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RULINGS, OPINIONS, ETC.

Agencies Issue New FAQs Regarding SBC Implementation and Mental Health Parity

Once again, the U.S. Departments of Labor (DOL), Health and Human Services, and of the Treasury have issued a set of frequently asked questions (FAQs) regarding the Patient Protection and Affordable Care Act (PPACA) and other health benefit issues. This recent guidance, the seventh in a series of FAQs that the agencies have published, focuses on the effective date for the Summary of Benefits and Coverage (SBC). The FAQs also provide clarity regarding the application of certain aspects of the Mental Health Parity and Addiction Equity Act (MHPAEA). Below is a summary of two of the most broadly applicable issues addressed by the recent guidance.

Summary of Benefits and Coverage. Under PPACA, both insured and self-insured group health plans will at times be required to provide participants and beneficiaries with an SBC. The SBC is intended to be a concise, easy-to-read document containing information about plan benefits and coverage options. For insured medical plans, the obligation to provide the SBC is on either the insurer or plan administrator. For self-insured medical plans, the obligation to provide the SBC is on the plan administrator.

Under PPACA, the effective date for SBC disclosure obligations was March 23, 2012. However, the FAQs make it clear that this effective date will be delayed until after the final regulations are issued. The FAQs further note that the final regulations will include "an applicability date that gives group health plans and health insurance issuers sufficient time to comply." Although the effective date for this disclosure requirement has been delayed, plan administrators should take steps now to contact their medical insurance providers and third party administrators to determine which party will have the responsibility for drafting and distributing the SBC when the law becomes effective.

Mental Health Parity and Addiction Equity Act. Under MHPAEA, plans and insurers are prohibited from imposing more restrictive limitations on mental health and substance abuse benefits than medical/surgical benefits offered under their plans. The type of prohibited discrimination extends to non-quantitative treatment limitations. For example, a plan cannot require prior authorization for the medical necessity of mental health and substance abuse benefits if prior authorization is not required for medical/surgical benefits. Similarly, a plan would be in violation of MHPAEA if it routinely approved inpatient benefits for medical/surgical benefits for a period of seven days before a treatment plan was submitted to the patient's provider and approved by the plan, but routinely approved inpatient mental health and substance abuse disorder benefits for a period of only one day before a treatment plan was submitted. Again, plan administrators should contact their insurers and third party administrators to confirm that their plan terms and operation are in compliance with MHPAEA.

All of the DOL FAQs from this series can be found by clicking on the "FAQs" tab on the left side of the DOL Employee Benefit Security Administration website at www.dol.gov/ebsa. You can go directly to this most recent release at: www.dol.gov/ebsa/faqs/faq-aca7.html

Health Plan Not Liable for Health Care Provider Negligence

In *Cervantes v. Health Plan of Nevada, Inc.* (Supreme Court of Nevada, 2011), the plaintiff sued Health Plan of Nevada, Inc. and others for personal harm suffered as a result of an illness she claims to have contracted while receiving treatment at an out-patient facility that was part of her health plan's network of providers. Even though the defendants did not deliver the negligent care that resulted in her illness, she sued them anyway on the theory that they should not have permitted a "blatantly unsafe" provider to remain in the provider network. By so doing, she alleged that the defendants breached their duty to deliver quality care.

The court held in favor of the defendants. According to the court, the viability of the plaintiff's claim hinged on whether the defendants "merely facilitated" the selection of providers or "leased out" its existing network of providers. The court found that the self-funded Employee Retirement Income Security Act of 1974 (ERISA) plan selected its own providers, retaining the defendants as agents for the purposes of negotiating contracts with the providers and, as such, merely facilitated the selection of providers. Because the plan selected its own providers, the activities of the defendant on behalf of the plan were not independent of the plan. In other words, the selection of providers was an administrative decision that could not expose the plan to damages based on personal harm. Based on the court's rationale, the decision might have been different if the defendants had "leased" their provider network to the plan. Cervantes v. Health Plan of Nevada, Inc. (Sup. Ct. of Nevada, 2011)

IRS Extends Deadline for Section 436 Amendment

Internal Revenue Code § 436 (IRC) was added by the Pension Protection Act of 2006 (PPA) and provides for limitations on benefit payments and accruals that do not meet certain funding level targets required by PPA. The Internal Revenue Service (IRS) has extended the deadline for sponsors of defined benefit plans to adopt amendments reflecting the provisions of IRC § 436.

The deadline had been December 31, 2011 for calendar-year plans. In Notice 2011-96, the deadline was extended to the latest of the following:

- The last day of the first plan year beginning on or after January 1, 2012 (December 31, 2012 for calendar-year plans)
- The last day of the plan year in which Section 436 is first effective for the defined benefit plan
- The due date, including extensions for the sponsor's tax return for the tax year, which contains the first day of the defined benefit plan year for which Section 436 is first effective

The IRS also issued sample amendments that a defined benefit plan sponsor could use to adopt amendments to reflect IRC § 436 requirements. Sponsors of defined benefit plans should review whether IRC § 436 amendments had been adopted and whether any additional actions will need to be taken before the end of the plan year beginning in 2012.

Subrogation: When Does "Full Reimbursement" Not Mean Full Reimbursement?

The plaintiff in a subrogation case coming out of the Court of Appeals for the Third Circuit was involved in a car accident. The self-insured medical plan under which he was covered paid $66,866 to cover his medical expenses stemming from multiple surgeries. The plan had a subrogation provision that required full reimbursement be made to the plan for any medical bills paid out of "any monies received." The plaintiff recovered settlement amounts totaling $110,000, $44,000 of which had to be paid to his attorneys. Citing the plan's subrogation language, the plan sponsor, U.S. Airways, demanded full reimbursement from the plaintiff of the $66,866. When he did not pay, the plan sponsor sued under the Employee Retirement Income Security Act of 1974 (ERISA) seeking "appropriate equitable relief."

The plaintiff argued that it would be inequitable if he were required to reimburse the plan in full when he had not been fully compensated for his injuries. The plaintiff also argued that the plan sponsor would be unjustly enriched because the plan sponsor would receive full reimbursement without contributing to associated legal costs borne by the plaintiff. The federal trial court that heard the case, however, agreed with the plan sponsor and awarded full recovery from the plaintiff via a summary judgment order.

The plaintiff appealed to the Third Circuit, which recently held the plan is not entitled to full reimbursement. At issue was the meaning of "appropriate equitable relief." In reversing the federal trial court's ruling, the Third Circuit found that it would be a windfall for U.S. Airways to fully recover from the plaintiff without paying a share of attorney's fees. The court reasoned that through the use of the ERISA term "appropriate equitable relief," Congress intended to allow the defenses typically available in equity, including unjust enrichment. The case was remanded to the district court for a determination of what portion of the attorney's fees should be paid by the plan sponsor.

Prior to the ruling in this case, the Third Circuit aligned with a number of other circuit courts, which have refused to impose any limits on the right of reimbursement. It remains to be seen whether the decision in this case will influence other circuit courts to similarly modify their positions. (*U.S. Airways, Inc. v. McCutchen*, 3rd Cir. 2011)

Provision in Asset Purchase Agreement Blocks Buyer From Increasing Retired Acquired Employees' Health Premiums

The Court of Appeals for the Fifth Circuit held that a provision in an asset purchase agreement (APA) relating to post-retirement medical and life insurance benefits for acquired employees constituted a plan amendment, and that the provision was assumed in the buyer's subsequent bankruptcy.

The relevant provision in the APA stipulated that the buyer provide acquired employees with post-retirement medical and life insurance benefits that were no less favorable than those benefits provided under the seller's benefit plans. An increase in premium payments required of acquired employees was considered to be a reduction in benefits. The buyer was entitled to reduce benefits with the seller's consent, which could not be withheld to the extent that the seller had reduced benefits under its
benefit plans.

Subsequent to the acquisition, the buyer filed for Chapter 11 bankruptcy. The confirmation order and plan of reorganization rejected certain executory contracts, including the APA. The confirmation order also provided that retiree benefits were executory contracts that were assumed pursuant to the plan of reorganization. The plan of reorganization likewise provided that the buyer's various benefit programs were executory contracts that were assumed under the plan of reorganization.

After emerging from bankruptcy, the buyer raised retired acquired employees' premiums on three separate occasions. Affected retirees then brought suit.

Applying the test announced in *Halliburton Co. Benefits Committee v. Graves*, the Fifth Circuit held that the APA constituted an effective amendment of the buyer's plans. Since the APA was in writing, contained a provision directed to an Employee Retirement Income Security Act of 1974 (ERISA) plan, and all plan amendment formalities were satisfied, the APA was deemed to be an amendment to the buyer's plans. That the buyer never intended the APA to be an amendment to its plans was irrelevant.

Having found that the APA constituted an effective plan amendment, the court also found that the APA provision was assumed in bankruptcy. The court reasoned that the APA provision was at once a contractual obligation and a plan amendment. While the contractual obligation to the seller was rejected in the bankruptcy, the plan amendment was assumed. Thus, in failing to obtain the seller's consent to increase premiums, the buyer failed to operate its plan in accordance with its provisions.

The court raised the issue but expressed no view as to whether including a clause in the APA stating that no plan amendment was intended would have acted to prevent the provision at issue from being a plan amendment. (*Evans v. Sterling Chemicals Inc. Employee Benefits Plan Committee*, 5th Cir.)

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