Ruling on Degree of Deference Given to Physician Recommendations, Wellness Programs, and Tax Problems Involving Loans from Qualified Plans

*Gayle M. Meadors, PC**

Tthe column for this issue will address recent court cases and an Equal Employment Opportunity Commission (EEOC) ruling.

COURT RULES TREATING PHYSICIAN RECOMMENDATIONS MUST BE CONSIDERED, THOUGH NOT CONTROLLING, IN ANALYZING DISABILITY CLAIM

A recent decision out of the 7th Circuit court of appeals is instructive in how carefully sponsors of Employee Retirement Income Security Act of 1974 (ERISA) plans must handle claims filed by plan participants. In the case of *Love v. National City Corp. Welfare Benefits Plan* (decided July 23, 2009), an employee named Nancy Love was diagnosed with multiple sclerosis in 2001. Her employer granted her short-term disability benefits and then long-term disability benefits for a total of two years. At the end of two years, the definition of disability switched under the long-term disability plan from not being able to perform the employee's particular job to being "unable to perform the duties of any other occupation for which you are, or could become, qualified by education, training or experience."

The claims administrator for the disability benefits plan, Liberty Mutual, hired an independent physician to review medical records submitted by the treating physician of Love. The independent physician found no disability but did ask for comment from the treating physician. No responding comment was ever issued by the treating physician. The employee's claim for continuing disability benefits was denied.

The employee appealed the denial and submitted three new reports, a physical-therapy evaluation, a functional-capacity evaluation, and a vocational evaluation, each prepared by a different doctor. Each concluded that Love had limited functional ability.

A second independent physician was hired by Liberty Mutual to review these reports, and this physician, like the first independent physician, concluded there was no disability. Benefits were again denied, and the employee filed a lawsuit against the plan.

The 7th Circuit stated it would review the denial of benefits to see if the decision to terminate long-term disability benefits was arbitrary and capricious. This is the ERISA standard for plans where the plan has granted discretion to the administrator to determine eligibility for benefits.

The court concluded that the plan administrator failed to comply with ERISA in that there was not a sufficient explanation of why the information from the treating physicians was discounted and on what basis a different conclusion was reached.

> *In this case neither the initial termination letter nor the subsequent letter denying Love's appeal sufficiently explained the denial. Both letters asserted that all relevant medical evidence had been considered, but neither letter explained why the reviewer chose to discredit the evaluations and conclusions of Love's treating physicians....We are troubled by the fact that neither [the independent physician's] report nor Liberty Mutual's letter addressed the contrary findings of Love's treating physicians or explained why Liberty Mutual chose to discredit them.*
>
> *These explanations are insufficient to meet ERISA's requirement that specific and understandable reasons for a denial be communicated to the claimant. As we have noted, "[b]are conclusions are not a rationale." The Plan must provide a reasonable explanation for its determination and must address any reliable, contrary evidence presented by the claimant. The Plan did not explain why it chose to discount the near-unanimous opinions of Love's*

*Attorney-at-Law, 20 South Clark Street, 25th Floor, Chicago, IL 60603; phone: 312-558-1255; fax: 312-896-9590; e-mail: gmm@erisalaw-chicago.com.
Copyright © 2009 by Greenbranch Publishing LLC.

treating physicians. While plan administrators do not owe any special deference to the opinions of treating physicians, they may not simply ignore their medical conclusions or dismiss those conclusions without explanation. We do not hold that the evidence here requires a finding that Love is totally disabled, only that ERISA requires the Plan to provide a more thorough explanation for its determination than it has here. The Plan acted arbitrarily by terminating Love's benefits without sufficiently explaining its basis for doing so.

For treating physicians, this case stands for the proposition that the opinion of the treating physician, while not paramount in determining an employee's disability, must be given a serious and thorough review; and a differing opinion that dismisses the treating physician's analysis must provide a detailed explanation to the plan participant of the basis for the varying opinion. A mere conclusionary statement will not be sufficient under ERISA.

The court did not rule on whether Love was disabled or not but remanded the case to the lower court to have the plan review the claim once again, and "if it concludes that she does not meet the [disability] definition it must adequately explain the reasons supporting its decision, including at a minimum an explanation of why it is discounting the medical opinions of Love's treating physicians."

POSSIBLE LEGAL DIFFICULTIES AHEAD FOR WELLNESS PROGRAMS AND HEALTH RISK ASSESSMENTS

Many employers that are supportive of wellness programs to both improve the health of employees and hopefully reduce the costs of health benefits require that an employee undergo a health risk assessment, and then based on the results, ask the employee to undertake certain actions to improve his or her health. Very often, employers use a financial or other type of incentive to encourage participation in such a wellness program.

For years, employers have known there are limits on the amount of the incentive. The most notable limit is the 20% differential set forth in the wellness plan regulations under HIPAA. Hence, financial incentives have been designed to fall within this limit.

The EEOC has now indicated such wellness program incentives may be in legal jeopardy. In March 2009, the EEOC issued an opinion letter to a municipality stating that a requirement that an employee undergo a health risk assessment is a violation of the Americans With Disabilities Act. The municipality required that all employees who sought coverage under its group health plan would need to fill out a brief questionnaire and have a few medical tests done such as blood pressure testing and a blood sample. Those employees who refused could not enroll in the group health plan.

The EEOC stated a wellness program would be permitted only as long as it was "voluntary." It then defined voluntary in very narrow terms:

Disability-related inquiries and medical examinations are also permitted as part of a voluntary wellness program. A wellness program is voluntary if employees are neither required to participate nor penalized for non-participation. Id. Q&A 22, at 405:7718-19. In this instance, however, an employee's decision not to participate in the health risk assessment results in the loss of the opportunity to obtain health coverage through the employer's plan. Thus, even if the health risk assessment could be considered part of a wellness program, the program would not be voluntary, because individuals who do not participate in the assessment are denied a benefit (i.e., penalized for non-participation) as compared to employees who participate in the assessment.

This language seems to indicate any financial incentive offered by an employer to participate in the wellness program such as a reduction in the otherwise payable premium would be illegal since it would deny the benefit of the reduced premium to those employees who choose not to participant in the wellness program. Not only does this position fly in the face of reality, which indicates employees typically will only be motivated to participate in a wellness program if there is some sort of reward for doing so, but it appears to be contrary to President Obama's stated endorsement of wellness programs as a way to reduce healthcare costs.

It is to be hoped that the EEOC will rethink its position and view the HIPAA wellness plan provisions as a safe harbor against any claims under the Americans With Disabilities Act.

WATCH OUT FOR REFINANCED LOANS UNDER QUALIFIED PLANS

Most 401(k) plans and some profit-sharing plans contain provisions under which a plan participant can take out a loan against his or her plan balance. The loan generally cannot exceed the lesser of: (1) 50% of the vested account balance; or (2) $50,000. Additional rules apply to this calculation.

While these limits are straightforward when a plan permits only one loan at a time, matters get complicated when a plan permits multiple loans or the refinancing of an existing loan.

Under IRS regulations issued in 2002, a refinanced loan is treated as a continuation of the prior loan plus a new loan to the extent of any increase in the loan balance. Hence even with a refinancing, the amount borrowed under the first loan must still be paid back under the terms

of the first loan (generally no more than five years from the date the loan starts), and only the balance of the refinanced loan can be subject to a new five-year period measured from the date of refinancing.

A recent tax court decision indicates the perils of making a mistake in the calculations as found in *Billups v. Commissioner of Internal Revenue*, TC Summary Opinion 2009-86. Billups had a loan with an outstanding balance of $27,013. He took out a new loan of $39,643, which included the balance due from the first loan of $27,013 plus $12,630 in cash. On the date of the replacement loan he had an account balance of $52,863.38.

Under IRS rules discussed above, both the original loan that was refinanced and the new loan were considered outstanding on the same day. From IRS regulation 1.72(p)-1 Q&A-20(a)(2):

> *For purposes of section 72(p)(2) and this section (including the amount limitations of section 72(p)(2)(A)), if a loan that satisfies section 72(p)(2) is replaced by a loan (a replacement loan) and the term of the replacement loan ends after the latest permissible term of the loan it replaces (the replaced loan), then the replacement loan and the replaced loan are both treated as outstanding on the date of the transaction.*

Under the facts in this case, the amount of the two loans was $66,655.46. Not only did that exceed the $50,000 overall loan limit but it vastly exceeded the 50% of the vested account balance limit of $26,431.69 by $39,748.06. The plan participant was not only taxed on the amount of the loan that exceeded the permissible limit but he had to pay the 10% excise tax as well since he was not age 59½.

This case serves as a reminder that plans and their service providers need to make sure that procedures are in place to avoid such a situation or at least warn the plan participant that a refinancing may result in a taxable event. ■

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.