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EMPLOYEE BENEFITS DEVELOPMENTS FEBRUARY 2013

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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Health Care Reform: HHS Proposes Substantial Reinsurance Fee

The Patient Protection and Affordable Care Act (PPACA) establishes, among other things, a transitional reinsurance program to provide payments to health insurance issuers that cover higher-risk populations in connection with health care reform. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The transitional reinsurance program is in place for 2014, 2015, and 2016. PPACA requires a reinsurance pool of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. It also requires annual contributions to the U.S. Treasury of $2 billion, $2 billion, and $1 billion for those years, respectively. These contributions are funded by health insurance issuers and by self-insured group health plans.

Under recently issued proposed regulations, the Department of Health and Human Services (HHS) would impose an estimated reinsurance fee of $5.25 per month ($63 per year) per covered life beginning in 2014. Covered lives include covered employees and covered dependents, and multiple methods are offered for counting covered lives.

With respect to a fully insured policy, the health insurance issuer must pay the reinsurance fee. For self-funded major medical coverage, the self-insured plan is ultimately liable for the reinsurance fee. By November 15 of each year, contributing entities must submit to HHS the average number of covered lives of reinsurance contribution enrollees for the year. Within 15 days of submitting the annual enrollment count to HHS or December 15, whichever is later, HHS will notify contributing entities of required contributions, and those contributions are due within 30 days. So, for example, the 2014 reinsurance fee will be due no later than January 15, 2015.

Not all group health programs will be subject to the reinsurance fee. The group health programs excepted from the reinsurance fees include health savings accounts, health flexible spending accounts, stand-alone dental and vision plans, most employee assistance plans, and disease management and wellness programs. Under a nonduplication rule included in the proposed regulations, if a plan sponsor maintains two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives, then the multiple plans would be treated as a single self-insured group health plan for purposes of calculating any reinsurance fees. (77 Fed. Reg. 73118)

CASES

No ERISA Section 510 Violations Found in Pair of Sixth Circuit Cases

Section 510 of the Employee Retirement Income Security Act (ERISA) prohibits employers from retaliating or discriminating against participants in employee benefit plans for exercising rights they are entitled to under the plans. It also prohibits employers from discharging or discriminating against plan participants for the purpose of interfering with the attainment of any right to which the participants may become entitled under a plan. To establish an ERISA benefit interference claim, a plaintiff must demonstrate by the preponderance of evidence that prohibited employer conduct was taken for the purpose of interfering with the attainment of any right the participant may become entitled to under the plan. In two recent cases heard by the U.S. Court of Appeals for the Sixth Circuit, plaintiffs alleged their employment was terminated, in part, because of the high medical costs they or their spouses incurred while covered by their employers' plans. However, in both cases, the courts held that the plaintiffs failed to provide sufficient evidence that their employers terminated their employment with the specific intent of avoiding the payment of future medical expenses. As a result, neither claim was successful.

The issue of ERISA Section 510 claims has recently been discussed as a potential concern for employers contemplating reducing their employees' hours to avoid shared responsibility payments under PPACA. Under these provisions of PPACA, employers could be liable for tax penalties if they fail to provide affordable, minimum value coverage to their full-time employees (average 30 hours of service per week). The question that has been raised is whether reducing an employee's hours to fewer than 30 hours per week would interfere with the employee's right to attain a plan benefit, and thus constitute an ERISA Section 510 claim. Although this is an open question, as the cases in the Sixth Circuit illustrate, such a claim would be required to show an employer's specific intent to interfere with an employee's attainment of a benefit. While we believe business decisions regarding workforce scheduling would survive a Section 510 claim, employers should seek legal advice before making significant changes in an employee's work schedule if the change would result in a loss of benefits. (*Gaglioti v. Levin Group Inc.* (6th Circuit 2012) and *Laws v. HealthSouth Northern Kentucky Rehabilitation Hospital LP* (6th Circuit 2012))

Failure to Process Rollover Request May Constitute Fiduciary Breach

A district court has held that a plan's failure to comply with a participant's rollover instructions, resulting in the participant's account losing approximately $25,000 in value, may constitute a breach of the plan administrator's fiduciary duty.

John Segura was an employee of Dr. Reddy's Laboratories until his employment terminated on June 30, 2011. Dr. Reddy's was both the plan sponsor and plan administrator of the Dr. Reddy's 401(k) profit-sharing plan in which Segura was a participant. The plan provided for distributions to be made in event of a participant's separation from service or death.

Following his termination, Segura worked for Dr. Reddy's as an independent contractor while employed by Klein Hersh International. On July 27, 2011, Segura requested his account balance in the Plan be rolled over to an individual retirement account. Dr. Reddy's denied Segura's request on August 9, 2011, for the stated reason that Segura was still providing services to Dr. Reddy's, and he therefore did not qualify for a distribution. No additional explanation was offered by Dr. Reddy's, and no provisions of the plan were cited.

Dr. Reddy's argued that Segura was considered a leased employee for the period from July 1, 2011, until October 7, 2011, and thus was not considered to have incurred a separation from service under the plan until October 7, 2011. Dr. Reddy's approved Segura's request for a rollover distribution at that time. During the period from Segura's initial rollover request on July 27, 2011, until October 7, 2011, Segura's account lost approximately $25,000 in value.

Without deciding the factual issue of whether Segura incurred a separation from service on June 30, 2011, or October 7, 2011, that would entitle him to a distribution under the plan, the district court assumed for purposes of Dr. Reddy's motion to dismiss that Segura incurred a separation from service on June 30, 2011, as alleged in his complaint, and held that the facts alleged by Segura in his complaint stated a cause of action for breach of fiduciary duty. The court held that the alleged breach of fiduciary duty arose from the fact that Dr. Reddy's August 9, 2011, denial letter made a material misrepresentation or omission by failing to offer any explanation of why Dr. Reddy's considered Segura still employed for purposes of the plan.

The holding highlights the continuing importance of following a plan's claims procedures, which, if they are to be compliant with ERISA, must require that a notice denying a participant's claim for benefits set forth, among other items, specific reasons for the adverse determination and specific references to the plan provisions on which the determination is based. Of course, not only does a failure to follow a plan's claims procedures potentially implicate fiduciary issues, it also potentially affects the degree of deference a court may afford a plan administrator's decision to deny a participant's claim for benefits. (*Segura v. Dr. Reddy's Laboratories, Inc.* (D.N.J. December 21, 2012)

Improper Delegation to TPA Results in Loss of Deferential Review

A recent case illustrates the importance of ensuring that an employer's delegation of claims authority to a third-party administrator (TPA) is accomplished in accordance with the documents governing the plan. Where fiduciary responsibilities are properly delegated to a TPA, benefit denial decisions that are challenged in court are generally reviewed by the court under a standard that is quite favorable to the employer. Under this standard, referred to as the "Firestone standard" after the seminal case on this issue, a court will generally uphold a TPA's decision to deny a benefit if there is any

reasonable basis for the decision, even if the court would have arrived at a different conclusion.

In *Belheimer v. Federal Express Corp. Long Term Disability Plan*, the administrative service agreement between FedEx and the TPA delegated to the TPA the authority to decide claims. The plaintiff argued that such a grant of authority was not proper because the governing plan document did not authorize the delegation of discretionary claims authority to the TPA. The result, according to the plaintiff, is that the TPA's decision to deny his claim for long-term disability benefits should be afforded no deference by the court. The court agreed with the plaintiff finding that FedEx had failed to follow proper procedures to amend the official plan document to allow such a delegation. The court found that, in the absence of a plan provision authorizing delegation, the delegation in the administrative services agreement was nothing more than an "outsourcing" of the appeals function; therefore, the TPA's decision was not entitled to deferential review.

We expect PPACA to spark employer interest in self-funded health plans. Employers who choose to self-fund and to delegate the authority to decide claims to their TPA through an administrative services agreement should be sure the governing plan document authorizes the delegation. We should note that such a delegation appearing only in the SPD may not be considered an appropriate delegation. (*Belheimer v. Federal Express Corp. Long Term Disability Plan*, (D.S.C. Nov. 28, 2012))

Eighth Circuit Upholds Company Denial of Severance Benefits

A recent decision by the Court of Appeals for the Eighth Circuit, upholding a company's decision to deny severance benefits to a terminated employee, demonstrates the importance of maintaining a severance plan document under ERISA and of following the plan's terms and claims procedures. In this case, a 25-year company employee was terminated for attempting to remove, or "misappropriate," company property, specifically, a set of speakers. When the terminated employee requested severance under the company's severance pay plan, he was informed in a claim denial notice that because his actions were deemed as willful misconduct, he was not entitled to benefits under the severance plan. The plan's summary plan descriptionspecifies that benefits are provided to eligible employees upon an involuntary termination "due to unsatisfactory job performance for reasons other than willful misconduct." The company determined that the employee was ineligible for benefits under the terms of the plan because he was terminated for violating company policy, which was deemed willful misconduct.

Following exhaustion of the claims appeal process, the employee filed suit challenging the denial of his severance benefits. Finding in favor of the company, a district court granted the company's claim for summary judgment on the employee's ERISA claim. On appeal, the Eighth Circuit cited the plan's language giving discretionary authority to the plan administrator in upholding the district court's decision to review the company's interpretation of the plan for abuse of discretion, rather than applying a less deferential standard of judicial review. Although it found the district court erred in relying on an affidavit that was not in the administrative record in making is decision, the appeals court concluded the error "was harmless as the administrative record reasonably supports the conclusion" the company reached. Under the abuse-of-discretion standard, the Eighth Circuit upheld the district court's ruling that the administrator's interpretation of the plan was reasonable and that the decision to deny benefits was supported by substantial evidence. The court noted that there is no indication in the administrative record that the employee was discharged for any reason other than violation of company policy, and that the court is "limited to determining whether a reasonable person could have interpreted and applied the

ERISA plan in the way that the administrator did." The court also rejected the employee's argument that his claim was not afforded a full and fair review, noting the company provided the employee with a sufficient explanation for the denial of his claim, including the specific misconduct involved. (*Carr v. Anheuser-Busch Companies, Inc.* (8th Circ. 2012))