SongMondress PLLC
ATTORNEYS AT LAW
720 Third Avenue, Suite 1500, Seattle, Washington 98104
Tel: 206.398.1500 Fax: 206.398.1501

Legal Developments Impacting Health and Welfare Plans
(Other than Health Care Reform)
2015 Year-End Update

1. Federal law does not expressly require that ERISA health plans cover **same-sex spouses**. However, in 2015 the Equal Employment Opportunity Commission ("EEOC") took the position that sexual orientation is protected under federal anti-discrimination law (Title VII). Therefore, health plans that do not cover same-sex spouses may be targets for discrimination lawsuits. Also, insured plans may need to cover same-sex spouses in order to comply with state insurance law.

2. The Third Circuit Court of Appeals joined the Fifth and Sixth Circuits in holding that benefit denial notices must mention the plan's **deadline to file a lawsuit challenging the benefit denial** in order for the deadline to be enforceable.[1]

3. In a January 2015 decision, the U.S. Supreme Court ruled that courts should not infer a lifetime health care benefit for retirees when a collective bargaining agreement promises employer-paid retiree health benefits, is silent on duration of the benefits, and the agreement has a general durational clause.[2] In so doing, the Court struck down an inference applied for 30 years in the Sixth Circuit, originating from a case known as "Yard-Man."[3] The Court explained that Yard Man places "a thumb on the scale in favor of vested retiree benefits in all collective-bargaining agreements," and that instead, ordinary principles of contract interpretation should apply to determine an employer's obligation to provide permanent health coverage to retirees.

4. New guidance was issued on **wellness programs**:

   - Under HIPAA nondiscrimination rules, wellness programs must be reasonably designed to promote health or prevent disease. In April 2015 guidance, the DOL, IRS and HHS identified several types of programs that may not meet this requirement and will be subject to scrutiny, including programs that collect a substantial amount of personal health information without helping individuals make behavioral changes or that are designed to discourage sick individuals from enrolling in the employer's health plan.

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[1] *Mirza v. Insurance Adm'r of America, Inc.*, 800 F.3d 129 (3d Cir. 2015). The holding would also apply to retirement plan benefit denial notices.
[2] *M&G Polymers USA, LLC v. Tackett*, 135 S.Ct. 926 (2015).
[3] *International Union, United Auto., Aerospace, & Agricultural Implement Workers of Am. v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983).

- The EEOC published proposed amendments to its Americans with Disabilities Act regulations. In a welcome departure from prior EEOC guidance, the proposed changes would allow wellness programs to provide rewards or impose penalties (albeit more limited rewards and penalties than are allowed under the HIPAA nondiscrimination rules).

- The EEOC also issued proposed changes to its Genetic Information Nondiscrimination Act regulations, to clarify when wellness programs may offer rewards in exchange for a dependent's health information.

5. The Second Circuit Court of Appeals allowed participants to bring a fiduciary breach claim against a third-party administrator for violating **mental health parity** requirements. In general, the federal mental health parity law does not allow plans to apply restrictions to mental health or substance abuse benefits that are greater than those applied to medical benefits. In the Second Circuit case, the third-party administrator allegedly applied more restrictive medical necessity, preauthorization and concurrent review procedures to the plan's mental health benefits.[4]

6. The Health Coverage Tax Credit ("HCTC") expired at the end of 2013 but has now been reinstated through the end of 2019. The DOL's model **COBRA notice** previously referenced the HCTC but has not yet been updated following the HCTC's reinstatement.

7. Consistent with informal DOL guidance, the Seventh Circuit held that ERISA's claim and appeal procedures do not apply to a **payment dispute between an insurer and its network provider** if the participant did not assign the benefit claim to the provider. Instead, the dispute is governed by the terms of the PPO contract between the insurer and the provider.[5]

8. In October 2015, the DOL, IRS and HHS agreed that if a participant requests documents that are subject to disclosure under ERISA or the federal mental health parity law (such as the plan's medical necessity criteria), the plan administrator **cannot refuse to provide the documents on the basis that they are proprietary**.

9. For 2016, the **annual dollar limit** on employee contributions to a health FSA is staying at $2,550. The limit on HSA contributions for self-only coverage is staying at $3,350, but the limit for family coverage increased to $6,750 (up from $6,650 in 2015).

From all of us here at Song Mondress, your employee benefits law firm.

Not intended as legal advice.

[4] *N.Y. State Psychiatric Ass'n v. UnitedHealth Group*, 2015 WL 4940352 (2d Cir. 2015).
[5] *Pa. Chiropractic Ass'n v. Independence Hosp. Indem. Plan, Inc.*, 2015 WL 5853690 (7th Cir. 2015).