

ERISA Health Plan Update

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Preface

Health care reform impacts not only the design of health plans, but ERISA's and the Internal Revenue Code's numerous requirements. This impact is enormous, and immediate for non-grandfathered plans. This update is not intended to provide an overview of the new legal landscape; it merely selects a few provisions for your reading. Look for additional updates in the future.

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New Health Care Reform Nondiscrimination Rules Will Affect All Employers

Complex, largely mathematical nondiscrimination requirements have long dictated the design of "qualified" retirement plans (such as 401(k) plans, defined benefit plans, etc.). These nondiscrimination rules are aimed to ensure that rank-and-file employees sufficiently receive benefits under the plan. Otherwise, the employer and employees may not obtain the plan's favorable tax benefits. Health plans historically have largely escaped nondiscrimination rules. With the new health care reform requirements, this is about to change.

Background

Internal Revenue Code Section 105(h) has for decades imposed nondiscrimination rules on self-funded health plans (including cafeteria plans). If a self-funded health plan, also known as a self-insured plan, did not meet the Section 105(h) requirements, certain key employees in the plan would be taxed on all or a portion of the plan's benefits. In the self-funded plan arena, the nondiscrimination rules commonly were ignored and/or not known by employers, and furthermore the Internal Revenue Service never seemed particularly active in enforcing these rules. In contrast, fully insured plans have never been subject to these requirements.

*Nondiscrimination rules
now apply to fully insured
health plans*

Under the new legislation, the nondiscrimination requirements under Section 105(h) not only continue to apply to self-funded plans, but now also apply to non-grandfathered fully insured plans. The new rules are effective with respect to plan years beginning six months after March 23, 2010. This means that for many plans the new rules are effective on January 1, 2011.

Nondiscrimination Rules - Continued

New Consequences

The new rules will mean that some health plans as currently configured will trigger income tax consequences to an employer's key employees. We fully suspect that the Internal Revenue Service will have a heightened interest in enforcing the new rules, tagging key employees whose employers do not comply. As with all of the Internal Revenue Code's and ERISA's nondiscrimination rules, the "devil is in the details," and opportunities will exist to best position the employer and its key employees.

An employer that provides richer benefits, pays greater premiums, has more generous eligibility provisions, or makes other distinctions between employees, of any nature, will need to review the new rules to avoid unintended, unpleasant tax consequences for key employees.

Absence of Discretionary Authority Language In Health Insurance Policy Hurts Employer

Disputes over benefits between participants and their employers are common. When a dispute evolves into litigation, the court's decision often turns on the language in the plan document. A recent case, like the hundreds or perhaps thousands that precede it, highlights the critical importance of the written word when disputes arise.

Background

In *Jobe v. Medical Life Insurance Company*, 2010 WL 986642 (8th Cir. 2010)¹, the employee sued the employer over the denial of long-term disability benefits. The crux of this decision involved the absence of so-called *Firestone* language. *Firestone* language in a plan document grants discretion to the plan fiduciaries over plan matters and the determination of benefits. A well-drafted plan will contain correct *Firestone* language; many, and perhaps most, medical, disability, and dental plans do not contain such language.

The employer often wins in court when its plan has adequate Firestone language; the employee often wins otherwise

When a dispute between an employee and an employer arises regarding benefits, courts generally will apply a deferential standard of review to the employer's determination of benefits if the plan has adequate *Firestone* language. This deferential standard of review means, in many cases, that the court will not disturb the employer's denial of benefits - the court will second-guess the employer's denial of benefits only if the court determines the employer's decision was "arbitrary and capricious," without any merit.

For a plan without *Firestone* language, the court applies a *de novo* standard of review. This means that the court will study the facts closely and make its own determination of eligibility of benefits, without deferring to the employer's decision. In these cases, the court often overturns the employer's denial of benefits.

In short, the employer most often prevails in court when its plan has adequate *Firestone* language and the employee often wins when such language is deficient or absent.

¹ The *Jobe* case is an easy and educational read for employers and their advisors administering and maintaining health benefits. You may find it at www.erisalawgroup.com under "Firm Publications." If you are involved with employee benefits/ERISA, reading at least one case a year will make you a better plan sponsor and consumer of ERISA services.

Absence of Discretionary Authority Language - Continued

The Decision

In the *Jobe* case, the disability insurance policy did not contain *Firestone* language (which grants the plan administrator discretionary authority to determine benefits). The plan's summary plan description did contain such language. The summary also contained typical language that the terms of the plan would control in the event of a conflict between the plan terms and the summary plan description.

The trial court held in favor of the employer. On appeal, the Eighth Circuit, agreeing with three other appeals courts (the Ninth Circuit, governing Idaho, the Seventh Circuit, governing Illinois and Wisconsin, and the Eleventh Circuit), overturned the trial court, remanding the case back to the trial court to review the case *de novo*. The Eighth Circuit rejected a number of tenable arguments advanced by the employer, including that the summary plan description was in fact part of the formal plan document (and thus contained the necessary *Firestone* language). The court explained that the summary plan description cannot vest authority in the fiduciary that the plan does not grant. Throughout its holding, the Eighth Circuit made clear the now-settled law that in the event the plan terms and the summary plan terms conflict, in almost all cases the terms that are most favorable for the employee will prevail.

*If the plan and SPD
conflict, whatever is best
for the employee prevails*

Lessons For Plan Sponsors

Most plans providing medical, disability, dental, life and other ERISA "welfare" benefits are furnished by insurance companies, consultants, and/or brokers. Most employers maintain their welfare benefits through a hodgepodge of self-funded and/or insured plan documents, including certificates of coverage, that neither include a consolidated plan (often called a "wrap document") nor, arguably more important, a consolidated summary plan description. These numerous documents invariably contain conflicting language, and most often fail to include strongly recommended language regarding issues that arise when a benefit dispute arises. *Firestone* language is only one such example. Other examples include claims procedures and other simple disclosures that ERISA requires employers to make to employees.

*The typical employer's
hodgepodge of health
plan policies, certificates,
and summaries invariably
include significant
conflicting provisions*

An employer that desires the benefit of the doubt in the event of a dispute, or simply an employer desiring that its medical and other welfare plans be compliant with ERISA, is strongly advised to have experienced ERISA counsel review and revise the plan documents and employee communications. Absent such review, the likelihood that an employer may be seriously disadvantaged in a dispute that leads to costly litigation is a near certainty.

But, there is now more . . . continue reading . . .

Plan Sponsors Must Act Now to Comply With New Internal and External Claims Procedures

Health care reform makes significant and widespread changes to ERISA. One of those changes relates to claims procedures which in turn directly affects the courts' deference to employer claim determinations (discussed in the preceding article). Also, plans, summary plan descriptions, and health plan operations will need to be modified as early as later this year (effective January 1, 2011) to comply with the expanded claims procedure requirements.

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Plan Sponsors Must Act Now - Continued

The new Public Health Service Act sets forth standards for both internal and external claims review processes for medical and other health benefits (the standards apply to group health plans and issuers offering individual and group policies, but do not apply to grandfathered plans or excepted benefits under HIPAA).

*Health plan claims
procedures must
change under health
reform now*

If an employer fails to strictly adhere to the new internal claims procedure requirements, the employee or other claimant will be deemed to have exhausted the internal claims and appeals process. The claimant can then immediately initiate external review of the claim (that is, a review by a third party independent of the plan sponsor), and including pursuing available legal remedies under ERISA. Under these circumstances, if a claimant brings a claim under ERISA, the court will proceed as if the claim was denied and is charged to review the claim without deference to the employer's determination.

As a result, even with proper *Firestone* language, a court will now apply a *de novo* standard of review, rather than the arbitrary and capricious one, if an employer does not properly adopt and implement the new health plan claims procedures. Unlike the previous ERISA claims requirements, the new law requires strict adherence to the claims procedure rules. All employers, now under health care reform, are even more strongly advised to consult with legal counsel to avoid not only noncompliance with ERISA, but also unfortunate prejudicial standing if a health plan dispute spirals into litigation.

Action Required

Finally, and perhaps most notably, all plan sponsors of non-grandfathered insured or self-funded plans, even governmental plans not subject to ERISA, must take steps now to comply with the new claims procedures. These new procedures make numerous material changes to the existing Department of Labor procedures, including the addition of an external appeal process. The Department of Labor just released a temporary extension for some (not all!) of the new requirements from January 1, 2011 to July 1, 2011. To avoid harsh sanctions, as well as litigation, employers must now begin to address the new procedures.

Miscellaneous

Jeffery Mandell's interview on *Fiduciary Implications When Changing Service Providers* was recently published in the 401(k) Advisor, May 2010, Volume 17, Number 5. To review the article, please visit our website at www.erisalawgroup.com under "Firm Publications."

For additional information or if you have questions, contact Jeffery Mandell or John Hughes at (208)342-5522 or 1-866-ERISALAW.

This bulletin is intended to provide general information only and does not provide legal advice. This bulletin does not discuss potential exceptions to the above rules. The application of ERISA laws can be complex. For information regarding the impact of these developments under your particular facts and circumstances, please call us. This material may also be considered attorney advertising under court rules of certain jurisdictions.

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