Ethical Considerations for Attorneys – Advising Health Care Plans

ABA Joint Committee on Employee Benefits
Health & Welfare Benefit Plans
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Corporate Governance

- Establishing the benefits committee
  - Delegation of authority
    - Check plan documents – who can act
    - Proper documentation for set-up

- Committee structure
  - Committee members
  - Outline duties and responsibilities of the committee

- Establishing the committee is a settlor function
Advising the Committee

- Advising the committee
  - Attorney/client relationship with the committee
    - Applies to both inside and outside counsel
  - Settlor functions
    - Committee structure, guidelines, procedures
    - Discussion of plan design and amendments
    - Fiduciary training for committee members
    - Attorneys not advising a fiduciary in these circumstances
  - Fiduciary functions
    - Advice to the committee relating to interpreting and administering the plan
      - Vendor selection
      - Monitoring performance
      - Eligibility decisions and claims review
    - The attorney/client privilege will have limited application regarding committee advice
Advising the Committee

- Benefits determinations (eligibility, coverage, claims or appeals)
  - Define fiduciary duty in the particular circumstance
    - Role of Committee
    - Role of service provider
    - Verify assignment/acceptance of fiduciary duty
  - Establish full record
  - Outline standards for review
  - Document proceedings
Advising the Committee

- Ethical considerations for the attorney
  - Explain dual nature of the relationship (settlor v. fiduciary; company v. committee)
  - What must happen if an adverse situation arises
  - Use engagement letter for committee representation

- Co-fiduciary liability
  - Remember, the attorney is not a fiduciary, but advises fiduciaries about their actions
    - In-house attorneys should clearly define their role with - and within - the committee (ex-officio or non-voting member)
  - Responsibility to perform due diligence when selecting vendors and to establish appropriate monitoring procedures
    - Contract review
    - Business associate agreements
    - Proper documentation
  - Responsibility to monitor activities of vendors and to consider whether to remove or report co-fiduciary, based on the circumstances
Checklist – Issues for Review
Assessing Ethical Considerations

- Initial Consideration
  - Settlor functions
  - Fiduciary actions of plan sponsors
  - Committee’s role
  - Attorney’s role

- Establishing the Committee
  - Committee structure
  - Committee procedures
  - Ethical considerations for the Attorney
Checklist – Plan Implementation

- Documenting the plan
  - Plan documents
  - Authority/approval
  - Committee actions

- Plan Implementation
  - Hiring vendors and service providers
  - Communicating the plan to employees
  - Roles of Committee and Attorney
Checklist – Plan Administration

- Benefits determinations
  - Plan sponsor’s role
  - Third party administrator’s role
  - Auditor’s review
  - Appeals to the Committee

- Standard of Review
  - Abuse of discretion
  - Conflicts of interest

- Ethical issues for the Attorney
  - Advising a plan fiduciary
  - Inherent conflict of interest

- Actions of Attorney when conflict is identified
  - Notify client
  - Distinguish work product
  - Separate engagement letter
Checklist – Employer Liability

- Employer liability based on service provider’s negligence
  - Employer’s control over the provider
  - Contract issues
  - Incentive compensation

- Ethical responses of Attorney
  - Advise employer of conflict and propose course of action
  - Advise Committee about discoverable materials
  - Conduct internal conflicts check
  - Analyze potential for disengagement
The Case Study - #1

- Employer has 1,200 employees with a group health plan (Plan) set out in a wrap document, which was amended and restated in 2014. Benefits are funded through a VEBA.
- For 2016, the Plan has 3 options: 1) a PPO; 2) an HDHP/HSA; and 3) the “Secure Care Agreement” (SCA). The SCA works as follows:
  - The SCA consists of a health reimbursement arrangement (HRA). Certain participants with chronic health care conditions have had been identified by the TPA; their coverage under either Option 1 or 2 is suspended. The TPA assists the participant in securing coverage through the public Marketplace.
  - The SCA is available only to participants who have elected Option 1 or 2. The TPA identifies, from its records, participants who have ongoing claims over a certain dollar level where claims records indicate a chronic condition, for example, cancer treatment.
  - The cost of the Marketplace coverage is paid with funds from the HRA. In addition, the participant is reimbursed from the HRA for deductibles, co-pays and other out of pocket expenses.
  - The HRA also will pay for any preventive care services not provided by the Marketplace coverage; there are no annual or lifetime limits imposed on the HRA, according to the TPA.
The Case Study - #1 (cont’d)

- Auditors for the Plan recently conducted their review of the Plan and Plan administration for the 2016 Form 5500. The Auditors have raised concerns about the SCA. In particular, the Auditors have asked whether the SCA is compliant with the Affordable Care Act and with other tax rules.
- One of your partners serves as outside counsel for the ABC Company. Previously, you have done one or two limited-scope employee benefit projects for the ABC Company relating to their 401(k) plan. The partner contacts you to ask if you would review the SCA program and address the concerns expressed by the auditors.
- The ABC Company has a Benefits Committee that is responsible for making decisions about all of the company’s benefit plans, including the group health plan. The Committee includes the VP of Finance, the VP of Human Resources and the Director of Benefits.
- ABC Company has a general counsel but no employee benefits counsel. The ABC Benefits Committee does not have regular outside benefits counsel.
Case Study – #2

- Employer has 10,000 employees in 5 states and maintains a group health plan that has two coverage options: 1) a PPO option that meets the ACA minimum value and affordability requirements for employee-only coverage (bronze level); and 2) a PPO option that offers lower deductibles and expanded coverage at a higher premium rate (silver level).
- The employer (to the best of its knowledge) has met all requirements under the ACA regarding compliance with offers of coverage and reporting.
- During 2016, the employer receives 150 notices from the Marketplace indicating that certain of its employees received advance premium tax credits (APTC) in 2015.
- Employer seeks guidance from outside counsel regarding the best way to handle these notices, including researching the notices, filing appeals and any responsibility to contact the employees (or former employees) involved.
Case Study – #3

- Employer has 10,000 employees in 5 states and maintains a group health plan that has two coverage options: 1) a PPO option that meets the ACA minimum value and affordability requirements for employee-only coverage (bronze level); and 2) a PPO option that offers lower deductibles and expanded coverage at a higher premium rate (silver level).

- Employer has a retiree medical plan covering 7500 retirees that receives payments from the Retiree Drug Subsidy program. The retiree plan previously received payments from the Early Retirement Reimbursement Program; the plan covering pre-65 retirees was terminated in 2015.

- The Benefits Committee for the employer plans decided at its last meeting that the employer can ignore the notices received from the TPAs regarding ACA Section 1557 compliance.
Questions or Comments?

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