BNA

Pension & Benefits Daily

Your Health Plan's Hidden Dangers: Litigation and Compliance Risks in the New Health Reform Environment

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Many employers are suffering from health care reform fatigue. After the implementation of plan design changes for 2011, many employers hoped for a healthy break to prepare for the play or pay requirement and plan design mandates of 2014. Unfortunately, there is no rest for the weary as the biggest traps are not the costs looming in the future, but rather the new litigation and regulatory risks that are present today.

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Today's employer-sponsored group health plan is riddled with potential compliance missteps that could cost employers thousands of dollars in penalty taxes and even more in potential Employee Retirement Income Security Act litigation exposure. Employers now need to take proactive steps to shield themselves from these hidden dangers.

This article addresses five aspects of the Patient Protection and Affordable Care Act (''PPACA'' or the ''Act'') that could result in significant costs to a plan sponsor if steps are not taken to ensure compliance: plan design mandates, internal and external claims review, enhanced notification requirements, nondiscrimination, and play or pay. This article analyzes the risks associated with noncompliance and provides a list of action items employers should implement to mitigate the risk of noncompliance.

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I. Risk Areas

A. Plan Design Mandates

Is your health plan grandfathered from the Act's requirements? The answer to this question was the major focus for most employers during their health plan renewals in 2010. The answer determined which of the Act's plan design mandates applied, including eliminating lifetime maximums and restricting annual maximums for essential health benefits, restricting rescissions and cancellation of coverage, providing preventive care with no cost sharing and providing emergency care without prior authorization and out-of-network surcharges.[1] Such plan mandates became effective for plan years beginning after Sept. 22, 2010, and other mandates will become effective in 2014.[2]

Even if a plan is grandfathered it will almost surely be temporary. Many plan design changes result in a loss of grandfathering and it's conceivable that grandfathering could be lost inadvertently by the employer failing to comply with one of the many conditions imposed for maintaining grandfathering.

Employers that fail to comply with plan design mandates face liability exposure from two principle areas: (1) excise taxes imposed by the Internal Revenue Code and (2) lawsuits by participants under ERISA. This liability exposure exists even if the plan is fully insured.

1. Excise Taxes

Tax code section 4980D imposes an excise tax on an employer if its group health plan fails to comply with certain statutory requirements, including the Act.[3] The excise tax is $100 per day for each individual whose benefits are not in compliance. For example, if a plan failed to satisfy a plan design mandate for all plan participants, the penalty would be $100 per day for each participant. Because these taxes can be substantial, there is an excise tax limit for ''unintentional failures'' equaling the lesser of 10 percent of the amount paid or incurred by the employer during the preceding tax year for group health plans or $500,000.

Since 2010, employers are required to self report and pay these taxes on IRS Form 8928 (Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code). The form must be filed on or before the due date for filing the employer's federal income tax return (determined without extensions). No excise taxes will be imposed, however, if the employer can demonstrate to the satisfaction of the Internal Revenue Service that the employer did not know, or by exercising reasonable diligence would not have known, of the failure or that the failure was due to reasonable cause rather than willful neglect and the employer corrects the failures retroactively by putting affected individuals in the position they would have been in had the failure not occurred, no later than 30 days after the employer first knew or by exercising reasonable diligence would have known of the failure. Even in these situations, however, the employer is instructed to file Form 8928 and enter zero for the tax due.

2. ERISA Litigation

If a plan fails to satisfy a plan design mandated by the Act, participants could file a lawsuit under ERISA to enjoin any act or practice that violates ERISA or to obtain other appropriate equitable relief to redress such violations or enforce any provisions of ERISA. Earlier this year, the Supreme Court expanded the types of equitable remedies that are available under ERISA.[4]

B. Internal and External Claims Procedure

Nongrandfathered group health plans must amend their claims procedures to comply with new rules related to internal claims review and appeals and to adopt an external review procedure. While enforcement of many of the new internal claims review and appeal rules will not occur until Jan. 1, 2012, sponsors of group health plans (particularly self-insured group health plans) must be sure that they have properly updated their plan documents and have adopted processes to ensure compliance with the regulations.

Failure to comply with these requirements exposes the employer to the same excise taxes discussed above under the plan design mandate section. Perhaps more importantly, however, particularly for self-funded plans, any failure to comply with these requirements generally results in the claimant being deemed to have exhausted his or her administrative remedies and may file an ERISA lawsuit, calling into question whether the benefit claim will be adjudicated by the court under the standard abuse of discretion review.[5] There is a very limited exemption to this strict compliance standard, however, for ''de minimis'' violations that do not cause, or are likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant.[6]

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[1] For a complete list of the plan design mandates that became effective for plan years beginning on or after Sept. 23, 2010, see Eric Keller and Andrea Gehman, ''Health Care Reform Requires Action in 2010: Action Items Employers Must Implement Before Year-End,'' 169 Pension & Benefits Daily (Sept. 2, 2010) (169 PBD, 9/2/10; 37 BPR 1995, 9/7/10). For a summary of all plan design mandates required by the Act, see Stephen Harris, Eric Keller, and Ethan Lipsig, ''Health Care 'Reform' Provides No Relief for Employers,'' available at www.paulhastings.com/publications.

[2] Plan design mandates that become effective for plan years beginning after Dec. 31, 2013, include no waiting periods longer than 90 days; no annual limits; and nongrandfathered plans must cover clinical trials and related costs and services and are subject to certain out-of-pocket maximum limits.

[3] Other statutory requirements include COBRA, HIPAA's portability and nondiscrimination requirements, the Genetic Information Nondiscrimination Act (''GINA''), the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act (requiring coverage for minimum hospital stays for mothers and newborns) and Michelle's Law (requiring coverage of dependent children students who are on medically necessary leaves of absence from school).

[4] *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878-1881, 50 EBC 2569 (2011) (95 PBD, 5/17/11; 38 BPR 990, 5/24/11).

[5] DOL Reg. § 2590.715-2719(b)(2)(ii)(F)(1). This regulation states that if a claimant decides to pursue remedies under ERISA Section 502(a), then the claim or appeal is ''deemed denied.'' Prior DOL claims regulations from 1977 included such language and courts concluded that because a deemed denial did not involve the exercise of discretion, the claim was subject to a de novo standard of review.

[6] DOL Reg. § 2590.715-2719(b)(2)(ii)(F)(2).

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C. Enhanced Notice Requirements—The Four-Page Summary of Benefit Coverage

The Summary Plan Description, accompanied by the occasional Summaries of Material Modification, is no longer enough to satisfy the notice requirements related to group health plans. The Act has established a new notice requirement in the form of a four, double-sided page Summary of Benefit Coverage (''SBC'') that must be understandable by the average enrollee and have print no smaller than 12-point font.[7] This new notice requirement is effective March 23, 2012, and applies to grandfathered and nongrandfathered plans alike.

The administrator of the group health plan and, for insured plans, the group health insurance insurer must provide the SBC to each participant or beneficiary for each benefit package offered under the plan before enrollment or renewal of coverage. If there is any material change in the terms of the plan or coverage that affects the SBC content that occurs other than renewal of coverage, participants and beneficiaries must be provided at least 60 days notice before the change is effective. In addition to including certain definitions, the SBC must contain, among other things: (1) information related to coverage and cost-sharing for specific categories of benefits; (2) the exceptions, reductions, and limitations of the coverage; (3) the cost-sharing provisions of the coverage including deductibles, coinsurance, and copayments; (4) a statement about whether the plan provides ''minimum essential coverage'' as defined in the Act; (5) a statement that the SBC is only a summary and that the plan document should be consulted to determine the governing contractual provisions of coverage; and (6) a ''coverage facts label''—referred to as ''coverage examples'' in the proposed rules and similar to a ''Nutrition Facts'' label required for packaged food—to illustrate three common benefit scenarios: having a baby, treating breast cancer, and managing diabetes. The Department of Labor has published a model SBC template, instructions and related materials on its website at www.dol.gov/ebsa.

Failure to comply with these requirements for SBCs can result in a penalty of up to $1,000 per failure. In addition, participants may sue under ERISA by alleging that the administrator (usually the employer) breached its fiduciary duties by providing a disclosure that was materially misleading (either because the description had an error or omitted information that was alleged to be material). The Supreme Court's recent decision in *CIGNA v. Amara* expanded the types of remedies that might be available for this type of claim to include reformation, equitable estoppel and surcharge.[8]

D. Nondiscrimination

Nongrandfathered, insured group health plans are required to satisfy the nondiscrimination requirements of tax code Section 105(h) that previously applied only to self-insured group health plans. These rules prohibit discrimination in favor of highly compensated individuals (''HCIs''), which, as defined by tax code Section 105(h)(5) includes the highest paid 25 percent of the workforce—a much broader definition than used for other employee benefit plans.

Failure to comply with this requirement is subject to the excise taxes discussed under Part I.A. above for plan design mandates. In addition, as discussed in that same section, employees could bring an action under ERISA to enjoin any noncompliant act or practice or obtain other appropriate equitable relief. Such relief might include a court order requiring the plan to provide nondiscriminatory benefits, which could significantly expand the cost associated with the plan.

The IRS has issued guidance stating that this requirement will not be enforced by IRS, DOL, or the Department of Health and Human Services until regulations are issued and requesting comments in connection with drafting of those regulations.[9] However, this nonenforcement period is not binding on private litigants under ERISA.

E. 'Play or Pay' Requirement

Beginning in 2014, employers (determined on a controlled group basis) with at least 50 full-time employee equivalents are required to offer full-time employees health coverage or pay a penalty for each full-time employee if *any* full-time employee is not offered coverage and enrolls in and receives an income-based tax credit to participate in an insurance exchange for that month.[10] The monthly penalty is 1/12 of $2,000 per full-time employee (disregarding the first 30 full-time employees). A full-time employee is one employed at least 30 hours per week on average. (Part-time employees are converted into full-time equivalents by dividing their average monthly hours by 120.) For example, assume an employer has 5,000 full-time employees. If that employer does not offer *one* full-time employee coverage for one month and the employee enrolls in an insurance exchange and receives the income-based tax credit for that month, the employer must pay a penalty equal to $828,333 (calculated as 1/12 of 2000 times 4,970). If this practice continued for an entire year and the number of full-time employees remained constant, the penalty would be $9,940,000.

There are many issues associated with this requirement that remain unanswered, including how and when the number of full-time employees will be determined and how this requirement will interact with another Act requirement that limits waiting periods for plan years beginning after Dec. 31, 2013, to 90 days. IRS has provided proposals and solicited comments on this and various other issues associated with this requirement.[11]

Not surprisingly, IRS has proposed that employee determinations be made using common law standards.[12] Applying this principle to the play or pay penalty could increase significantly the stakes for employers who misclassify workers as independent contractors and other nonemployees as misclassification could lead to penalties that are applied to the entire full-time employee workforce and not just the affected individuals. Accordingly, employers who have not recently reviewed their worker classification policies and practices should do so to ascertain whether their compliance profile is acceptable in light of the increased risks created by the Act's play or pay requirement.

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[7] Proposed DOL Reg. § 2590.715-2715.

[8] *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878-1881, 50 EBC 2569 (2011) (95 PBD, 5/17/11; 38 BPR 990, 5/24/11).

[9] Notice 2011-1, 2011-2 I.R.B. 259 (Dec. 22, 2010).

[10] Code § 4980H(a).

[11] Notice 2011-36.

[12] Id. at § IV.B.

II. Risk Mitigation Strategies

The Act's requirements are extensive and represent a significant expansion of federal regulation of health insurance. And employers that fail to cause their health plans to comply with these requirements face exposure to potentially significant excise taxes and possible ERISA claims. Health plans have become in essence similar to qualified retirement plans in that there are numerous technical requirements that the plan must satisfy and there is the potential for significant liability exposure for noncompliance even if the benefits are fully insured by an insurance carrier.

Accordingly, to mitigate the risk for noncompliance, employers should be thinking about health plan compliance in the same way they would think about ensuring their tax code Section 401(k) plan or other tax-qualified retirement plan is in compliance. Below are a few specific action items we suggest employers pursue:

■ Appoint an individual who is responsible for ensuring compliance. This individual would keep abreast of all new requirements and serve as a quarterback for all of the employer's appropriate health plan vendors (e.g., brokers, insurers, third party administrators, legal counsel).

■ Request legal counsel to review plan documents, summary plan documents, enrollment materials, and participant communications, including the SBC and any Summary of Material Modification, before they are finalized to ensure documentary compliance with the new rules. While many brokers, insurers, and TPAs will provide templates or assistance in this area, they do not provide legal advice and will not be responsible for noncompliance.

■ Create a system to regularly audit the plan and its operations. The excise taxes described above do not apply if the employer can demonstrate that it did not and would not have known of the error through exercising reasonable diligence.

■ For nongrandfathered, self-funded plans, work with legal counsel and other vendors to adopt standard claims notification documents that are in compliance with claims procedure regulations and establish procedures to ensure all timing requirements are met. Have vendors include these services, including guarantees, in their service agreements. Further, request legal counsel to review all agreements with all claims fiduciaries and independent review organizations, if applicable.

■ Adopt internal procedures to ensure that all applicants and enrollees are timely receiving the SBC and any Summary of Material Modification to the SBC.

■ Conduct periodic audits of benefit coverage to ensure accuracy of information contained on the SBC.

■ Most discriminatory provisions for fully insured plans are likely to relate to eligibility. Employers with nongrandfathered, fully insured plans should review all eligibility provisions to ensure they are covering employee classes equally and executive classes are not receiving specialized coverage—either in cost, benefits, or perks, such as broader coverage for dependents.

■ Employers with nongrandfathered, fully insured plans should review severance policies and programs, a major hidden risk for discrimination errors. The one-off severance agreement for an executive may trigger discrimination excise taxes for the rest of the workforce—a huge penalty for a minor error.

■ Employers should work with legal counsel to review their worker classification policies for independent contractors and other contingent workers and confirm the classifications are legally justifiable or make adjustments where appropriate.

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