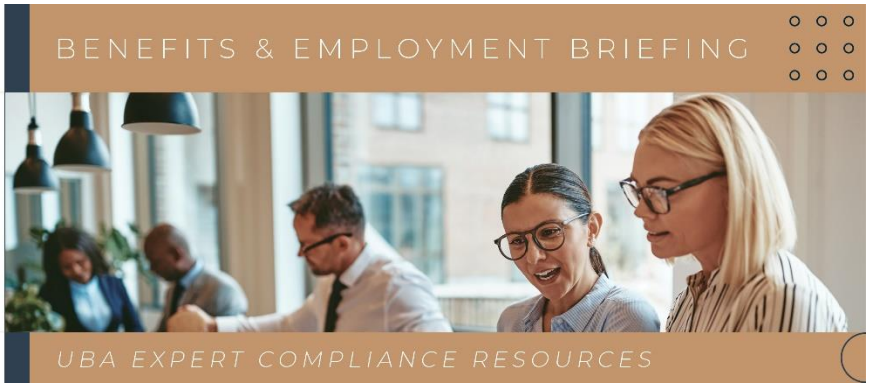

Stay compliant

Welcome to the UBA Partner Firm exclusive quarterly newsletter delivering insights about employee benefits and labor law compliance.

Benefits & Employment Briefing | Fall 2023

Biden Administration Releases Mental Health Parity Proposed Regulations, Targeting Compliance

On July 25, 2023, the U.S. Departments of Treasury, Labor, and Health and Human Services (the "Departments") released proposed rules on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), ensuring that health plans provide coverage for mental health and substance use disorder treatments (such as those for anxiety) at the same level as physical health care coverage (such as medical and surgical benefits related to heart disease or diabetes).

Specifically, these proposed regulations:

- Propose new standards for determining network composition and out-of-network reimbursement rates
- Sunset the ability for non-federal government plans to opt out of federal parity requirements
- Codify standards for non-quantitative treatment limitations (NQTLs) requirements, such as medical management techniques like prior authorizations

- Require that health plans acknowledge and address any differences in access to mental health and substance use disorder benefits from medical or surgical benefits
- Request feedback on proposed data requirements related to a health plan's NQTLs and network composition

Once these proposed regulations are published in the Federal Register, the agencies will accept comments for 60 days.

When the MHPAEA was amended by the Consolidated Appropriations Act, 2021 (CAA), a provision was added to the law, requiring health plans and issuers to document comparative analyses of both the design and application of their NQTLs. Health plans and issuers must then provide these analyses to the Departments and any applicable state agency, upon request.

The Secretaries of the Departments must then report these results to Congress annually, known as the MHPAEA Comparative Analysis Report to Congress (Report). A Report has been submitted for both 2022 and 2023, satisfying the CAA's requirements.

Among other things, these Reports address MHPAEA enforcement priorities and activities. Most recently, the 2023 Report explicitly stated that mental health parity enforcement is a top priority for the Employee Benefits Security Administration (EBSA), the employee benefits enforcement arm of the U.S. Department of Labor (DOL). Specifically, in its 2023 Report, the EBSA has announced that it will devote almost 25 percent of its enforcement work to MHPAEA NQTLs.

Over the past year, the EBSA increased staff specialization in its dedicated NQTL Task Force, developed new investigative tools specifically for MHPAEA investigations as well as hired and consulted with subject matter experts on mental health and substance use disorder (MH/SUD) diagnoses, treatments, review processes, and certain types of NQTLs.

Bracing for yet another regulatory responsibility, employers offering group health plans are responsible for ensuring that their health plan complies with the MHPAEA, including these newly proposed regulations.

Employers should keep these best practices in mind:

- Review the MHPAEA Self-Compliance Tool from the DOL annually, helping you navigate your legal responsibilities.
- Discuss the proposed regulations with your broker and third-party administrator, ensuring compliance with the MHPAEA comparative analyses rules.
- Consider whether you need to hire a qualified consultant to prepare your comparative analyses if your third-party administrator does not prepare the report (or only prepares part of the report).
- Consult with legal counsel if you've identified any MHPAEA concerns that may lead to non-compliance.

What Employers Should Know in Light of Increased Health Plan Fiduciary Litigation

The Consolidated Appropriations Act of 2021 (CAA '21) has caused quite a stir, making it one of the biggest health plan challenges for employers since the passage of the Affordable Care Act.

Under the CAA '21, the Transparency in Coverage rule, and related Department of Labor (DOL) guidance, employers are now required to report drug pricing to governmental regulators, account for pricing when shopping for employee's health care solutions and monitor both direct and indirect health plan broker compensation. These requirements have increased employers' fiduciary responsibilities, resulting in a noticeable uptick in litigation.

Increased fiduciary responsibilities may remind employers of the Pension Protection Act of 2006 (PPA) when transparency in retirement plans became paramount – followed by hundreds of court cases over the transparency and reasonableness of plan fees. Until this day, these retirement plan cases show no signs of slowing down.

This transparency transition – along with the increased fiduciary responsibilities – is now occurring on the health plan side, with the fiduciary buck stopping with the employer. In fact, a class-action plaintiff's attorney who pioneered much of the 401(k) and 403(b) plan fee litigation is now looking to health plans, as reported by the National Association of Plan Advisors (NAPA).

Recent health plan claims asserted in courts have included:

- A breach of fiduciary duty by allowing a benefits consultant to take undisclosed commissions from the insurance company.
- A breach of fiduciary duty where the claims administrator underpaid benefits for health care received from out-of-network providers.
- A breach of duty from "hidden," undisclosed, or unreasonable fees.
- A breach of fiduciary duty for failing to disclose certain payment data according to law.
- A breach of fiduciary duty for the mismanagement of claims.

Health plan fiduciary cases resulting from the CAA '21 are just now being filed in courts nationwide. So, at this point, it's not clear if and how many of these fiduciary claims have merit.

However, with the health plan environment changing legislatively and potentially in the courts, employers should keep four best practices in mind.

1. Understand the plan's fees and charges, determining whether they are reasonable for the services provided in return.
2. Adopt formal governance processes and procedures for the health plan, such as conducting periodic requests for proposal for providers and vendors, auditing claims, and monitoring third-party providers.
3. Review the plan's third-party administrators and claims administrators, analyzing the administrator's network adequacy, service quality, and employee satisfaction, among others.

4. Understand the contractual obligations and protections between the employer and any third-party vendor, including fee disclosures, machine-readable files, and direct or indirect consultant fee disclosures.

While good fiduciary governance is always a critical element of an employer's fiduciary responsibilities, employers should also keep abreast of the many changes in this area – adjusting their governance as necessary.

Missing or Incorrect TINs on ACA Filings: Recent IRS Updates and Guidance

Over the years, many employers have reported troublesome Social Security Number (SSN) issues cropping up when filing Affordable Care Act (ACA) notices with the Internal Revenue Service (IRS). Many have received "AIRTN500" error messages, which indicate incorrect SSNs or Taxpayer Identification Numbers (TINs).

These error messages are confusing, often leaving employers frustrated, especially if they submitted W-2s to the IRS and the Social Security Administration (SSA) on the employee's behalf for years without problems.

Earlier this month, the IRS updated some relevant information in its Publication 1586, "Reasonable Cause Regulations & Requirements for Missing and Incorrect Name/TINs on Information Returns," including penalty rate tables adjusted for inflation.

Employers who are required to file IRS Form 1095-C are subject to penalties for failure to promptly correct information on returns and for failure to furnish correct statements to individuals on a timely basis. Although the IRS has stated that the "AIRTN500" error messages are not formal notices of penalties or proposed penalties, this does not mean it cannot assess penalties later.

The IRS may waive penalties against employers if they can show that the failure was due to reasonable cause and not willful neglect. To establish this reasonable cause defense, employers should properly request TINs from employees.

Solicitation of Missing TINs

If an employer notices a missing TIN, then it must be requested initially at the time the employee is hired or when the health plan application is completed, such as for dependents. If the TIN is not received after this initial request, then the filer (the employer) must make up to two annual requests until a TIN is obtained.

If the employer does not receive the TIN after the initial request, then the employer must again request the TIN on or before:

- December 31 of the year in which the employee is hired or the health plan application is completed (for employees hired and applications completed before December) or
- January 31 of the following year (for employees hired and applications completed in the preceding December).

The second request must be made after the prior year's request and before December 31 of the year following the employee's hire date or application for benefits.

For Forms 1095-B, employers will not be subject to any penalties for failure to report a TIN if a date of birth is provided when a TIN is unavailable. This exception became effective on December 15, 2022.

Additionally, an employer is not required to request a TIN from an individual who had their health coverage terminated.

Solicitation of Incorrect TINs

If the employer has received an incorrect TIN, it is not obligated to make additional requests for the TIN unless it is notified by the IRS or health plan broker notifies the employer that a correction is needed.

When the employer is notified by the broker or the IRS of an incorrect TIN through a penalty notice (Notice 972CG), then the employer must request the TIN on or before December 31 of the year in which it was notified, or the following year if notified in the preceding December.

When the employer receives a backup withholding notice (CP2100/CP2100A) from the IRS or its broker, the employer must send a "B" Notice to the individual, stating that the individual will be subject to backup withholding if a certified TIN is not produced.

If the employer receives a second notice of an incorrect TIN (for the same individual) within a three-year period, then the employer must send a second "B" Notice to the individual stating that they will be subject to backup withholding unless the employer receives verification of the individual's TIN from either the IRS or Social Security Administration.

Finally, if the employer is notified that the TIN is incorrect following the year it requested a correction, then a second request must be made on or before December 31 of the year that the employer was notified of the incorrect TIN.

IRS Publication 1281, "Backup Withholding for Missing and Incorrect Name/TIN(s)" has a helpful flow chart that illustrates the process for requesting TINs.

Because penalties for failures to report correct information increase as time goes on, employers should request and obtain correct TINs from employees as soon as possible. If a TIN is incorrect but the employer has engaged in the proper solicitation procedure, the employer may be successful in having the penalties waived because the employer acted in a reasonable manner.

Based on these clarifications and updates, employers may want to review and revise their ACA reporting procedures, confirming that their solicitations are appropriately timed and documented.

The Plan Document Language Governs; Two Recent Court Cases

Under the Employee Retirement Income Security Act of 1974, as amended (ERISA), the plan document is the official governing document, detailing the plan's named fiduciary, eligibility, benefits, funding, and claims and appeals procedures.

For most health and welfare plans, this governing document is the wrap plan (as a standalone plan or combined with the summary plan descriptions).

Because the plan document governs the plan's terms, operation, and administration, you often hear the phrase: "The plan document language governs."

Recently, two courts reminded us of this foundational ERISA principle, essentially holding that an employer's actions may not be upheld if the plan terms are not followed.

Messer vs. Bristol Compressors

In *Messer*, the U.S. Court of Appeals for the Fourth Circuit ruled that a board of directors' resolution intended to terminate a severance plan was insufficient, as the plan required other actions to occur for a termination to be effective.

In this case, an employer terminated more than 100 employees, who were then denied severance upon their terminations. The employer stated that the severance plan had been previously terminated and, therefore, did not apply to these employees at this time.

It was undisputed in this case that ERISA governed the severance plan.

The provisions of the severance plan were included in the company's employee handbook, specifically stating that:

> Nothing in this handbook is meant to create an employment contract and nothing in this handbook may be modified or amended except in writing by the Human Resources department. The Company reserves the right to modify, change, or eliminate provisions in this handbook.
>
> . . . .
>
> The Company may change the provisions of this Handbook at any time and the programs and policies outlined in this Handbook are not contractual in nature.

Before this group of employees was terminated, the employer's board of directors passed a resolution, terminating the severance plan in the company's best interests. No further action, however, was taken to complete the severance plan's termination.

The district court determined that the board resolution was sufficient to terminate the severance plan.

Upon appeal, the 4th Circuit agreed that the employer had given itself the discretion to amend the plan at any time. However, the 4th Circuit stated that "[a]mendments or modifications of ERISA plans 'must be implemented in conformity with the formal amendment procedures and must be in writing."

The severance plan, wholly contained within the employee handbook, specifically stated that "nothing in this handbook may be modified or amended except in writing by the Human Resources department."

The 4th Circuit found that the lower court's reasoning was misplaced, instead determining that the plan termination was ineffective since the employer did not follow the plan's provisions.

Laake vs. Benefits Committee, Western & Southern Financial Group Company

In *Laake*, the U.S. Court of Appeals for the Sixth Circuit ruled that a de novo standard of review of the lower court's decision is appropriate where the plan ignored its own provisions when making claims benefits determinations. A de novo standard of review occurs when the court looks at the issues with fresh eyes, without any deference to the lower court.

In this case, an employee who participated in the employer's long-term disability (LTD) plan was granted disability benefits. If the disabling event was due to a mental, nervous, psychiatric, or chronic pain condition, then the plan limited the payment of any LTD benefits to 24 months.

After 24 months, the plan stopped paying the employee's LTD benefits, stating that the employee failed to provide proof that the disability was not due to a chronic pain condition.

The employee sued, while the employer maintained that the plan granted the employer's benefits department the discretionary authority to determine any LTD claims.

The district court, however, ruled in favor of the employee.

Upon appeal, the 6th Circuit agreed that the plan granted discretionary authority to determine LTD claims under the plan; however, that discretionary authority was given to the employer's "benefit committee," not to the "benefits department."

The Court noted that the "benefits committee" and the "benefits department" are "two separate arms of the employer" with separate and distinct functions under the plan.

Further, the Court determined that any discretionary authority given to the "benefits committee" could not be delegated to the "benefits department."

The Court stated that if it agreed with the employer that the "benefits committee" and "benefits department" are "functionally the same because they operate within the same corporate family, [the Court] would be disregarding the explicit terms of the Plan."

Since the plan granted sole discretionary authority to the "benefits committee" and not to the "benefits department," the benefits department did not have the authority under the plan document to make a claims

determination. The 6th Circuit upheld the lower court's decision, stating that the 6th Circuit should rule the employee's LTD claims denial de novo.

Employer Takeaways

It's always good to get back to the basics, which is exactly what these courts did in their analyses. However, what does it mean for employers?

- Read your plan documents and extraneous summaries, such as handbooks, to ensure consistency.
- Conduct periodic audits of in-house administration or of third-party administrators to ensure plan documents are administered in accordance with plan terms.
- Ensure that administrative delegations are aligned with actual practices.
- Review amendment and termination provisions and make updates as needed to reflect actual corporate practices.
- Review fiduciary and committee delegations or consider establishing a committee and more formal governance policies.

These cases serve as a reminder of the importance of procedural compliance with benefit plans terms, especially if benefits are being modified or eliminated or the plan is being amended or terminated. Failing to pay attention to plan procedures can undoubtedly lead to unintended consequences, as evidenced by these two cases.