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U.S. Airways v. McCutchen and Equitable Relief under ERISA

The United States Supreme Court heard oral arguments on November 27, 2012 in U.S. Airways, Inc. v. McCutchen. The case raises the issue of whether a self-funded benefit plan is entitled to full reimbursement for payments made to a plan participant injured in an accident where the participant sues and recovers damages from a third party.

In U.S. Airways v. McCutchen, James McCutchen, the plan participant, was involved in a serious car accident. U.S. Airways, a self-funded health benefit plan, paid $66,866 for his medical expenses. McCutchen retained his own attorneys and filed a negligence action against the driver who caused the accident. The case ultimately settled, but because the driver had limited insurance coverage, McCutchen received a payment of only $10,000. With assistance from his attorneys, McCutchen recovered an additional $100,000 from his own insurance company. McCutchen's attorneys received a forty percent contingency fee and McCutchen's net recovery was $66,000 – less than the total amount paid by the plan.

U.S. Airways demanded that McCutchen reimburse them for the full amount of his medical expenses. Under the terms of the plan, a beneficiary was required to reimburse the plan for any amounts it paid out of any monies recovered from a third party. McCutchen argued that U.S. Airways did not take into account his legal fees, which reduced his recovery amount to less than the amount demanded by the plan. U.S. Airways then filed a suit in federal court under Section 502(a)(3) of the Employment Retirement Security Income Act ("ERISA") seeking "appropriate equitable relief." The district court granted summary judgment to U.S. Airways, holding that the plan's subrogation and reimbursement provision entitled the company to full reimbursement.[1]

McCutchen appealed the district court's decision, and the United States Court of Appeals for the Third Circuit vacated the lower court's judgment.[2] In its decision, the court of appeals agreed with McCutchen that the statutory term "appropriate" in Section 502(a)(3) of ERISA means that courts must exercise discretion to limit relief to what is appropriate under traditional equitable principles.[3] The court of appeals also acknowledged that its interpretation conflicts with that of several other circuits,[4] each of which has held that courts may not apply equitable theories to alter the express terms of a plan.

Specifically, the Third Circuit held that awarding full reimbursement to U.S. Airways was inequitable under the principle of unjust enrichment because it would leave McCutchen "with less than full payment for emergency medical bills."[5] The court of appeals believed that full reimbursement would amount to "a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery."[6] The Third Circuit then remanded the case to the district court for a determination of what would constitute appropriate equitable relief in this case.

After the Third Circuit's decision, U.S. Airways filed a petition for certiorari, which the United States Supreme Court granted on June 25, 2012. In its merit brief, U.S. Airways challenges the Third Circuit's decision on textual, common-law and policy grounds. Specifically, U.S. Airways argues that the Third Circuit's holding is incompatible with the plain language of Section 502(a)(3) of ERISA, which it argues, authorizes equitable relief only to "enforce the terms of the plan."[7] U.S. Airways also contends that the Third Circuit's rule would "reduce the reimbursements on which self-funded plans rely to remain solvent and thus would discourage employers from offering benefits in the first place."[8]

In response, McCutchen argues that the plan's claim under Section 502(a)(3) must be decided in accordance with the common-law doctrine of subrogation, which refers to the right of an insurer to recover payments from the insured of a third party. McCutchen and his attorneys argue that under common law, an insurer's subrogation right was always limited by the principle of unjust enrichment and the common fund doctrine – the obligation to contribute to the attorney's fees and costs incurred in securing a benefit.[9] McCutchen also disagrees with the plan's policy argument, stating that reimbursement amounts have little actual effect on plan coverage.[10]

The Supreme Court is expected to issue its decision sometime in June. For further information about this case, please contact our office.

[1] *U.S. Airways, Inc. v. McCutchen*, 2010 U.S Dist. LEXIS 89377 (W.D. Pa. Aug. 30, 2010).
[2] *U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3rd Cir. 2011).
[3] *Id.* at 676.
[4] The Third Circuit's opinion conflicts with previous opinions from the Fifth, Seventh, Eighth, Eleventh and D.C. Circuits.
[5] *Id.* at 679.
[6] *Id.*
[7] Brief of Petitioner at 17-24, *U.S. Airways, Inc. v. McCutchen*, No. 11-1285 (Aug. 29, 2012).
[8] *Id.* at 16.
[9] Brief of Respondent at 11, *U.S. Airways, Inc. v. McCutchen*, No. 11-1285 (Oct. 18, 2012).
[10] *Id.* at 12-13.

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One Gap in ACA Closed: HHS Releases Proposed Regulation on the Premium Stabilization Rule

While the Patient Protection and Affordable Care Act (ACA) was awaiting passage into law, there was a growing concern among Congress that its changes to insurance underwriting practices, especially as they apply in the individual and small group markets, had the potential to destabilize these markets. Accordingly, ACA attempted to address these concerns by directing the Department of Health and Human Services (HHS) to develop a series of "premium stabilization" programs. One of these programs is called the transitional reinsurance program. Specifically, each state is required to establish a transitional reinsurance program to help stabilize premiums for coverage in connection with its health care Exchange program. Reinsurance fees are fees imposed on both self-insured and insured group health plans which are distributed to insurers selling coverage on the state health care Exchanges to offset the cost of covering individuals with high claims.

On March 23, 2012, HHS published a final rule called the Premium Stabilization Rule, which implemented several standards for health insurance issuers and third party administrators of self-insured group health plans. The Premium Stabilization Rule focused on issues of reinsurance, risk corridors and risk adjustment pursuant to Title I of ACA. Under this rule, HHS would collect new fees from health insurance issuers and from third party administrators (TPAs) on behalf of their clients that are self-insured plans from the years 2014-2016. However, after this rule was published, various questions were raised in connection with this rule, including whether self-administered, self-insured group health plans must pay a reinsurance fee, or if the fee is only applicable to self-insured plans that use a TPA.

On December 7, 2012, HHS released a proposed regulation revising the Premium Stabilization Rule that sheds some light on several questions of interest to multiemployer insured and self-insured group health plans.

Most significantly, the modified rule specifically requires self-insured, self-administered group health plans to make reinsurance contributions. This requirement also includes self-insured, self-administered multiemployer health plans. Typically, for an insured plan, the health insurance issuer pays this fee. However, for a self-insured plan, the plan is responsible for the reinsurance fee instead of the plan sponsor. This means the plan itself can pay the fee from plan assets, unlike the "effectiveness fee," under the Patient Covered Outcomes Research Trust Fund Rule, which must be paid by the plan sponsor.[1] It is also important to note that the U.S. Department of Labor (DOL) has approved the proposed rule. The rule explicitly states that the DOL has reviewed the proposed rule and advised that paying the required reinsurance contributions would constitute a permissible expense of the plan for purposes of ERISA because the payment is required by the plan under the ACA.

Contribution Rate for Reinsurance Fees

The rule also includes an estimate of the reinsurance contribution rate per participant for 2014. In 2014, the total reinsurance contributions are anticipated to be $12.02 billion dollars. Using this anticipated number, HHS estimates that the 2014 contribution rate would be $5.25 per person per month ($63/year) and then the amount would decrease in succeeding years.

Procedure for the Submission of Reinsurance Fees

The proposed rule also describes the procedure by which the reinsurance fees must be submitted. It states that a contributing entity must first submit an annual enrollment to HHS no later than November 15 of benefit year 2014, 2015, and 2016. The annual enrollment count should be the average number of covered lives of reinsurance contribution enrollees for each benefit year.[2] HHS proposes several methods that a self-insured group health plan may utilize to determine the average number of covered lives: (1) Actual Count Method; (2) Snapshot Count Method; (3) Snapshot Factor Method; and (4) Form 5500 Method.

Under the Actual Count Method, the number of covered lives is determined by taking the sum of the number of lives covered under the plan for each day of the first nine months of the benefit year and then dividing that total by the number of days in those nine months. For a calendar year plan, this would include the months of January through September.[3]

Under the Snapshot Count Method, the number of covered lives is determined by totaling the number of lives covered under the plan on one date during each of the first three quarters of the benefit year and then dividing that sum by three.[4]

Under the Snapshot Factor Method, the number of covered lives is determined by adding the total number of lives covered on any date (or multiple dates if an equal number of dates are used for each quarter) in each of the first three quarters of the benefit year. The number of lives covered is calculated by adding the number of participants with self-only coverage on that date; and the number of participants with coverage other than self-only coverage on that date multiplied by a factor of 2.35.[5]

Under the Form 5500 Method, a contributing entity may also rely on the Form 5500 enrollment data, despite the fact that this data may reflect enrollment in a previous benefit year. For a plan that offers self-only coverage, the number of lives is determined by adding the total number of participants covered at the beginning and end of the benefit year, as reported on the Form 5500, and dividing by two.

Once the contributing entity calculates and submits the average number of covered lives of reinsurance contribution enrollees for each benefit year, HHS will notify each contributing entity of the reinsurance contribution rates to be paid based on that annual enrollment count. The contributing entity must submit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year. It is also important to note that for participants with both Medicare coverage and employer-provided group health coverage, the reinsurance fee is required only if the employer coverage is the primary payer of medical expenses under the Medicare Secondary Payer rules.

It is necessary for Plan administrators and fiduciaries to fully understand this rule and its procedures. For more information, please contact our office.

[1]Ewing, Mike. TFBC, LLC. *Client Bulletin: HHS Publishes Proposed Regulations on Reinsurance Fee, Self-Insured, Self-Administered Health Plans Included*. (December 11, 2012).
[2]*Id.* at 2.
[3]Kayi, Katuri. *HHS Issues Transitional Reinsurance Fee Guidance*, TruckerHuss.com. (December 2012).
[4]*Id.*

Erroneous Benefit Statements Provided by a Previous Plan Administrator Does Not Necessarily Create Liability for a Plan, says Minnesota District Court

In *Ronald Kendall v. Twin Cities Iron Workers Pension Plan, Board of Trustees of the Twin City Iron Workers Pension Plan*, the United States District Court for the District of Minnesota granted the Defendants' motion for summary judgment, thereby dismissing the Plaintiff's claim alleging a denial of benefits under ERISA.[1] This holding affirmed the Board of Trustees discretion with regard to benefit determinations, despite erroneous reporting statements provided to the participant by a prior plan administrator. Although favorable to the Plan, this case signifies a growing trend in litigation surrounding benefit miscalculations and inaccurate benefit statements.

In *Kendall*, Mr. Kendall worked as an ironworker from 1976 until his retirement in 2009. Mr. Kendall was also a participant, first under the Local 793 Pension Plan, and then under the TWIC Plan, after a merger in 2005. Until 2005, he received monthly statements from the third party administrator for the Local 793 Pension Plan, outlining his "reported hours," which were calculated based on an assumed contribution rate. In 2006, the TWIC Plan administrator prepared an accrued pension benefits estimate inconsistent with the "reported hours" statements provided before 2005; thereby revealing the statements before 2005 were incorrect. Upon retirement in 2009, Mr. Kendall applied for pension benefits. The actual benefits Mr. Kendall received reflected the 2006 estimate and the actual number of hours worked. Nevertheless, Mr. Kendall alleged he was entitled to a larger pension benefit, as reflected in the statements received through 2005. The Trustees denied these benefits and denied his appeal. Consequently, Mr. Kendall filed a lawsuit against the TWIC Plan and the TWIC Board of Trustees for a denial of benefits under ERISA.

In its holding, the district court pointed out that both parties agreed that the statements provided to Mr. Kendall before 2005 reflect many more hours than those actually worked; Mr. Kendall was made aware of the actual number of hours worked in various statements provided throughout his employment. Additionally, the court held that the TWIC Plan's calculations were reasonable because the Plan language was clear, the Trustees' decision aligned with the Plan's goals, the Trustees' decision was reasonable under the *Hutchins* standard,[2] and finally, because the same calculations were consistently applied for other participants.

The court also noted that the "reported hours" statements provided by the Local 793 Plan included disclaimers stating the numbers were not confirmed; consequently, Mr. Kendall may not hold the TWIC Plan to these calculations. The court, therefore, concluded the TWIC Plan did not abuse their discretion when calculating Mr. Kendall's retirement benefits based on the actual number of hours worked.

Ultimately, the district court held that the TWIC Plan cannot be held to a previous administrator's erroneous reporting statements. The court also noted that the Board of Trustees bears the ultimate decision making authority with respect to benefit calculations and therefore, has discretion in order to carry out the goals of the Plan. The court thereby granted the Plan's motion to dismiss the case.

As evident in this case, inaccurate benefit estimates and discrepancies in statements are a matter of growing concern. Multiemployer plans should be aware that although case law is currently in their favor, this issue is growing momentum. Therefore, it is beneficial to ensure plan language regarding retirement and pension benefits is clearly drafted and consistent benefit calculations are applied for all participants. It is also helpful to include disclaimers in participant statements that clarify the calculations provided are estimates, not confirmed by the Plan.[3]

[1] *Ronald Kendall v. Twin Cities Iron Workers Pension Plan, Board of Trustees of the Twin City Iron Workers Pension Plan*, 10-CV-3140, U.S. District Court, District of Minnesota (2012).
[2] The *Hutchins v. Champio Int'l Corp.* Court found under an abuse of discretion standard, it may only invalidate the Trustee's decision if it is unreasonable. "An interpretation is reasonable if a reasonable person could have reached a similar decision, given the evidence before him.
[3] The district court pointed out in *Kendall* that the disclaimers were beneficial to the Trustees' argument.

We encourage you to contact

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Governor Signs Controversial Mechanics Lien Bill into Law

In today's economy, construction projects that are foreclosed upon are sometimes sold for a fraction of their once-expected value.[1] The money from these sales is frequently insufficient to pay lenders and mechanics lien claimants in full. As a result, these parties regularly compete over what money remains from the sale. When deciding what parties get how much and when, priority is the answer. For nearly a year, the Illinois General Assembly debated a bill that decided whose claims have priority in foreclosure sales. On February 24, 2011, the Illinois General Assembly introduced House Bill 3636, a bill that intended to overturn an Illinois Supreme Court holding in *LaSalle Bank National Association v. Cypress Creek*.

In *Cypress,* the Illinois Supreme Court had to decide who has priority and to what assets that priority applies. In *Cypress,* the developer of a building borrowed about $8 million from its construction lender (i.e. bank) to buy land and build the project. When the developer defaulted, the bank was still owed more than $3 million. The developer also underpaid two contractors who each recorded mechanics liens against the project. The bank and the contractors then foreclosed on the project and the bank bought it at a sale for $1.3 million. Afterwards, the parties involved wanted to know how the $1.3 million should be split.

The court sided with the bank and said the money should be split into two bags: (1) the value of the project before any construction; and (2) the value that the construction added to the project.[2] With respect to the first bag, the court decided that the bank would receive first priority because it recorded its mortgage before either contractor ever had a contract for the project. For the second bag, the court decided that the bank and the contractor would receive their proportion of the value they each added to the project. The bank's position on the second bag is determined by its loan proceeds which went to pay others who provided labor and materials that added value to the project.[3] This case has been dubbed the "death of the mechanics lien" because it essentially gave construction lenders (i.e. banks) the same priority position as contractors with mechanics liens when it comes to money in the second bag – or money representing the value that the construction added to the project, and probably, the price paid at the foreclosure sale.[4] After *Cypress*, many contractors, subcontractors, and real estate developers in Illinois pronounced their objections.[5] Because of *Cypress*, banks now have priority of not just the value of the land, but also the value of all improvements on the land.

Soon after *Cypress* was decided, House Bill 3636 was filed in the General Assembly. Before *Cypress*, banks received the value of the land and mechanics lien claimants received the value of the improvements erected on the property – which made sense since mechanic lien claimants supplied the labor and materials. House Bill 3636 reversed *Cypress* and brought the Mechanics Lien Act back to its original intent. House Bill 3636 provided that the lien of the first mortgage holder shall not be preferred to the value of any subsequent improvements on the property.

House Bill 3636 was drafted to reverse the effects of *Cypress*; however, rigorous debate in the General Assembly between those representing the interest of contractors and those representing the interests of bankers stalled the passage of the Bill until very recently. Finally, both the Illinois House of Representatives and the state Senate passed the Bill and on February 11, 2013, Governor Quinn signed the Bill into law.

[1] Glazov, Joshua. *Construction Lenders Prevail in Controversial Illinois Mechanics Lien Priority Case*. News and Insights on MuchShelist.com. (July 19, 2011).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] Wolfe, Scott Jr. *Illinois Mechanics Lien Rises from the Dead; HB 3636 Approved to Amend Mechanical Lien Act,* The Lien Blog. (January 11, 2013).

Surviving an Audit Investigation of Your Apprenticeship and Training Fund

In the past several years, the U.S. Department of Labor (DOL)'s Employee Benefits Security Administration (EBSA) has made audits of apprenticeship and training funds a significant priority. Prior to this focus, enforcement efforts against apprenticeship and training funds have been largely ignored by EBSA, leaving fiduciaries in the dark about their ERISA obligations in the administration of these funds. It is important for fund administrators and trustees to know what to expect when an apprenticeship and training fund is audited by the EBSA.

Although apprenticeship and training programs are distinctive insofar as they are primarily established to provide vocational training to participants in the labor force, ERISA still requires that these types of funds be maintained with the same fiduciary standards as other types of funds.[1] Training plan fiduciaries are subject to and must abide by the general fiduciary standards in Part 4 of ERISA, including: (1) must be established pursuant to a written agreement; (2) the assets must be held in a trust by one or more trustees; (3) fiduciaries act with care, skill, and prudence; (4) fiduciaries must diversify the investments of the plan; (5) fiduciaries must act in accordance with the plan documents; (6) fiduciaries may not engage in non-exempt prohibited transactions; and (7) fiduciaries must discharge their duties solely in the interest of the plan's participants and beneficiaries, and for the exclusive purpose of providing apprenticeship or training benefits to participants.

The process of an EBSA audit of an apprenticeship and training fund is similar to that of a pension or welfare fund. The first contact from EBSA will be through an audit letter which details a lengthy list of documents and policies that the EBSA investigator may want to inspect. The EBSA investigator has the right to examine any of the documents produced, and may require additional documents throughout the audit process. Not surprisingly, funds that have documents that are easily accessible

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Americans with Disabilities Act: Issues Affecting Apprenticeship Programs

A labor organization or joint labor management committee is included in the definition of a Covered Entity for purposes of the Americans with Disabilities Act ("ADA").[1] Typically, ADA issues affect apprenticeship programs when a qualified individual with a disability applies for admission into the program. For this reason, it is important for the program to understand its legal obligations under the ADA.

To begin with, most, if not all apprenticeship programs, have written physical requirements for apprentice applicants. However, these qualification standards cannot be used to screen out an individual with a disability, or a group of individuals with a disability, unless the standard or criteria is shown by the program to be job-related and consistent with business necessity.[2] Simply put, an individual with a disability cannot be automatically excluded from a job opportunity unless he/she is actually unable to do the job.[3] If an applicant cannot meet a specific qualification standard because of a disability, the ADA requires the program to demonstrate the importance of the standard by showing that it is job-related and consistent with business necessity. This standard is generally referred to as the essential functions of the job, or the fundamental job duties of the position.[4] The question then becomes whether the disabled applicant is able to perform the essential functions of the job, with or without a reasonable accommodation from the program.

The ADA requires apprenticeship programs to provide reasonable accommodations to qualified individuals with disabilities, unless to do so would cause an undue hardship to the program. A reasonable accommodation may be some modification or adjustment to an application process or to the educational environment itself, which would enable an individual with a disability to enjoy the same benefits and privileges as those enjoyed by similar individuals without disabilities.[5] To determine the appropriate reasonable accommodation, or whether one is required at all, it is usually necessary for the program to initiate an informal interactive process with the disabled candidate. This process should identify the precise limitations resulting from the disability and potential reasonable accommodations that could help the candidate overcome those limitations.[6]

Absent some undue hardship, an apprenticeship program has a legal obligation to provide a reasonable accommodation to a qualified individual with a disability. For this reason, training programs should consult with counsel when these issues arise.

[1] 29 C.F.R. § 1630.2(b).
[2] 42 U.S.C. §§ 12112(b)(6) and 1211(a); 29 C.F.R. § 1630.10.
[3] *See* 29 C.F.R. § 1630.10.
[4] It should be noted that the EEOC and courts analyze several factors to determine the essential functions of a particular job. Marginal functions are not included in what is to be considered essential to the job.
[5] 29 C.F.R. § 1630.2(o)(1).

Amending a Multiemployer Plan is Not a Fiduciary Act, says Second Circuit

In *Janese v. Fay*,[1] the Second Circuit held that multiemployer pension plan trustees did not breach fiduciary duties by adopting plan amendments that reduced future benefit accruals because adopting plan amendments is not a fiduciary action.

Participants and beneficiaries of the Niagara-Genesee & Vicinity Carpenters Local 280 Pension and Welfare Funds (collectively the "Funds") brought a lawsuit in federal district court against present and former trustees and managers (the "defendants") of the Funds. The participants and beneficiaries alleged in their complaint that the defendants depleted the assets of the Funds by passing amendments designed to manipulate pension calculations in order to grant higher payouts to certain trustees and the manager of the Funds.[2] The participants also alleged in their complaint that some of the trustees failed to monitor the conduct of their co-fiduciaries, thereby allowing the adoption of the improper amendments.[3]

In response, the defendants argued that the claims specifically challenging plan amendments should be dismissed because amending the plan documents was not an exercise of fiduciary duty actionable under the Employment Retirement Income Security Act ("ERISA").[4]

The federal district court rejected the defendants' argument, holding that amending a multiemployer plan was a fiduciary action.[5] Following the district court's ruling, both parties appealed to the Second Circuit Court of Appeals.

On appeal, the Second Circuit noted that in prior cases involving multiemployer pension plans, it held that the act of amending a plan should be treated as a fiduciary function, which obliges a fiduciary to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."[6] However, the Second Circuit also noted that since the time of its prior decisions, the United States Supreme Court issued a number of rulings concerning the distinction between settlor and fiduciary functions in the single-employer setting. Specifically, the Second Circuit acknowledged that in *Curtiss-Wright Corp. v. Schoonejongen*,[7] the Supreme Court held that employers and plan settlors are "generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."[8] The Second Circuit also noted that the Supreme Court's decision in *Lockheed Corp. v. Spink*[9] extended the ruling of *Curtiss-Wright* to include pension plans. In *Lockheed*, the Supreme Court held that "plan sponsors who alter the terms of a plan do not fall into the category of fiduciaries."[10]

Even though the Supreme Court's opinions in *Curtiss-Wright* and *Lockheed* all involved single-employer plans, the Second Circuit held that the Supreme Court's language analyzing fiduciary duties under ERISA was equally applicable to multiemployer plans. Accordingly, the Second Circuit vacated the district court's ruling and held that amending a benefit plan was not a fiduciary function and that nothing in the Supreme Court's decisions could be interpreted to create an exemption for multiemployer plans.[11]

[1] *Janese v. Fay*, 692 F.3d 221 (2d Cir. 2012).
[2] *Id.* at 224.
[3] *Id.*
[4] The defendants also argued that the alleged wrongful conduct occurred outside the six-year limitations period for breaches of fiduciary duty under ERISA.
[5] *Id.* at 476-77.
[6] 692 F.3d at 225.
[7] 514 U.S. 73 (1995).
[8] *Id.* at 78.
[9] 517 U.S. 881 (1996).
[10] *Id.* at 890.
[11] 692 F.3d at 227.

ACA Update – Women's Preventive Services

The Patient Protection and Affordable Care Act (PPACA)[1], the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010, contains extensive new benefit plan mandates for self-insured plans, including coverage of certain preventive care services for women. Preventive care focuses on disease prevention and health maintenance, including early diagnosis of disease, identification of those at risk of developing specific health problems, counseling, and other necessary interventions to avert potential health problems.

As of January 1, 2013, non-grandfathered Health Plans, as defined under the PPACA[2], are required to cover twenty-two new recommended women's preventive services published by the U.S. Preventive Services Task Force (USPSTF). These new services must be provided at 100%, without cost-sharing, when delivered by an in-network provider.

Accordingly, the new required recommended services are as follows:

- **Anemia** screening on a routine basis for pregnant women;
- **Bacteriuria** urinary tract or other infection screening for pregnant women;
- **BRCA** counseling about genetic testing for women at higher risk;
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40;
- **Breast Cancer Chemoprevention** counseling for women at higher risk;
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- **Cervical Cancer** screening for sexually active women;
- **Chlamydia Infection** screening for younger women and other women at higher risk;
- **Contraception** including Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, but not including abortifacient drugs;
- **Domestic and interpersonal violence** screening and counseling for all women;
- **Folic Acid** supplements for women who may become pregnant;
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- **Gonorrhea** screening for all women at higher risk;
- **Hepatitis B** screening for pregnant women at their first prenatal visit;
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women;
- **Human Papillomavirus (HPV) DNA Test** including high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
- **Osteoporosis** screening for women over age 60 depending on risk factors;
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk;
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- **Sexually Transmitted Infections (STI)** counseling for sexually active women;
- **Syphilis** screening for all pregnant women or other women at increased risk;
- **Well-woman visits** to obtain recommended preventive services.

It is important to keep in mind that plans have some discretion and flexibility with regard to coverage. Plans are not required to cover these services if delivered by out-of-network providers.[3] Additionally, plans have discretion regarding reasonable medical management to determine the frequency, method, treatment or setting for an item or service, if not already specified in the recommendations or guidelines.[4] If a preventive service is not recommended or provided for by the guidelines, the Plan may still cover it and allow member cost sharing.[5]

Please contact our office for further details regarding these preventive services.

[1] 29 CFR 2590.715-2713
[2] 29 CFR 2590.715-1251
[3] 29 CFR 2590.715-2713
[4] 29 CFR 2590.715-2713
[5] 29 CFR 2590.715-2713

The Sunset of the Pension Protection Act

The Pension Protection Act of 2006 (PPA) provides comprehensive reform aimed at protecting the funding status of multiemployer plans. The purpose of the PPA is to help protect participants of pension and retirement plans, while encouraging savings. However, the PPA's funding rules will sunset[1] as of the first plan year after December 31, 2014, unless legislative action is taken. Currently, there is no other pension reform legislation in the works to replace the PPA or to extend the current laws.

For calendar year multiemployer plans, the PPA sunsets on January 1, 2015. Accordingly, 2014, is the last year a calendar year plan must determine what funding zone it is categorized as. The PPA designates three funding zones for the status of a multiemployer pension plan: (1) "Green Zone" for healthy; (2) "Yellow Zone" for endangered; and (3) "Red Zone" for critical. There is, however, one exception to this rule. If the multiemployer pension plan was certified as either "endangered" or "critical" for the 2014 plan year, the pension plan must continue to operate under its funding improvement plan or rehabilitation plan until the end of the designated period.

In addition to the sunset of funding rules for plans in "endangered" or "critical" status, other rules that are expiring include: penalties for failure to serve timely actuarial certifications, and notice requirements to participants, bargaining parties, PBGC and the IRS.

Please keep in mind that certain provisions will not expire, including: the shortening of amortization periods to a maximum of fifteen years or less for short term benefits; expanded notice requirements and access for participants and contributing employers; withdrawal liability reforms; special solvency testing for Plans in Reorganization; and protection against retaliation for the exercise of rights under ERISA.

The purpose of this sunset is to examine the effects of the PPA on multiemployer plans and small employers participating in multiemployer plans in order to implement new pension legislation. Ultimately, the goal is to improve the funded status of all pension plans. In order to examine the PPA's effectiveness, the PPA requires that in addition to the sunset provisions, the U.S. Department of Labor, Department of the Treasury, and the Pension Benefit Guaranty Corporation (PBGC) conduct a study regarding the effects of the PPA on the operation and funding status of multiemployer plans. According to the PPA, the report must propose legislative recommendations to Congress by December 31, 2011, so that new legislation may be drafted before or soon after the sunset of the PPA. Because this deadline was not met, Congress, on October 19, 2012, requested that these reports be provided immediately. However, no study has been issued and no legislative action has been taken to extend the PPA rules, establish the PPA as permanent law, or to create new provisions to take the place of the existing rules.

Accordingly, absent legislative action, multiemployer plans should be prepared for the sunset of the PPA at the end of 2014. For more information regarding the PPA, please contact our office.

[1]A Sunset provision provides that the law shall cease to have effect after a specific date, unless further legislative action is taken to extend the law.

Surviving an Audit Investigation of Your Apprenticeship and Training Fund (cont. from page 4)

and current policies that are in place will find the process of undergoing an audit less burdensome. Policies for the investment of plan assets, travel and conference reimbursement guidelines, and collection procedures should be updated or adopted if not already done.[2] No matter the precise focus of the investigator, each investigator will always require the production of basic fund documents including, but not limited to, the Trust Agreements, IRS tax-exempt status forms for Form 5500's, trustee meetings minutes, and financial records.

After the initial audit letter and production of requested documents, the investigation continues to an interview of a fund representative who has knowledge of the various operations of the fund. This representative, generally the director of training, is asked questions designed to determine whether the fund is operating in accordance with the law and written plan documents. This is also the time when the investigator has the opportunity to ask the fund representative questions regarding specific expenditures revealed in the fund's financial documents.

Last April 2012, the DOL issued a bulletin, highlighting possible prohibited transactions amongst apprenticeship and training funds. These transactions include graduation expenses and advertising and marketing expenses. It is critical that fiduciaries remember that all fund expenditures are governed by the exclusive purpose rule, which mandates that expenditures shall be made for the exclusive purpose of participants and beneficiaries.

In conclusion, some of the many purposes of an EBSA audit are to examine financial controls and to ensure compliance with fund policies and ERISA regulations. Apprenticeship and training fund plan administrators must understand their duties, as well as review their policies and procedures, to ensure that they are meeting their fiduciary responsibilities.

[1]Thayer, Gary and James W. Versocki, *Yes, An Apprenticeship Fund is an ERISA Fund*, Benefits Magazine, p. 28 October 2012.

[2]*Id.* at 30.

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Sole Proprietors Not Required to Contribute to Multiemployer Pension Fund, says Court

Recently, a District Court located in the Sixth Circuit ruled that the co-owners of a sole proprietorship that employs no workers are not obligated to contribute to a multiemployer employee benefit fund providing pension benefits to employees covered by a collective bargaining agreement ("CBA"). [1]

The two defendants are co-owners of a sole proprietorship located in Michigan. The co-owners executed a CBA which obligated the sole proprietorship to make fringe benefit contributions to several multiemployer employee benefit funds providing pension, health, and welfare benefits to covered employees. During the course of 8 years, the sole proprietorship did not employ any other full-time or temporary workers; instead, all work conducted by the sole proprietorship was performed by the two co-owners. A payroll compliance audit of the sole proprietorship revealed significant deficiencies to the funds. The co-owners disputed their obligation to make employee fringe benefit contributions to the funds because they had no employees during the audit years. The trustees of the funds filed a lawsuit to collect the unpaid contributions.[2]

In the lawsuit, the trustees argued that the sole-proprietorship was actually a partnership and that the CBA treated partners as employees if they worked with tools. The CBA required fringe benefit contributions for every hour of work performed by an employee; however, the court said that the CBA did not define the term "employee."[3]

In its analysis, the court relied on a U.S. Supreme Court decision that held "the term 'employee' means any individual employed by an employer" and that "a working owner may have dual status" as an "employee" and "employer" under ERISA. The co-owners argued that they were not employees or participants of any ERISA plans under ERISA rules; however, the court dismissed this argument because the regulations referenced were limited to deciding what plans qualified as ERISA employee benefit plans and did not define who was an employee or participant under ERISA.[4]

The Court then decided that the co-owners could be considered both "employees" and "owners." In order to remedy this distinction, the Court inspected the CBA to discover whether the co-owners were required to make contributions to the funds. After examining the CBA, the court decided that the co-owners fell into one of the CBA's exceptions in terms of the individual funds. The Court studied the pension fund terms and ruled that the fund limited participation by excluding "sole proprietors" from its definition of "employees." Specifically, the CBA "expressly prohibited an employer who is a sole proprietorship from making contributions to the Pension Plan."[5] The Court granted summary judgment in favor of the defendants and stated that there was no evidence supporting the trustees' argument that the sole proprietorship was actually a partnership and concluded that it did not owe contributions to the pension fund. However, the Court did not hold the same for the health and welfare funds because copies of the plan documents had not been presented to the court. Although this court's decision is a narrow holding, it is demonstrative of the importance of understanding the specific terms of each plan document. As confirmed by this case, sometimes the wording of plan document definitions, such as who qualifies as an "employee," can be the difference between a successful and unsuccessful collection lawsuit.

[1] *Trustees of the Bricklayers Pension Trust Fund-Metropolitan Area v. LaPointe,* E.D. Mich., 2:12-CV-11455-PJD-RSW, 12/19/12).
[2] *Id.*
[3] *Court Finds Sole Proprietorships Not Required to Contribute to Multiemployer Pension Fund*, Bloomberg BNA Pension and Benefits Report; 40 BPR 25.
[4] *Id.*
[5] *Id.*