Employee Benefits & Executive Compensation Update

Government Softens Its Approach to Internal and External Appeals for Group Health Plans

Our Fall 2010 Newsletter addressed and described interim final regulations issued last summer by the Departments of Labor, Health and Human Services and the Treasury, as required by the Patient Protection and Affordable Care Act ("PPACA"). These regulations imposed new internal and external appeals requirements for non-grandfathered group health plans. As recounted in our Spring 2011 Newsletter, the enforcement of certain aspects of these appeals rules has been delayed until plan years beginning on or after January 1, 2012.

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Now, the three government agencies have issued amendments to their prior guidance in an attempt to make the appeals requirements slightly less stringent for plan administrators and health insurers. The amended regulations became effective on July 22, 2011. Some of the more important changes made by the amended regulations that will impact non-grandfathered plans are as follows:

- Urgent Care Claim Review Period. The previous mandate that urgent care claims be reviewed within 24 hours has been reversed and the original ERISA requirement of 72 hours (unless it is possible to respond sooner) has been restored. The amended regulations do clarify, however, that the plan must defer to the claimant's health care provider's determination of whether or not a claim involves urgent care.

- Culturally and Linguistically Appropriate Notices. PPACA requires plans and health insurers to provide relevant notices in a "culturally and linguistically appropriate manner." The previous regulations required notices to be provided in non-English if certain thresholds regarding the percentage of non-English employees sharing a common language are satisfied. The amended regulations revise that approach and now require plans to provide non-English notices only if the same non-English language is used by 10% or more of the entire population residing in a relevant county, as determined by data published by the United States Census Bureau.

- External Appeals Changes. The amended regulations make several changes to the external appeals process. More specifically:

  – *Deemed Exhaustion of Internal Appeals Process*. The previous interim final regulations provided that claims could skip any remaining internal appeals stages and immediately move to an external review if the plan or health insurer fails to strictly adhere to all of the internal appeals requirements. Now, the amended guidance provides that this "deemed" exhaustion will not apply in cases of *de minimis* violations of the internal appeals requirements or for certain types of non-prejudicial actions by the plan or health insurer.

  – *Temporary Limit on the Types of Determinations Eligible for External Review*. The earlier regulations provided that all adverse benefit determinations could be subject to external review by an independent review organization ("IRO"). Under the amended guidance, however, only certain types of adverse benefit determinations will be eligible for external review. For now, the only types of adverse benefit determinations which can be appealed externally are those that involve medical judgment (as determined by the IRO) or those that involve a rescission of coverage. Claims that only involve the plan administrator's interpretation of plan terms (as long as that interpretation does not involve medical judgment) are not eligible for external review; rather, the claimant must proceed to litigation if he or she wishes to continue pursuing the matter. It is important to note, however, that these particular rules are only temporary. After the Departments have had an opportunity to further study the use of IROs, a broader range of adverse benefit determinations may become eligible for external review.

  – *Binding Effect of IRO Decisions*. With respect to external decisions by an IRO, the amended guidance clarifies that an IRO's decision on appeal is binding on a plan or health insurer, as well as the claimant. The plan or health insurer is required to provide any benefits pursuant to the IRO's decision without delay. This is true even if the plan or health insurer intends to appeal the IRO's decision in court.

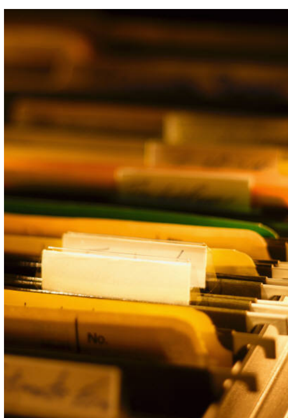
- *Safe Harbor*. In order to comply with the regulations, self-funded plans should contract with at least two IROs and take turns assigning external appeals to them. The amended regulations provide an interim enforcement safe harbor for self-funded plans that contract with at least two IROs before January 1, 2012 (three IROs before July 1, 2012) and rotate external claim reviews among them.

Because the previous regulations were in interim final form, plans were required to begin complying with those rules (subject to the enforcement delay discussed in our Spring 2011 Newsletter) in plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). To remain in compliance with the appeals requirements of PPACA, many plans were amended previously to incorporate the requirements of the interim final regulations. In light of the revised guidance, plan sponsors should review their plan provisions to determine whether additional amendments are necessary to reflect the changes in the internal and external appeals rules. If so, amendments should be adopted before the plan year in which the changes take effect (in other words, plans should be amended no later than December 31, 2011 for calendar year plans).

CIGNA Corp. V. Amara: What Are the Practical Implications for Employers?

On May 16, 2011, the U.S. Supreme Court issued an opinion that may change the way that employers and plan participants look at their summary plan descriptions. ***As a result of* CIGNA v. Amara*, it may now be easier for a plan participant to win a lawsuit against a plan that has an incomplete, inaccurate, or misleading summary plan description.***

CIGNA v. Amara arose from CIGNA Corp.'s conversion from a traditional defined benefit pension plan to a cash balance plan. In November 1997, CIGNA sent its employees a newsletter announcing that it intended to substitute a new "account balance plan" for its traditional defined benefit plan, under which many employees had already accrued a benefit. CIGNA's initial description of the new plan was, according to the Court, incomplete and misleading. Some parts of the description (such as the claim that CIGNA would have no cost savings) were altogether false. The District Court held that CIGNA violated ERISA sections 102(a) and 104(b), which require a plan administrator to provide summary plan descriptions and summaries of material modifications that are written in a manner calculated to be understood by the average plan participant and that are sufficiently accurate and comprehensive to reasonably apprise such participants of their rights and obligations under the plan. The Supreme Court agreed.



Examining the terms of the new plan and CIGNA's promises to its employees, the District Court chose to "reform" (*i.e.*, change) the terms of the new plan to match the summary plan description. Rejecting as inapplicable the specific statutory basis (claims for benefits under ERISA section 502(a)(1)(B)) that the District Court had relied on to provide a remedy, the Supreme Court gave guidance to the District Court that strongly implied that reformation or other equitable relief could be provided under an alternative statutory provision (equitable relief under ERISA section 502(a)(3)), assuming that the District Court made certain specific findings. The Court held that if a summary plan description or other plan information given to employees is misleading or false, the plan participant can ask the court only for equitable relief, which might include reforming the provisions of the plan to match the reasonable expectations of the plan participants.

In addition, the Supreme Court removed one of the most difficult hurdles that a plan participant must prove when suing the plan – the need to prove reliance upon the faulty summary plan description. The Court held that although plan participants must show "actual harm" was caused by the faulty summary plan description, they do not need to show that they acted or relied upon the faulty document. In fact, they do not even need to show that they have read the summary plan description, since fellow employees or informal workplace discussion, as the Supreme Court surmises, would let them know if plan changes would likely prove harmful.

CIGNA v. Amara leaves plan sponsors with some definite lessons about their summary plan descriptions:

- Because a court may now be empowered to change the plan to match a faulty summary plan description, the plan sponsor, which often does not even write the summary plan description, may be forced to pay benefits it never intended to pay. This is especially true since participants are required only to show that the summary plan description was harmful and not that they relied on (or even read) the summary plan description. Plan sponsors will want to carefully review their summary plan descriptions to ensure that they accurately and completely summarize the terms of the plan and do not mislead plan participants.

- Importantly, while not the direct holding of the case, the Supreme Court was careful to explain that a summary plan description: (1) does not *automatically* "become" a part of the plan document (and thereby automatically supersede the terms of the plan document) just because there is an inconsistency between the summary plan description and the plan document, as many lower courts held in the past; and (2) is not the same as a plan document. These comments cast some doubt on the acceptability of using SPDs, certificates or booklets provided by insurers or claims processors as both the summary plan description and plan document. Best practices in this area suggest that a plan sponsor maintain a separate plan document and summary plan description for its group health plan.

Professional Update

Upcoming Presentations and Seminars:

- In July, *Douglas Neville* co-founded the Gateway St. Louis Chapter of the American Society of Pension Professionals and Actuaries. Mr. Neville serves on the Board of Directors of the chapter and as its Secretary. The chapter's first meeting will be held on September 7, 2011 and will feature a half-day educational program on topics of interest to benefits professionals.

- *Douglas Neville* will be speaking at the ESOP Association Heart of America Chapter meeting in Kansas City on August 24, 2011. The presentation, which will be part of a panel discussion on ESOP sustainability, will focus on corporate governance in ESOP companies and legal developments impacting ESOPs.

- The Firm is co-sponsoring "Get the Most Out of Your ESOP," a 3-day conference in St. Louis organized by the National Center for Employee Ownership. On September 26, 2011, the first day of the conference, *Douglas Neville* and *Daniel Janich* will be speaking on "Plan Design Features That Support Ownership Culture."

- On September 29, 2011, Greensfelder will be hosting a Business and Bagels event for our clients. *Douglas Neville* and *Kristy Wrigley-Durer* will be speakers, along with individuals from Holmes Murphy. The event will include a panel discussion of recent legal and compliance updates since last year's health care reform legislation (PPACA), including the anticipated outcome of the current court cases challenging the constitutionality of PPACA and the expected impact PPACA will have on employers, group health plans and health care providers, as well as tips and strategies for businesses to consider in light of these important issues. To learn more about this upcoming event, including registration information, please contact Nicole Weinacht at nlc@greensfelder.com.

Recent Activity:

- *Kristy Wrigley-Durer* was recently interviewed for the *Illinois Business Journal* article "Health Reform Law Rumbling Down Tracks Toward a Showdown in U.S. Supreme Court" by Alan J. Ortbals.

- *Daniel Janich* was recently interviewed for the *Chicago Daily Law Bulletin* article "Some lawyers say FDIC proposal too far reaching" which discusses the FDIC's controversial new rule on executive compensation.

- *Daniel Janich's* article "Without Proper Planning, Contingent Workers Pose Serious Legal Risks to Employer Benefit Plan" was published in the July issue of *Employee Benefit Plan Review*. To request a copy of this article, contact Nicole Weinacht at nlc@greensfelder.com.

Our Spotlight's On …

Our congratulations to:

- Associate *Mary Khouri* and her husband on the birth of their new son, James Anthony Khouri, on June 13, 2011.

- Associate *Kristy Wrigley-Durer* on her marriage to Jared Durer on June 25, 2011.

Employee Benefits & Executive Compensation Update is published quarterly to inform our clients and friends of important employee benefits and executive compensation issues that may impact their business operations and employment relationships.

Back issues of this newsletter publication are available for review and/or download at the Greensfelder, Hemker & Gale, P.C. website www.greensfelder.com. If there is any subject matter that you would like us to address in an upcoming issue, we would welcome hearing from you.

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