Supreme Court Upholds Health Reform Law; Participant Must Cooperate in Claims Review; Stop Loss Concerns; and Brokerage Windows in Defined Contribution Plans

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SUPREME COURT RULES ON HEALTH REFORM LAW

On June 28, 2012, the U.S. Supreme Court finally rendered its decision on the constitutionality of the Patient Protection and Affordable Care Act (PPACA), which is the formal name of the health reform legislation. The decision is *National Federation of Independent Business et al v. Sebelius* No. 11-393. While the court upheld PPACA's mandate that individuals must have health insurance in effect, it did not agree with the administration's argument that the commerce clause of the U.S. Constitution permitted Congress to pass such a requirement in the name of regulating interstate commerce:

> *The Government says that health insurance and healthcare financing are "inherently integrated." But that does not mean the compelled purchase of the first is properly regarded as a regulation of the second. No matter how "inherently integrated" health insurance and health care consumption may be, they are not the same thing: They involve different transactions, entered into at different times, with different providers. And for most of those targeted by the mandate, significant health care needs will be years, or even decades, away. The proximity and degree of connection between the mandate and the subsequent commercial activity is too lacking to justify an exception of the sort urged by the Government. The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to "regulate Commerce."*

Instead the court said Congress through its ability to tax could penalize citizens who refused to obtain health insurance.

The court did strike down PPACA's requirement that all the states had to expand their Medicaid program to cover a much larger group of uninsured individuals in the state. Instead the court said while a state could choose to expand Medicaid and receive additional federal funds for doing so, PPACA could not threaten a state by stating that no Medicaid funds would be provided by the federal government unless Medicaid was expanded.

Where does all this leave employers? Clearly various deadlines set forth in PPACA must be met. Examples of deadlines that have taken or will shortly take effect in upcoming months are:

- W-2s for 2012 must include the value of employer-provided health insurance.
- As of July 1, 2012, claims review must meet new, more stringent review requirements.
- As of August 1, 2012, rebates received from an insurer due to the medical loss ratio must be distributed or used in a manner required by law.
- For open enrollments occurring on or after September 23, 2012, a summary of benefits and coverage must be issued.
- Starting January 1, 2013, no more than $2500 can be contributed to a health flexible spending account under a cafeteria plan.

EMPLOYEES HAVE RESPONSIBILITY TO PROPERLY RESPOND TO INSURER REQUEST

A recent District Court case illustrates that a failure to respond can doom what otherwise might be a valid claim filed by a plan participant. In *Scott v. Hartford Life and Accident Insurance Co.*, S.D. Miss., 8/3/2012, an employee filed a claim for disability benefits under her employer's long-term disability plan. The plan had an exclusion for

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preexisting conditions. (Note: While group medical plans generally can have no or very limited preexisting condition limitations, such exclusions are still permitted under group long-term disability plans.)

The insurer, based on the submitted employee medical records, believed that the disabling injury the employee claimed was caused by a preexisting condition before the employee suffered a fall. Although the insurer requested additional medical information so that it could determine whether the preexisting condition was a factor in the injury that occurred as a result of the fall, the employee refused to provide any additional information. In the view of the court, the failure to cooperate by the employee permitted the insurer to deny the claim.

As the court stated:

> *In summary, Defendants received medical records from Plaintiff indicating that her back problem was the result of a condition predating her slip-and-fall. The policy excludes coverage for disability caused by, contributed to, or resulting from a pre-existing condition. The policy defines a pre-existing condition as one for which Plaintiff received medical treatment or advice during the three months prior to the policy's effective date. On multiple occasions, Defendant requested further information from which it could determine whether Plaintiff received such medical treatment or advice, but Plaintiff failed to provide the requested documentation. Therefore, Defendant denied her claim.*
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> *Plaintiff argues that the evidence she submitted to Defendant shows that she is disabled, that she does not have a pre-existing condition, that her injury was work-related, and that no reasonable person would have demanded further information. Whether Plaintiff is disabled is irrelevant to the Court's analysis, as Defendant's decision was based upon Plaintiff's failure to provide information regarding the alleged pre-existing condition. Plaintiff may be disabled, but if her disability was caused by, contributed to, or resulted from a pre-existing condition, the policy provides no coverage. The pertinent issue, therefore, is whether Defendant's decisions to request further information and to deny coverage for Plaintiff's failure to provide it were "made without a rational connection" to the known facts.*
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> *In the Court's opinion, the Administrative Record contains evidence supporting Defendant's denial. Dr. Michael Patterson believed that Plaintiff had a pre-existing condition that was asymptomatic prior to her slip-and-fall, and Dr. Kelly Bernardo stated that Plaintiff's back problem was congenital and merely manifested itself at the time of the accident. In light of this evidence, it was reasonable for Defendant to seek further information from Plaintiff as to whether she had received medical treatment during the three months prior to the policy's effective date. Defendant provided Plaintiff with a Medical History Form, but Plaintiff failed to complete and return it to Defendant. Plaintiff also failed to provide any written explanation as to whether she had seen any medical providers during the three months prior to the policy's effective date. Accordingly, Defendant did not abuse its discretion by denying Plaintiff's claim for benefits.*

This serves as a reminder that whether or not on the merits a plan participant would prevail on a claim, if the participant fails to comply with reasonable requests to determine the validity of the claim, the party reviewing claims has a reasonable basis to deny the claim.

MAKE SURE PLAN COVERAGE MATCHES STOP LOSS POLICY

Employers who sponsor a self-insured group health plan almost always have a stop loss policy to cover extraordinary risks. While the stop loss policy provides valuable protection, it only works in conjunction with risks as defined in the stop loss policy. Typically the stop loss policy will incorporate by reference the terms of the underlying group health plan. Employers who provide health coverage on an *ad hoc* basis beyond the terms of the written group health plan may find themselves liable for all claims incurred due to that extension of coverage.

In *CLARCOR Inc. v. Madison National Life Insurance Co* out of the 6th Cir, 7/31/12 (unpublished), an employer found out the hard way that even a compassionate extension of health coverage could end up backfiring. Under the facts in the case, an employee went out on Family and Medical Leave Act leave for 12 weeks. Following that, the employee was placed on short-term disability leave. She was then terminated and was offered continuing coverage under COBRA.

The employee had over $600,000 in expenses. Since the stop loss policy provided coverage after a deductible of $250,000 the employer submitted the claim to the stop loss carrier. However, the stop loss carrier denied the claim in its entirety by concluding the employee was ineligible for coverage. The court reviewed the facts in the case and agreed with the stop loss carrier.

The court found that the employee lost coverage at the end of the Family and Medical Leave Act leave and should have been offered COBRA at that time. The clear terms of the group health plan stated only active, full-time employees were eligible for coverage. There was no coverage for inactive employees on a short-term leave of absence. This

case serves as a stark reminder that an employer has to either carefully follow the written terms of its plans that are coordinated with stop loss coverage; or if it wants to obtain insurance for additional risks (e.g., for retiree medical), those additional risks have to disclosed to the stop loss carrier and paid for accordingly.

401(K) PLANS WITH BROKERAGE WINDOWS

As readers of this column know from the March/April 2012 issue, defined contribution plans under the Employee Retirement Income Security Act of 1974 that permit self-direction of investments by participants must disclose to plan participants certain investment fees so that participants know how expensive various investment options are. The Department of Labor (DOL) in Field Assistance Bulletin 2012-02, published May 15, 2012, took the position that any plan that offered a brokerage window had to monitor the investments made through the brokerage window and had to provide disclosure information on a certain percentage of the investments made through the brokerage window.

In response to this Bulletin, the plan sponsor community raised a very loud objection. Since in most cases the rationale behind providing a brokerage window was to allow a plan participant to make an investment from a virtually unlimited universe of investment options, how was an employer to provide disclosure especially when the employer in most cases did not even know what investment decisions were made?

In reaction to the employer response, the DOL on July 30, 2012, issued another Field Assistance Bulletin 2012-02R addressing just the brokerage window issue. Basically, the DOL said that if a plan already has other designated investment alternatives then the fact that the plan offers a brokerage window does not require disclosure of all investments made through the window. The DOL did state, however, that if a plan tried to avoid disclosure by offering only a brokerage window with no designated investment alternatives, such an arrangement would be inviting scrutiny from the DOL. ■

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.