EMPLOYEE BENEFITS DEVELOPMENTS JULY 2011

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Employee Benefits

RULINGS, OPINIONS, ETC.

Circuit Court Upholds Fiduciary Exception to Attorney-Client Privilege

Plan fiduciaries should be aware that communications with benefit plan attorneys may not be privileged. The Department of Labor (DOL) recently investigated the management of two multiemployer funds in connection with a $10.1 million loss of Employee Retirement Income Security Act of 1974 (ERISA) plan assets resulting from investments in entities related to Bernard Madoff. In 2009, the DOL issued two subpoenas requesting documents relating to the administration of the funds. The administrators of the funds provided documents partially responsive to the subpoenas but redacted portions of some documents and wholly withheld other portions, claiming they were protected by attorney-client and work product privileges. The DOL filed a petition in federal district court to obtain compliance with the subpoenas. Upon briefing and a hearing, the district court granted the DOL's petition. On appeal, the Fourth Circuit Court of Appeals affirmed the district court's order granting the DOL's petition to enforce the subpoenas. In affirming the district court's decision, the Fourth Circuit joined four other circuit courts, including the Second Circuit of New York, in concluding that the fiduciary exception to the attorney client privilege applied under ERISA.

Rooted in the common law of trusts, the fiduciary exception is based on the rationale that the benefit of any legal advice obtained by a trustee regarding matters of trust administration is for the benefit of the beneficiaries. Consequently, courts have generally found that the attorney-client privilege generally may not be used to insulate the fiduciaries from the parties (i.e., the beneficiaries) who the fiduciaries are obligated to serve. In this particular instance, the Fourth Circuit held that the fiduciary exception to attorney-client privilege "extends to communications between an ERISA trustee and a plan attorney regarding plan administration." The Fourth Circuit also concluded that "application of the fiduciary exception to the attorney-client privilege in the context of a subpoena issued by the secretary of labor under ERISA does not require a showing of good cause; instead, its application turns on the

context and content of the individual communications at issue." (*Solis v. The Food Employers Labor Relations Association, 4th Cir. 2011*)

Treasury, IRS Seek Public Input and Comment on Health Care Reform Shared Responsibility Provisions

Under health care reform, employers with 50 or more full-time employees that do not offer affordable health coverage to their full-time employees may be required to make a shared responsibility payment. Small employers with fewer than 50 full-time employees will be exempt from these new rules, which take effect in 2014. The Treasury and IRS solicited public input and comment on several issues that will be the subject of future proposed guidance, as the Treasury and IRS work to provide information to employers on how to comply with the new shared responsibility rules. In particular, the Treasury and IRS requested comment on possible approaches employers could use to determine who is a full-time employee. The request for comment and input was designed to ensure that the Treasury and IRS continue to receive broad input from stakeholders on how to best implement the shared responsibility provisions in a way that is workable and administrable for employers, allowing them flexibility and minimizing burdens. (*IRS Notice 2011-36; IR-2011-50, May 3, 2011*)

Final Rules Issued Regarding Reasonable Health Insurance Premium Increases

Under the Affordable Care Act (health care reform), any proposed rate increase at or above 10 percent by an individual or small group market insurer must be scrutinized by independent experts to ensure justifiability. The Department of Health & Human Services has issued final regulations that describe the process of how independent experts will scrutinize any proposed increase. In most situations, the individual states will have the primary responsibility for reviewing the rate increases. The Centers for Medicare & Medicaid Services (CMS) will provide this review for states that do not have the resources or authority to review rates. CMS has found that 40 states, the District of Columbia, and the U.S. Virgin Islands have effective review processes for all insurance markets. In three states, CMS will partner with the states to conduct reviews. In seven states and four U.S. territories, CMS will independently conduct the reviews. (76 Fed. Reg. 29964; CMS Fact Sheet, http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html)

Department of Labor Modifies Effective Dates for Fee Disclosure Rules

The DOL has published final regulations modifying the applicability dates for certain fee disclosure rules. In July 2010, interim final regulations under the ERISA § 408(b)(2) were issued, requiring covered service providers of retirement plans to disclose comprehensive fee information and possible conflict of interest information to ERISA fiduciaries. The original applicability date was for contracts or arrangements in existence on or after July 16, 2010. The new applicability date for ERISA § 408(b)(2) fee disclosure has been set as April 1, 2012.

In October 2010, the DOL also published a final regulation regarding employer disclosure to participants of plan and investment costs for self-directed 401(k) and other individual account plans under ERISA § 404(c). Under the revised applicability date, the ERISA § 404(c) participant disclosure will be effective 60 days following the applicability date of the ERISA § 408(b)(2) fee disclosure regulation. The change was made so that the ERISA § 408(b)(2) disclosure regulation will be in force before plans are required to disclose fees to participants.

The DOL also amended a transitional rule that requires quarterly disclosures to participants and beneficiaries. As amended, the transitional rule will require the first quarterly disclosure be made no later than 45 days after the end of the quarter in which plans would otherwise be required to make the initial ERISA § 404(c) participant disclosure. Again, this change was necessary so that the first quarterly disclosure to participants and beneficiaries would not be due until after the employer is required to provide the initial disclosure under ERISA § 404(c). (76 Fed. Reg. 31544)

IRS Announces Extensions and New Filing System for Deferred Vesteds

For many years, qualified retirement plans have been required to file a Form SSA with the plan's annual Form 5500 to report participants who have separated from service with deferred benefits, but who have not yet been paid out by the end of the plan year following the year of separation. Form SSA was replaced by Form 8955-SSA for plan years beginning after 2008, yet the new forms have only recently become available. The information about deferred vested benefits is passed on to the Social Security Administration and results in a reminder of deferred benefits available from an employer plan. Revenue Procedure 2011-31 has announced an electronic filing system for the filing of Form 8955-SSA, though the forms may also be filed on paper. The new procedures are part of the IRS Filing Information Returns Electronically (FIRE) System and are available for returns filed in 2011 (including calendar year filings for the 2010 cycle). The filing system is available to both plan administrators and their service providers. For plans that have an outside provider who compiles these returns, the forms may be filed electronically by the service provider. The IRS has just announced that the due date for the Form 8955-SSA for both the 2009 and 2010 plan years is the later of 1) January 17, 2012, or 2) the due date that generally applies for the filing of Form 8955-SSA. Further information on these filing rules may be found at the IRS website (www.irs.gov) under the retirement plan community banner. (*Revenue Procedure 2011-22*)

Plan Administrator Not Obligated to Provide Benefit Accruals for Unpaid Hours

Nurse participants in a hospital retirement plan were upset that their unpaid meal breaks, during which they were required to work, and an unpaid 20-40 minute period of patient status review before the official start of their shifts were not counted for benefit purposes in the hospital's retirement plans. The plan administrator and plan documents based benefit accruals on wages reportable on Form W-2. The nurses' argument is that wages should have been paid for these unpaid periods. Two lawsuits were filed related to the dispute: a state court action claiming violation of state wage and hour laws and a federal claim under ERISA that the plan administrators had improperly disregarded the unpaid service periods in determining retirement plan benefits. The ERISA claims were dismissed in federal district court, and the U.S. Court of Appeals for the Third Circuit has now upheld the district court ruling. The Third Circuit reasoned that only wages actually paid to

employees are reportable on Form W-2. While the underlying dispute relates to the amount of wages that should be paid, the plan administrators have properly administered the plan by considering only wages actually paid and reported. (*Henderson v. University of Pittsburgh Medical Center, 3d Cir. 2011*)

Agencies Issue Amendments to the PPACA Claims and Appeals Processes

The Treasury, DOL, and the Department of Health and Human Services jointly issued amendments to the interim final rules governing the internal claims and appeals and the external review processes required under the Patient Protection and Affordable Care Act (PPACA). As previously reported, PPACA contains a number of provisions affecting the claims and appeal procedures of non-grandfathered health plans. During the past 12 months, the agencies issued two rounds of guidance regarding the implementation of these important provisions. As with the previous guidance, the most recent guidance generally provides relief for plan sponsors and administrators. Below is a summary of the amendments:

Expedited Notification for Urgent Care Benefit Determinations. Previously, the interim final regulations required a plan to notify a claimant of benefit determinations involving urgent care as soon as possible, but no later than 24 hours after receipt of the claim. Under the new amended regulations, so long as the plan defers to the attending provider over whether the claim involves a matter of urgent care, the urgent care determination can be made as soon as possible, but not later than 72 hours. This extension is consistent with the urgent claim review process required by ERISA.

Additional Notice Requirements for Internal Claims and Appeals. The July 2010 regulations required a plan to include treatment and diagnostic codes, and the meaning of those codes, in any notice of adverse benefit determination. Under the amended regulations, plans are no longer required to automatically provide diagnosis and treatment codes. Instead, the adverse benefit determination must notify the claimant of his or her opportunity to request the codes and their meanings. The amendment also clarifies that a plan must not consider a request for diagnosis or treatment information as a request for an internal appeal or external review.

Deemed Exhaustion of Internal Claims and Appeals Processes. Courts generally require claimants to exhaust administrative proceedings before going to court or seeking external review. However, the July 2010 regulations permitted claimants to immediately seek judicial review if a plan failed to strictly adhere to all of the July 2010 regulation requirements for internal claims and appeals processes. The amended regulations provide exception to the strict compliance standard for procedural errors that are considered:

- De minimis
- Non-prejudicial
- Attributable to good cause or matters beyond the plan's control
- In the context of an ongoing good-faith exchange of information
- Not reflective of a pattern or practice of non-compliance

Also, the claimant is entitled upon written request to an explanation of the plan's basis for asserting that it meets the exception.

Form and Manner of Notice. PPACA requires group health plans to provide relevant notices in a culturally and linguistically appropriate manner. The July 2010 regulations required that notices be provided in a non-English language based on separate thresholds depening on the number of plan participants who are literate in the same non-English language. The amended regulations establish a single threshold for people literate only in the same non-English language: 10 percent or more of the population residing in the claimant's county, as determined by American Community Survey data published by the United States Census Bureau.

Scope of the Federal External Review Process. Under the July 2010 regulations, claims eligible for external review included any adverse benefit determination unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of the group health plan. The new amendment restricts the broad scope of claims eligible for the federal external review process and to claims that involve medical judgment, as determined by an external reviewer, or a rescission of coverage.

Clarification Regarding Requirement That External Review Decisions Be Binding. The July 2010 regulations provided that an external review decision by an Independent Review Organization (IRO) is binding on the plan as well as the claimant, except to the extent that other remedies are available under state or federal law. The new amendment adds language to the final regulations stating that the plan must provide benefits pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review and unless or until there is a judicial decision otherwise.

The effective date of the amendments to the claims and appeals procedures affecting non-grandfathered plans is July 22, 2011.

The amended regulations and revised model notices for adverse benefit determinations are available at www.dol.gov/ebsa/healthreform.

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