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BENEFITS BRIEF

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Recent DOL Actions Address Impermissible Wellness Programs As Well As Fiduciary Status of Changed Out of Network Provider Payment Methodologies

The Department of Labor ("DOL") filed a complaint against Macy's, Anthem, and Cigna, alleging that Macy's began using a different provider reimbursement rate for out-of-network charges with respect to the Macy's, Inc. Welfare Benefits Plan ("Health Plan") without updating the out-of-network provider reimbursement methodology outlined in the Health Plan's summary plan description ("SPD") and that the tobacco surcharge Macy's assessed under its wellness program did not comply with the Health Insurance Portability and Accountability Act of 1996's ("HIPAA") wellness rules because it did not allow or disclose the availability of a "reasonable alternative standard" for obtaining the reward. *Acosta v. Macy's, Inc. et al.,* S.D. Ohio, No. 1:17-cv-00541, *complaint filed* 8/16/17, *amended complaint filed* 8/29/17. The DOL claims that the failure to outline the correct out-of-network provider reimbursement methodology in the plan document constituted a breach of fiduciary duty by Macy's as plan administrator, and also by Anthem and Cigna, the third party administrators ("TPAs") of the self-funded Health Plan. The DOL further claims that the wellness program's failure to offer a reasonable alternative standard, and disclose the availability of such standard, was a breach of fiduciary duty, a prohibited transaction, and a violation of the HIPAA wellness rules.

The wellness program allegations are significant in that, while the DOL has raised wellness issues in informal inquiries and audits, this is the first time the DOL has filed a lawsuit alleging that an ERISA plan did not comply with the HIPAA wellness rules. In 2014, the Equal Employment Opportunity Commission ("EEOC") brought court actions against three employers alleging that their wellness programs violated the Americans with Disabilities Act's prohibition against involuntary medical examinations with mixed results – two cases were dismissed and one was resolved with a $100,000 settlement.[1] The DOL has been specifically asking about wellness programs in its routine health plan audits, and this complaint provides insight into the DOL's focus on wellness programs.

The complaint is also significant in that it signals an active DOL enforcement posture under the new Trump Administration. The complaint follows a recent DOL complaint and

[1] *See* Complaint and Demand for Jury Trial, EEOC v. Orion Energy Systems, Inc., No. 1:14-cv-1019 (E.D. Wis. Aug. 20, 2014); Complaint and Demand for Jury Trial, EEOC v. Flambeau, Inc., No. 3:14-cv-00638 (W.D. Wis. Sept. 30, 2014); Motion for a Temporary Restraining Order and a Preliminary Injunction, EEOC v. Honeywell International Inc., No. 0:14-cv-04517 (D. Minn. Oct. 27, 2014). In *Honeywell*, the court dismissed the EEOC's suit to prevent Honeywell from penalizing workers for failure to participate in a corporate wellness program. In *Orion*, the EEOC's claims were resolved with a $100,000 settlement. In *Flambeau*, the Seventh Circuit upheld a district court's dismissal of the EEOC's challenged to Flambeau Inc.'s wellness program.

settlement against MagnaCare, a TPA of self-insured plans, for failing to disclose and obtain consent for its fees, and DOL just recent weighed in with an amicus brief in a case involving United HealthCare (*Peterson v. United HealthCare*), supporting a claim by plaintiffs that United's practice of overpayment recovery ("cross plan offsetting") violates ERISA.

Failure to Disclosure Changes to Out-of-Network Payment Methodology

According to the complaint, the Health Plan's SPD provided that the reimbursement of out-of-network claims would be based on the "maximum reimbursable charge," which was further defined as essentially the lesser of the provider's normal charge for a similar supply or service, or the amount determined by the claims administrator based on charges made by providers in the geographic area. Both Anthem and Cigna used a database created by a third party to determine the maximum reimbursable charge. Later, TPAs began using a multiple of the Medicare Allowable Rate, instead, as the basis for the maximum reimbursement charge, which is based on provider costs rather than provider charges. According to the complaint, Macy's did not amend its Health Plan document or SPD to reflect the change.

The DOL alleges that by failing to follow the Health Plan document, Macy's, Anthem, and Cigna failed to act solely in the interest of participants and for the exclusive purpose of providing benefits (ERISA § 404(a)(1)(A)) and failed to follow the plan's governing documents (ERISA § 404(a)(1)(D)). The DOL also alleges co-fiduciary liability against each of the TPAs and Macy's because, by failing to comply with ERISA § 404(a)(1) in the administration of their specific responsibilities, they enabled another fiduciary to commit a breach. The DOL asks the court to appoint an independent fiduciary, at the defendants' expense, in order to re-adjudicate all out-of-network claims that were processed during the period at issue.

Impermissible Wellness Program

With respect to the Macy's complaint, the DOL indicates that Macy's assessed a monthly surcharge that ranged from $35 to $45 since 2011 for tobacco users enrolled in the Health Plan. According to the DOL complaint, for plan year 2011, Macy's offered participants a one-time opportunity to avoid the tobacco surcharge by declaring their tobacco status, enrolling in a tobacco cessation program, and providing an affidavit indicating that all covered members had been tobacco free for six consecutive months. The complaint does not indicate whether the surcharge was waived retroactively to cover the period before the participant submitted the "tobacco-free" affidavit.

For plan year 2012, the wellness program imposed a surcharge on tobacco users unless they certified that were enrolled in a tobacco cessation program and had been tobacco-free for 6 months. Once a participant certified they were tobacco-free for 6 months, the surcharge was waived going forward, but no retroactive reimbursements were made. Starting in plan year 2013, the wellness program allowed participants to request a "reasonable alternative" way to avoid the surcharge where it was "medically inadvisable" for tobacco users to quit using tobacco. Again, the surcharge was not waived retroactively.

Starting in plan year 2014, the wellness program allowed a reasonable alternative for all tobacco users and waived the surcharge for those who certified they were tobacco-free or "working towards" being tobacco-free. The complaint does not indicate whether the surcharge was waived retroactively. Macy's deposited the tobacco surcharge funds into the Health Plan's trust and used the funds to pay medical claims and plan administrative expenses.

In its complaint, the DOL notes that HIPAA added section 702 to ERISA, which prohibits discrimination in health coverage based on a health factor, and that the nondiscrimination rules generally prohibit a plan or issuer from charging similarly situated individuals different premiums or contributions based on a health factor, but provide an exception allowing a plan or issuer to establish premium discounts or rebates or modifying otherwise applicable copayments for certain wellness programs. The Departments of Labor, Treasury, and Health and Human Services published final rules in December 2006, which were later updated in final rules published in June of 2013 (the "HIPAA Wellness Rules").[2]

Under the HIPAA Wellness Rules, a wellness program that provides a reward requiring an individual to satisfy a standard related to a health factor must provide a "reasonable alternative standard" for obtaining the reward for certain individuals and must disclose the availability of a reasonable alternative standard in all plan materials describing the terms of the program. In the 2006 regulations, the reasonable alternative only had to be provided to individuals for whom it was unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or for whom it was medically inadvisable to attempt to satisfy the otherwise applicable standard. The wellness program was permitted to require a doctor's note that the initial standard was medically inadvisable. The 2013 regulations (effective for plan years on or after 1/1/14) expanded the reasonable alternative requirement for tobacco and other health outcome-based programs so that the reasonable alternative had to be provided to anyone who failed to meet the initial health standard, regardless of medical reason. Under both sets of regulations, the reward had to be provided for completion of the reasonable alternative, even if the individual's health outcome did not improve (for example, even if the individual did not actually stop smoking).

The Preamble to the 2013 regulations also clarified that the wellness program must provide the "same full reward" to individuals who meet a reasonable alternative standard that they would have received if they had met the initial standard, so that plans may be required to pay a reward or reimburse a surcharge retroactively.

The DOL alleges that Macy's violated the HIPAA Wellness Rules because it did not (1) allow a "reasonable alternative standard" to avoid the surcharge, (2) provide notice of such "reasonable alternative standard," or (3) reimburse the surcharge retroactively for participants who completed a "reasonable alternative standard." The DOL claims that Macy's violation of the HIPAA Wellness Rules ultimately resulted in Macy's breaching ERISA's exclusive benefit rule and failing to discharge its duties in accordance with the documents and instruments governing the Health Plan.

What is particularly interesting about the DOL's complaint is the DOL's allegation that by reason of the above actions the Health Plan also engaged in various prohibited transactions, including the use of plan assets by a party in interest, dealing with plan assets in Macy's own interests, and acting on behalf of a party whose interests are adverse to the interests of the Health Plan and plan participants. In essence, DOL is saying that by "overcharging" certain employees it reduced its own obligations to fund the plan, an act of self-dealing according to DOL. The DOL goes on to make the much more straightforward claim that the Plan violated the nondiscrimination rules under section 702(b) of ERISA.

The DOL has asked the court to order Macy's to reimburse all participants who paid the tobacco surcharge from July 1, 2011 through the present, plus interest, and to revise any tobacco surcharge wellness program it intends to maintain to comply with the HIPAA Wellness Rules. The complaint also seeks to enjoin Macy's from collecting tobacco surcharges until it revises its wellness program to comply with the HIPAA Wellness Rules.

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[2] See our prior Benefits Brief, Agencies Issue Final HIPAA Wellness Program Rules under ACA, available at: http://www.groom.com/media/publication/1259_Agencies_Issue_Final_HIPAA_Wellness_Program_Rules_under_ACA_Final.pdf.

Key Takeaways for Plans and Third Party Administrators

Provider Reimbursement Allegations

The provider reimbursement allegations highlight the risks associated with creating or changing payment methodologies without consent or documentation. In the *Macy's* complaint, changing provider reimbursement methodology unilaterally was viewed as a potential fiduciary act. *To mitigate this risk, the plan sponsor should be careful to amend the plan before changing the reimbursement methodology, so that the plan administrator and TPAs are not exercising discretion over the plan.*

While not entirely analogous, the *Macy's* complaint builds on DOL's recent consent order with MagnaCare, a TPA of ancillary services. The DOL's complaint alleged that MagnaCare acted in a fiduciary capacity when it charged an undisclosed "Network Management Fee" for ancillary services. This exercise of discretion was both a breach of fiduciary duty and self-dealing because in this case it caused extra compensation to be paid to *Magnacare*. *Acosta v. MagnaCare Admin. Servs., LLC,* 1:16-cv-07695-DAB (S.D.N.Y., May 26, 2017). MagnaCare agreed to pay $16 million in monetary relief, and also agreed to more robust fee disclosure.

Wellness Program

The Macy's complaint signals a potential shift in the DOL under the Trump Administration and a potential – and stricter – focus on wellness program compliance. Plans should make sure that their wellness programs provide the required alternatives and notices and that they are paying the same reward regardless of whether someone meets the initial standard or the alternative.

Plan sponsors should be aware that there are potentially significant financial penalties if the DOL is successful in a suit of this nature. Under the ACA, noncompliant programs could be subject to penalties under the Internal Revenue Code and Public Health Service Act of up to $110 per day (neither penalty is within the jurisdiction of DOL however). If DOL obtains a settlement amount from, or court judgment against, a fiduciary as a result of its breach, ERISA section 502(l)(1) requires that DOL assess a penalty amounting to 20% of such amount. DOL has some discretion to waive or reduce the 20% penalty if the fiduciary acted reasonably and in good faith, but that may be hard to argue where the rules are clear on how a program is to be administered. Even in the absence of a judgment or settlement, DOL can assess a penalty against a breaching fiduciary with respect to an ERISA-covered welfare plan of up to 5% of the amount involved in a prohibited transaction for each year that the transaction continues. Any penalties imposed under ERISA section 502(i) are offset by the penalties imposed under section 502(l).