



HEALTH CARE REFORM FOR GROUP PLANS: REQUIREMENTS FOR SUMMARY OF BENEFITS AND COVERAGE

by: Kimberly J. Ruppel

The future of the Patient Protection and Affordable Care Act (the "Act") is in the hands of the Supreme Court, which is expected to issue an opinion in June.

Whether the Court upholds the individual mandate component of the Act or not, group health plans will continue to be regulated by the Departments of Health and Human Services, Labor, and the Treasury (the "Departments").

Prior to the recent oral argument, the Departments issued a final set of regulations pertaining to a summary of benefits and coverage ("SBC") and a uniform glossary of health coverage related terms which apply to group health plans and health insurance issuers in the group and individual markets. These regulations are likely to remain in effect (in some fashion) regardless the outcome of the High Court's ruling.

Despite protests lodged during the comment period, large and self-insured plans -- which must continue to provide summary plan descriptions and open season materials that accurately describe the plan and any coverage options -- are not exempt from these regulations. Following is a summary of these new final regulations as applicable to self-funded group health plans or administrators, and group health plan insurance issuers.

What is required?

Generally speaking, the SBC must be provided without charge upon application, by the first date of any change in coverage, upon renewal, or upon request (within seven business days). An SBC must be provided to each participant or beneficiary with respect to each benefit package for which the participant or beneficiary is eligible. However, upon renewal, the plan or issuer is required to provide a new SBC only with respect to the benefit package in which the participant or beneficiary is enrolled.

In the case of an insured group health plan, the regulations do not require duplication of efforts. That is, either the plan administrator or the insurance issuer must provide the SBC, but not both. The SBC must be provided to both the participant's and the beneficiary's last known address, if different.

An SBC is not required for stand-alone dental or vision plans or a health FSA if that coverage constitutes excepted benefits. However, plans and issuers should be careful to coordinate with administrative service providers for carve-out arrangements, such as pharmacy benefit managers or managed behavioral health organizations, to ensure that SBCs are accurate.



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What content is necessary?

In general, the SBC must contain the following content:

1. Uniform definitions of standard insurance and medical terms;
2. Description of coverage;
3. Exceptions, reductions and limitations of coverage;
4. Cost sharing, including deductible, coinsurance and copayment obligations;
5. Renewability and continuation of coverage;
6. Coverage examples (to be described more fully in future regulations to be issued by the Departments, but anticipated examples include common benefit scenarios such as pregnancy or chronic medical conditions);
7. Statement that the SBC is only a summary and that the plan document or insurance contract must be consulted for full coverage terms and provisions;
8. Separate contact information for questions about the plan, network providers, prescription drug coverage and the uniform glossary (including how to obtain a copy).

Notably absent is a requirement to include premium information. This allows an insurance issuer to provide an SBC to a group health plan upon application, and obviates the need to provide a second SBC upon effective coverage, so long as the SBC remains otherwise unchanged.

What format is required?

The SBC must be presented in a uniform format, use terminology understandable by the average enrollee, not exceed four double sided pages in length and not include print smaller than 12-point font. The SBC may be provided in hard copy or electronically so long as certain conditions are met, including providing information regarding how to access the electronic copy, and issuing a paper copy upon request. Further, the SBC must contain culturally and linguistically appropriate language.

The SBC may be provided as a stand-alone document or in combination with other plan summary materials, such as a summary plan description, so long as the other requirements of an SBC are satisfied.

What is the purpose?

These regulations were designed to promote accurate descriptions of benefits and coverage, to develop standards for the definitions of terms used in health insurance coverage and to ensure that information is presented in clear language and in a uniform format. The anticipated benefits of these regulations include: (1) employees will have better information regarding the value of their health benefits as part of their total compensation; (2) employers and health insurance issuers will be more competitive regarding price, benefits and quality which is intended to improve the overall efficiency of health insurance and labor markets; and (3) consumers can make informed decisions when shopping for coverage.

According to the Departments, these goals justify the anticipated \$73 million annual cost to group health plans and health insurance issuers to compile and provide a SBC and a uniform glossary of terms.

When do these regulations apply?

These regulations, which are effective as of April 16, 2012, apply to disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For those participants and beneficiaries who enroll otherwise, such as new or special enrollees, the new requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012. For group and individual health insurance coverage, the new requirements apply to health insurance issuers beginning on September 23, 2012.

What if a plan or issuer fails to comply?

If a self-funded group health plan, its administrator, or a group health plan insurance issuer "willfully fails to provide the information required" by these new regulations, the non-compliant party shall be subject to a fine of not more than \$1,000 per such failure.

Related links:

For the full set of final regulations, click here: <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=25818>

Further guidance on compliance, including information on how to obtain a SBC template and the uniform glossary is available at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.



ACCIDENTAL DEATH AND DISMEMBERMENT CASE UPDATE

By: Julie H. Johnston

Following is a summary of three recent and noteworthy Court of Appeals decisions upholding plan administrators' denials of ADD benefits, establishing a pattern of deference even in light of procedural errors which may be an outgrowth of the Supreme Court's decision in *Conkright v. Frommert* 130 S. Ct. 1640 (2010).

Sixth Circuit Declines To Re-Write Plan Terms

In the matter *Hernandez v. Hartford Life & Accident Ins. Co.* 2012 U.S. App. LEXIS 3293 (6th Cir. 2012), a husband and his deceased wife's estate sued seeking to recover benefits which they alleged were wrongfully

denied following the death of the wife. Mrs. Hernandez died two months after suffering a leg fracture that was surgically repaired. It was undisputed that the cause of her death was a pulmonary embolism. The policy at issue expressly excluded coverage for death caused by "circulatory malfunction". The parties agreed that a pulmonary embolism is a circulatory malfunction. However, the plaintiff argued that the cause of the circulatory malfunction - relating to the broken leg - was accidental, so that coverage should not be excluded. The plan administrator disagreed and denied the plaintiffs' claim for benefits under the plan based on its determination that a pulmonary embolism was a "circulatory malfunction" and was not, therefore, an accidental event. The Sixth Circuit upheld the insurer's interpretation of the policy terms because the plaintiffs did not dispute that the pulmonary embolism was the immediate cause of the decedent's death even though the accident causing the leg fracture led to it. It was undisputed that the pulmonary embolism was a "circulatory malfunction," and that the plan terms specifically excluded from coverage a loss caused by a circulatory malfunction.

Tenth Circuit Finds No Prejudice Despite Error

In *Brimer v. Life Ins. Co. of N. Am.*, 2012 U.S. App. LEXIS 2601 (10th Cir. 2012), claimants Kimberly Brimer and her sons, Matthew and Christopher Brimer, claimed entitlement to benefits under a group accident policy insuring their husband and father. Kimberly Brimer and her son Matthew returned from a weekend trip to find James Brimer dead in the family home. A death certificate indicated that the death was an accident caused by combined drug toxicity from ingestion of several prescribed medications. The insurer initially denied the claim under a policy exclusion for voluntary self-administration of drugs, but on an administrative review, it denied the claim on four grounds; (1) affirming the original determination; (2) finding no coverage because the death was not accidental; (3) finding that coverage was excluded as the death was intentional; and (4) finding that coverage was excluded because the loss resulted from sickness, disease or medical treatment thereof.

The district court concluded that LINA properly denied the claim, and the Brimers appealed, arguing that they were denied a full and fair review since they were not allowed to present evidence on the "medical treatment" policy exclusion upon which the defendant ultimately relied. On appeal, the Tenth Circuit found that the insurer violated the ERISA requirement of a full and fair review when its administrative appeal decision added a different policy exclusion as justification for denying the claim. Nonetheless, the court concluded that remand was not warranted because the claimants did not show that they were prejudiced. The claimants had conceded that the only relevant evidence was the policy itself, which was in evidence before both the insurer on administrative review and the district court at trial. As a result, the insurer's decision was upheld based on the evidence already before the Court.

The majority also found that the Brimers forfeited the argument that the medical treatment and the voluntary self-administration of drug exclusions conflicted and were ambiguous, which was the subject of a dissenting opinion.



Fifth Circuit Defers To Administrator's Interpretation

In another matter involving the same insurer and a death caused by self-administration of narcotics, *Smith v. Life Ins. Co. of N. Am.*, 2012 U.S. App. LEXIS 2354 (5th Cir. 2012), the ERISA governed policy contained exclusions for death caused by suicide; sickness or disease (including mental infirmity); and voluntary ingestion of any drug unless taken in accordance with a physician's instructions.

Based on the scene and the autopsy, it appeared that the deceased had ingested multiple drugs, most (but not all) of which were prescribed. The Fifth Circuit concluded that LINA did not abuse its discretion in determining that the death fell under the voluntary ingestion exclusion and found that the district court erred in awarding benefits to the plaintiff. The Fifth Circuit noted that the lower court's decision did not afford appropriate deference to the plan administrator and mistakenly applied the doctrine of *contra proferentem* to construe the ambiguity in the term "voluntary" against the administrator. The Fifth Circuit further noted that LINA exercised reasonable discretion in interpreting the voluntary ingestion exclusion, and based on the undisputed facts surrounding the insured's death, *i.e.* that it was caused by an overdose of self-administered powerful narcotics, it was reasonable to conclude that it fell within the voluntary ingestion exclusion.

Each of the above decisions are encouraging for plan administrators and indicate propensity of the appellate courts to afford deference to administrators' coverage decisions, so long as their reasoning is not arbitrary or capricious.

In *Hernandez*, the court stated in closing, "[W]e cannot say that Hartford's decision is not rational in light of the plan's provisions. We cannot find that the decision is not the result of a deliberate, principled reasoning process or that it is not supported by substantial evidence. We cannot therefore hold that the decision is arbitrary and capricious. Even if we were inclined to do so, we simply have no liberty to rewrite the terms of the plan."

In the *Brimer* case, the court showed deference by dismissing the insurer's errors in its own administrative appeals process as non-prejudicial to the plaintiffs in light of the facts, holding that even though the administrative process was flawed and violated ERISA's requirement of a full and fair review, the denial of benefits was appropriate.

In the other accidental overdose case, *Smith*, the appellate court reversed the district court's initial grant of summary judgment in favor of the plaintiffs, once again deferring to a plan administrator's interpretation of its own policy, even when a more narrow construction of a specific term in the policy would result in the grant of benefits under the policy.

SELECT CIRCUIT COURT CASE SUMMARIES



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Edited by: Kimberly J. Ruppel

First Circuit - *De Novo* Review Focuses On Procedural Errors



Scibelli v. Prudential Ins. Co. of America., 666 F.3d 32 (1st Cir. 2012)

Although Prudential determined that the insured was totally disabled for the purposes of waiving the premium for an individually purchased life insurance policy, the insurer denied his estate's claim for proceeds under a group life insurance policy, based on the conclusion that the insured was not totally disabled when he stopped working for the plan sponsor, and therefore was not eligible for a premium waiver. Prudential argued that the definition of disability under the Group Policy was different than that of the Individual Policy, but in its initial determination cited a definition of disability different than that of the Group Policy at issue. Further, Prudential's initial determination was rendered over a year after the insured's employer forwarded his claim, and was only communicated to the employer - not to the insured. Seven years later, the insured inquired as to his coverage and was

advised by his employer that it had received notice of a denial of the claim from the insurer.

Because Prudential was unable to prove that the insured was informed of the denial, it agreed to allow an appeal of the decision at



that time. However, by that time, Prudential no longer had copies of the majority of the medical records relied upon for its original denial, nor did the insured's providers, who followed a policy of routinely destroying records after seven years. As a result, Prudential upheld its denial, based on the lack of medical records to establish that the insured was disabled when he stopped working.

The First Circuit found that the plaintiffs were "prejudiced by Prudential's seven-year delay in giving Jajuga notice that his claim had been denied." Explaining that "had Jajuga been informed within ninety days of the denial of his September 1998 claim, the additional records of his medical condition as of May 1997 would not have been routinely destroyed." *Id.* at 33-34. Further, the Court rejected Prudential's argument that the definitions of disability in the Individual Policy (disabled from "any gainful work") under which benefits were paid, and the Group Policy (disabled from "any job") under which benefits were denied, were materially different. Ultimately, the Court found the relevant evidence in the administrative record sufficient to conclude that the plaintiffs were entitled to benefits.



Fourth Circuit - Reasonable Interpretation Of Pre-Disability Earnings Provision

Fortier v. Principal Life Ins. Co., 666 F.3d 231 (4th Cir. 2012).

A plan participant claimed that the claim administrator misconstrued the plan's definition of pre-disability earnings and therefore incorrectly denied disability benefits under the plan. The administrator agreed that the participant was disabled, but determined that because the participant

received benefits pursuant to a separate, individual disability policy in excess of the maximum amount to which the participant was entitled to receive under the policy at issue, no benefits were payable. The participant argued that the administrator erroneously deducted one-time startup business expenses from the calculation of pre-disability income, when otherwise pre-disability earnings were sufficiently large to entitle the participant to the maximum benefit under the group policy, notwithstanding the individual policy benefits. Because the policy entrusted the administrator with complete discretion, the Court deferred to its reasonable interpretation of definitional terms in calculating pre-disability earnings.

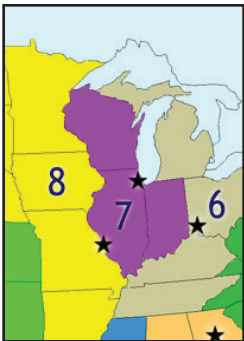


Sixth Circuit - *Moench* Presumption Does Not Apply at the Pleading Stage

Pfeil v State Street Bank and Trust Co., 2012 U.S. App. LEXIS 3482 __ F.3d __ (6th Cir. 2012)

Participants in the ESOP alleged the trustee breached fiduciary duties under ERISA by continuing to allow participants to invest in GM common stock even though reliable public information indicated that

GM was headed for bankruptcy. In response to a motion to dismiss based on ERISA section 404(c), the district court assumed the *Moench* presumption of prudence applied at the pleading stage and concluded that the participants pleaded sufficient facts to overcome the presumption. The Sixth Circuit noted that district courts in the Circuit had split on the issue of whether the presumption created a heightened pleading standard, and recognized the split in other circuit jurisdictions as well. The Court concluded that a plaintiff does not need to plead enough facts to overcome the presumption of prudence in order to survive a motion to dismiss, clarifying that the presumption is evidentiary in nature and not a pleading requirement.

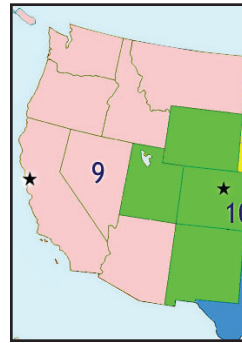


Eighth Circuit - Active File Review Precluded Finding An Impermissible "Rubberstamp" Denial

Carrow v. Standard Ins. Co., 664 F.3d 1254 (8th Cir. 2012)

A plan participant applied for long-term disability benefits following complications arising from hip surgery. After a subsequent

hip replacement surgery, the participant's surgeon concluded that he should be able to return to work at his normal duties. The participant returned to work as recommended for a few months, but then stopped working due to pain. At that point, the participant's primary treating physician concluded that he was totally disabled from working and he submitted a new claim for benefits. After payment of benefits for the 24 month "own occupation" period, Standard determined that the participant was not entitled to continued payment of benefits under the "any occupation" period. The participant argued that Standard's decision was improperly based on a "file review" of a consulting, non-examining physician, which was contrary to the opinion of the treating physician. However, in part because Standard asked its consultant specific questions about the participant's treating physician's recommendations and did not simply rubberstamp its consultant's reports, the Court disagreed and found substantial evidence supporting the plan administrator's decision.



9th Circuit - Assertion of "Participant" Status Sufficient To Confer Subject Matter Jurisdiction

Leeson v. Transamerica Disability Income Plan, 2012 U.S. Dist. LEXIS 1248, 51 BNA 2889 (9th Cir. 2012).

A former employee challenged the termination of his long-term disability benefits. On remand from a prior appeal, the plan filed a motion to dismiss for lack of subject matter jurisdiction, arguing, for the

first time, that the former employee did not have statutory standing as a plan participant to file an ERISA action. The district court, relying on *Curtis v. Nevada Bonding Corp.*, 53 F.3d 1023 (9th Cir. 1995), granted the defendant's motion to dismiss because the plaintiff lacked standing to pursue an ERISA claim.

The 9th Circuit reversed. Relying on *Arbaugh v. Y & H Corp.*, 546 U.S. 500 (2006), the Court overruled the jurisdictional implications of *Curtis* and concluded that whether the former employee was a participant for purposes of ERISA is "a substantive element of his claim, not a prerequisite for subject matter jurisdiction." The Court explained that "[b]y asserting a colorable claim that he is a plan participant" the former employee satisfied the threshold for establishing federal court subject matter jurisdiction and the issue of participant status is a merit-based determination to be determined on summary judgment or trial.

ERISA LITIGATION & EMPLOYEE BENEFITS COUNSELING

Practice Area Overviews

ERISA Litigation

Dickinson Wright's ERISA litigators are well versed in every aspect of ERISA litigation. This federal statute gives rise to suits brought by plan participants and others bringing claims ranging from challenges to the denial of life, disability or health benefits to allegations of breach of fiduciary duties by benefit or pension plan administrators. We have represented insurers, employers and other plan fiduciaries in numerous contexts, by defending benefit decisions and procedural challenges, counseling and defending clients regarding fiduciary obligations and plan administration, resolving coordination of overlapping policies and conflicting beneficiary claims, and interpreting the intricacies of the statutory framework. Our experience in the trial and appellate courts, as well as in the mediation arena, serves our clients effectively and efficiently.

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