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# **Navigating Troubled Waters: ERISA Plan Administrators with a Conflicted Interest**

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# ERISA Plan Administrators with a Conflicted Interest

## I.

### ERISA Plan Fiduciary

#### Fiduciary Action –

There is no more basic function a fiduciary undertakes than the vigil over another's assets to ensure they are used for the intended purpose

# ERISA Plan Administrators with a Conflicted Interest

## Plan Administrator –

Every ERISA-covered pension plan must be created pursuant to a written document that names at least one fiduciary who is authorized (jointly or severally with any other plan fiduciaries) to control and manage plan operation and administration, referred to as the “plan administrator.” ERISA § 402(a), 29 U.S.C. § 1102(A) (2001)

# ERISA Plan Administrators with a Conflicted Interest

## Functional Analysis –

Anyone who exercises discretion or control over the Plan or the Plan administration may be held to be a fiduciary under ERISA regardless of title or position. While day-to-day ministerial tasks won't create a fiduciary status, if a person has final authority to allow or disallow benefits, then such a person is a fiduciary within the meaning of ERISA.

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## “Two Hats” –

An administrator is a fiduciary “only to the extent” that he is acting in an administrative or managerial capacity in relation to the plan. In fact, unlike a fiduciary at common law, under ERISA, a fiduciary may have financial interests adverse to the participants and beneficiaries of the ERISA plan and may take actions that directly harm the beneficiaries. When employers wear “two hats” by serving as both an employer and the plan’s administrator, they “assume fiduciary status only when and to the extent that they function in their capacity as plan administrators, not when they conduct business that is not regulated by ERISA.”

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## Prudent Person Rule –

The ERISA Prudent Person Rule requires a plan fiduciary to independently and diligently investigate potential actions involving a plan. The test for evaluating a fiduciary's prudence in plan administration is one of conduct. The key issue in reviewing a fiduciary's action under ERISA is whether the fiduciary arrived at his or her decision by way of a prudent investigation in the circumstances then prevailing. If the fiduciary's investigation is intensive and discharged with the greatest degree of care that could be expected under all the circumstances by reasonable beneficiaries and participants of the plan, then the fiduciary should not be found liable under ERISA.

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### Personal Liability –

ERISA § 409 provides that a fiduciary that breaches his fiduciary duties will be “personally liable to make good to such plan any losses to the plan resulting from each such breach.” The Supreme Court made clear that § 409 only allows recovery to the plan as a whole, rather than individual participants.

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## Limiting Liability –

ERISA Section 410(b) allows a plan fiduciary to purchase insurance for his or her own account to protect the fiduciary against liability for breaches of fiduciary duty under ERISA and to pay the costs of defending an action against the fiduciary. The employer sponsoring a plan may also purchase fiduciary liability insurance to cover plan fiduciaries.

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## Service Providers –

Persons who have no power to make any decisions as to plan policies, interpretations, practices or procedures, but who perform only administrative functions for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons, are not fiduciaries with respect to the plan. Only persons who perform one or more of the functions described in ERISA Section 3(21)(A) with respect to an employee benefit plan are fiduciaries. A person who performs purely ministerial functions for an employee benefit plan is not a fiduciary.

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## II.

### Plan Administration

#### 1. Claims Procedures

ERISA § 503 provides that every Plan must:

- 1) have a procedure for filing claims for benefits
- 2) provide for written notice of claim denial, and
- 3) provide a reasonable opportunity for full and fair review of denied claims.

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## Department of Labor Claims Procedure Regulations:

- Statutory notice requirements for claim denials, time limits for filing appeal, and time limits for decisions on review
- Content requirements for denial and appeal notices
- Describe claims procedure in the SPD
- No unduly burdensome processing procedures
- Allow authorized representative from acting on behalf of claimant
- Processes to verify consistent determinations are made in accordance with Plan
- Timely notification of time limits for furnishing notice of claim denial, for requesting review and that apply to decisions on review

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## First: Define the Type of Claim

- “Claim for benefits” means “a request for plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims”
- “Pre-service claim” is any “claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care”

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- “Post-service claim” means any “claim for a benefit under a group health plan that is not a pre-service claim”
- “Urgent care claims” –  
Claims for medical care or treatment that, by applying normal deadlines –
  - (A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
  - (B) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject claimant to severe pain that cannot be adequately managed without the treatment that is the subject of the claim

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## ■ Timing of Benefit Decisions:

### Initial Benefit Determination – Non-health care claims:

- Adverse decisions only - 90 days after receipt of the claim
- One extension for up to an additional 90 days if
  - special circumstances require extension and
  - you give written notice of extension to claimant within 90 days and
  - notice states
    - the special circumstances requiring additional time and
    - the date you expect to render decision

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Initial Benefit Determination – Pre-service & Urgent:

Denial for failure to follow proper claim filing procedures:

Must give notice of failure and proper procedures no later than 5 days (24 hours in the case of urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

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## Health Care Claims – Urgent Care, Other:

- Any decision (adverse or not) –72 hours after receipt of claim
  - If claimant fails to provide sufficient information to make decision, you must notify claimant no later than 24 hours after receipt of the claim of the specific information necessary to complete the claim.
- You must afford the claimant at least 48 hours to provide the specified information.
- You have 48 hours from 1) your receipt of the specified information, or 2) the end of the period afforded the claimant to provide the specified additional information to make final decision

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## Health Care Claims – Concurrent care decisions:

- Decisions to reduce or terminate pre approved ongoing course of treatment before end of treatment:
  - Notice - “at a time sufficiently in advance of the reduction or termination” to allow claimant to appeal and obtain determination on review of that adverse benefit determination before the benefit is reduced or terminated. As such, if possible you should give at least 180 days in advance of the decision, although the Department of Labor has indicated that it would not require a full 180 days in every circumstance.
- If claimant asks for additional treatment beyond the original period of ongoing treatment:
  - Any decision (adverse or not) - within 24 hours of receipt of the claim, if claim made at least 24 hours prior to the expiration of the time or treatment period.
  - If claim for additional treatment not within 24 hours of scheduled termination, then treated as regular claim (under regular urgent or non urgent care rules)

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## Health Care Claims – Pre-Service, Non-urgent:

- Any decision (whether adverse or not) - 15 days (or shorter time if appropriate to medical circumstances) of receipt of claim.
- Extension – 1 for up to 15 days, if you
  - Determine extension is necessary due to matters beyond Plan's control and
  - notify claimant in original 15-day period of
    - circumstances requiring extension and
    - date you expect to render a decision.
- Lack of information provided by Claimant;
  - Must give Claimant at least 45 days from the notice to provide information requested.

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Health Care Claims – Post-service claims, non urgent:

- Adverse decisions - 30 days after receipt of the claim
- Extension – 1 for up to 15 days, if you
  - determine extension is necessary due to matters beyond the Plan's control and
  - notify claimant in original 30-day period of
    - circumstances requiring extension and
    - date you expect to render a decision
- Lack of information provided by Claimant –
  - must give Claimant at least 45 days from the notice to provide information requested

# ERISA Plan Administrators with a Conflicted Interest

## Disability claims:

- Adverse decision – 45 days after receipt of the claim.
- Extension – 2 extensions for up to 30 additional days each, if you
  - determine extension is necessary due to matters beyond the Plan's control and
  - notify claimant in original 45-day period (or the original 30 day extension in the case of a second extension) of
    - circumstances requiring extension and
    - date you expect to render a decision
- Notice of extension – must explain:
  - the standards on which entitlement to a benefit is based,
  - the unresolved issues that prevent a decision on the claim, and
  - the additional information needed to resolve those issues.
  - Give Claimant at least 45 days to provide the specified information

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## Calculating time periods:

- Begin on date claim is filed, regardless if all the information necessary to make a benefit determination accompanies the filing.
- Extensions for failure to submit information necessary to decide claim:
  - Period for making determination is suspended from date on which notification of extension is sent to the claimant until date on which claimant responds to request for additional information or your deadline to respond, whichever is earlier.
  - Once your deadline to provide information has passed, you have the 15 or 30 day extension from that date to respond

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## Content of Initial Determination Letter:

- Must be in writing or electronic communication, unless otherwise specified. For urgent care, your initial ABD can be provided orally, provided you follow up with written or electronic notification not later than 3 days after the oral notification.
- Your initial determination letter must contain the following (in manner understood by the claimant):
  - (i) Specific reason(s) for adverse determination
  - (ii) Reference to specific plan provisions as basis for decision
  - (iii) Description of additional material or information necessary to perfect the claim
  - (iv) Explanation of why such material or information is necessary
  - (v) Description of the plan's review procedures, including time limits for such
  - (vi) Statement of Claimant's right to bring a civil action under ERISA following review

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## Content of Initial Determination Letter

### Group Health or Disability Plan:

- Reliance on internal rule, guideline, protocol, or other criterion in making the adverse determination, you must –
  - provide the specific rule, guideline, protocol, or other criterion; or
  - provide statement that rule, guideline, protocol, or other criterion was relied on in making adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to claimant upon request
- Decision based on “medical necessity” or experimental treatment or similar exclusion or limit, you must –
  - explain the scientific or clinical judgment used in the determination, applying the terms of the Plan to the claimant’s medical circumstances, or
  - State that such explanation will be provided free of charge upon request
- Urgent care –
  - A description of the expedited review process applicable to such claims.

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## Appeal of adverse benefit determinations:

- Reasonable opportunity to appeal decision to an appropriate named fiduciary under which there will be a full and fair review of the claim and the adverse decision:
  - At least 60 days following receipt of an ABD notification to appeal;
  - Give Claimant opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
  - Upon request and free of charge, give claimant reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
  - Fiduciary must take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

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Additional requirements for Group health plan and disability plan appeals:

- Provide claimants at least 180 days, not 60, from receipt of decision to appeal;
- Cannot afford deference to the initial decision maker,
- Review by named fiduciary who is neither the individual who made ABD nor a subordinate of such individual;
- Medical judgment, including determinations in regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary:
  - Consult with a health care professional who has appropriate medical training and experience
  - Identify any medical or vocational experts whose advice was obtained, without regard to whether the advice was relied upon in making the benefit determination;
  - Health care professional consulted for medical necessity determination has to be different than any professional consulted in connection with the ABD or the subordinate of any such individual; and
- Urgent care claims, the appeals process must provide an expedited review and:
  - Oral or written appeal by the claimant; and
  - Transmit all necessary information, including the plan's benefit determination on review to claimant by telephone, facsimile, or other available similarly expeditious method.

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## Timing of notification of benefit determination on review

### Non-health claims:

- Decision on Appeal - 60 days after receipt of request for review,
- Extension – 1 for special circumstances (such as the need to hold a hearing) requiring extension. To get extension:
  - Furnish written notice to claimant prior to end of initial 60-day period,
  - Notice to include special circumstances requiring extension and date you expect to render a decision.
  - In no event can extension exceed 60 days (120 days total).

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## Group health plans – Urgent care claims:

- Decision – ASAP, taking into account the medical exigencies, but no later than 72 hours after receipt of request for review.

## Group Health Plans – Pre-service claims:

- Decision - “reasonable period of time appropriate to the medical circumstances”
- Reasonable depends on how many appeals you offer:
  - 1 appeal - maximum = 30 days after receipt of request for review.
  - 2 appeals – maximum = 15 days after receipt of request for review

# ERISA Plan Administrators with a Conflicted Interest

## Group Health Plans – Post-service claims:

- Decision - “reasonable period of time appropriate to the medical circumstances”
- Reasonable depends on how many appeals you offer:
  - 1 appeal – maximum = 60 days after receipt of request for review
  - 2 appeals – maximum = 30 days after receipt of request for review

# ERISA Plan Administrators with a Conflicted Interest

## Disability claims:

- Decision – “reasonable period of time”, which regardless of the number of appeals cannot be later than 45 days after receipt of the request for review

## Calculating time periods:

- Begin on date appeal is filed in accordance with provisions of Plan, but without regard to whether all the information necessary to make a benefit determination on review accompanies the filing,
- If extension for failure to submit information is permissible, period for making benefit determination on review is suspended from date notification of extension is sent until date claimant responds to request for additional information or the deadline to submit additional information, whichever is earlier.

# ERISA Plan Administrators with a Conflicted Interest

## Content of Decision on Appeal:

- Written or electronic notification of the plan's determination on review.
- If the decision is adverse to the claimant, the notice of decision must include, at minimum:
  - Specific reason(s) for adverse determination;
  - Reference to specific plan provisions on which you base your decision;
  - A statement that claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
  - statement describing any voluntary appeal procedures and claimant's right to obtain information about such procedures
  - A statement of the claimant's right to bring an action under ERISA

# ERISA Plan Administrators with a Conflicted Interest

## Additional Requirements for Group Health plans:

- Reliance on an internal rule, guideline, protocol, or other criterion:
  - State the specific rule, guideline, protocol, or other criterion or
  - State that a rule, guideline, protocol, or other criterion was relied on and that you will provide a copy of the rule, guideline, protocol, or other criterion free of charge to the claimant upon request;
- Medical necessity or experimental treatment or similar exclusion or limit:
  - Either explain the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or
  - State that such explanation will be provided free of charge upon request
- Provide the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

# ERISA Plan Administrators with a Conflicted Interest

- Consequences of Flawed Denial Notice
  - Claimant's obligation to exhaust administrative remedies may be excused, giving claimant right to seek immediate relief in Court
  - Time for appeal may be extended indefinitely
  - Administrator may be liable for penalties up to \$100 per day

# ERISA Plan Administrators with a Conflicted Interest

## Fiduciary Duties and Possible Breach

U.S. Supreme Court Case:

*LaRue v. DeWolff, Boberg & Associates*

- Pension Case
- Prior S.Ct. cases said remedies for breach of fiduciary duty had to be for the entire plan, not individual
- S.Ct. in LaRue says a 401K participant can sue for breach of fiduciary duty for damage to his individual circumstance

# ERISA Plan Administrators with a Conflicted Interest

## Fiduciary Duties and Possible Breach

U.S. Supreme Court Case:

*LaRue v. DeWolff, Boberg & Associates*

- If case is expanded outside the 401K arena, case has grave consequences for plan fiduciaries, could be held responsible for individual injuries
- Best practice is to have your plan, SPD and other documents drafted so that all decision making fits into the Plan's claim procedures as discussed above. By making decisions under and consistent with the Plan's and the DOL's claims procedures, you increase the likelihood that the decision will be upheld

# ERISA Plan Administrators with a Conflicted Interest

## Benefit Denial & Judicial Review

- Standard of Review – Level to Which a Court will Scrutinize Your Decision
  - In benefit determination cases, Courts have employed 2 standards:
  - De novo = the Court starts afresh and will ignore your prior decision
  - “Arbitrary and capricious” = Even if Court were inclined to disagree with you, Court does not do so unless your decision was arbitrary or capricious. Great deference to the decision made.
    - Deferential review requires Plan language granting administrator broad discretion in interpretation and administration of Plan
- Prior S.Ct. case – *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989). If plan administrator reserves a discretionary right to interpret plan terms, Courts will apply an arbitrary and capricious standard of review

# ERISA Plan Administrators with a Conflicted Interest

## ■ Conflicts of Interest

- U.S. Supreme Court Case: *Met. Life Ins. Co. v. Glenn* (2008)

## ■ Facts of Case

- Administrator & Insurer of Long-Term Disability Plan
- Plaintiff was a participant of the Plan
- Plaintiff was diagnosed with severe heart conditions
- The Plan provided Discretionary Authority to the Administrator
- Plaintiff applied for benefits and was given initial benefits.
- Plaintiff was denied extended disability benefits because MetLife found that she could perform some work.

# ERISA Plan Administrators with a Conflicted Interest

## Inherent Conflict of Interest

- Dual Role Administrators
  - When administrator acts in a dual role, that is, it both administers and interprets the Plan (i.e. makes benefit decisions) and makes the actual payments on the claims, it operates under a conflict of interest
  
- Third Party Providers
  - Could have conflict of interest where making dual decisions or where financial incentive is involved in denial of claims
  - MetLife involved a Third Party insurer with conflict

# ERISA Plan Administrators with a Conflicted Interest

## Weight of Conflicts

- Conflict of interest does not automatically entitle Court to ignore your decision and issue a de novo review
- Conflict is one factor that a court should consider in review of denial of claims
- Significance depends on “facts of case”
  - Conflict of interest factor significant –
    - Circumstances suggest a higher likelihood that it affected the benefits decision,
    - History of biased claims administration.
  - Conflict of interest factor less significant –
    - Administrator has taken active steps to reduce potential bias and promote accuracy,
    - Walling off claims administrators from those interested in firm finances,
    - By imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits

# ERISA Plan Administrators with a Conflicted Interest

## Conflict of Interest as Tiebreaker

- Where other “factors” are “closely balanced” any one factor, including the conflict of interest could be the “tie breaker” in deciding whether to uphold or overturn an administrator’s decision.
- If the Court does not weigh the conflict of interest heavily against the administrator, the deferential standard of abuse of discretion will apply - Court will only overturn your decision where it is clear that you abused your discretion.

# ERISA Plan Administrators with a Conflicted Interest

## Considerations for Nonsubscribers

- Overcome the conflict by establishing procedures and strategies to lessen the impact the conflict has on Court's review
  - Create a claims review committee to handle all reviews of claims
  - Comprise committee with decision makers who are separate than financial decision makers of company
  - No re-numeration be paid to the committee to influence outcome of decision
  - Wall off claims administrators from those interested in firm finances
  - Impose management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits
  - Clearly define the roles and duties of committee
  - Consider having separate committees for claims review and other administration issues

# ERISA Plan Administrators with a Conflicted Interest

## Considerations for Nonsubscribers

- Don't automatically have CEO, CFO and COO as the final decision maker
- Consider out-sourcing claims decisions to third party administrators who are not rewarded for the number of claims they deny
- Actively review claims denial rate
- Keep accurate records of claims to refute any allegation that the administrator has a history of claim denials
- Create detailed procedures for committee to follow or hire TPA with detailed procedures in making claims decisions
- Ensure compliance with annual or more frequent audits of your claims review committee
- Follow carefully all claims procedures developed by ERISA or your plan, including those discussed earlier.
- Provide all requests for documents and rules to participants consistent with Plan
- Adopt procedures to make consistent benefit determinations across participants.
- Document decisions and meetings of committee members.
- Consider appointing hourly or front line employees to the benefit claims review committee.
- Engage legal counsel or your third party provider who assisted in implementing the plan to review Plan and procedures to determine if there are any areas for improvement.

# ERISA Plan Administrators with a Conflicted Interest

## III.

### Other ERISA and Administrator Issues

#### 1. Arbitration

- Alternative method of settling disputes outside the Courtroom. Federal law generally favors arbitration, however, ERISA's claim procedures provide differently
- A plan's procedures may provide for arbitration of benefit dispute on appeal, provided two conditions are met:
  - First, arbitration must be conducted within timeframes and notice requirements applicable to appeals
  - Second, arbitration must be nonbinding – that is, arbitration may not limit claimant's ability to challenge benefit determination in court
- Binding arbitration a permissible, post -appeal, but voluntary option:
  - To be “voluntary” the plan's claims procedure must provide:
    - No exhaustion of remedies for failing to use voluntary appeal
    - statute of limitations tolled during voluntary appeal;
    - voluntary appeal only after the claimant has pursued the appeal(s) required by the regulation;
    - plan provides claimant sufficient information to make informed judgment about whether to pursue voluntary appeal
    - no fees or costs are imposed on the claimant as part of the voluntary appeal process

# ERISA Plan Administrators with a Conflicted Interest

## Waiver of Arbitration

- *Perry Homes v. Cull* - Texas Supreme Court case (2008)
- First time court found waiver of arbitration based on “substantial invocation of the litigation process”
- Two Prongs:
  - Substantially invoked litigation process
  - Such process caused a detriment to the opposing party
- The factors the Court considered in *Perry Homes* were:
  - Plaintiff who initiated lawsuit was attempting to invoke arbitration
  - Invocation of arbitration was not done until 4 days before trial
  - Plaintiff had steadfastly opposed arbitration, including filing 79 page response opposed to Defendants’ motion to compel arbitration
  - 14 months had elapsed in the case
  - Plaintiffs took multiple depositions and engaged in other discovery

# ERISA Plan Administrators with a Conflicted Interest

Lessons to learn from *Perry Homes*:

- Ask for arbitration early
- File all pleadings, subject to right to move to compel arbitration
- Don't engage in too much discovery over the merits of the case
- Don't wait until the eve of trial
- Don't oppose arbitration and then change mind when things look glib

# ERISA Plan Administrators with a Conflicted Interest

## New Legislation and Regulations

### Form 5500: New Reporting and Disclosure Requirements

- Effective for plan years beginning on or after January 1, 2009 (Forms filed in 2010)
- Mandatory electronic filing of Form 5500 - DOL's E-Fast program
- Schedule C - disclosures of compensation to Service Providers
  - Only required for "Large Plans," defined as plans with 100 or more participants
  - Disclosure of fees paid directly or indirectly to service providers receiving \$5,000 or more in total compensation for plan services
  - "Direct compensation" – compensation paid directly by a plan sponsor to a service provider as well as compensation paid or debited directly from a plan account (note, this generally does not include payments made by the plan sponsor that are not reimbursed by the plan)
  - "Indirect compensation" – all compensation other than direct compensation, received by a service provider in connection with services provided to the plan or in connection with a person's position with the plan.

# ERISA Plan Administrators with a Conflicted Interest

- With respect to Direct Compensation, Plan sponsor must:
  - identify each service provider paid more than \$5,000,
  - describe the relationship of the service provider to the plan sponsor (or to any person known to be a party in interest to the plan),
  - provide total direct compensation paid to service provider and
  - State whether the service provider received any “indirect compensation.”
  
- With respect to Indirect Compensation, Plan sponsor must:
  - provide service provider’s name and tax identification number
  - state that the service provider received indirect compensation and
  - provide total amount of the indirect compensation received by the service provider (actual or estimated).

# ERISA Plan Administrators with a Conflicted Interest

## Mental Health Parity Act

- Amendment to MHPA enacted on October 3, 2008
- Applies to non-subscriber plans that offer mental health benefits to employees.
- Effective for Plan years beginning after October 3, 2009, and includes the following:
  - If plan includes medical/surgical benefits *and* mental health benefits, mental health benefits must be no more restrictive than medical/surgical benefits;
  - If plan includes medical/surgical benefits *and* substance use disorder benefits, substance use disorder benefits must be no more restrictive than substantially all medical/surgical benefits;
  - No separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits;
  - Standards for medical necessity determinations and reasons for denial of benefits relating to mental health and substance use disorder benefits made available upon request to participant
  - Parity requirements of existing law (regarding annual and lifetime dollar limits) will continue and will be extended to substance use disorder benefits.

# ERISA Plan Administrators with a Conflicted Interest

## Americans with Disabilities Act for 2009

- Effective - September 25, 2008
- Act to be construed in favor of broad coverage of individuals
- Retains ADA's basic definition of “disability” (impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment)
- The Act:
  - Expands the definition of “major life activities” by including two non-exhaustive lists:
    - first list includes many activities EEOC has recognized (e.g., walking) as well as activities EEOC has not specifically recognized (e.g., reading, bending, and communicating);
    - second list includes major bodily functions (e.g., “functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions”);
  - Mitigating measures other than “ordinary eyeglasses or contact lenses” shall not be considered;
  - Episodic impairment is disability if it would substantially limit a major life activity when active;
  - Individuals covered only under “regarded as” prong are not entitled to reasonable accommodation

# ERISA Plan Administrators with a Conflicted Interest

## Family Medical Leave Act Regulations

- Effective on January 16, 2009
- Among other things, the amendment created two new types of FMLA leave:
  - Leave to permit a “spouse, son, daughter, parent, or next of kin” to take up to 26 workweeks of leave to care for a “member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.”
  - Leave for “any qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.”
- Existing FMLA requirement that group health coverage be continued during periods of FMLA leave apply.
- Existing FMLA provisions relating to intermittent leave, reduced leave schedules, the substitution of paid leave for unpaid FMLA leave, required notices and medical certifications generally apply.
- Group health plan documents and other employee benefits communications materials should be reviewed to determine if your disclosures concerning leave under the FMLA should be amended

# ERISA Plan Administrators with a Conflicted Interest

## Other Case Law

- State Law Negligence Claims Survive ERISA Preemption (5th Circuit Case): *McAteer v. Silverleaf*
  - Upholds prior *Hook v. Morrison* case which says that an employee who foregoes ERISA claim in favor of solely bringing his nonsubscriber negligence claim is not preempted and does not give rise to removal to Federal Court

# ERISA Plan Administrators with a Conflicted Interest

## ■ Using Disclaimers in Plan to Avoid Coverage Misrepresentations to Providers (2008 S.D. Texas Case):

### *Tenet Healthcare Ltd. v. UniCare Health Plans of Tex., Inc.*

- Healthcare provider attempted to verify coverage of participant under the Plan
- Administrator mistakenly verified coverage, however, with important reservations
- Disclaimer: “[t]his is not a guarantee of benefits. All charges are subject to medical necessity, member eligibility, and all plan provisions in effect at the time services are rendered. These benefits are also contingent on the eligibility of the condition being treated.”
- Based on the facts of the case (mainly that Administrator did not know at time that employee was not eligible and its records reflected that employee was eligible), the Court found that the provider could not rely on any contrary representation concerning benefits by the Administrator in face of the disclaimer. This was a negligent misrepresentation case.
- Disclaimers won’t always save the day, however, under the right set of facts a disclaimer of eligibility representations could prevent you from paying benefits for an ineligible employee.
- Plans, with assistance of counsel, should consider amending plan documents and communications documents with providers to take advantage of disclaimers.
- Caution: Many commentators are criticizing this case and being a district court case, it is subject to being overturned.

# ERISA Plan Administrators with a Conflicted Interest

## Helpful Links:

- <http://www.dol.gov/compliance/laws/comp-erisa.htm>



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