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Benefits Counselor - February 2023

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Benefit Plans and the End of the COVID-19 Emergencies

On January 30, 2023, the Biden Administration issued a Statement of Administration Policy announcing that it intends to terminate the COVID 19 National Emergency (National Emergency) and Public Health Emergency (PHE) declarations, effective May 11, 2023.

National Emergency

The Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS) extended certain timeframes applicable to group health plans, disability and other welfare plans, pension plans, and participants and beneficiaries of these plans during the National Emergency. Named the "Outbreak Period," the extension was effective March 1, 2020, and concludes on the earlier of one year following the date the deadline was originally tolled or the date that is 60 days following the end of the National Emergency (*i.e.*, July 10, 2023). As a reminder, days during the outbreak period cannot be counted towards the:

Group Health Plans

- Deadline to request enrollment in a group health plan due to a special enrollment event under HIPAA;
- 60 day period for a qualified beneficiary to elect COBRA;
- 30 day grace period to pay COBRA premiums;
- 45 day period from the election of COBRA continuation coverage to the date the first payment may be due;
- Deadline to provide a COBRA election notice;
- Deadline to request an external review of a denied appeal; and
- Date to perfect a request for external review.

All Plans under the Employee Retirement Income Security Act of 1974 (ERISA)

- Period to file a benefit claim under the plan's claims procedure; and

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- Period to file an appeal of a claim denial.

With the conclusion of the National Emergency, these deadlines will return to their pre pandemic operation for participants on July 10, 2023.

Public Health Emergency

In addition to the Outbreak Period changes, the end of the PHE may impact health plan coverage of various COVID 19-related services. During the PHE, plans are required to cover all COVID 19 diagnostic tests and vaccinations without cost sharing. The conclusion of the PHE means that health plans can require participants to assume a greater share of these costs. For example, plans will be able to require participants to satisfy any deductible, copayments or coinsurance for COVID 19 tests, as well as COVID vaccinations given by out-of-network providers. Non-grandfathered plans must continue to cover COVID vaccines provided in-network without cost-sharing as an Affordable Care Act (ACA) preventive care service.

Plan sponsors should begin working with service providers to ensure their claims processing systems and administrative procedures are updated in advance of the May 11 deadline.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Agencies Issue Proposed Rule on ACA's Contraception Coverage Mandate

On January 30, 2023, the U.S. Department of Health and Human Services (HHS), together with the DOL and the Department of the Treasury (the Agencies), issued a proposed rule that will limit exemptions from the ACA's contraception coverage mandate and expand access to contraceptive services (Proposed Rule).

The ACA currently requires non grandfathered group health plans and health insurance issuers offering non grandfathered group or individual health insurance coverage to cover contraception and contraceptive services for women without cost sharing when provided in network. In 2018, the Agencies released regulations exempting certain organizations with "sincerely held religious beliefs" or "sincerely held moral convictions" from the ACA contraception coverage mandate. The Proposed Rule would remove the exemption for moral convictions while retaining the existing religious belief exemption. Furthermore, the Proposed Rule would establish "independent contraceptive arrangements," an independent avenue for individuals to obtain contraception coverage without cost-sharing, if

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their employer objects to the contraception coverage mandate.

The Agencies request comments on the Proposed Rule by April 3, 2023.

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

The U.S. Court of Appeals for the Ninth Circuit recently reissued its opinion in *Wit v. United Behavioral Health*, confirming its initial determination that United Behavioral Health (UBH) is not required to reprocess 67,000 denied mental health and substance use disorder claims.

As we discussed in our April 2022 and April 2019 Benefits Counselors, the dispute in *Wit* began when participants alleged that UBH improperly denied treatments for mental health and substance use disorders based on internal guidelines inconsistent with its insurance policies. Plaintiffs argued that UBH should be required to "reprocess" the denied claims using guidelines that comply with the generally accepted standards of care (GASC). The U.S. District Court District Court for the Northern District of California agreed, finding that UBH's guidelines deviated from GASC and ordering UBH to reprocess 67,000 denied claims using independent claim guidelines.

In an unpublished opinion last year, the Ninth Circuit reversed the District Court decision and the reprocessing order. That decision focused solely on the merits of plaintiffs' fiduciary breach claims, finding that the District Court misapplied the standard of review by substituting its own interpretation of the insurance plans at issue instead of reviewing UBH's interpretation for abuse of discretion. After several calls for rehearing, the Ninth Circuit withdrew its initial unpublished decision and released a new published decision on January 26, 2023, that expands on its prior analysis.

Consistent with the initial unpublished opinion, the Ninth Circuit retained its holding that the District Court misapplied the abuse of discretion standard of review by substituting its own interpretation in place of UBH. However, the Ninth Circuit also expanded on its initial holding by finding that "reprocessing" is an inappropriate class wide remedy for benefit claims under section 1132(a) of ERISA. In so doing, the Ninth Circuit emphasized that reprocessing is not itself a remedy but is instead a means to achieve the remedy plaintiffs actually seek—the recovery of denied benefits. By allowing plaintiffs to request reprocessing as a class wide remedy, the Ninth Circuit suggested that it would improperly expand substantive rights because ERISA does not provide reprocessing as a standalone

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remedy.

The Ninth Circuit found that the District Court improperly excused absent class members from establishing they had exhausted the plans' administrative remedies. Doing so, the Ninth Circuit argued, improperly abridged UBH's affirmative defense of failure to exhaust and expanded absent class members' right to seek judicial remedies.

RETIREMENT PLAN DEVELOPMENTS

PBGC Issues Withdrawal Liability Condition Exemption for Special Financial Assistance Program

On January 25, 2023, the Pension Benefit Guaranty Corporation (PBGC) issued a final rule regarding the Special Financial Assistance (SFA) program for underfunded multiemployer pension plans (Final Rule). The PBGC previously published a final rule implementing the SFA program in July 2022 (the 2022 Final Rule). The Final Rule supplements the 2022 Final Rule.

As discussed in our July 2022 Benefits Counselor, the 2022 Final Rule placed conditions on the interest rate and methodology SFA plans must use when calculating withdrawal liability. For example, the 2022 Final Rule required plans to phase in SFA financing over the projected SFA period for purposes of determining underfunding. These conditions are intended to ensure that SFA funds are used for benefits, not subsidizing employer withdrawals. However, in response to comments, the PBGC issued the Final Rule to establish a limited exception process for SFA plans to opt out of the withdrawal liability conditions.

To qualify for the exception, a plan sponsor must demonstrate that:

- The SFA withdrawal liability conditions would result in increased employer withdrawals; and
- The exception will not increase the amount of the plan's special financial assistance or increase the PBGC's risk of loss.

Plan sponsors must submit a request for an exception to the PBGC that contains certain identifying, actuarial and financial information before the plan's initial or revised SFA application is filed. The Final Rule is effective January 26, 2023.

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GENERAL DEVELOPMENTS

DOL Updates Penalties for 2023

The DOL has adjusted the civil monetary penalties that may be assessed for various benefits related violations, effective for penalties assessed after January 15, 2023. The Inflation Adjustment Act of 2015 requires an annual adjustment of civil penalty levels for inflation.

Some of the notable increases include:

- **Form 5500**. The penalty for a plan administrator's failure to file an annual report for the plan has been increased to $2,586 per day, up from $2,400.
- **Certain Retirement Plan Disclosures**. The penalty for various retirement plan disclosure failures, including a multiemployer plan's failure to provide notice upon request of a potential withdrawal liability; the failure to provide notice of a funding based limit on benefits or benefit accruals; and the failure of plans with automatic contribution arrangements to provide the required notice to participants has been increased to $2,046 per day, up from $1,899.
- **Blackout Notices**. The penalty for a failure to provide blackout notices or notices of diversification rights increased to $164 per day, up from $152.
- **Improper Distribution**. The penalty on a plan fiduciary who makes an improper distribution has been increased to $19,933 per improper distribution, up from $18,500.
- **GINA Violations and CHIP Notices**. Penalties for violations of the Genetic Information Nondiscrimination Act of 2008 (GINA) and failures relating to disclosures regarding the availability of Medicaid and Children's Health Insurance Program (CHIP) have increased to $137 per employee per day, up from $127.
- **SBC**. The maximum penalty for failing to provide a summary of benefits and coverage (SBC) increased to $1,362 per failure, up from $1,264.

Seventh Circuit Addresses Retroactive Effect of Disability Claims Regulations

In its January 19, 2023, opinion in *Zall v. Standard Insurance Co.*, the U.S. Court of Appeals for the Seventh Circuit confirmed that the "full and fair review" provisions of the DOL's 2018 regulations on disability claims and appeals procedures apply retroactively to all disability claims filed after January 1, 2002.

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The dispute in *Zall* started when Standard Insurance Company (Standard) terminated a participant's disability benefits in 2019, six years after it had initially approved the claim. In terminating the participant's benefits, Standard relied on the report of a consulting physician but did not provide the report to the participant. The participant sued, arguing that Standard failed to conduct a "full and fair" review of his claim as required by ERISA.

The decision of the U.S. District Court for the Western District of Wisconsin hinged on which version of the DOL's disability claims and appeals regulations applied to the participant's claim: (1) the 2002 version, requiring claims administrators to provide claimants with documents and records only upon request; or (2) the 2018 updated version, requiring claims administrators to provide all documents and records irrespective of a participant request.

Initially, the District Court found that the 2018 regulations were inapplicable to the participant's appeal, claiming that the regulations applied solely to claims filed after 2018. The Seventh Circuit disagreed, emphasizing that the plain text of the 2018 regulations states that they apply retroactively to "claims filed after January 1, 2003," except as otherwise stated. The Seventh Circuit further reasoned that general principles disfavoring retroactivity only apply to substantive rules, whereas procedural rules do not raise the same concerns. The Seventh Circuit concluded by stating Standard had ample time following the 2018 regulations to update its procedures to account for the new disclosure requirement. Ultimately, the Seventh Circuit's decision in *Zall* serves as a helpful reminder for plan sponsors to update their administrative policies and procedures following regulatory changes in a timely manner.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Health Plan Compliance Deadlines and Reminders

Form M 1: Association health plans and other multiple employer welfare arrangements (MEWAs) that provide health coverage must file their annual Form M 1 with the DOL by March 1, 2023.

Medicare Part D Creditable Coverage Disclosure: Calendar year plans providing prescription drug coverage must provide the annual creditable coverage disclosure to the Centers for Medicare & Medicaid Services (CMS) by March 1, 2023 (or, for fiscal year plans, 60 days after the beginning of the plan year).

HIPAA Breach Reporting: Plans must file annual breach reports with the HHS's

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Office for Civil Rights (OCR) by March 1, 2023. The annual breach report is for breaches involving fewer than 500 individuals that occurred during the preceding year. Breaches involving 500 or more individuals must be reported no later than 60 calendar days from the date of the breach's discovery.

Furnish Forms 1095 B and 1095 C to Participants. Subject to limited exceptions, plan sponsors of self funded health plans and Applicable Large Employers (ALEs) must distribute Forms 1095 B and 1095 C to participants by March 2, 2023.

File Forms with IRS. Plan sponsors and ALEs must file the transmittal Forms 1094 B and 1094 C with their corresponding Forms 1095 with the IRS by February 28, 2023, or March 31, 2023, if e-filing.

Retirement Plan Compliance Deadlines and Reminders

Form 1099 R: Plan sponsors must file the Form 1099 R with the IRS by February 28, 2023, or March 31, 2023, if e filing.

Reinhart's Employee Benefits Practice is one of the largest and most tenured in the country:

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