EMPLOYEE BENEFITS DEVELOPMENTS MAY 2016

Hodgson Russ Newsletter
May 25, 2016

RULINGS, ETC.

Agencies Issue New FAQs on the Affordable Care Act. The Departments of Labor, Health and Human Services, and the Treasury (the agencies) issued another set of frequently asked questions (FAQs) regarding the implementation of the Affordable Care Act (ACA). This recent guidance, the thirty-first in a series of FAQs that the agencies have published, focuses on certain preventive care services, out-of-network emergency services, out-of-pocket limitations as applied to reference-based pricing, mental health parity, and the Women's Health and Cancer Rights Act. Some of the issues discussed in this guidance are highlighted below. The FAQs answer questions from stakeholders to help people understand the laws and benefit from them.

Bowel Medications for Colonoscopies Must Be Covered Without Cost-Sharing. Under the ACA's preventive services mandate, non-grandfathered group health plans must cover the full cost of a colonoscopy if it is scheduled and performed as a screening procedure. Under the newly issued FAQ guidance, group health plans may not impose cost sharing for the bowel preparation medications prescribed in connection with the procedure. The FAQ provides that bowel preparation medications, when medically appropriate and prescribed by a health care provider, are an integral part of the preventive screening colonoscopy, and therefore, must be covered without cost sharing, subject to reasonable medical management.

Retroactive Termination of Teacher's Health Coverage Violates the ACA Prohibition on Rescissions.

The agencies ruled that the following school district health insurance administrative practice would result in an impermissible termination of health insurance coverage under the ACA's prohibition against rescissions of health insurance coverage:

A school teacher is employed by a school district through a 10-month teaching contract from August 1 to May 31. The teacher's health coverage through the district is for the plan year from August 1 to July 31. The teacher resigns on July 31 indicating that she does not intend to continue employment with the district for the following school year. The plan unilaterally terminates the teacher's coverage

Attorneys

Peter Bradley
Michael Flanagan
Richard Kaiser
Ryan Murphy

Practices & Industries

Employee Benefits

retroactively to May 31, the last day of the teacher's active employment.

Under the FAQ guidance, the termination of coverage under the district's policy has retroactive effect and, therefore, is impermissible if (a) all premiums for the period of coverage are paid; and (b) the teacher did not commit fraud or make an intentional misrepresentation of a material fact with respect to coverage. The agencies noted that the district could terminate coverage *prospectively* under these circumstances, subject to other applicable Federal and State laws or collective bargaining agreements.

Out-of-Network Emergency Services – Balance Billing. Under the ACA, non-grandfathered group health plans cannot impose cost sharing (i.e., copayments or coinsurance) on out-of-network emergency services in an amount that is greater than the cost sharing that is imposed for in-network emergency services. This requirement does not prohibit an out-of-network emergency care provider from billing the difference between the provider's usual charge and the amount paid to the provider by the group health plan (i.e., balance billing).

The FAQ guidance provides that a plan must meet a "minimum payment standard" for out-of-network emergency services before enrollees can be required to assume responsibility for balance bills. To satisfy the minimum payment standard, a plan must pay an amount that is not less than the greatest of the following three amounts (adjusted for in-network cost sharing):

- the median amount negotiated with in-network providers for the emergency service;
- the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (e.g., the usual, customary, and reasonable (UCR)); or
- the amount that would be paid under Medicare for the emergency service.

Under the guidance, a group health plan must disclose how it calculates the amount under the minimum payment standard, including the method the plan generally uses to determine payments for out-of-network services (e.g., the UCR amount). Group health plans that are governed by ERISA must furnish the documents and data used to calculate the minimum payment amount to plan participants (or their authorized representatives) within 30 days of a request. In addition, ERISA plans and non-ERISA, non-grandfathered group health plans, must disclose the minimum payment amount documents and calculations in connection with appeals of disputed claims. Importantly, characterization of this information as proprietary or commercially valuable cannot be a basis for non-disclosure.

Coverage for Individuals Participating In Approved Clinical Trials. If a non-grandfathered group health plan provides coverage to a qualified individual in connection with an approved clinical trial, the plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with the trial. Routine patient costs include all items and services that are typically covered for a qualified individual who is not enrolled in a clinical trial. Among other things, routine patient costs do not include the investigational item, device, or service being studied in the approved clinical trial.

The FAQ guidance provides that if a plan generally covers chemotherapy to treat cancer, the plan may not limit coverage of chemotherapy for an individual due to the fact that it is provided in connection with the individual's participation in an approved clinical trial for a new anti-nausea medication. In addition, if a plan typically covers items and services to

diagnose or treat certain complications or adverse events, the plan may not deny coverage of such items and services when provided to diagnose or treat complications or adverse events (e.g., side effects) in connection with an individual's participation in an approved clinical trial.

The agencies note that a group health plan is not required to provide benefits for routine patient costs provided outside of the plan's health care provider network (i.e., out-of-network routine patient costs) unless out-of-network benefits are otherwise provided under the plan.

ACA Limitations on Cost-Sharing As Applied to Reference-Based Pricing. Non-grandfathered group health plans must ensure that any annual cost-sharing imposed under the plan does not exceed the limits prescribed by the ACA. The limits for 2016 and 2017 are:

	Self-Only Coverage	Other Than Self-Only Coverage
2016	$6,850	$13,700
2017	$7,150	$14,300

As a general rule, if a plan includes a network of providers, the plan is not required to count an individual's out-of-pocket spending for out-of-network items and services toward the maximum out-of-pocket limit. The FAQs create an exception to this rule for plans that utilize reference-based pricing.

When a plan pays a fixed amount for a particular procedure (e.g., a knee replacement), which certain providers will accept as payment in full (so-called reference-based pricing), the plan must ensure that enrollees will have access to an adequate network of quality providers that will accept the reference price as payment in full. If a plan maintains an adequate network of reference-based providers, the plan is not required to count an individual's out-of-pocket expenses for services rendered by other providers. If a plan does not maintain an adequate network of reference-based providers, the plan must count an individual's out-of-pocket expenses toward the individual's maximum out-of-pocket limit.

The agencies will consider all the facts and circumstances when evaluating whether a plan's reference-based pricing design is reasonably designed to ensure adequate access to quality providers at the reference price. The FAQ cites to prior guidance on this issue and other issues relating to reference-based pricing.

The Women's Health and Cancer Rights Act (WHCRA). WHCRA provides protections for individuals who elect breast reconstruction in connection with a mastectomy. Under WHCRA, if a group health plan covers mastectomies, the plan must provide coverage for certain services, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. Under the FAQ guidance, group health plans that cover mastectomies must provide coverage for nipple and areola reconstruction as a required stage of breast reconstruction under WHCRA. This includes coverage for nipple and areola reconstruction, including nipple and areola repigmentation to restore the physical appearance of the breast. Under WHCRA, plans and issuers may impose deductibles and coinsurance

for these benefits only if the cost-sharing requirements are consistent with those established for other benefits under the plan.

IRS Provides Guidance for Hybrid Plans Utilizing Whipsaw Lump Sum Calculation. Many hybrid plans, such as cash balance plans, provide that any lump sum distribution amount is equivalent to the hypothetical account balance maintained under the plan. This type of plan would satisfy an age discrimination safe harbor under Internal Revenue Code (Code) Section 411 because the accumulated benefit under the plan is the current balance of the hypothetical account. However, some plans provide that the single sum distribution amount is equivalent to the present value of the accrued benefit using the actuarial sums set out in Code § 417(e)(3). In a recent chief counsel advice email, the Internal Revenue Service (IRS) indicated that these types of so-called "whipsaw" plans are not eligible for the lump sum benefit safe harbor. However, the IRS did indicate that these plans are generally eligible for the safe harbor age discrimination provision for indexed benefits found in Code § 411(d)(5)(E). Hybrid plans that utilize the so-called whipsaw method should review whether they are eligible and comply with this safe harbor. It should be noted that chief counsel advice is not binding on the IRS but is a good indication of the current IRS position with respect to the matter. (CCA 201617006)

CASES

Case Highlights Importance of Following Claim Procedures. The U.S. Court of Appeals for the Second Circuit recently ruled that, to receive deferential judicial review, a plan administrator must follow procedures in full conformity with the Department of Labor (DOL) claims procedure regulation. The only exception to full conformity is where an administrator is able to show that the error was both inadvertent and harmless. By rejecting the "substantial compliance" standard used in some other jurisdictions, the court upped the compliance ante for plan administrators. Under the DOL regulations, plan administrators must follow rules regarding timing and content of claim denials. For example, the regulations require notification of an adverse benefit determination will, in a manner calculated to be understood by the claimant, include a number of specific pieces of information, such as: 1) the reason for the adverse determination; 2) reference to the specific plan provision on which the determination is based; 3) a description of any additional material information necessary for a claimant to perfect the claim and an explanation of why such material or information is necessary; and 4) a description of the plan's review procedures and applicable time limits, including a statement of a claimant's right to bring a civil action under ERISA following an adverse benefit determination on review. If a plan administrator follows the DOL claims procedure, a reviewing court will generally grant substantial deference to an administrator's decision, and it is rare for a reviewing court to overturn that decision. However, in this case, rather than fully complying with the DOL claims procedure, the plan administrator simply stated "Service Not Authorized" when notifying the plaintiff that her claim was denied. As such, the court ruled that the plan administrator's decision is not entitled to substantial deference by a reviewing court. However, it was not all bad news for the plan administrator. The court also held that a participant or beneficiary is not entitled to civil penalties for a plan's failure to comply with the claims procedure regulation. In light of this decision, plan administrators should review their claims procedures from a documentary and operational perspective to ensure that they are in full compliance with the applicable claim procedure rules. *Halo v. Yale Health Plan* (2nd Cir. 2016).

Plan Administrator's Denial of ERISA Severance Benefits Found Reasonable. Three former executives recently lost their bid to continue with their severance claims under ERISA when the U.S. District Court for the Southern District of New York dismissed the claim against their former employer. The executives were terminated from employment with a subsidiary in 2012 following a strategic review by the parent company.

Following their termination, the executives filed for benefits under the company severance plan, which provides severance benefits for employees who experience a "qualifying termination." A qualifying termination is defined under the plan as "an involuntary separation . . . because of a reduction in force (RIF) or job elimination or because of a consolidation, merger, or reorganization or other business related changes." The plan administrator denied the executives' claim, on the basis that the plan provision granting benefits for terminations due to "other business related changes" referred to job losses due to third-party transactions such as mergers and divestitures. Concluding that the executives had been terminated due to an internal "change in leadership," rather than on account of a third-party transaction, the administrator determined that the executives were ineligible for severance benefits. In the benefit denial letters, the administrator also cited the subsidiary's failure to perform and the executives' roles as senior leaders as the basis for their terminations. On appeal, the plan administrator reaffirmed the claim denial, reiterating its interpretation of the plan terms and its claim that the executives were terminated because they were senior leaders within an organization that was not performing.

The executives brought suit, alleging that the company failed to pay them their severance benefits and interfered with their benefit rights under ERISA. They argued that their terminations fell within the meaning of a "qualifying termination" under the severance plan, rejecting the company's claim that the term referred only to changes involving third parties. The court disagreed, noting that the plan explicitly confers upon the plan administrator the discretionary authority to determine eligibility for benefits. As a result, the administrator's decision to deny benefits may be overturned only if it was arbitrary and capricious, that is, "without reason, unsupported by substantial evidence or erroneous as a matter of law." Concluding that the administrator's interpretation of the plan terms was, "at a minimum, reasonable," the court dismissed the executives' ERISA § 502(a)(1)(B) claim for benefits. This case underscores the importance of including discretionary authority language for plan administrators in severance plans.

The court also dismissed the executives' claim that the company falsely characterized their termination as due to poor job performance, for the purposes of interfering with and preventing them from obtaining severance benefits to which they were entitled, in violation of ERISA § 510. Noting that § 510 "is designed to protect the employment relationship that gives rise to an individual's benefit rights, not to create an action for wrongfully withheld benefits," the court held that the executives were seeking the same remedy – payment of their severance benefits – via two alternative means, and dismissed the claim. *Zeuner v. SunTrust Bank* (S.D.N.Y. 2016)

Ninth Circuit Opinion Addresses Burden of Proof Where Participant Brings a Claim for Pension Benefits. In 2010, a participant contacted the ADT Security Services Pension Plan about benefits, and was told the administrator could not find any information on the participant's employment with the plan sponsor. Even after the participant provided documentation regarding his employment with ADT-related entities, the administrator concluded the documents sent by the participant failed to establish that he had a vested pension. The participant filed a formal claim with the plan committee, and his claim was denied because of a lack of plan records indicating his eligibility for Plan participation in the Plan, his actual participation in the Plan, or his eligibility for Plan benefits, including whether the participant was credited with sufficient

continuous service. The participant appealed the committee's decision and the claim on appeal was again denied for a lack of clear records presented by the participant that he had the requisite service to earn a pension benefit. The participant filed a lawsuit and a federal district court held that the applicable standard of review was abuse of discretion and that the Committee did not abuse its discretion in denying the participant's pension benefits.

The participant appealed the district court's decision. Following an analysis regarding the burden of proof, the Court of Appeals for the Ninth Circuit, in a 2-1 decision, reversed and remanded the case for further proceedings without expressing a view on the participant's eligibility for Plan benefits. The Ninth Circuit noted that the district court "faithfully applied" the Ninth Circuit's precedent in reviewing the plan committee's denial of benefits for abuse of discretion. But the Ninth Circuit ultimately ruled that "the district court incorrectly placed the burden of proof on Barton for matters within defendants' control." A rule that places the burden of proving entitlement to ERISA benefits makes sense where "the claimant has better—or at least equal—access to the evidence needed to prove entitlement." But, in a case where the plan sponsor or plan administrator "solely controls the information that determines entitlement, leaving the claimant with no meaningful way to meet his burden of proof," that rule may no longer make sense. Accordingly, the Ninth Circuit held that where a claimant "through documentary or other objective evidence, has made a prima facie case that he is entitled to a pension but has no means except for information in the defendant's control to establish that his work was for a 'covered employer' and of sufficient duration, the burden then shifts to the defendant to produce such information."

The Ninth Circuit's decision was not unanimous and the dissent offered strong criticisms of the majority's opinion. The dissent called the majority's effort to fashion an "ad hoc" exception to the abuse of discretion standard a "disaster." The dissent asserted in its conclusion that the "majority's requirement that the district court allocate a burden of proof when it is supposed to be reviewing a plan administrator's decision for abuse of discretion makes no sense and is contrary to our case law."

It remains to be seen whether the participant in this case will succeed in securing the pension benefit he has been seeking. But, at least in the Ninth Circuit, this decision seems to expose plans to a greater potential for arguments by participants that plans should assume a greater burden of proof in denying benefit claims, especially where it can be argued that the plan or its administrator controls the information that determines entitlement. This case also serves as a reminder of the importance of records retention procedures that will allow a plan to adequately evaluate and respond to benefit claims. *Estate of Barton v. ADT Security Services Pension Plan* (9th Cir. 2016)