EMPLOYEE BENEFITS DEVELOPMENTS JULY 2010

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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Health Care Reform Update

Regulations implementing the Patient Protection and Affordable Care Act (PPACA) have been coming out at a steady pace. In late June and July, the U.S. Departments of Labor, Health and Human Services, and Treasury issued three important regulation packages:

- Interim Final Rules Relating to Preexisting Condition Exclusions, Lifetime and Annual Dollar Limits on Benefits, Rescissions, and Patient Protections. *75 Fed. Reg. 37188(June 28, 2010)*
- Interim Final Rules Relating to Coverage of Preventive Services. *75 Fed. Reg. 41726 (July 19, 2010)*
- Interim Final Rules Relating to Internal Claims and Appeals and External Review Processes. *75 Fed. Reg. 43330 (July 23, 2010)*

Each set of regulations is addressed below, in turn.

Interim Final Rules Relating to Preexisting Condition Exclusions, Lifetime and Annual Dollar Limits on Benefits, Rescissions, and Patient Protections

In late June, the agencies issued interim final rules implementing a new "Patient's Bill of Rights." The new Patient's Bill of Rights rules detail a set of protections that apply to group health plans for plan years beginning on or after September 23, 2010 (e.g., January 1, 2011 for calendar year plans). They are:

- **No Pre-Existing Condition Exclusions for Children Under Age 19**
  For plan years beginning on or between September 23, 2010 and December 31, 2013, group health plans may not deny coverage to children under the age of 19 based on a pre-existing condition. For plan years beginning on or after January 1, 2014, all pre-existing condition exclusions are prohibited regardless of an individual's age. The ban includes both benefit limitations (e.g., an insurer

refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and coverage denials (e.g., an insurer refusing to cover a child because of the child's pre-existing medical condition). These protections will apply to all group health plans (including grandfathered group health plans).

- **No Arbitrary Rescissions of Health Plan Coverage**
  Effective for plan years beginning after September 23, 2010, group health plans (*including grandfathered plans*) will be prohibited from rescinding coverage — whether a single individual, an individual enrolled in family coverage, or an entire group of individuals — unless the individual (or person seeking coverage on behalf of the individual) engages in fraud or an intentional misrepresentation of material facts. Group health plans seeking to rescind coverage must provide at least 30 days advance notice to give affected individuals time to dispute the determination. Prospective coverage terminations and *retroactive* terminations for nonpayment of premiums are not prohibited.
- **No Lifetime Limits on Coverage**
  Effective for plan years beginning after September 23, 2010, group health plans (*including grandfathered plans*) must not establish any lifetime limit on the dollar amount of *essential health benefits* for any individual. While regulations defining essential *health benefits* are yet to be issued, the statute contains a listing, in general terms, of the types of services that are considered essential. Until regulations are issued, the interim final rule imposes a good-faith requirement in connection with the determination of *essential health benefits*.
- **Notice Requirement**
  If an individual reached a lifetime limit before the effective date of the ban and the individual is otherwise still eligible under the plan, the plan must furnish the individual a written notice that the lifetime limit no longer applies. Written notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Individuals must be given at least 30 days to consider whether to enroll and coverage must be effective no later than the first day of the first plan year beginning on or after September 23, 2010.
- **Restricted Annual Dollar Limits on Coverage**
  Group health plans (*including grandfathered plans*) may not impose annual dollar limits with respect to essential health benefits effective for plan years beginning on or after January 1, 2014.

Before January 1, 2014, restricted annual limits are permitted as follows:

- For plan years beginning on or after September 23, 2010, plans will be allowed to set annual limits on essential health benefits that cannot be less than $750,000;
- For plan years beginning on or after September 23, 2011, the minimum limit will be $1.25 million; and
- For plan years beginning on or after September 23, 2012 but before January 1, 2014, the minimum limit will be $2 million.

- **Rights Pertaining to Choice of Primary Care Providers**
  If a group health plan requires or permits an individual to designate a participating primary care provider, health plan members must be allowed to designate any available participating primary care provider as their provider, and parents must be allowed to choose any available participating pediatrician to be their children's primary care provider. If a group health plan provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care physician, the plan may not require a female enrollee to obtain an authorization or referral for obstetrical or

gynecological (OB-GYN) care. Notice of these rights must be provided to participants. The interim final rules contain model notice language. These requirements, which are effective for plan years beginning after September 23, 2010, *do not* apply to grandfathered plans.

- **Rules Relating to Emergency Services**
  Under the interim final rule, group health plans will not be allowed to require prior authorization of emergency services, and will not be allowed to charge higher cost-sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network. The interim final rule contains a detailed set of rules on how health plans should reimburse out-of-network providers of emergency services. These new rules, which are effective for plan years beginning after September 23, 2010, do not apply to grandfathered plans.
- **Action Steps**
  Plan sponsors should:
  - Determine whether they maintain any grandfathered group health plans. The rules pertaining to choice of primary care providers and emergency services do not apply to grandfathered plans.
  - Determine the date by which all plans must be in compliance with the pre-existing condition exclusion limitations, the ban on rescissions, the ban on lifetime limits, and the restricted annual limit rules, and the date by which non-grandfathered plans must be in compliance with the rules pertaining to choice of primary care providers and emergency services (January 1, 2011 for calendar year plans).
  - Discuss the new Patient's Bill of Rights rules with insurers and third-party administrators and amend insurance contracts/administrative service agreements to reflect compliance responsibilities.
  - Provide a special enrollment notice to each individuals who reached a lifetime limit before the effective date of the ban (January 1, 2011 for calendar year plans) and who is otherwise still eligible under the plan.
  - Amend plan documents and SPDs to reflect the new rules.

Interim Final Rules Relating to Coverage of Preventive Services

The interim final rules require coverage of recommended preventive health services without copayments, co-insurance requirements, or deductibles when delivered by an *in-network* provider. A group health plan that has a network of providers is not required to cover recommended preventive services delivered by an *out-of-network* provider, and may impose cost-sharing requirements for recommended preventive services delivered *out-of-network*. Preventive services that are not on the list of recommended preventive health services are not subject to the coverage mandate. A group health plan may impose cost-sharing for office visits relating to preventive care services in limited circumstances.

The interim final rules apply to group health plans for plan years beginning on or after September 23, 2010 (e.g., January 1, 2011 for calendar year plans). There is a delayed effective date for preventive care recommendations that have been in effect for less than one year. For example, beginning January 1, 2011, calendar year group health plans are only required to provide first-dollar coverage of recommended preventive services issued on or before December 31, 2009.

The new rules *do not* apply to grandfathered group health plans. Grandfathered plans may implement first-dollar coverage of some or all of the recommended health services without jeopardizing grandfather plan status.

The preamble to the interim final rule includes the following link to the complete list of recommended preventive services: http://www.healthcare.gov/center/regulations/prevention/recommendations.html. This web list will be updated from time to time and will include the date on which the recommendation or guideline was adopted or accepted.

- **Action Steps**
  Plan sponsors should:
  - Determine whether they maintain any non-grandfathered group health plans (to which the new coverage mandates will apply).
  - Determine the date by which the non-grandfathered plan must be in compliance (January 1, 2011 for calendar year plans).
  - Discuss the new coverage mandate with insurers and third-party administrators and amend insurance contracts/ administrative service agreements to reflect compliance responsibilities.
  - Amend plan documents and SPDs to include first-dollar coverage of recommended preventive care services.

Interim Final Rules Relating to Internal Claims and Appeals and External Review Processes

Under ERISA, a participant whose benefit claim has been denied has the right to receive a written explanation of the specific reasons for the denial. Furthermore, aggrieved participants must be afforded a reasonable opportunity for a full and fair review of the decision denying the claim. Regulations promulgated by the U.S. Department of Labor (DOL) address these requirements in detail. Health plans that are not subject to ERISA (e.g., plans maintained by state and local governments and church plans) may be required to comply with state laws that impose similar requirements.

The new rules *do not* apply to grandfathered plans.

Under the recently issued interim final rules relating to internal claims and appeals and external review processes, non-ERISA plans will be required to comply with federal standards for adjudicating claims. ERISA plans remain subject to existing DOL claims regulations as supplemented by the new interim final rules. The interim final rules are effective for plan years beginning on or after September 23, 2010.

- **Internal Review**
  Under the interim final rule, all non-grandfathered plans must have an *internal* review procedure that:
  - Affords participants the right to appeal when a health plan denies a claim for a covered service or rescinds coverage;
  - Provides participants with detailed information about the grounds for the denial;
  - Requires notice to participants of their right to appeal and the procedure for doing so;
  - Ensures a full and fair review of the denial; and

- Provides participants with an expedited appeals process in urgent cases.

- **External Review**
  If a health plan member's internal appeal is denied (and in some cases before it is denied), the member will have the right to an *external* review of the claim by an independent review organization.

- **Self-Insured Plans**
  The new claims adjudication rules will be of particular interest to sponsors of self-insured health plans. And while self-insured ERISA plans have long been subject to existing DOL regulations, the new interim final rules add some important new requirements:

  - Plans must apply the new internal claims procedures to coverage rescissions and adverse decisions relating to eligibility for coverage.
  - Plans will have 24 hours to make decisions on urgent claims. Under existing DOL regulations, plans have 72 hours.
  - Failure to strictly adhere to the new internal claims rules will enable claimants to bypass the internal claims process and proceed directly to external review process or even litigation. Under existing law, a claimant does not generally have this right where an ERISA plan has substantially complied with the claims regulations.
  - During the pendency of an internal appeal, an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.
  - Self-insured ERISA plans will be required to comply with a federal *external* review process. A self-insured non-ERISA plan (e.g., a nonfederal government plan) *will not* be subject to the federal external review process if it is subject to a state external review law that meets minimum standards detailed in the NAIC Uniform Model Act.
  - Group health plans will be required to provide notice upon request of available internal claims and appeals and external review processes in a "culturally and linguistically appropriate manner." If a plan covers fewer than 100 participants at the beginning of a plan year, and 25 percent or more of all plan participants are literate only in the same non-English language, the plan is required to provide notices upon request in the non-English language. If a plan covers 100 or more participants at the beginning of a plan year, and 10 percent or more of all plan participants (or, if less, 500 participants) are literate only in the same non-English language, the plan must provide notices upon request in the non-English language. If a plan meets these thresholds, the plan must include a statement in the English versions of all notices, prominently displayed in the non-English language, offering to provide the notices in the non-English language.

- **Action Steps**
  Plan sponsors should:
  - Determine whether they maintain any non-grandfathered group health plans (to which the new requirements will apply).
  - Determine the date by which the non-grandfathered plan must be in compliance (generally, January 1, 2011 for calendar year plans).

- Discuss the new requirements with insurers and third-party administrators and amend insurance contracts/ administrative service agreements to reflect compliance responsibilities.
- Amend plan documents, SPDs, and claims procedures to reflect the requirements of the interim final rules.

IRS Issues 401(k) Plan Compliance Questionnaire

In May, the IRS issued a 401(k) compliance check questionnaire to a sample set of 1,200 plan sponsors. This questionnaire is intended to help the IRS identify common areas of non-compliance and gauge the overall integrity of the country's 401 (k) plan system. Information gathered from the questionnaire will be analyzed and published by the IRS in a report in 2011. Although completion of the questionnaire is voluntary, failure to complete the questionnaire could subject the plan sponsor to audit risk. Because the questionnaire is a compliance check and not an audit, any errors discovered during an internal review by a plan sponsor can be corrected under the self-correction and voluntary compliance components of the Employee Plans Compliance Resolution System. Although the IRS sent the compliance questionnaire to only a limited group of 401 (k) plan sponsors, all plan sponsors can view the questionnaire and use it as a basis for conducting their own self-audits to identify and correct plan errors. A periodic review of a plan's documentary and operational compliance is recommended because correcting errors discovered during a self-audit is generally less expensive than correcting errors discovered during an IRS audit. The IRS compliance questionnaire is located at http://www.irs.gov/pub/irs-tege/epcu_401k_questionnaire.pdf.

Final Rules on Diversification Requirements Issued

The IRS recently issued final regulations on the diversification requirements generally applicable to defined contribution plans that hold publicly traded employer securities. Those diversification requirements generally provide that participants and beneficiaries in defined contribution plans must have the right to divest amounts invested in employer securities and to reinvest an equivalent amount in other investment options. The final regulations are largely similar to proposed regulations published in January 2008. However, the final regulations:

- No longer treat a multiemployer plan as holding employer securities if they are held indirectly through an investment fund managed by an independent investment manager and do not exceed 10 percent of the fund;
- Provide that the determination of whether the value of employer securities exceeds 10 percent of the total value of the fund's investments is made for the plan year as of the end of the preceding plan year; and
- Provide that when a fund that indirectly holds employer securities fails to meet the requirement that the investment be independent of the employer (including a situation when the fund no longer meets the percentage limitation rule), the plan does not fail to satisfy the diversification requirements merely because it does not offer those rights for up to 90 days after the investment fund is treated as holding employer securities.

Under the diversification rules, a plan may not restrict a participant's right to invest in or to divest employer securities any more than it restricts any other plan investment options. However, the final regulations modify some of the permitted restrictions and provide that:

- A plan may have more frequent transfers to and from stable value funds and qualified default investment alternatives than a fund invested in employer securities.
- A plan may not allow reinvestment of divested amounts in the same employer securities account, but may allow investment of those amounts in another employer securities account if the only difference between the two accounts is the Code §402(e)(4) cost or other basis.
- Under a transitional rule, certain leveraged ESOPs may allocate matching contributions to an otherwise frozen employer stock fund.

The final regulations are effective for plan years beginning on or after January 1, 2011. A plan may rely on Notice 2006-107, the proposed regulations, or the final regulations to satisfy the diversification requirements until the final regulations are effective.

CASES

Unpaid Employer Contributions Are Plan Assets

In the face of financial difficulties, numerous challenges confront a business owner. Deciding which bills to pay first and how to handle creditors generally may require special advice and counsel regardless of whether there is a bankruptcy filing. Dealing with contribution obligations to pension and medical plans can be especially difficult. A recent case illustrates how the failure to meet collective bargaining obligations for contributions to pension and welfare funds can be compounded under statutory rules. After a corporate officer failed to make the required contributions and used corporate funds to pay other creditors, a recent federal court found that the employer breached its fiduciary duties under the plans. The court decided that unpaid plan contributions constituted assets of the plan in the hands of the employer. There is a fiduciary obligation to apply plan assets for the benefit of plan beneficiaries. Furthermore, it is required that plan assets be held in trust. Thus, in addition to breaching the fiduciary duty of properly applying plan assets, the employer was found to have engaged in a prohibited transaction by using those assets for the benefit of other creditors. (*Road Sprinkler Fitters Local Union No. 669 v. Dorn Sprinkler Co.*, S.D. Ohio 2010)

Pension Plan May Be Obligated to Pay Incorrectly Calculated Monthly Benefits

Courts have been reluctant to require pension plans to pay out incorrectly calculated benefits that are communicated to participants but do not properly follow the terms of the plan. If a participant relies on the improper benefit calculation and takes action consistent with this reliance, a claim might be made that the plan is "estopped" from asserting that only the lower, properly calculated benefit may be paid out of the plan. A recent federal appeals court has allowed an estoppel claim to proceed where a participant had communicated with the plan administrator about the terms of an early retirement. The plan provided a benefit statement and benefit election form showing the amount of the monthly benefit. The participant then retired and started collecting a monthly benefit. Almost two years later, the plan contacted the participant to advise

him that the benefit was incorrectly computed and was more than $500 less per month if done properly. The lawsuit began when the plan reduced the benefit and attempted to collect over $11,000 in overpayments. In permitting the participant to proceed with his estoppel claim to the higher benefit, the appeals court found that a pension plan might be required to pay a benefit in excess of the proper plan formula where in addition to the basic elements of estoppel—a representation made by one party that is reasonably relied upon by the other to his potential detriment—the participant can show sufficiently compelling circumstances that balance the equity in favor of the participant. In this case, it was alleged that the plan formula was sufficiently complex that it did allow a participant to readily calculate his own benefit and the representation was made in a clear written election form. This decision is not a final one in favor of the participant who still must prove his allegations sufficiently in a trial. The court has opened the door, however, to the possibility that a pension plan may be required to pay a benefit in excess of the plan formula as a result of erroneous representations made to a participant. (*Bloemker v. Laborers' Local 265 Pension Fund*, 6th Cir. 2010)

Stock Drop Case of the Month

A federal trial court recently ruled that an employer/plan sponsor did not breach its fiduciary duties by continuing to offer company stock in its 401(k) plan even as the share price dropped. The lawsuit stemmed from the employer/plan sponsor's announcement that it had inflated its expected earnings, which caused the company's stock price to drop. The court ruled that the employer/plan sponsor qualified for 404(c) safe harbor protection and, therefore, exempted the plan fiduciaries from liability. The judge rejected the plaintiff's contention that the plan was not a 404(c) plan because the plan's fiduciaries had never explicitly determined the plan would qualify as such – the court ruled that no legal requirement of such a determination exists. The court ruled the employer/plan sponsor satisfied 404(c) by providing plan participants with enough information to allow them to make informed decisions about their investment in the company stock.

The court also dismissed the plaintiff's claim that the plan violated ERISA by acquiring and holding more than 10 percent of the plan assets in company stock. The court found it was the participants, and not the employer/plan sponsor, who caused the plan to hold more than 10 percent of its assets in company stock because the investments were made by the participants. (*Rogers v. Baxter International Inc.*, N.D. Ill. 2009)

Arbitration in Multiemployer Withdrawal Liability Disputes Must Be Pursued Timely

A recent case serves as a reminder to employers that arbitration of disputes of withdrawal liability of the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA) must be pursued in a timely manner or the employer may have no recourse. In a recent case, an employer experienced a withdrawal from a multiemployer pension fund when it ceased to have any collectively bargained employees for whom contributions to the fund were required. The employer was informed of its withdrawal liability, the administrative remedies under MPPAA, and the fund's administrative rules. The employer did not respond to this notice. Under law, the deadline for requesting arbitration of the dispute was January 28, 2008. In October 2007, the employer wrote to the fund protesting the determination of complete withdrawal and requested a review of assessment of withdrawal liability. The request for review also informed the fund that it had hired a union employee and

would resume making contributions to the fund. The fund denied the request for review in November 2007 and indicated that whether the hiring of an additional employee would abate withdrawal liability would depend on the law. The employer did not pursue any course of action at that time. In October 2008, the fund sued the employer and in February 2009, more than one year after the deadline for arbitration, the employer filed a demand for arbitration. The District Court for the District of New Jersey ruled in favor of the plan on a motion for summary judgment, finding that the employer's failure to timely seek arbitration waived all administrative remedies it had with respect to the plan. Employers facing withdrawal liability assessments or claims should be careful to be certain that all deadlines are met to seek arbitration or else face the possibility of loss of the ability to pursue what may or may not be a legitimate defense to the assessment. (*Einhorn v. Kaleck Brothers Inc.*, D.N.J., 2010)

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