Benefits Counselor – August 2022

POSTED:

Aug 11, 2022

RELATED PRACTICES:

Employee Benefits

https://www.reinhartlaw.com/practices/employee-benefits

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS, DOL and IRS Address Contraception Coverage in FAQs

The Department of Health and Human Services (HHS), Department of Labor (DOL), and Department of Treasury (IRS) (collectively, "Departments") issued a new set of FAQs to clarify protections for contraceptive coverage under the Affordable Care Act (ACA). The guidance comes after the Departments issued a joint letter last month warning health plan sponsors and insurers of possible future enforcement actions for non grandfathered plans that do not comply with the ACA contraceptive coverage mandate. As a reminder, the ACA requires non grandfathered group health plans and insurers to cover at least one form of contraception within each category identified by the Food and Drug Administration (FDA), as well as contraceptive services or approved products deemed medically appropriate by a participant's attending provider.

Among other things, the FAQs direct plan sponsors and health insurance providers to:

- Cover items and services integral to the furnishing of recommended preventive services, including coverage for anesthesia for tubal ligation procedures and for pregnancy tests administered prior to the placement of an intrauterine device, regardless of whether the items are billed separately.
- Cover, without cost sharing, contraceptive services and FDA-approved contraceptive products not included in the Health Resources & Services Administration (HRSA) Guidelines but deemed medically appropriate by the participant's attending provider.
- Cover FDA-approved emergency contraception, such as levonorgestrel and ulipristal acetate, when the medication is prescribed by an attending physician, including prescriptions for advanced provision.

The FAQs also provide guidance to plans and issuers for applying reasonable medical management techniques to contraceptive coverage and include a list of examples of unreasonable medical management techniques. The FAQs confirm that plans and issuers may not require an individual to submit an appeal through the claim and appeal procedures to obtain an exception to a medical

management technique.

The Departments also noted that although states may attempt to restrict contraceptive coverage, such restrictions would be preempted to the extent that they conflict with the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act of 1974 (ERISA). The Departments concluded the FAQs by describing the enforcement process for violations of the contraceptive coverage mandate.

HHS Updates ACA Nondiscrimination Rule in New Proposal

On July 25, 2022, HHS's Office of Civil Rights issued a new proposed rule implementing ACA section 1557 (Proposed Rule). ACA section 1557 provides that an individual shall not be excluded from participation in, denied the benefits of, or subjected to discrimination under any health program or activity provided or administered by a covered entity based on race, color, national origin, sex, age or disability. The Proposed Rule reverses many of the changes made by a 2020 Final Rule, which limited ACA section 1557's prohibitions against discrimination based on gender identity or termination of pregnancy.

Some of the key provisions in the Proposed Rule include:

- Application to HHS Programs and Health Insurers. The 2020 Final Rule limited the scope of ACA section 1557 to only those programs and activities conducted by HHS under Title I of the ACA. The Proposed Rule would expand ACA section 1557 to apply to *all* health programs and activities administered by HHS. It further reiterates that ACA section 1557 applies to health insurance issuers and some third party administrators (TPAs) that receive federal financial assistance. The Proposed Rule would expand the definition of federal financial assistance to include Medicare Part B.

- Nondiscrimination on the Basis of Sex. The Proposed Rule defines discrimination based on sex to include discrimination based on sexual orientation and gender identity. It also clarifies that sex discrimination includes discrimination based on sex stereotypes; sex characteristics, including intersex traits; and pregnancy or related conditions, including pregnancy termination.

- Staff and Training Requirements. The Proposed Rule would require covered entities to (1) implement ACA section 1557 nondiscrimination policies and procedures that address effective communication, the provision of language assistance for limited English proficient individuals, and reasonable modifications to policies for people with disabilities and (2) provide employees

with training on the applicable policies and procedures.

- Notice of Language Assistance Services. The Proposed Rule would reinstate the notice of language assistance services in the 15 most common languages spoken in the relevant state but require covered entities to provide only annually and upon request. Covered entities would also have to post in prominent physical locations and on their websites.
- Telehealth Services. The Proposed Rule would extend ACA section 1557's nondiscrimination provisions to health programs and services offered through telehealth services. These protections attempt to ensure that individuals with disabilities and limited English proficient individuals have meaningful access to telehealth programs.
- Religious Freedom Exemptions. Addressing the applicability of federal conscience and religious freedom laws, the Proposed Rule establishes a process whereby individuals can raise religious or conscience based concerns with HHS. HHS will then determine whether the individual is wholly exempt from or entitled to a modification of ACA section 1557's requirements. HHS noted that case by case determinations allow it to account for any harm an exemption or modification could have on third parties.

HHS requests comments and requests for public hearing within 60 days following publication of the Proposed Rule in the Federal Register.

Eleventh Circuit Finds Fiduciary Breach During Open Enrollment

On June 28, 2022, the U.S. Court of Appeals for the Eleventh Circuit ruled that ERISA beneficiaries can sue under ERISA section 502(a)(3) to recover monetary benefits lost due to a breach of fiduciary duty during the enrollment process. In *Gimeno v. NCHMD, Inc.*, a participant elected to enroll in both supplemental life insurance coverage and employer paid coverage. For three years following the enrollment, the participant's employer deducted premiums and provided benefits summaries consistent with the supplemental coverage. However, when the participant died and his spouse filed a claim for benefits, the insurer denied the claim because the participant never submitted evidence of insurability—a requirement that was never disclosed during the enrollment process.

The participant's spouse sued the employer under ERISA section 502(a)(3), which permits beneficiaries to request "appropriate equitable relief" for violations of the statute or terms of the plan. Granting a motion to dismiss, the U.S. District Court

for the Southern District of Florida found that compensatory relief is not equitable and is therefore unavailable under ERISA section 502(a)(3).

Reversing the lower court's decision, the Eleventh Circuit found that certain forms of monetary relief are available in equitable suits under ERISA section 502(a)(3). The court emphasized that, in light of the Supreme Court's decision in *CIGNA Corp. v. Amara,* the employer's status as a fiduciary makes a critical difference, differentiating the monetary relief from the sort of compensatory damages traditionally unavailable in lawsuits seeking equitable remedies. Joining every circuit court to address the issue, the Eleventh Circuit found that ERISA section 502(a)(3) creates a cause of action for monetary relief for breach of fiduciary duty.

Ninth Circuit Reverses Lower Court—Enforces Plan's "Self-Help" Provision

In its July 25, 2022, opinion in *Mull v. Motion Picture Industry Health Plan*, the U.S. Circuit Court of Appeals for the Ninth Circuit declined to set aside a group health plan's "self help" recoupment provision. In *Mull*, a participant's covered dependent was injured in a car accident, for which the Plan paid medical benefits. The Plan included a "self help" recoupment provision whereby the covered dependent was required to reimburse the Plan if the covered dependent recovered damages from a third party. After the dependent settled for damages with a third party but failed to reimburse the Plan, the Plan applied its share of the family's future covered expenses as a credit against the dependent's reimbursement obligation, effectively ceasing future benefit payments.

Reversing a lower court judgment, the Ninth Circuit concluded that the Plan's actions were permitted by the clear and unambiguous terms of the recoupment provision. The Ninth Circuit found that the recoupment provision lacked the kind of "unduly oppressive" terms that courts recognize as unconscionable. Therefore, by becoming a participant in the Plan, the participant and his dependents knowingly accepted the contractual obligation to repay any third party recoveries.

In addition to unconscionability, the plaintiff also argued that the recoupment provision was unenforceable because ERISA section 503(a)(3), which permits suits for equitable relief, provides the sole remedy for a plan against a beneficiary. Dismissing this argument, the Ninth Circuit noted that ERISA's judicial remedies were not intended to preclude extra judicial contractual remedies such as the recoupment provision. The Ninth Circuit further noted that the recoupment provision does not violate ERISA's civil enforcement scheme.

Reinhart

RETIREMENT PLAN DEVELOPMENTS

DOL Updates QPAM Exemption in Proposed Rule

On July 26, 2022, the DOL issued a proposed rule (QPAM Proposed Rule) amending Class Prohibited Transaction Exemption 84 14, the Qualified Professional Asset Manager (QPAM) Exemption. The QPAM Exemption permits plan investment advisors who meet specified financial standards to act on behalf of plans and enter into transactions that would otherwise be prohibited under ERISA. The DOL's QPAM Proposed Rule is intended to address substantial changes in the financial industry after the QPAM Exemption was first released in 1984, providing further protection to plans, participants and beneficiaries.

- Updated Asset Under Management and Equity Thresholds. The QPAM Proposed Rule updates the asset under management and equity thresholds required for registered investment advisers and other types of QPAMs.
  - Assets under management increased from $85,000,000 to $135,870,000.
  - Equity capital for banks, savings and loans, and insurance companies from $1,000,000 to $2,720,000.
  - Equity capital for registered investment advisors and broker dealers increased from $1,000,000 to $2,040,000.

- Foreign Criminal Convictions and Prohibited Misconduct. The QPAM Proposed Rule clarifies that foreign criminal convictions of a type substantially similar to U.S. federal or state crimes will disqualify an investment manager from relying on the QPAM Exemption. The rule also adds a new category of disqualifying conduct, "Prohibited Misconduct," which includes criminal conduct forming the basis for a non prosecution or deferred prosecution agreement, systematic patterns of non compliance with the QPAM Exemption in connection with otherwise non exempt transactions, and providing the DOL with misleading information in connection with the QPAM Exemption.

- Ineligibility Period. The QPAM Proposed Rule reiterates that the 10 year ineligibility period for criminal convictions begins on the date the trial court enters its judgment, regardless of whether the judgment is appealed. On appeal, a person is no longer considered "convicted" only upon a subsequent final judgment reversing the initial conviction. For prohibited misconduct, ineligibility begins on the date in which the DOL issues an Ineligibility Notice.

The QPAM Proposed Rule also includes a one year mandatory wind down period following a QPAM's ineligibility date. During this period, the QPAM and its current clients can rely on the QPAM Exemption for transactions entered into before the ineligibility date. The QPAM cannot rely on the QPAM Exemption for new transactions or new plans. To qualify for the wind down period, the QPAM must satisfy specific notice, indemnification and termination requirements.

Ineligible QPAMs can apply for supplemental individual exemption relief, provided the applicant supplies the DOL with a detailed explanation of why such change is necessary and in the interests of plan participants and beneficiaries.

- New Recordkeeping Requirements. The QPAM Proposed Rule requires QPAMs to maintain records demonstrating compliance with the QPAM Exemption for a period of six years. QPAMs will also be required to provide a one time notice to the DOL of its intent to rely on the QPAM Exemption. In the Preamble to the Proposed Rule, the DOL notes that it intends to publish a list of entities relying on the QPAM Exemption on the DOL website.

The DOL requests comments and requests for public hearing by September 26, 2022.

Sixth Circuit Denies Motion to Dismiss in Excessive Fee Dispute

The U.S. Court of Appeals for the Sixth Circuit weighed in on the appropriate pleading standard for excessive fee disputes in its July 13, 2022, decision in *Forman v. TriHealth Inc*. In *Forman*, TriHealth Inc. employees alleged that the company's 401(k) plan failed to offer cheaper institutional class investments instead of more expensive retail share classes. TriHealth Inc. filed a motion to dismiss, claiming that the plaintiffs failed to adequately state a claim for breach of fiduciary duty. The U.S. District Court for the Southern District of Ohio agreed, dismissing the class action complaint last year.

On appeal, the Sixth Circuit reversed the District Court's decision, finding that the plaintiffs stated a plausible claim for fiduciary breach with respect to TriHealth Inc.'s investments in more expensive mutual fund share classes. TriHealth Inc. had previously argued that the more expensive shares were offset by a revenue sharing component, where mutual funds reduce fees for certain investors, making the investments less expensive. Acknowledging that TriHealth Inc. may have had justifiable reasons for investing in retail share classes (*i.e.,* the fund being too small to qualify or the cost being offset by revenue sharing), the Sixth Circuit noted that "taken in the most flattering light" the

plaintiffs' allegations permitted the reasonable inference that TriHealth Inc. failed to leverage its significant plan assets to negotiate more attractive share classes with lower fees.

Ultimately, the Sixth Circuit concluded that the pleading stage is too early to make such judgments, and that discovery may be necessary to conduct the context specific inquiry required for excessive fee disputes.

D.C. Circuit Addresses Withdrawal Liability Interest Rates

On July 8, 2022, the U.S. Circuit Court of Appeals for the D.C. Circuit joined the Sixth Circuit in addressing a multiemployer pension plan's use of the "Segal Blend" for calculating an employer's withdrawal liability. In *United Mine Workers of America 1974 Pension Plan v. Energy West Mining Company*, a pension plan assessed withdrawal liability against an employer using the Segal Blend, an interest rate methodology that blends the interest rate used for the plan's minimum funding purposes with the estimated annuity purchase rate for benefits being settled (based on the Pension Benefit Guaranty Corporation's annuity interest rates).

Citing the Sixth Circuit's decision in *Sofco Erectors, Inc. v. Ohio Operating Engineers*, the court found that the Segal Blend violated ERISA because it did not represent the actuary's best estimate of the "anticipated experience under the plan." Instead, the court noted that in this instance, the Segal Blend produced a lower withdrawal liability interest rate than an assumption based on the Plan's historical investment performance, thereby generating a higher withdrawal liability assessment. The court emphasized that, in order to be the actuary's best estimate of anticipated experience under the Plan, the withdrawal liability interest rate must be similar to the minimum funding rate, although the two figures need not be identical.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

General Benefits

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2021, the Form 5500 filing deadline was July 31, 2022. However, for plans that obtained an extension, the Form 5500 must be filed by October 15, 2022.

Summary Annual Report Deadline for Calendar Year Plans. Plan administrators

whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year end (*e.g.*, for plan years that ended December 31, 2021, the deadline is September 30, 2022). However, if a plan receives an extension for filing its Form 5500, the nine month deadline is extended by two months.

Retirement Plans

Annual Funding Notice. Calendar year defined benefit plans with 100 or fewer participants generally must provide an annual funding notice by the earlier due date of Form 5500 due date or the date of its filing, including extensions.

Health and Welfare Plans

Health Reimbursement Arrangements. Plan sponsors of HRAs integrated with other group health plan coverage must offer participants an annual opportunity to opt out of and waive all future reimbursements from their HRA. An opt out notice can be provided with open enrollment materials to satisfy this requirement.