ERISA Update

PENSION & EMPLOYEE BENEFITS ISSUES

A periodic review of the latest legal developments affecting employee benefits, of interest to clients, union officials, fund administrators, trustees and attorneys.

Spring 2002

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U.S. SUPREME COURT SAYS ERISA DOESN'T AUTHORIZE REPAYMENT LAWSUIT IN SUBROGATION CASE

By: Monica R. Heath, Esq.

When a Plan's participant or a family member is injured in some way which will give rise to a personal injury action, a subrogation issue arises for self-funded Health and Welfare Plans since, almost without exception, participants turn to these Funds to pay their medical

expenses in the same way that they would for any other injury. The purpose of third party liability and subrogation provisions in self-funded Plans is to assist the Plans' participants in meeting their present medical expenses resulting from the injury while shifting the ultimate liability for payment of these medi-

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HIPAA's ELECTRONIC TRANSACTION STANDARDS COMPLIANCE DRAWS NEAR

By: Michael S. Travinski, Esq.

When the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") was enacted, it included "Administrative Simplification" provisions. HIPAA's Administrative Simplification requires the Department of Health and Human Services ("HHS") to adopt national standards for covered entities in their electronic health care transactions. The goal of the standards is to make health care claims processing more efficient. Health plans (including both funded and self-insured multi-employer plans), health care providers, and health care clearinghouses are covered entities that must comply with the standards. A health plan's business associates, such as a third-party administrator, must also be in compliance.

The first set of standards that HHS issued under Administrative Simplification was the Electronic Transaction Standards, commonly referred to as the Electronic Data Interchange Standards, or "EDI". Covered entities must comply with the Electronic Transaction Standards by October 16, 2002. There are two exceptions to this deadline, however. First, covered entities may obtain a one-year

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ERISA DOESN'T AUTHORIZE REPAYMENT LAWSUIT IN SUBROGATION CASE

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cal expenses to the responsible party through litigation. Recoupment opportunities arise for plan fiduciaries when a covered person makes a recovery for the same injuries from that third party. However, on January 8, 2002, in Great-West Annuity & Life Insurance v. Knudson, 122 S. Ct. 708, the United States Supreme Court significantly limited plans' ability to recoup these benefits in federal court.

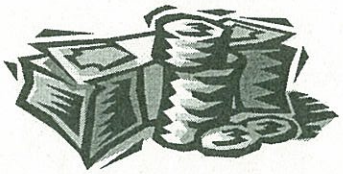
In Knudson, Janette Knudson, the plan beneficiary, was rendered a quadriplegic in a car accident. At that time, she was covered by her husband's employee benefit plan. Under the terms of the plan, the plan had the right to recover from the beneficiary any benefits paid by the plan that she was entitled to recover from a third party. The plan paid all but $75,000 toward Mrs. Knudson's covered medical expenses of $411,157. Mrs. Knudson sued the car manufacturer in state court and recovered $650,000. Of that amount, only $13,839 was allocated to medical expenses to reimburse the plan. The plan then filed suit against the Knudsons under ERISA in federal court seeking reimbursement of the entire amount it had paid for Mrs. Knudson's medical expenses.

In a 5-4 opinion written by Justice Scalia, the Supreme Court ruled against the plan, holding that reimbursement from payments made to a beneficiary by a third party is not the equitable relief authorized by ERISA. The Supreme Court said that ERISA does not give a health plan the right to sue a beneficiary for reimbursement after she receives tort damages from the third party responsible for her injuries.

The complete impact of Knudson is, as yet, uncertain. ERISA plans will now have to look more closely at recouping benefits in the state court where the plan beneficiary brings the tort action. Justice Scalia also left open the possibility that plans can bring restitution claims in federal court against any constructive trust or attorney holding the beneficiary's funds if the beneficiary no longer has the proceeds of the lawsuit.

Knudson has already been distinguished by a federal case in the Northern District of Illinois in a decision dated January 14, 2002, Wal-Mart Stores Inc. Associated Health and Welfare Plan v. Varco. In Wal-Mart, the Judge found that Wal-Mart's reimbursement action was, unlike the one in Knudson, for "appropriate equitable relief under ERISA". The Wal-Mart Health Plan had sued the individuals who had possession of the settlement funds and had petitioned the District Court for a temporary restraining order and preliminary injunction pending the District Court's decision on its entitlement to reimbursement from the settlement proceeds.

The very least Knudson means for self-funded plans is that plan fiduciaries must assume a more active role in monitoring their pending subrogation claims and the associated court actions to allow the plans to exercise the maximum range of legal options available to enforce their recoupment provisions.



ROLLOVERS AND CASHOUTS CHANGES AHEAD

By: James C. Shake, Jr., Enrolled Actuary

Included in the benefit plan changes of the 2001 Tax Act are provisions that make it potentially easier for employees to combine benefits, earned under various retirement plans over a career, into one convenient location. The changes also make it somewhat more difficult for former employees to squander retirement plan distributions prior to retirement.

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HIPAA's ELECTRONIC TRANSACTION STANDARDS COMPLIANCE DRAWS NEAR

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extension if they submit a compliance plan to HHS by October 16, 2002. Second, small health plans (health plans with annual receipts of five million dollars or less) have three years to comply and thus they must be in compliance by October 16, 2003.

Electronic Data Interchange occurs when health care information is transmitted electronically between health care providers and health plans as part of a standard transaction. Under the EDI Standards, health plans are required to accept and process certain standard health care transactions from health care providers electronically. In doing so, health plans are required to use standard electronic codes for each of the eight standard transactions. The electronic codes, in effect, enable health care providers' and health plans' computer systems to effectively communicate with one another. If a health plan performs any one of these eight standard transactions, whether electronically, on paper, or over the phone, then it must be able to support the standard electronic code for that particular transaction: claims; enrollment; eligibility; payment and remittance advice; premium payments; claim status; referral certification and authorization; and coordination of benefits. In addition to the EDI Standards, health plan computer systems must also be able to recognize standard transactions that use Standard Medical Code Sets, which identify a particular diagnosis, procedure and/or treatment. As an alternative to changing existing computer systems to comply with the standards, health plans are permitted to use a health care clearinghouse. A health care clearinghouse is an organization that receives non-standard electronic data codes, and then converts and transmits the data into the required standard code (and vice-versa).

As the compliance date for the EDI Standards and the Medical Code Sets Standards is drawing closer, self-administered health plan administrators should make a decision whether to make changes to existing computer systems or contract with a health care clearinghouse to meet the standards. Administrators of large plans should also determine if they need more time to comply with the standards. If so, they may take advantage of the one-year extension by filing a compliance plan with HHS by October 16, 2002. It is expected that HHS will develop a model compliance plan by the end of March 2002. Plans that use a third-party for administration should take affirmative action as well. Plan administrators of those plans should verify well in advance of the applicable compliance date that its third-party administrator is equipped for compliance.

Penalties for non-compliance are substantial. If not in compliance by the applicable compliance date, health plans are subject to a one hundred dollar fine, per violation, with a maximum of twenty-five thousand dollars, per violation in a calendar year.

ROLLOVERS AND CASHOUTS CHANGES AHEAD

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The new law allows distributions from most retirement plans to be rolled over to most other types of retirement plans, beginning after December 31, 2001. For example, a distribution from a tax-sheltered annuity retirement plan may now be rolled over to any qualified retirement plan, rather than only to an Individual Retirement Account (IRA). There are still limitations on transferring distributions from certain types of retirement plans of tax-exempt employers.

Surviving spouses who are beneficiaries of a retirement plan account may also rollover distributions to their own employer's plan, rather than only to an IRA, provided the Plan accepts rollover contributions. Plans that wish to

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ROLLOVERS AND CASHOUTS - CHANGES AHEAD

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accept these rollover contributions will need to be amended to permit receipt of rollovers from the expanded list of allowable plans.

In connection with these new rollover requirements, revised tax notices are required to be given to former participants by plans making these distributions. The IRS has published an updated safe-harbor rollover notice that meets the new requirements.

Another new tax law provision requires that any Plan's mandatory cash-out distribution of $1,000 or more must be automatically transferred to an IRA account for the participant, unless the participant formally elects otherwise. However, this requirement will not become effective until after the IRS issues final regulations. This will make it harder for former participants to spend distributions for reasons other than retirement.

These changes will affect all retirement plans and you will need to be aware of them in order to help your Plan participants.

MENTAL HEALTH PARITY ACT EXTENDED

By: Denise E. Grey, Esq.

The Mental Health Parity Act ("MHPA") has recently been extended to December 31, 2002. The MHPA's original text included a sunset provision specifying that the MHPA's provisions would not apply to health benefits or services furnished on or after September 30, 2001. The amendment to the MHPA effectively extends the sunset provision date fifteen months.

The MHPA was originally signed into law on September 26, 1996. The law requires that dollar limitations made on lifetime mental health benefits and annual dollar limitations for mental health benefits must be equal to medical or surgical plan maximums. Under the MHPA, Group Health Plans, Insurance Companies and HMOs offering mental health benefits are no longer allowed to set annual or lifetime dollar limits on mental health benefits that are lower than the dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose a dollar limit on mental health benefits offered under the plan.

The MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency. In addition, health plans are not required to include mental health benefits in their benefit package. The requirements under MHPA apply only to those plans offering mental health benefits. Health plans are still able to set certain terms and conditions (such as co-pays and office visit maximums) which limit the amount, duration and scope of mental health benefits.

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