WINSTEAD

Another Lesson on Bullet Proofing Your Claims Process

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On July 12, 2018, a previous alert entitled "Bullet Proofing Your Claims Process" discussed lessons learned from a recent 5th Circuit decision in *White v. Life Insurance Company of North America*, (5th Cir. June 13, 2018, revised June 14, 2018) in which not all materials in the claims file had been provided to the participant. This month we have new lessons learned from different missteps in handling claims and appeals from the 10th *Circuit in McMillan V. AT&T Umbrella Benefit Plan No. 1*, No. 17-5111, (10th Cir. August 13, 2018). The court criticized the medical expert's reports for being conclusory, failing to consider all the demands of the individual's actual position and failing to consider and discuss all the demands of the position and the other opinion on the individual's status.

Takeaway—The ERISA claim and appeal procedures need to be followed carefully and claim and appeal denials need to be carefully drafted considering and discussing in the claim and appeal denial letters all of the evidence submitted, including addressing any weaknesses or omissions in the information submitted. When there is a request for documents related to a claim or appeal pay close attention to what is requested and what the plan administrator has in its file and carefully assess what is relevant in light of the applicable court decisions. Review the expert consults in the file to see what they reviewed and if they reviewed all information in the file, if they analyze all of the arguments raised by the participant, and if the analysis considers the plan's requirements.

Given the change in the disability claim and appeal procedure requirements that became effective for any disability based benefit claims on April 1, 2018, and the regular litigation over disability claims, it may be prudent to carefully review the forms being used, the process being followed, how document requests are addressed, and how those match with the current requirements. It is important to review all of your plans to verify whether there a disability based benefits included in the plan that may require compliance with the new disability claims procedures (e.g., disability retirement under a 401(k), disability pension benefits, a waiver of premium for persons disabled under a welfare benefit plan). It is important to carefully review the procedures any third party processing your claims will be using and the correspondence they will use both with participants and with outside medical experts to verify they comply with and include the plan's terms, the requirements of the disability claims procedure regulations and that they will facilitate a full and fair review when reviewed by a court.

Wilderness Programs and Residential Treatment Center Litigation Continues

As many employers head into annual enrollment season, it is important to take note that there have been a number of cases challenging exclusions for "residential treatment center and wilderness therapy" and certain other similar therapies as violating the Mental Health Parity and Addiction Equity Act ("MHPAEA"). These cases have been successfully surviving motions to dismiss because, in the context of these particular plans, the exclusion for this type of care was a qualitative exclusion (or non-quantitative) that only applied to mental health care.

Takeaway—It is important to review every health plan's exclusions and contrast the exclusions with the coverages the plan provides for medical/surgical care to see if there are exclusions that might violate the MHPAEA's prohibition on non-quantitative treatment limitations because the exclusion applies only to benefits protected under the MHPAEA and there is coverage of a similar type of service in the medical/surgical care benefits (e.g., medical coverage includes nursing home care services while the same plan excludes residential treatment coverage for mental health).

Association Health Plan Guidance

Much has been said about the Association Health Plans ("AHP"). Final regulations and other guidance has been issued. Fully insured association health plans may be available as soon as September 1, 2018, certain associations that existed and sponsored a self-insured plan may be available on and after January 1, 2019, and any other association (new or existing) may establish a self-insured AHP on or after April 1, 2019. AHPs permit self-employed and small employers to purchase health insurance from the AHPs presumably on a more cost effective basis. The new rules only apply to new AHPs and do not impact those formed under prior U.S. Department of Labor ("DoL") guidance.

AHPs may not charge higher premiums or deny coverage to people because of per-existing conditions or cancel coverage because an employee or a covered family member becomes ill. This will not discuss all of the AHP requirements, but will focus on what employers choosing to pursue AHP coverage should consider.

AHPs must comply with COBRA, HIPAA, the Affordable Care Act or ACA, MHPAEA and ERISA. The AHP plan administrator must furnish the summary plan description, summary of material modifications and the summary of benefits and coverage to the participants. The AHP is required to file the Form 5500 and Form M-1 with the DoL, not the employer. While the guidance issued to date indicated that COBRA applies to the AHP, it also indicated there will be more guidance on whether the COBRA requirements will apply to an employer electing coverage through the AHP when the employer normally would not be subject to COBRA because it had fewer than 20 employee in the prior plan year. An employer who decides to purchase coverage through an AHP will not be subject to the employer shared responsibility tax just because the AHP has other employers with 50 or more full time equivalent employees, as long as the adopting employer (and its controlled group of entities) is not subject to the employer shared responsibility tax on its own per the IRS website Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act.

Takeaway—As the new AHPs form, employers and self-employed individuals can assess whether the administration shifted to the AHP and the cost of coverage is advantageous for their particular situation.

Retirement Plan Incentive to Attract and Retain Employees With Student Loan Debt

Private Letter Ruling ("PLR") 201833012 recently approved a 401(k) plan design providing a matching contribution for an employee's repayment of their student loan obligation as not violating the "contingent benefit" rule requirement that prohibits a 401(k) plan from qualifying under the tax law requirements if any other benefit is conditioned (directly or indirectly) on the employee electing to have the employer make or not make contributions on the employee's behalf (i.e., the employee's salary reduction contributions or ROTH contributions) instead of receiving cash. (Matching contributions made as the result of the employee's elective salary reduction contributions are excepted from this prohibition.) The plan permitted the employee to elect out of the matching contribution for the year and instead to still be eligible to make salary reduction or ROTH contributions, and instead of the matching contribution on the salary reduction or ROTH contribution, the employer made a contribution based on the amount of student loan reduction payments the employee made. This provides an incentive to improve the employee's financial health by reducing student loan debt and enhanced the employee's retirement savings.

If the 401(k) plan in question also qualifies as a "bona fide benefit plan" under the Fair Labor Standards Act ("FLSA"), this design may also help such repayments to avoid inclusion in the employee's "regular rate of pay" which is used to calculate overtime for non-exempt employees. While there are no rulings from the DoL's Wage and Hour Division on such design to date, this technique may help to both encourage employee's with student loans to improve their financial health, while enhancing their retirement savings and reducing the employer's risks under the FLSA. Cases differ on how other education benefits are treated under the FLSA and the FLSA does not have a carte blanche exclusion for ERISA plans or benefits that are not currently included in the employee's income for tax purposes.

Takeaway—Careful consideration of all of the potentially applicable laws to a new benefit design is needed so that the addition of a new benefit design does not leave the employer at risk under other laws.

Retiree Medical Benefits and VEBA Guidance

In PLR 201833014, the Internal Revenue Service ruled on one employer's use of funds originally set aside for retiree medical benefits that were being transferred to a sub-account to pay medical benefits for active employees. As employer's increasingly move their retiree medical obligations to a retiree health reimbursement arrangement with a paired private exchange offering Medicare Supplement Insurance and other coverage, including Part D plans, careful analysis of all applicable requirements is important. This PLR provides the analytical framework for reviewing whether the change in the purpose of the funds might trigger an excise tax or cause the employer sponsoring the VEBA to recognize income under the tax benefit rule.

Takeaway—When moving retiree medical benefits to a new benefit design or structure, there are many considerations, such as tax requirements with respect to how it is funded, Medicare secondary payer, Medicare Part D notice requirements, collective bargaining agreement terms, ERISA notification requirements and others. Excise taxes could potentially apply to a VEBA are a consideration as well as potential income tax ramifications for the employer. It is

important to remember that a PLR is only guidance for the taxpayer who requested it and it does not provide protection for any other taxpayer.

Guidance Issued on Publicly Traded Company Executive Compensation Deduction Limit Changes

Late last year, a law originally known as the Tax Cuts and Jobs Act ("TCJA") altered the compensation deduction allowed for publicly traded companies for compensation paid to the select group of executives who are subject to the $1M compensation limit. The TCJA eliminated the exclusion from the $1M limit on deduction amounts paid as performance based compensation and subjecting such performance based compensation to the $1M limit. It also added a "once in always in" rule that requires the limit to continue to apply even if the individual would not for the current tax year be part of the group subject to the rule. The law included transition rules for certain existing agreements. Guidance was issued on the transition rules in the form of Notice 2018-68 and what the Notice actually means is still under analysis. Due to the detailed factual nature of its application, this only provides notice of the existence of the guidance on the transition rules and not an explanation of how it might apply to any particular situation.

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