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HEALTH PLAN DEVELOPMENTS

Ninth Circuit Reverses *Wit* Decision Addressing Standards for Behavioral Health Coverage

In *Wit v. United Behavioral Health*, the U.S. Court of Appeals for the Ninth Circuit recently reversed the federal district court's ruling that United Behavioral Health (UBH) breached its fiduciary duty to health plan participants by administering claims related to mental health and substance abuse using internal guidelines that were overly restrictive and inconsistent with generally accepted standards of care (GASC).

As discussed in our April 2019 Benefits Counselor, participants alleged that UBH: (1) improperly denied treatments for mental health and substance use disorders by using internal guidelines that were inconsistent with its insurance policies (which required coverage consistent with GASC); (2) violated its fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) by arbitrarily and capriciously denying benefits; and (3) violated standards of care required by state laws. The district court agreed that UBH's guidelines deviated from GASC and found that UBH's restrictive claim guidelines constituted a breach of fiduciary duty and an arbitrary and capricious denial of benefits under ERISA. As a result, the court ordered UBH to reprocess 67,000 denied claims using independent claim guidelines and not UBH's internal guidelines.

Among other arguments, UBH argued on appeal that the district court incorrectly applied the abuse of discretion standard. The Ninth Circuit agreed and reversed the lower court's decision and the reprocessing order. The court concluded that the district court misapplied the standard of review by substituting its interpretation of the plans for UBH's rather than reviewing the insurer's determinations for an abuse of discretion. In this case, because the plans gave UBH discretionary authority to interpret the terms of the plans, UBH's application of the plan's standards could be reviewed only for abuse of discretion, and the court could only overturn UBH's decision if it was unreasonable. According to the Ninth Circuit, UBH's interpretation—that the plans do not require consistency with the GASC—was not unreasonable. The court noted that although the plans excluded treatment for coverage inconsistent with GASC, the plans did not mandate coverage for all treatment that is consistent with GASC.

The Ninth Circuit also ruled that an alleged conflict of interest based on UBH serving as the plan administrator and insurer for insured plans (which are its main revenue source) would not change the outcome on the facts of the particular case.

HHS Increases Civil Monetary Penalties for HIPAA, SBC and MSP Violations

The Department of Health and Human Services (HHS) has announced its annual inflation adjustments to civil monetary penalties in its regulations. These adjustments apply to penalties assessed on or after March 17, 2022, for violations occurring on or after November 2, 2015.

The following key changes could affect sponsors of group health plans:

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification**. The HIPAA administrative simplification rules include standards for privacy, security, breach notification and electronic health care transactions. HIPAA includes four tiers of culpability for violations. The indexed penalty amounts for each violation of a HIPAA administrative simplification provision are as follows:

Culpability	Minimum Penalty/Violation	Maximum Penalty/Violation	Annual Limit
Lack of Knowledge	**$127** (up from $120)	**$63,973** (up from $60,226)	**$1,919,173** (up from $1,806,757)
Reasonable Cause	**$1,280** (up from $1,205)	**$63,973** (up from $60,226)	**$1,919,173** (up from $1,806,757)
Willful neglect, corrected within 30 days	**$12,794** (up from $12,045)	**$63,973** (up from $60,226)	**$1,919,173** (up from $1,806,757)
Willful neglect, not corrected within 30 days	**$63,973** (up from $60,226)	**$1,919,173** (up from $1,806,757)	**$1,919,173** (up from $1,806,757)

- **Medicare Secondary Payer (MSP)**. The indexed amounts for certain violations of the MSP rules applicable to group health plans are as follows:
  - Incentives. The maximum penalty for offering incentives to Medicare-eligible individuals not to enroll in a group health plan that would otherwise be primary to Medicare is $10,360 (up from $9,753) per individual.
  - Nondisclosure. The daily maximum penalty for the failure of responsible reporting entities to provide information identifying situations where the group health plan is or was primary to Medicare is $1,325 (up from $1,247) for each failure.

CMS Issues Guidance on HIPAA Electronic Transaction Standards

On March 22, 2022, the Centers for Medicare & Medicaid Services' (CMS) National Standards Group (NSG) issued two guidance letters regarding HIPAA administrative simplification provisions related to electronic health care transactions. NSG is responsible for administering compliance with the standards for electronic transactions.

One of the guidance letters clarifies covered entities' obligation to require that business associates comply with HIPAA regulations. This letter includes a reminder that engaging a business associate to provide services related to a transaction for which an electronic transaction standard has been adopted does not relieve a covered entity from its responsibility to also comply with all applicable requirements. The guidance notes that NSG may find a covered entity noncompliant if its business associate fails to comply with the electronic transaction standards.

The second guidance letter clarifies the transaction standards for electronic funds transfer (EFT) and electronic remittance advice (ERA). According to the guidance, if a provider requests that a health plan conduct a payment transaction in accordance with HIPAA's EFT and ERA transaction standards, the health plan must do so. When a provider makes such a request, the health plan must comply regardless of whether the provider is in the plan's network or otherwise affiliated with the plan. In contrast, if a provider does not request that the health plan use EFT and ERA standards or does not complete the plan's enrollment process, the plan's use of such standards is not required. Instead, a health plan may pay claims consistent with its usual practice, including by using virtual credit cards, which are not covered by the EFT standards.

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RETIREMENT PLAN DEVELOPMENTS

DOL Announces Plan to Investigate Cryptocurrency-Based Investments in 401(k) Plans

On March 10, 2022, the U.S. Department of Labor (DOL) issued Compliance Assistance Release No. 2022-01 warning plan fiduciaries to exercise extreme care before considering adding a cryptocurrency option to a 401(k) plan's investment lineup. The guidance reminds fiduciaries of their obligations of prudence and loyalty in selecting and monitoring investment options and reiterates that fiduciaries may not shift responsibility to participants to avoid imprudent investment options.

The guidance highlights five "serious concerns" with including cryptocurrencies and other related products as a 401(k) investment option:

- **Speculative and Volatile Investments**: The Securities and Exchange Commission has cautioned that investment in a cryptocurrency is highly speculative. Also, cryptocurrencies have been subject to extreme price volatility, which can have a devastating impact on participants.
- **The Challenge for Plan Participants to Make Informed Investment Decisions**: It can be extraordinarily difficult for participants to make informed decisions about cryptocurrencies because they are novel and it can be challenging to separate facts from "hype."
- **Custodial and Recordkeeping Concerns**: Cryptocurrencies are not held like traditional plan assets in trust or custodial accounts, and methods of holding cryptocurrencies can be vulnerable to hackers and theft. Furthermore, with some cryptocurrencies, misplacing a password can result in the asset being lost.
- **Valuation Concerns**: It is challenging to reliably and accurately value cryptocurrencies as there is no generally accepted model for valuing cryptocurrencies. Relatedly, there is a potential for inconsistent accounting treatment with respect to these investments.
- **Evolving Regulatory Environment**: Because the legal landscape governing cryptocurrency markets is evolving, fiduciaries will need to evaluate how regulatory requirements can be met and address the possibility that other agencies could limit or prevent the use or trading of cryptocurrency investments in response to illegal activity.

Based on these concerns, the DOL anticipates that it will investigate plans that offer participant investments in cryptocurrencies and related products. The

guidance further cautions that plan fiduciaries overseeing or allowing such investments through brokerage windows should expect questioning from the DOL regarding how they can square their actions with their fiduciary obligations.

IRS Reissues Proposed Regulations for Multiple Employer Plans

On March 25, 2022, IRS released proposed regulations regarding multiple employer plans (MEP) under section 413(c) of the Internal Revenue Code and withdrew the proposed regulations the IRS issued in July 2019. The new proposed regulations would provide an exception from the "unified plan rule" for defined contribution MEPs. Under the unified plan rule (also known as the "bad apple" rule), the failure by one or more participating employers to satisfy a qualification requirement results in the disqualification of the MEP.

The 2022 proposed regulations provide an exception to the unified plan rule in two situations: (1) a failure to provide information, which occurs when a participating employer fails to provide information necessary to determine whether the MEP meets the plan qualification requirements upon reasonable request by the MEP administrator; or (2) a failure to take action, which is a failure of a participating employer to timely comply with the MEP administrator's request to take action needed for the MEP to meet the plan qualification requirements.

If one of the above failures occurs, an MEP could invoke the exception to the unified plan rule to avoid disqualification provided certain conditions are met. One condition is that the plan document must include a description of the procedures that would be followed to address a participating employer failure. Another requirement is that the MEP administrator send up to three notices with specific information regarding the failure to an unresponsive participating employer. The last of these notices, if applicable, must be provided to participants who are employees of the participating employer (and their beneficiaries) as well as the DOL. After the third notice is sent, the unresponsive employer has the opportunity to either take remedial action or initiate a spinoff of plan assets and account balances held on behalf of employees of the employer to a separate single employer plan established and maintained by the employer. If the employer elects a spinoff, it must generally be completed within 180 days of the date on which it was initiated.

If the participating employer fails to take remedial action or initiate a spinoff, the MEP administrator must stop accepting contributions from the employer and its employees, provide notice to participants (and their beneficiaries) and provide participants with an election with respect to their plan benefits. The participants

may roll over their accounts into an eligible retirement plan or leave their accounts in the plan until they are eligible for a distribution under the terms of the plan.

Finally, the regulations provide that if the MEP has a pooled plan provider (PPP), the PPP must perform all the administrative duties that are required of it during the year of the participating employer failure for the unified plan exception to apply.

Among other changes, the 2022 proposed regulations removed the provision providing that an MEP is ineligible for the exception to the unified plan rule if it is under examination before the first notice is sent. Additionally, under the 2022 proposed regulations, the MEP is no longer required to take action to initiate a spin-off and plan termination to address an unresponsive participating employer. As noted, the participating employer must elect a spin-off under the 2022 proposed regulations.

The IRS will accept comments on the 2022 proposed regulations until May 27, 2022. A public hearing on the proposed regulations is scheduled for June 22, 2022. The regulations will be effective once they are published as final regulations in the federal registrar; however, the proposed regulations can be relied upon until the regulations are finalized.

House Approves SECURE 2.0

On March 29, 2022, the House of Representatives voted to approve the Securing a Strong Retirement Act of 2022 (SECURE 2.0). SECURE 2.0 includes most provisions from an earlier version of the bill approved by the Ways and Means Committee and similar legislation approved by the Education and Labor Committee known as the Retirement Improvement and Savings Enhancement Act.

SECURE 2.0 builds on the Setting Every Community Up for Retirement (SECURE) Act of 2019 and includes a variety of measures aimed at increasing retirement savings and streamlining plan administration. Among other provisions, the SECURE 2.0 includes the following measures: (1) requires new 401(k) and 403(b) plans to include automatic enrollment and escalation features; (2) increases the catch-up contribution limit and mandates that catch-up contributions are made as Roth contributions; (3) increases the required beginning date age; (4) expands coverage of long-term, part-time workers; (5) treats student loan repayments as elective deferrals for matching purposes; (6) creates a retirement savings lost and found database; (7) increases the cap on mandatory distributions; (8) simplifies

reporting and disclosure requirements; (9) relaxes the required minimum distribution rules; and (10) expands the self-correction program.

The bill now heads to the Senate, where a group of lawmakers is currently working on its own SECURE 2.0 proposals.

GENERAL DEVELOPMENTS

Fourth Circuit Rules Administrator's Failure to Respond to Information Request Demonstrated Futility

In *Wilson v. UnitedHealthcare Ins. Co.,* the U.S. Court of Appeals for the Fourth Circuit ruled that UnitedHealthcare Insurance Co. (United)—the plan administrator and insurer—breached its fiduciary duties under ERISA by failing to respond to a participant's document request even though HIPAA prevented the administrator from providing some of the documents requested.

This case involved a health plan's denial of coverage for residential treatment for a participant's minor dependent. During the claims review process, the participant's attorney wrote to the plan requesting various documents related to the claims, including the plan document and the minor's medical records. The attorney's letter included a HIPAA authorization to allow the documents to be released on the minor's behalf. However, the plan administrator did not respond to the letter and document request because the signature on the HIPAA authorization was illegible, and the minor signed it on his own behalf. After the plan administrator failed to respond to the attorney's letters and document request, the participant filed suit in federal court under ERISA challenging the claim denial. The lower court dismissed the participant's claims for a failure to exhaust the plan's administrative remedies.

On appeal, United argued that it had no obligation to produce the requested documents because the HIPAA authorization was fatally defective and the requested documents were all protected by HIPAA. The court rejected this argument finding that ERISA required the administrator to produce the requested plan documents that did not contain the minor's individually identifiable health information, regardless of the validity of the HIPAA authorization. The court held that by failing to respond to the letter and document request the administrator impeded the appeal process and put the participant "at a distinct disadvantage in understanding how to proceed." As a result, the administrator made a clear showing of futility and the participant was excused from the exhaustion requirement.

Besides arguing that the HIPAA authorization was invalid, United asserted that it could not contact the participant's attorney regarding the HIPAA authorization without violating HIPAA by disclosing information about the minor. The court rejected this argument noting that contacting the attorney would not disclose any of the minor's individually identifiable health information. Furthermore, according to the court, although HIPAA did not require United to inform the participant's attorney of the issues with the HIPAA authorization, ERISA's fiduciary duties did require such a notification.

Ultimately, the court remanded the case to United as the administrator to perform a full and fair review of the participant's claim.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Retirement Plan Deadlines

Required Minimum Distributions. Plans must begin to pay initial required minimum distribution payments by April 1, 2022.

Corrective Distributions for Excess Elective Deferrals. The deadline for processing corrective distributions for elective deferrals in excess of the Code section 402(g) limit is April 15, 2022. The elective deferral limit for 2021 was $19,500 ($26,000 with catch up contributions).

Annual Funding Notice. Calendar year defined benefit plans with over 100 participants must provide the Annual Funding Notice by April 30, 2022.