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TRUCKER ✦ HUSS
A PROFESSIONAL CORPORATION
ERISA AND EMPLOYEE BENEFITS ATTORNEYS

One Embarcadero Center
12th Floor
San Francisco, California
94111-3617
Telephone: (415) 788-3111
Facsimile: (415) 421-2017
Email: info@truckerhuss.com
www.truckerhuss.com

A New Approach to Abuse of Discretion Review

ALYSSA OHANIAN
AND
CLARISSA KANG

The Ninth Circuit Court of Appeals recently applied a searching analysis under the abuse of discretion standard of review — one that takes into account all circumstances and will not uphold denial simply if there is a single reasonable basis to deny benefits — even where there was no finding that a conflict of interest existed. In *Pacific Shores Hospital v. United Behavioral Health,* the Ninth Circuit reversed a district court judgment and held that a health plan's third-party administrator ("TPA") abused its discretion by denying a participant's health benefit claim and relying on "a number of obvious mistakes" made by the TPA's physician reviewers during their review of the participant's medical history and condition.[1]

Factual Background

In *Pacific Shores,* an employee of Wells Fargo, called Jane Jones by the court, was covered under the Wells Fargo & Co. Health Plan (the "Plan"), a self-funded plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). United Behavioral Health ("UBH"), a TPA for the Plan, was responsible for reviewing Plan mental health and substance abuse claims including those for anorexia nervosa.

Jones was admitted to Pacific Shores Hospital ("PSH") for acute inpatient treatment for severe anorexia nervosa and major depression. Through an assignment of rights to payment under the Plan, PSH submitted a claim to UBH for the costs of treatment during Jones's inpatient stay, but UBH refused to pay for more than three weeks of acute inpatient treatment.

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[1] *Pac. Shores Hosp. v. United Behavioral Health,* 12-55210, 2014 WL 4086784 (9th Cir. Aug. 20, 2014).

District Court Decision

PSH sued UBH and the Plan, seeking payment for the additional days of acute inpatient treatment. The district court held a bench trial on the administrative record and ruled in favor of UBH, concluding that Jones's administrative record provided a reasonable basis for UBH's denial of additional acute inpatient care.[2]

Ninth Circuit Decision

PSH appealed, and the Ninth Circuit reversed, holding that UBH abused its discretion in refusing to pay for additional days of inpatient treatment. On appeal, PSH asserted that although the Plan had granted the discretion to make claim determinations to the TPA, the court should adopt a less deferential standard of review of UBH's decision. PSH made three points in support of this argument, which provided the court with reasons to hold that even under an abuse of discretion standard of review, UBH's decision was not reasonable in consideration of all of the circumstances of the claim.

Missteps Throughout UBH's Benefits Denial

First, PSH contended that there were procedural irregularities in UBH's benefits denial, such that the court should review the denial *de novo*. The court disagreed, stating that it was "painfully apparent that UBH did not follow procedures appropriate to Jones's case." For instance, although UBH stated that Jones's case required medical evaluation due to its "medical and psychiatric complexity," UBH's decision was based almost entirely on telephone conversations and voicemail messages. The court also noted that no PSH hospital records or independent examination results were ever put into the administrative record. In addition, UBH's physician evaluations contained "obvious factual errors that could easily have been corrected" if UBH had consulted its administrative record or the PSH hospital records.

Second, PSH argued that the court should have considered materials outside Jones's administrative record to review UBH's denial. The district court had declined to consider documents outside the administrative record, which is typical in cases involving an abuse of discretion analysis. However, the Ninth Circuit explained that when the administrator's decision contains procedural irregularities, a court may review extrinsic evidence to assess the implications of the irregularities. The court noted that despite the "medical and psychiatric complexity" involved in Jones's case, the administrator issued its decision based solely on UBH's telephone conversations and conflicting information. The court concluded that expansion of the record at the district court level would be appropriate where the administrator makes a coverage determination based solely on an administrative record and where actual medical records would be helpful to assess the accuracy of the medical facts upon which the administrator makes its coverage determination. The court even stated that the "choice to conduct only a paper review raises questions about the thoroughness and accuracy of the benefits determination."

Finally, PSH argued that although UBH was a TPA, it was operating under a conflict of interest, and the court should have considered this conflict as one factor in deciding whether UBH abused its discretion. PSH further asserted that UBH had a "self-interest" in continuing its contractual relationship with Wells Fargo, and Wells Fargo had a self-interest, as a direct funder of the Plan, in minimizing benefit payments paid from the Plan by UBH.

The court declined to rule on these three arguments for lowering the standard to *de novo*, concluding that even under the more deferential abuse of discretion standard of review (without any additional scrutiny because of a conflict of interest) and based on the record that UBH had before it, UBH had unreasonably and improperly denied benefits to Jones.

Court Breaks from "Any Reasonable Basis" Test Even in the Absence of a Conflict of Interest

The court revisited its previous holding in *Horan v. Kaiser Steel Retirement Plan* in 1991 that it would uphold a plan administrator's benefit claim decision if it were grounded

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[2] *Pac. Shores Hosp. v. United Behavioral Health,* CV 10-5828 PSG CWX, 2011 WL 6402435 (C.D. Cal. Dec. 19, 2011) rev'd, 12-55210, 2014 WL 4086784 (9th Cir. Aug. 20, 2014).

in "any reasonable basis." This language in *Horan*, the court explained, could be read to mean that a court could make an "any reasonable basis" determination without looking at all the circumstances of the case. The court cited its 2011 decision in *Salomaa v. Honda Long Term Disability Plan* to confirm that this "unrealistic reading of the any-reasonable-basis test" is not good law when an administrator is operating under a structural conflict of interest. The court concluded that "[i]n all abuse-of-discretion review, whether or not an administrator's conflict of interest is a factor, a reviewing court should consider 'all the circumstances before it,' in assessing a denial of benefits under an ERISA plan."

In reviewing for abuse of discretion, the court explained, courts must consider "all of the relevant circumstances" for "any reasonable basis" supporting a plan administrator's decision. A plan administrator abuses its discretion if the administrator rendered its decision without any explanation, construed provisions of the plan in a way that conflicts with the plain language of the plan, failed to develop necessary facts for its determination, or relied on clearly erroneous findings of fact in making benefit determinations.

UBH Violated its Fiduciary Duty to Jones under ERISA

The court concluded that UBH fell short of fulfilling its fiduciary duty to Jones. As a claims administrator, UBH had a fiduciary responsibility under ERISA to discharge its duties with respect to a plan "solely in the interest of the participants and beneficiaries," [3] that is, "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." [4] Fiduciaries must discharge their duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man 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." [5] By employing and relying on three physician evaluators who made critical factual errors supporting UBH's denial decision, UBH breached its duty and improperly denied benefits under the plan.

Future Direction of Claims Adjudicated Under the Abuse of Discretion Standard

In *Pacific Shores*, the Ninth Circuit applied to a situation involving no conflict of interest, the more searching review that it had previously reserved for conflict of interest cases decided under the abuse of discretion standard. The court emphasized that it will not uphold a claims decision simply because it is supported by "any reasonable basis," as the court had originally held in *Horan v. Kaiser Steel Retirement Plan*. In addition, the Ninth Circuit suggested that the admission of extrinsic evidence — even where the abuse of discretion standard applies — may be appropriate in ERISA cases where the administrative record is not sufficient.

Two days after the Ninth Circuit decided *Pacific Shores,* the Sixth Circuit in *Butler v. United Healthcare of Tennessee, Inc.* took an approach similar to that of the Ninth Circuit in addressing a benefits denial.[6] In *Butler,* the court disagreed with United's argument that its denial of benefits could not have been an abuse of discretion because several physicians had stated that the medical care at issue was not medically necessary. The Sixth Circuit explained, "That reviewing physicians paid by or contracted with the insurer agree with its decision, though, does not prove that the insurer reached a reasoned decision supported by substantial evidence." [7] The court further noted that the reviewing physicians had not provided a fair opinion applying the standard for granting benefits to the facts of the case. Rather, the physicians had omitted the key fact of the insured's prior failed outpatient treatment and ignored United's guideline that allowed residential reha-

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3 29 U.S.C. § 1104(a)(1).

4 29 U.S.C. § 1104(a)(1)(A).

5 29 U.S.C. § 1104(a)(1)(B).

6 *Butler v. United Healthcare of Tennessee, Inc.,* 13-6446, 2014 WL 4116478 (6th Cir. Aug. 22, 2014).

7 *Id.* at *5.

bilitation where outpatient treatment had not worked in the past. The court concluded:

"If a decision to deny benefits could never be arbitrary and capricious when backed by the insurer's reviewing physicians, court review would be for naught. The insurer would invariably prevail so long as the insurer had physicians on its staff willing to confirm its coverage rulings. That also does not make sense." [8]

Pacific Shores and *Butler* are recent decisions that suggest a movement in the Circuit Courts of Appeals towards a less deferential approach to analyzing ERISA benefit claims decisions even under the abuse of discretion standard of review. Thus, claims administrators may find it more difficult to have their claims decisions upheld in the future, despite the applicability of the abuse of discretion standard of review.

Amendments to Excepted Benefits Regarding Dental Plans, Vision Plans and EAPs Finalized

TIFFANY N. SANTOS

On September 26, 2014,[9] the Department of the Treasury, Department of Labor and Department of Health and Human Services jointly finalized the amendments to the "excepted benefit" regulations regarding dental and vision plans and employee assistance programs ("EAPs"). While the amended regulations adopt the original proposed regulation language eliminating the contribution requirement for self-funded dental and vision plans to be "excepted" from Affordable Care Act (the "ACA") compliance and HIPAA's portability and nondiscrimination provisions, they make changes to the "excepted benefit" criteria for an EAP and defer finalizing provisions relating to the exception for limited wraparound coverage.

The final regulations apply to group health plans for plan years beginning on or after January 1, 2015. In the meantime, dental and vision benefits and EAPs may qualify as excepted benefits under the December 24, 2013 proposed regulations (see our January 2014 article for an overview of the proposed regulations).

Self-Insured Dental and Vision Plans

Prior to the issuance of the proposed regulations, a self-insured dental or vision-only plan could be an "excepted benefit" if it is "otherwise not an integral part of a group of a health plan" — meaning:

- Participants have the right to elect not to receive the coverage; and
- If elected, participants must pay an additional premium or contribution (even a nominal amount) for the coverage.

8 *Id.*

9 The final regulations will be published in the Federal Register on October 1, 2014.

In contrast, an insured dental or vision plan would be an "excepted benefit" simply if it was provided under a separate policy, certificate, or contract of insurance. To mitigate the different treatment of insured and self-insured dental or vision-only plans, the final regulations make the following changes for a self-insured dental or vision-only plan to be "excepted":

- **Eliminate the additional contribution requirement.**

  With the change, an individual who is eligible for "unaffordable" group medical coverage may accept "free" self-insured dental or vision-only coverage without losing eligibility for the premium tax credit under Section 36B of the Internal Revenue Code for individual Marketplace/Exchange coverage; and

- Clarify that a dental or vision-only plan is "otherwise not an integral part of the plan" if participants may decline coverage, or if claims are administered under a separate contract from any other benefit claims administration under the plan.

The preamble to the regulations also clarifies that because self-insured long-term care, nursing home care, home care, home health care, and community-based care are also subject to the "not an integral part of a group health plan" standard to be "excepted" benefits, the changes that apply to self-insured dental or vision-only coverage also apply to these benefits.

EAPs

The final regulations set forth the following four criteria that an EAP must satisfy to be an "excepted benefit":

- **EAP does not provide significant benefits in the nature of medical care:**

  To satisfy this standard, the amount, scope and duration of covered services are considered. The preamble clarifies that an EAP meets this requirement if it provides only limited, short-term outpatient counseling for substance use disorder services without covering inpatient, residential, partial residential or intensive outpatient care without requiring prior authorization or review for medical necessity. However, a disease management program that provides laboratory testing, counseling and prescription drugs for individuals with chronic conditions would not meet this criterion;

- **EAP benefits cannot be coordinated with the benefits under another group health plan:**

  To meet this standard, (i) participants in the other group health plan may not be required to exhaust benefits under the EAP before becoming eligible for benefits in the plan; and (ii) EAP eligibility cannot depend on participation in another group health plan (note: the final regulations eliminate the proposed regulations' restriction against the financing of the EAP by another group health plan);

- **EAP coverage must be provided at no cost:**

  A Plan sponsor may not condition employee eligibility on an employee premium or contribution requirement.

- **EAP may not impose any cost-sharing requirements.**

The preamble also clarifies that a wellness program may not be treated as an "excepted benefit" in order to circumvent the wellness program rewards, discounts or rebates requirements of Public Health Service Act Section 2705(j), simply by including it in an EAP.

While the final regulations provide welcome relief to sponsors of self-funded dental and vision-only plans, plan sponsors may wish to revisit their EAPs to determine if they meet the new "excepted benefit" criteria and amend the EAP as appropriate. Contact the author of this article for questions or for assistance in understanding these new regulations.

New Mid-Year Section 125 Permitted Election Changes Help Facilitate ACA Marketplace Enrollment

TIFFANY N. SANTOS

On September 18, 2014, the Internal Revenue Service ("IRS") issued Notice 2014-55, which allows an employee to revoke an election for employer-sponsored health plan coverage under a Section 125 cafeteria plan (but not a health flexible spending account ("FSA")) on a prospective basis in the following circumstances:

- Following a reduction in hours of service, an employee whose "full-time employee" status and eligibility for health plan coverage are "locked" during a stability period (for purposes of the look-back measurement period under Section 4980H of the Internal Revenue Code ("IRC")) wishes to enroll in individual Marketplace/Exchange coverage; and
- An employee who is eligible for a special enrollment period to enroll in individual Marketplace/Exchange coverage has enrolled or wishes to enroll in such coverage.

To allow these permitted election changes, the Section 125 plan must be amended on or before the last day of the plan year in which the elections are allowed (for example, December 31, 2015 for elections made in 2015 for a calendar-year plan). For election changes made during the 2014 plan year, the plan must be amended no later than the last day of the plan year that begins in 2015. The amendment may take effect retroactively if the Section 125 plan is operated in accordance with Notice 2014-55 and the plan sponsor informs participants of the amendment.

Mid-Year Election Changes Background

Elections under a Section 125 plan are irrevocable, except to the extent that the Section 125 plan incorporates the mid-year election change events permitted by Treasury Regulations Section 1.125-4. Under Treasury Regulations Section 1.125-4(c), a plan may allow an employee to revoke an election for coverage under a health plan if:

(i) a change in status occurs (for example, a change in employment status); and

(ii) the election change is consistent with the change in status (for example, if the employee loses eligibility for coverage under a group health plan, only then can she revoke her election and drop coverage).

Furthermore, for a change in employment status, the current regulations permit a mid-year election change only if the change causes the employee to gain or lose eligibility for coverage under the health plan. If the change in employment status does not affect an employee's eligibility for health plan coverage, the employee may not change her Section 125 plan election.

Interaction with Section 4980H Look-Back Measurement Method: To comply with the "offer of coverage" requirement and minimize the assessable payment under Section 4980H of the IRC, an applicable large employer may use the look-back measurement period method to determine an employee's "full-time" status and then "lock" that status and eligibility for health plan coverage during a subsequent stability period. Under this method, an employee could experience a reduction in hours (for example, go from full-time hours of 30 hours per week to part-time hours) during a stability period but not lose status as a "full-time employee" and maintain eligibility for health plan coverage. Because such an employee may qualify for a premium tax credit to purchase Marketplace/Exchange coverage, Notice 2014-55 relaxes the "loss of eligibility" requirement for a change in employment status event. Under the guidance, a Section 125 plan may allow an employee to prospectively revoke an election of coverage under a health plan (but not a health FSA) if:

- the employee who was reasonably expected to work an average of at least 30 hours per week experiences a reduction in hours so that she is reasonably expected to average less than 30 hours per week, even if the

reduction does not cause the employee to lose eligibility under the health plan; and

- the employee intends to enroll herself and any related individuals in another plan providing minimum essential coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Marketplace Special Enrollment: In circumstances where it may be more advantageous for an individual to enroll in Marketplace/Exchange coverage instead of the employer's health plan, Notice 2014-55 allows a Section 125 plan to permit an employee to revoke her health plan coverage election to facilitate the employee's enrollment in such coverage during a special enrollment period under Section 9801(f) of the IRC (for example, following a birth or marriage). The guidance allows a Section 125 plan to rely on the reasonable representation of an employee who has a Marketplace enrollment opportunity of her enrollment (or intent to enroll) in such coverage with an effective date that is no later than the date immediately following the last day of the revoked coverage.

While the above-referenced mid-year election change events are not required, an employer may wish to amend its Section 125 plan accordingly to give employees flexibility to drop their coverage when Marketplace coverage may make more financial sense to the employee's family than the employer-sponsored plan coverage. Contact the author of this article or the attorney with whom you normally work for questions or for assistance amending your Section 125 plan.

OTHER DEVELOPMENTS IN EMPLOYEE BENEFITS

IRS Announces PCORI Fee Increase

On September 18, 2014, the Internal Revenue Service ("IRS") published Notice 2014-56, announcing that the adjusted "applicable dollar amount" for the Patient-Centered Outcomes Research Institute ("PCORI") fee imposed by §§ 4375 and 4376 of the Internal Revenue Code will increase to $2.08 from $2.00 for policy and plan years ending on or after October 1, 2014 and before October 1, 2015. For policy or plan years ending on or after October 1, 2015, the adjusted applicable dollar amount will be published in the Internal Revenue Bulletin's guidance of general applicability.

The Affordable Care Act ("ACA") imposes a fee on issuers of certain health insurance policies[10] and plan sponsors of certain self-insured health plans[11] to help fund PCORI, a private, nonprofit corporation whose mission is to assist individuals in making informed healthcare decisions and improve healthcare delivery and outcomes. The PCORI fee applies to policy or plan years ending on or after October 1, 2012 and before October 1, 2019 and calculated by multiplying the average number of lives covered under the relevant policy or plan by the "applicable dollar amount" for that policy or plan year. Each year, the "applicable dollar amount" is adjusted based on the projected per capita amount of the National Health Expenditures.[12]

To pay the fee, issuers and plan sponsors must file the second quarter Form 720 with the IRS by July 31 of the year immediately following the last day of the plan or policy year.

— JENNIFER TRUONG

[10] 26 CFR Section 46.4315-1.

[11] 26 CFR Section 46.4376-1.

[12] See, §§ 4375(d) and 4376(d) and Treas. Reg. §§ 46.4375-1(c)(4) and 46.4376-1(c)(3).

FIRM NEWS

On September 9, **Callan Carter** spoke at a BLR webinar entitled, *Post-ACA Landscape: A Primer of Compliance Hurdles Organizations Now Face: Play or Pay, Same Sex Partners and More*.

On September 24, **Callan** moderated a seminar at MacCorkle Insurance Services on wellness programs.

Matt Gouaux was appointed to the Executive Committee of the Bar Association of San Francisco Taxation Section.

Matt will be speaking at the Mid-Sized Retirement and Healthcare Plan Management Conference in Las Vegas on September 8 on a panel entitled, *How to Correct Retirement Plan Errors*.

On September 16, **Matt** will give a legal update on recent IRS and DOL guidance at the *Pension Nuggets* program for Western Pension & Benefits Council in San Francisco.

Brad Huss will present at the ASPPA Annual Conference in Washington, DC, on October 26–29, at a workshop entitled, *Fiduciary Protections: The ERISA Bond and Fiduciary Liability Insurance*.

Clarissa Kang will be speaking at the ERISA Basics seminar presented by the ABA Joint Committee on Employee Benefits in Chicago on October 16–18, 2014. **Clarissa** will be participating in several panels at the conference, covering ERISA benefit claim administrative procedures, ethical issues and concerns for benefits practitioners, and QDROs and related spousal rights.

On September 11, **Clarissa** was quoted in Pension & Benefits Daily™ in an article entitled, *The Exhaustion of Administrative Remedies: A Nonstatutory Pillar of ERISA Litigation.*

Liz Loh and **Mary Powell** hosted a Trucker ✦ Huss webinar on October 2 entitled, *Health Care Reform Reporting Obligations under Internal Revenue Code sections 6055 and 6056*. Their webinar covered recently issued draft IRS forms and instructions for complying with employers' new employer reporting obligations under the ACA.

Nick White will also be presenting at the ASPPA Annual Conference on the following two panels entitled, *Breaking Down the Fiduciary Roles, Obligations and Service Models and Service Agreements: Let Your Practices Have Your Back/Protection Through Planning*.

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

Editor: Sonya M. Gordon, sgordon@truckerhuss.com

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Jahiz Noel Agard
jagard@truckerhuss.com
415-277-8022

Jennifer Dack Brooks
jbrooks@truckerhuss.com
415-277-8053

Callan G. Carter
ccarter@truckerhuss.com
415-277-8037

Barbara B. Creed
bcreed@truckerhuss.com
415-788-3111

Charles M. Dyke
cdyke@truckerhuss.com
415-277-8063

J. Marc Fosse
mfosse@truckerhuss.com
415-277-8045

Angel Garrett
agarrett@truckerhuss.com
415-277-8066

Matthew L. Gouaux
mgouaux@truckerhuss.com
415-277-8047

Robert R. Gower
rgower@truckerhuss.com
415-277-8002

Mikaela Habib
mhabib@truckerhuss.com
415-277-8009

R. Bradford Huss
bhuss@truckerhuss.com
415-277-8007

Clarissa A. Kang
ckang@truckerhuss.com
415-277-8014

Katuri Kaye
kkaye@truckerhuss.com
415-277-8064

Freeman L. Levinrad
flevinrad@truckerhuss.com
415-277-8068

Michelle Schuller Lewis
mlewis@truckerhuss.com
415-277-8038

Elizabeth L. Loh
eloh@truckerhuss.com
415-277-8056

Kevin E. Nolt
knolt@truckerhuss.com
415-277-8017

Virginia H. Perkins
vperkins@truckerhuss.com
415-277-8005

Barbara P. Pletcher
bpletcher@truckerhuss.com
415-277-8040

Mary Powell
mpowell@truckerhuss.com
415-277-8006

Tiffany N. Santos
tsantos@truckerhuss.com
415-277-8039

Eric Schillinger
eschillinger@truckerhuss.com
415-277-8071

Robert F. Schwartz
rschwartz@truckerhuss.com
415-277-8008

Benjamin F. Spater
bspater@truckerhuss.com
415-277-8011

Charles A. Storke
cstorke@truckerhuss.com
415-277-8018

Sean T. Strauss
sstrauss@truckerhuss.com
415-277-8028

Lee A. Trucker
ltrucker@truckerhuss.com
415-277-8020

Nicholas J. White
nwhite@truckerhuss.com
415-277-8016

LEGAL ASSISTANTS

Sonya M. Gordon
sgordon@truckerhuss.com
415-277-8060

Susan Quintanar
squintanar@truckerhuss.com
415-277-8069

TRUCKER ✦ HUSS
A PROFESSIONAL CORPORATION
ERISA AND EMPLOYEE BENEFITS ATTORNEYS
One Embarcadero Center
12th Floor
San Francisco, California
94111-3617

Telephone: (415) 788-3111
Facsimile: (415) 421-2017
Email: info@truckerhuss.com
www.truckerhuss.com