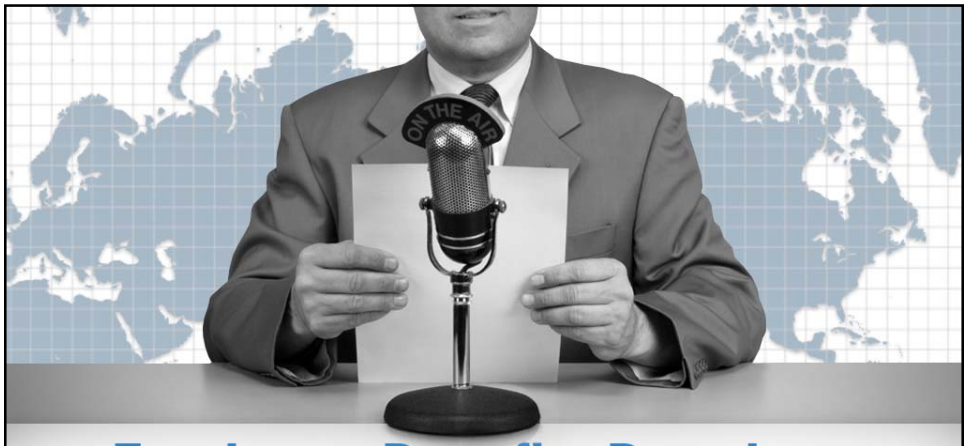

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Today's Topics

- **From the Case Files:** *Young vs. UPS:* Importance of Contractual Limitations Periods
- **Mark Your Calendars:** Technical Release 2011-01: More Time To Comply With Some PPACA Requirements
- **From the Case Files:** *Tibble v. Edison International:* A Minor Victory for Excessive Fees
- **In the Spotlight:** IRS Guidance on Reporting Cost of Health Coverage on Form W-2

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From the Case Files

Young vs. UPS: Importance of Contractual Limitations Periods

Casey K. Fleming

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From the Case Files

Statute of Limitations

- ERISA does not contain a statute of limitations for private actions to recover benefits
- Courts will look at the most closely analogous statute of limitations under state law
- State law breach of contract statute of limitations:
  - Wisconsin = 6 years
  - Illinois = 10 years

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From the Case Files

Contractual Limitations Period

- ERISA plan may include a reasonable contractual limitations period in the plan document(s)
- For example, the SPD at issue in *Young v. UPS* provided:
  - ***Limitation on Legal Action***
    - Any legal action to receive Plan benefits must be filed by the earlier of:
      - Six months from the date a determination is made under the Plan or should have been made in accordance with the Plan's claims review procedures, or
      - Three years from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

    Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

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From the Case Files

Young v. United Parcel Services, Inc. Employees' Short Term Disability Plan

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From the Case Files

Young v. UPS: Facts of the Case

- Plaintiff was receiving short-term disability benefits
- Disability benefits terminated March 11, 2008
- Appealed and received second-level appeal denial on October 17, 2008
- Filed a suit for benefits almost a year later on September 8, 2009

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From the Case Files

Young v. UPS: Plan Documents

- SPD contained "Limitation on Legal Action" provision – 6 months from the final determination date (April 17, 2009).
- Plan document did not contain the same language, but provided:
  - SPD incorporated by reference
  - In the case of a conflict, the SPD would govern
- Appeal denial letter did not reference the 6-month limitation on legal action

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From the Case Files

Young v. UPS: Plaintiff's Allegations

- The provision was an unauthorized amendment to the UPS Plan;
- The provision was ambiguous and unenforceable; and
- UPS breached its promise to inform her of the time limit for filing suit.

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From the Case Files

Young v. UPS: District Court Decision

- District Court ruled in favor of UPS
- Finding that the six-month limitation in the SPD is reasonable and enforceable
- Ms. Young Appealed

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From the Case Files

Young v. UPS: Court of Appeals Decision

- Allegation #1 – Provision was an unauthorized amendment because only included in SPD
- Court of Appeals Decision – Not an unauthorized amendment because SPD incorporated by reference and SPD will govern in case of a conflict
- Note: The 10th Circuit opinion highlighted that Ms. Young did not contend that the amendment failed to comply with the amendment procedures

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From the Case Files

Young v. UPS: Court of Appeals Decision (Cont.)

- Allegation #2 – Provision was ambiguous
- Court of Appeals Decision – Plan clear enough to convey that Plaintiff had to file her action by April 17, 2009

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From the Case Files

Young v. UPS: Court of Appeals Decision (Cont.)

- Allegation #3 – UPS breached promise to inform plaintiff of time limit
- Court of Appeals Decision – The SPD only required notice of time limits applicable to internal appeal process
- HELD: The 10th Circuit upheld the district court's decision

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From the Case Files

Young v. UPS: Action Items and Take-Aways

- Add a contractual limitations on action to your plan document(s) (subject to collective bargaining)
- Confirm that your plan document and SPD are consistent and indicate which document will govern in the case of a conflict
- Always follow the established plan and SPD amendment procedures
- Even though court did not require it, communicate the limitation period in your appeal denial notice

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Mark Your Calendar

Technical Release 2011-01

More Time To Comply With Some PPACA Requirements

Michael H. Woolever

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Mark Your Calendar

PPACA Changes To Internal Claims and Appeals Procedures

- PPACA expands ERISA's claims and appeals procedures to substantially all plans, including non-ERISA (church and government plans), as well as individual insurance policies.
- PPACA also subjects all plans to expanded claims and appeals requirements.

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Mark Your Calendar

PPACA Changes To Internal Claims and Appeals Procedures

- PPACA modifies and expands the requirements currently imposed by the DOL claims regulations as follows:
  - The period for making initial benefit determinations for urgent claims is shortened from 72 to 24 hours;
  - Claimants are entitled to prompt notice of any new or additional evidence or information considered or new denial rationale and a reasonable opportunity to respond to such new evidence or rationale within the normal claims review period;
  - Claims notices must be "culturally and linguistically appropriate" (using rules similar to SPDs);

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PPACA Changes To Claims and Appeals Procedures

- New claims and appeal requirements (cont.)
  - Claims notices must contain additional information, including date of service, provider name, claim amount, diagnosis code (with explanation) and treatment code (with explanation), and discussion of the basis for the decision and available internal appeals and external review procedures, including information as to how to initiate;
    - Notice must be self contained – may no longer require participant to request detailed explanation or copy of rule or guideline
- New conflicts of interest rules are imposed related to the selection of claims adjudicators and medical experts; and
- Failure to strictly adhere to new rules gives participants an immediate right to seek external review or file a lawsuit.

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Mark Your Calendar

Prior Interim Final Regulations and Other Guidance

- DOL issued interim final regulations on the new rules on July 23, 2010
  - Covered both new internal review requirements and new external review procedures
  - Revisions expected soon
- DOL issued guidance and compliance safe harbor on new external review process of self-funded plans on August 23, 2010 [Technical Release 2010-10]

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DOL Technical Release 2010-02

- DOL announced an "enforcement grace period" until July 1, 2011 for the following PPACA requirements:
  - 24 hour time period for making urgent care decisions
  - Requirement to provide culturally and linguistically appropriate notices
  - Requirements to expand the content and specificity of the benefit claim denial notices
  - Consequences of failure to strictly comply with new rules.

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DOL Technical Release 2010-02

- Non-enforcement was limited to self-funded non-federal government health plans who were "working in good faith" to implement the new rules.
  - Non-enforcement included right not to report excise tax liability if plan taking "steps toward compliance"
  - HHS encouraging states to allow similar non-enforcement period for insurers.

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DOL Technical Release 2011-01

- In mid-March, the DOL announced an extension of the non-enforcement period.
  - Rationale was the anticipated release of an amendment to the interim final regulations "in the near future".
- The extension does not cover all of the compliance requirements listed in Technical Release 2010-02.
- TR 2010-02 does not "address the rights of private parties in private litigation".

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DOL technical Release 2011-01

- Extension is generally until plan years beginning on or after January 1, 2012.
- Extension for obligation to provide expanded disclosure in EOB is until first day of first plan year beginning on or after July 1, 2011 (except for requirement to disclose diagnosis and treatment codes and their meaning)

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DOL Technical Release 2011-01

- The following additional disclosures need to be included in EOBs effective for plan years after June 30, 2011 –
  - Information sufficient to identity a claim
  - The reason for the adverse benefit determination
  - A description of available appeals and external review processes
  - Contact information for state health consumer assistance program, if operational

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Mark Your Calendar

External Review

- PPACA also requires plans to give participants a right to have many final benefit denials on appeal reviewed by an independent review organization.
  - Non-enforcement notices only deal with internal claims and appeals process, not external review
  - Separate guidance provided for external review safe harbor in Technical Release 2010-01 (August 26, 2010).

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From the Case Files

Tibble v. Edison International: A Minor Victory for Excessive Fees

Isaac J. Morris

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From the Case Files

Hotbed of Litigation

- Allegations of fiduciary breaches are rampant
  - Increased attention on fees paid by plans (Congress and Department of Labor)
  - Approximately 30 class actions alleging excessive fees since September 2006
- Why is this only a minor victory?

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From the Case Files

Fiduciary Duties

- Duty of Loyalty
  - Requires a fiduciary to discharge her duties with respect to a plan solely in the interest of the participants and beneficiaries
- Duty of Prudence
  - Requires a fiduciary to act with the care, skill, prudence and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims

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From the Case Files

Tibble v. Edison: Some Pertinent Facts

- Around $2 to $3 billion in assets during class period
- Plan originally offered 6 investment alternatives
- Union negotiations added 50 mutual funds — 10 "core" options and a mutual fund window
- Revenue sharing arrangements also added; previously all costs paid by sponsor

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From the Case Files

Tibble v. Edison: Only Two Claims at Trial

- *Money market fund*--Breach of duty of prudence
- *Class shares*--Breach of duties of loyalty and prudence
  - Retail shares selected before August 17, 2001
  - Retail shares selected after August 17, 2001

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From the Case Files

Tibble v. Edison: Money Market Fund — Duty of Prudence

- *Rejected* — fiduciaries have no duty to select the cheapest option available; fees are but one consideration, among many, for selection
  - Fees were within a reasonable range of alternatives
  - Had researched and compared fees, consistently monitored the fund's performance net of fees; and periodically reviewed fees (which were reduced several times)

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From the Case Files

Tibble v. Edison: Class Shares — Duty of Loyalty

- *Rejected* — a conflict of interest is not enough to establish a breach
  - Requires a motivating decision to serve the interests of others over the beneficiaries

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From the Case Files

Tibble v. Edison: Class Shares — Duty of Prudence

- *Granted post-2001* — fiduciaries never considered or evaluated the institutional share classes
  - If fiduciaries had considered institutional share classes, they would have selected them
  - Fiduciaries did succeed on pre-2001; not enough changes to revisit that decision

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From the Case Files

Tibble v. Edison: Class Shares — Unsuccessful Defenses

- Mandatory investment minimums—likely would have been waived
- Reliance on independent advice—must also show that reliance was reasonably justified

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From the Case Files

Tibble v. Edison: Action Items and Take-Aways

- Tibble should not be read as an outright prohibition of retail share classes
- Revisit existing retail offerings—were investigations prudent? Should you re-investigate now?
- Evaluate future available share classes—consider asking for waivers
- Consider who should bear administrative costs—plan or plan sponsor
- Document, document, document—your prudent and loyal actions

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In the Spotlight

IRS Guidance on Reporting Cost of Health Coverage on Form W-2

Leigh C. Riley

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In the Spotlight

Background and Effective Date

- Part of PPACA
- Intended to inform employees about value of coverage to make them better consumers
- Reporting requirement only – does not affect taxation of health plan benefits
- Optional for 2011 Form W-2s (issued in January 2012)
- Mandatory for 2012 Form W-2s (issued in January 2013)

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In the Spotlight

Employers Who Must Report

- All, except employer that filed fewer than 250 Form W-2s in prior year
  - Best reading is that this rule truly applies on employer-by-employer basis
  - Other than consolidated companies with common paymaster
- Includes church, state and local government, employers not subject to federal COBRA

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In the Spotlight

How to Report

- Form W-2, Box 12, Code DD
- If employee terminates mid-year:
  - No reporting if employee requests W-2 prior to end of year
  - Up to employer whether to report post-termination coverage value (such as COBRA)
- If no W-2 otherwise required (such as to retiree), then no reporting required

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In the Spotlight

What Coverages Must be Reported

- Employer-sponsored group health plan coverage, whether insured or self-insured
- But excluding (statute):
  - Long-term care
  - Disability and accident insurance (AD&D)
  - Liability insurance, such as auto liability
  - Workers compensation
  - Specified disease or illness (as long as not coordinated with medical plan)
  - Hospital indemnity or fixed indemnity (as long as not coordinated)
  - Dental or vision under separate policy, certificate or contract

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In the Spotlight

What Coverages Must be Reported

- And excluding (by rule*)
  - Archer MSA
  - Health Savings Account (HSA)
  - Employee contributions to medical flex spending account
  - Employer contributions to multiemployer plan
  - Health Reimbursement Arrangement (HRA)
  - Dental or vision not integrated with medical plan
  - Self-insured plan not subject to federal COBRA (such as church plan)
- *WARNING: This list of exclusions may change in the future.

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In the Spotlight

Calculating the Reportable Amount

- Employer and employee portions reported (employer only for medical flexible spending accounts)
- All plans – COBRA applicable premium method
- Fully insured only – insurance company premium amount
- Composite rate plan – can report composite rate amounts

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In the Spotlight

Dealing with Enrollment Changes During the Year

- Must track changes to coverage during the year
  - Example: Employee has single coverage for ½ year ($500 monthly value) and family coverage for ½ year ($1,000 monthly value). Reportable amount is 6 x $500 plus 6 x $1,000, for total of $9,000.
- For mid-period changes, use any reasonable method such as:
  - Beginning of month
  - End of month
  - Average or proration

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In the Spotlight

Changes in the Guidance

- Interim guidance only
- Future changes will not be effective until January 1 that is at least 6 months after date guidance issued
- Promise that no changes will be made for 2012

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In the Spotlight

What to Do Now

- Identify plans that must be reported
- Determine how to deal with mid-month changes
- Coordinate with payroll vendor and payroll systems

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Questions & Answers

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Mark Your Calendar

- The 2011 Employee Benefits Broadcast Series will take place on the following dates:
  - July 26, 2011
  - October 25, 2011

Employee Benefits Broadcast

Thank You

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