ERISA Remedies, Fee Disclosure, and Preventive Services

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U.S. SUPREME COURT DECISION ON ERISA REMEDIES

On May 16, 2011, the U.S. Supreme Court in the case of *Cigna Corp. v. Amara*, No. 09-804, decided that an error in the employee booklet (formally known as the summary plan description) did not require that the legal document be interpreted in a manner consistent with the employee booklet.

Under the facts in the case, there was a discrepancy between the wording of the legal plan document and the summary plan description with regard to benefits payable under the plan. The plan document indicated benefits were to be the larger of A or B, whereas the summary plan description indicated benefits would be A plus B. The Supreme Court concluded section 502(a)(1)(B) of ERISA allows a court to try to interpret a plan's provisions in light of external documents but it does not permit the court to modify the terms of the legal plan document.

> *To make the language of a plan summary legally binding could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers. Consider the difference between a will and the summary of a will or between a property deed and its summary. . . . None of this is to say that plan administrators can avoid providing complete and accurate summaries of plan terms in the manner required by ERISA and its implementing regulations. But we fear that the Solicitor General's rule might bring about complexity that would defeat the fundamental purpose of the summaries.*
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> *For these reasons taken together we conclude that the summary documents, important as they are, provide communication with beneficiaries about the plan, but that their statements do not themselves constitute the terms of the plan for purposes of §502(a)(1)(B). We also conclude that the District Court could not find authority in that section to reform CIGNA's plan as written.*

This language would seem to indicate that the prior holding of some courts that if there is a conflict between the plan document and the summary plan description, the summary plan description will prevail (since it is the document most relied upon by plan participants) is no longer valid.

However, the Court went on to say that a different section of ERISA, 502(a)(3), would permit other relief to the plan participant such as reforming the plan document, stopping the plan sponsor from asserting the terms of the plan, and monetary compensation assessed against a plan trustee (known as a surcharge) on account of a breach of fiduciary duties. This language indicates that even though a faulty summary plan description cannot be used to justify changing the terms of the plan, a faulty summary plan description can lead the plan fiduciary to pay damages to plan participants if they can show the defective summary plan description language caused harm. Hence plan sponsors still must be vigilant in ensuring that communications to plan participants are accurate.

DOL REGULATIONS ON FEE DISCLOSURE TO PLAN SPONSORS AND PLAN PARTICIPANTS

The Department of Labor (DOL) has been working on regulations to require plan service providers to disclose detailed fee information to plan sponsors (408b-2 regulation) and disclose plan fees to plan participants [404(a) and 404(c) regulation]. According to an announcement dated July 19, 2011 (76 Fed. Reg. 42539-42542), the regulations take effect April 1, 2012, for disclosure to plan sponsors and May 31, 2012, for disclosure to plan participants.

The regulations under ERISA section 408(b)(2) concern fee disclosure from service providers to plan sponsors. All service providers to retirement plans (defined contribution and defined benefit pension plans) must disclose to the employer that sponsors the retirement plan information about all the fees charged by the service provider. If the service provider does not provide this information, the plan sponsor must notify the DOL of this omission.

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Plan sponsors need this information in order to determine that any contract with a service provider is reasonable, the services provided are needed, and only a reasonable amount is paid for the services. This does not mean a plan sponsor always has to choose the vendor with the lowest cost, but it must conclude the fees charged are reasonable in light of the charges of competitors. Plan sponsors also need this information since it also has to be provided to plan participants as noted above in the listing of the deadlines.

To briefly summarize the requirements found in the regulations, a covered service provider (i.e., a service provider that expects to receive at least $1000 a year in direct or indirect compensation) must disclose whether it is a fiduciary, registered investment adviser, third-party administrator, recordkeeper, or provider of brokerage services and must make certain disclosures. First, the covered service provider must provide a description of the services to be provided. Second, for a fiduciary or registered investment adviser, a statement must be made as to that status. Third, compensation earned both directly and indirectly must be provided. Fourth, the covered service provider must indicate whether fees are billed or deducted directly from investments.

It should be noted that sometimes services are provided on a bundled basis (different types of services are not broken out). This frequently occurs when one entity provides both recordkeeping and investment services. If this is the case, a good faith estimate has to be provided of the cost of the distinct services.

These regulations apply only to the extent that fees are paid from plan assets. If the sponsor pays all service fees out of corporate assets and no plan assets are used to pay for any services, these regulations do not apply.

A separate set of regulations requires that the above information has to be distilled into a form that can be understood by plan participants so that the participants have an understanding of what expenses are being paid using assets from their account balance.

It is important for plan sponsors to contact service providers now to make sure the required information is being gathered so there are no unpleasant surprises as the deadlines approach.

ADDITIONAL GUIDANCE ON PREVENTIVE SERVICES UNDER HEALTH REFORM

On August 3, 2011, new guidance in the form of revised interim final regulations was issued by various governmental agencies with regard to what preventive services need to be included under group health plans under the Patient Protection and Affordable Care Act (PPACA). (The regulations are found in 76 Fed. Reg. 46621.) This guidance is effective August 1, 2011.

Starting with plan years beginning on or after August 1, 2012, group and individual healthcare plans (with exceptions noted below) must cover as preventive services with no cost-sharing the following services:

- Well-woman visits;
- Screening for gestational diabetes;
- Human papillomavirus DNA testing for women 30 years and older;
- Sexually transmitted infections counseling;
- HIV screening and counseling;
- U.S. Food and Drug Administration-approved contraception methods and contraceptive counseling;
- Breastfeeding support, supplies, and counseling; and
- Domestic violence screening and counseling.

The guidance states cost-sharing can be imposed on name-brand medications if a generic equivalent is available and safe.

Excepted from this requirement are grandfathered plans under PPACA and religious employers. There is still controversy over the religious employer exemption in that while it would cover a church, it appears to not extend to a church-sponsored institution such as a Catholic hospital. Comments are being accepted, and it is anticipated the religious exemption may likely be further clarified.

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.