered entities must still make reasonable determinations, even with the regulatory presumption, and may not add requirements for the requesting third party to fulfill.

After reviewing comments, the Department agreed to require Business Associates (and thereby for Business Associates to require their subcontractors to comply with the Final Rule) to secure attestations that comply with the requirements of attestations in the Final Rule).[114]

The Department intends the attestation requirement "to reduce the burden of determining whether the PHI request is for a purpose prohibited under 45 CFR 164.502(a)(5)(iii), but it does not absolve regulated entities of the responsibility of making this determination, nor does it absolve regulated entities of the responsibility for ensuring that such requests meet the other conditions of the relevant permission":

> We are modifying the proposal by revising 45 CFR 164.509(a)(1) to clarify that a regulated entity may not use or disclose PHI where the use or disclosure does not meet all of the Privacy Rule's applicable conditions, including the attestation requirement. While this is consistent with the existing requirements of the Privacy Rule, we determined that it was necessary to reiterate this requirement here based on comments we received.[115]

The Department is finalizing the contents requirements for attestations:

> The Department is finalizing the proposed content requirements with modifications as follows. Specifically, the Department is finalizing the proposal that an attestation must include that the person requesting the disclosure confirm the types of PHI that they are requesting; clearly identify the name of the individual whose PHI is being requested, if practicable, or if not practicable, the class of individuals whose PHI is being requested; and confirm, in writing, that the use or disclosure is not for a purpose prohibited under 45 CFR 164.502(a)(5)(iii). For purposes of the "class of individuals" described in 45 CFR 164.509(c)(1)(i)(B), the Department clarifies that the requesting entity may describe such a class in general terms – for example, as all individuals who were treated by a certain health care provider or for whom a certain health

> care provider submitted claims, all individuals who received a certain procedure, or all individuals with given health insurance coverage.[116]

Perhaps responding to the particular outspokenness of some state attorneys general, the Department would likely find it unreasonable under 2024 Privacy Rule for a covered entity to rely on statements in an attestation from a public official "who represents that [the] request is for a purpose that is not prohibited, if the request for PHI is overly broad for its purported purpose and the public official has publicly stated that [he/she/]they will be investigating health care providers for providing reproductive health care. In such cases, regulated entities should consider the circumstances surrounding an attestation to determine whether they can reasonably rely on the attestation."[117]

Nonetheless, a covered entity's reliance on material misrepresentations in an attestation that the covered entity actually knew were false would not be reasonable.

Covered entities submitted comments concerning one of the more complex determinations of attestations: whether the covered entity should treat an individual as a personal representative. Beyond a determination under the circumstances that the individual created the need for reproductive health services, e.g., as a child abuser or as an intimate partner who sexually assaulted the person for whom reproductive health care should be provided, the Department is also finalizing a rule that offers some guidance for such circumstances.

* * * * *

In sum, despite the thoughtful nature of HHS OCR, the Department, and the Office of the Secretary in evaluating the comments received in light of the purposes of the HIPAA Privacy Rules, those states and their handmaid groups that seek to enforce state abortion bans extraterritorially will undoubtedly sharpen their pencils to file laws against various provisions in the complex 2024 Privacy Rule.

III. CONCLUSION

One hundred years since suffragists were force-fed and dying, spat upon and assaulted with no police protection by thousands of men simply because they chose to march near the White House, their great-great-granddaughters remain captive. Held fast by resurrected laws passed by men when women had no separate legal status, women are still regarded, as literary critics describe the captive women in Ibsen's depressing plays, "spared from drudgery," but "cut off from functional activity":

> If their fathers and husbands were rich enough to keep them in indolence, they might be given excellent formalistic educations, but they were separated from the world and from life by a Chinese wall of proprieties which served to frustrate any desires for active self-expression. The wall was built of modesty, helplessness, delicacy, gratitude[;] and chastity was valued more. . . . Supreme virtue was obedient.

They were either more intimate servants, or decorative hothouse plants.[118]

Employee benefits plan designers, plan administrators and third-party administrators of group health plans, and employee benefits litigators, will find their clients caught between statutes that protect and statutes that invade reproductive health care decisions, extensive federal guidance and regulations, and widespread litigation challenges to that guidance and regulations. Far from removing those questions from the judicial arena, as Justice Alito boasted *Dobbs* would accomplish, decisions about reproductive health care will continue to repose in the hands of judges, not health care professionals.

Courts will face complex issues under the two new Final Rules described in this column, as states continue to pass "fetal personhood" laws that value the living mother less than the child not yet a natural person born alive. As yet another election that will turn on whether courts will actually uphold the will of the majority of Americans or the narrow minority view of representatives determined to cling to power in state legislatures by creating a caste system that devalues pregnant persons, the conflict between pragmatism and textualism described by Justice Breyer will play out on the national stage.

Meanwhile, maternity deserts will widen, and American maternal and infant mortality rates will remain the highest among economically developed nations. Women forced to carry stillborn babies will lose their lives and limbs from sepsis because their health care providers will not risk whether their abortions would qualify under the Texas statute as an exception to the six-week ban.

Young girls like the 10-year-old Ohio rape victim treated to reproductive health care by an Indiana OB/GYN then persecuted by the attorney general of Indiana (who tried to void her license but managed to secure her censure), and the 11-year-old in the Oscar-nominated docudrama entitled "Red, White, and Blue" forced to travel with her mother a thousand miles and to conceal the cause of their road trip because she matters far less to her own state and to the Supreme Court than the 500-600-cell blastocyst growing inside of her, not for months yet to become a 28,000-cell natural person born alive.

Sadly, how far we have not come.

NOTES

1. Stephen Breyer, Reading the Constitution: Why I Chose Pragmatism, Not Textualism (Simon & Schuster, New York, 2024).

2. For this concept, Justice Breyer cites Justice Felix Frankfurther, "Some Reflections on the Reading of Statutes," 47 Columbia Law Review. 527, 428 (1947).

3. Breyer, supra n 1, preface, p. xx.

4. 597 U.S. 215, 142 S.Ct. 2228 (2022).

5. States of Tennessee et al v. Equal Employment Opportunity Commission, No. 2:24cv84-DPM (E.D. Ark).

6. 429 U.S. 125 (1976).

7. 400 U.S. 542 (1971).

8. 414 U.S. 632 (1974).

9. The author suggests that readers take some time to read or to re-read *The Brethren* regarding Justices Black and Harlan.

10. *Supra*, n. 8, at 641.

11. *Id.*, note 9.

12. 417 U.S. 484 (1974).

13. 429 U.S. 146, at 152 (Dissent, Brennan, J.)..

14. Kathleen F. McGrath, "Pregnancy-Based Discrimination—General Electric Co. v. Gilbert—and Alternative Stat Remedies, 81 Dickinson L. Rev. 517 (1977), available at https://ideas.dickinsonlaw.psu.edu/dlra/vol81/iss3/6.

15. *Gilbert v. General Electric Co.*, 519 F.2d 661 (4th Cir. 1975), rev'd. 429 U.S. 125 (1976).

16. *Id.*, at 140-41.

17. *Supra*, n. 11, 429 U.S. at 150, n. 1.

18. The White House, "Honoring 60 Years of the Equal Pay Act and Advancing Pay Equity," June 10, 2023, available at https://www.whitehouse.gov/gpc/briefing-room/2023/06/10/honoring-60-years-of-the-equal-pay-act-and-advancing-pay-equity/#:~:text=In%201963%2C%20women%20overall%20were,pay%20gap%2C%20pay%20disparities%20persist.

19. *Id.*, at 138.

20. *Supra*, n. 12 at 151, n. 4.

21. *Id.*, at 147-48.

22. *Id.*, at 151.

23. *Id.*

24. *Id.*

25. *Supra*, n. 6, at 134.

26. *Id.*, at 136.

27. *Supra*, n. 6, at 134.

28. 404 U.S. 71 (1971) (Idaho statute excluding women from serving as executors of estates).

29. 411 U.S. 677 (1973) (federal statutes excluded women in military service from enrolling as dependent in their husbands' better military insurance unless the women were more than 50% dependent on their husbands for income).

30. *Supra*, n. 6, at 134.

31. *Id.*, at 135.

32. *Supra*, n. 12 at 149.

33. *Id.*

34. House Select Committee to Investigate the January 6th Attack on the United States Capitol, *The January 6th Report* (published by the New Yorker in partnership with Celadon Books (December 22, 2022), also available at https://www.govinfo.gov/content/pkg/GPO-J6-REPORT/pdf/GPO-J6-REPORT.pdf.

35. 429 U.S. at 160-62 (Dissent, Stevens, J.).

36. "Pregnancy Mortality Surveillance System," available at https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=About%20the%20Pregnancy%20Mortality%20Surveillance%20System%20(PMSS),-CDC%20conducts%20national&text=The%20Pregnancy%20Mortality%20Surveillance%20System%20(PMSS)%20defines%20a%20pregnancy-,or%20aggravated%20by%20the%20pregnancy.

37. *Id.*

38. https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

39. *Id.*

40. Eugene DeClerque and Laurie C. Zephryn, Commonwealth Fund Primer, "Severe Maternal Morbidity United States), October 2021, available at https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer.

41. *Id.*, p. 3.

42. *Id.*

43. World Health Organization. International statistical classification of diseases and related health problems, 10th revision (ICD–10). 2008 ed. Geneva, Switzerland. 2009, as noted in Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2021," Center for Disease Control, National Center for Health Statistics, Health E-Stats (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#ref2 and updating Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2020," NCHS Health E-Stats. 2022, p. 1, DOI: available at https://stacks.cdc.gov/view/cdc/113967.

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45. *Id.*

46. *Id.*

47. See, "Pregnancy Mortality Surveillance Systems," supra, n. 7, and tables contained therein.

48. Ranji, Usha, Alina Salganikoff, Lori Sobel, and Annette Gomez. "Financing Family Planning Services for Low-Income Women: The Role of Public Programs" @kkf.org, October 25, 2019, available at https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/. (Note: The Kaiser Permanente acknowledged the Kaiser Family Foundation as of October 2023 as one of three "cooperative" organizations within Kaiser Permanente on the Kaiser Permanente website.)

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52. 434 U.S. at 139-40.

53. 42 U.S.C. § 2000e(k).

54. *Id.* (italics added.).

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56. 42 U.S.C. §§ 703a and 704(h).

57. 42 U.S.C. § 2000gg-1.

58. Final Rule, Implementation of Pregnant Workers Fairness Act, 89 Fed. Reg. 29,096, 29,111 (April 19, 2024).

59. 42 U.S.C. § 2000gg(2).

60. 42 U.S.C. § 2000gg-5.

61. 42 U.S.C. § 2000gg(3).

62. 42 U.S.C. § 2000gg(4); ADA, as amended, 42 U.S.C. 12101 et seq.

63. 42 U.S.C. § 2000gg(6).

64. 42 U.S.C. § 2000gg-5(a)(2).

65. 42 U.S.C. § 2000gg-2(f)(1).

66. 42 U.S.C. § 2000gg-2(f)(2).

67. *City of Boerne v. Flores*, 421 U.S. 507 (1997).

68. *Board of Trustees of the University of Alabama v. Garrett*, 531 U.S. 356 (2001).

69. 42 U.S.C. § 2000gg-4.

70. 42 U.S.C. § 2000gg-2(g).

71. See the IFR, available at https://www.federalregister.gov/documents/2024/02/14/2024-02764/amendment-of-procedural-and-administrative-regulations-to-include-the-pregnant-workers-fairness-act#:~:text=The%20PWFA%20requires%20a%20covered,on%20the%20employer's%20operation%20of.

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75. *Id.*

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85. *Id.*, at ¶¶110-118.

86. The Guttmacher Institute, "Fact Sheet - Federal Policy Snapshot – The Weldon Amendment: Interfering with Abortion Coverage and Care," July 2021, available at: https://www.guttmacher.org/sites/default/files/factsheet/weldon-amendment.pdf.

87. *Id.*, at ¶¶126-130.

88. *Id.*, at ¶¶140-143.

89. 593 U.S. 659 (2021).

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91. 2024 Privacy Rule, Preamble, "3. Final Rule," 89 Fed. Reg. at 32979.

92. *Id.*, at 32978.

93. *Id.* at 32978 and at II.B. 32987.

94. *Id.*, at V. Summary of Final Rule Provisions and Public Comments and Responses, at 32996.

95. *Id.*, at 32997.

96. *Id.*, n. 187 citing 1 U.S.C. § 8(a).

97. 2024 Privacy Rule, Preamble, V.A.1. "Section 160.103 Definitions – 1. Clarifying the Definition of "Person," at 32997-32998.

98. *Id.*

99. *Id.* at 32998.

100. *Id.*, at 33014.

101. 2024 Privacy Rule, Preamble, V.A.3. "Section 160.103 Definitions – 3. Adding a Definition of "Reproductive Health Care," at 33005.

102. *Id.*, at 33005-33006.

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104. *Id.* at 33005.

105. "FDA Approves First Nonprescription Daily Oral Contraceptive," U.S. Good and Drug Administration (July 13, 2023), available at https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription=daily-oral-contraceptive.

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