

TABLE OF CONTENTS

Introduction	iii
Acknowledgments	vii

CHAPTER 1

ERISA Fiduciary Responsibilities

§ 1.01	Introduction	1-4.3
§ 1.02	Identifying the ERISA Fiduciary	1-5
	[1] Responsibility Determines Status	1-5
	[2] Directors as Fiduciary	1-6
	[3] Third Party Administrator As Fiduciary	1-6
	[a] Discretionary Authority	1-8
	[b] Control Over Assets	1-8
	[c] Administrative Service Contracts	1-8
	[4] Company Not <i>De Facto</i> Co-Administrator	1-9
	[5] ERISA Liability for Nonfiduciary Advisers	1-10
§ 1.03	Rules Prohibiting Transactions Between Plan and Party-in-Interest	1-11
	[1] Parties-in-Interest	1-11
	[2] Internal Revenue Service’s Disqualified Person Definition	1-11
	[3] Prohibited Transactions	1-12
	[4] Adoption and Expansion of the DOL Voluntary Fiduciary Correction Program (“VFCP”)	1-13
	[a] 2002 Guidance to VFCP	1-13
	[b] 2005 Guidance to VFCP	1-14.1
§ 1.04	Particular Plan Requirements	1-14.4
	[1] Introduction	1-14.4
	[2] Mandatory Plan Requirements	1-14.4
	[a] Named Fiduciaries	1-14.4
	[b] Funding Procedure	1-14.4
	[c] Plan Operation	1-15

HEALTH CARE BENEFITS LAW

	[d]	Plan Amendment Procedure and Payment Basis	1-15
	[e]	Voluntary Requirements	1-15
	[3]	Mandatory Trust Requirements	1-15
	[a]	Exemption of Certain Plans or Plan Assets	1-16
	[b]	Authority and Discretion of the Trustee	1-17
	[c]	Delegation of Authority to the Investment Manager.	1-17
	[4]	Plan Assets Must Be Held for the Exclusive Benefit of Participants	1-17
§ 1.05		Fiduciary Standards	1-39
	[1]	Prudent-Man Rule	1-39
	[2]	Adherence to Plan Documents.	1-40
	[3]	Allocating Fiduciary Responsibility	1-41
	[a]	Cofiduciary Responsibility	1-41
	[b]	Categorizing Fiduciary Responsibility.	1-42
	[i]	Fiduciaries Not Named	1-42
	[ii]	Trustees	1-42
	[iii]	Named Fiduciaries	1-43
	[c]	Limiting Responsibility	1-43
	[4]	Providers Must Pass Along Discounts.	1-44
§ 1.06		Claims Procedure.	1-45
	[1]	Filing a Claim for Benefits	1-45
	[2]	Failure to Process Claims Promptly	1-45
	[3]	Misrepresentation by Third Party Claims Administrator	1-46
	[4]	Misrepresentation by Employee	1-46
	[5]	Duty to Notify	1-47
	[6]	Failure to Provide Complete And Accurate Information To Beneficiary.	1-47
	[7]	Failure to Notify Plan of Termination	1-48
	[8]	Denial of Benefits	1-49
	[a]	Written Notice Of Claims Denial	1-49
	[b]	Authority to Reject Claims Upheld.	1-50
	[c]	Good Faith Duty Applies	1-50
	[d]	Conflicting Interests	1-51
	[e]	Insurance Policy Ambiguity	1-51
	[f]	Review Procedure.	1-52
	[g]	DOL Guidance on Claims Processing Regulations	1-52
	[h]	Claims Procedure Final Regulations.	1-52.1
	[i]	Structure and Scope of the Final Regulation	1-52.1

TABLE OF CONTENTS

	[ii]	Claim Determinations and Appeals	1-52.4
	[iii]	Content of Notices of Adverse Benefit Determinations	1-52.9
	[iv]	Preemption of State Law	1-52.10
	[i]	DOL Proposes Rules on Review of Disability Benefit Denials	1-52.11
	[i]	Background	1-52.12
	[ii]	Overview of Proposed Regulation	1-52.13
	[iii]	Statute of Limitations.	1-52.20
	[j]	Contractual Periods in ERISA Plans.	1-52.21
	[i]	<i>Heimeshoff v. Hartford Life & Accident Insurance Co.</i>	1-52.21
	[ii]	<i>Moyer v. Metropolitan Life Insurance Company.</i>	1-52.24
	[k]	Forfeiture of Right to More Favorable Judicial Review Standard.	1-52.27
	[i]	Background	1-52.27
	[ii]	Decision	1-52.28
	[l]	Untimely Claim Denial Decision Results in <i>De Novo</i> Review	1-52.33
	[i]	Background	1-52.34
	[ii]	Decision	1-52.36
	[m]	Kentucky District Court Upholds Arbitrary and Capricious Standard of Review	1-52.41
	[i]	Background	1-52.41
	[ii]	Decision	1-52.43
§ 1.07		Litigation Standard of Review	1-53
	[1]	Why Written Criteria Are Important	1-53
	[a]	Discretionary Authority	1-54
	[b]	Evaluation Standards	1-54
	[c]	Expert Testimony	1-55
	[d]	Denial Must Conform to Plan.	1-55
	[2]	Exclusions Unenforceable.	1-56
	[3]	Clinical Trial Not Excluded.	1-57
	[4]	Experimental Treatment Not Covered.	1-57
	[5]	<i>In Vitro</i> Not Covered	1-58
	[6]	Vicarious Liability	1-59
	[7]	Conflict of Interest.	1-60
	[a]	Background.	1-60
	[b]	Legal Standard	1-60
	[c]	Opinion	1-60.1
	[i]	Medical and Claims History.	1-60.1

HEALTH CARE BENEFITS LAW

	[ii]	Decision was Arbitrary and Capricious	1-60.4
§ 1.08		Plan Procedures Litigation	1-61
§ 1.09		Litigation Involving Medical Service Providers	1-64
	[1]	Claims by Medical Service Providers	1-64
	[a]	Standing Under ERISA	1-64
	[i]	<i>Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.</i>	1-64
	[ii]	<i>Advanced Orthopedics and Sports Medicine v. Blue Cross and Blue Shield of Massachusetts</i>	1-67
	[iii]	<i>Neuroaxis Neurosurgical Associates, PC v. Costco Wholesale Co.</i>	1-69
	[b]	Scope of Assignment	1-70
	[i]	<i>Sanctuary Surgical Center, Inc. v. UnitedHealthcare, Inc.</i>	1-70
	[ii]	<i>North Jersey Brain and Spine Center v. Aetna Inc.</i>	1-70
	[2]	Claims Against Medical Service Providers	1-74
	[a]	Statutory Standing Under ERISA	1-74
	[i]	Characterization of Relief Sought Can Be Determinative	1-74
	[ii]	Service Providers With Fiduciary Status Can Sue On Behalf of Plan	1-78
	[iii]	Associational Standing	1-82
§ 1.10		Litigation Involving Prescription Drug Overcharging	1-89
	[1]	<i>Mohr v. UnitedHealth Group Inc.</i>	1-89
	[a]	Facts	1-89
	[b]	Defendants Are Fiduciaries And Parties In Interest	1-99
	[c]	Defendants ERISA Fiduciary Duties	1-100
	[i]	The Duty of Loyalty	1-100
	[ii]	The Duty of Prudence	1-101
	[iii]	The Duty to Inform	1-101
	[iv]	Co-Fiduciary Liability	1-101
	[v]	The Duty Not To Discriminate	1-101
	[vi]	Non-Fiduciary Liability	1-102
	[d]	Defendants Breached Their Duties	1-102

TABLE OF CONTENTS

[e] Allegations 1-104

 [i] Violations of ERISA

 § 502(a)(1)(B) 1-104

 [ii] ERISA § 502(a)(3)

 for Violations of ERISA

 § 406(a)(1)(C) 1-104

 [iii] ERISA § 502(a)(2) and (3)

 for Violations of ERISA

 § 406(b) 1-105

 [iv] ERISA § 502(a)(2) and (3),

 for Violations of ERISA

 § 404 1-106

 [v] ERISA § 502(a)(3)

 for Violations of ERISA

 § 702 1-106

 [vi] ERISA § 502(a)(3)

 for Violations of ERISA

 § 405(a) 1-108

[2] *Negron v. Cigna Corp.* 1-109

 [a] Facts 1-109

 [b] Defendants Are Fiduciaries

 And Parties In Interest 1-118

 [c] Defendants ERISA Duties. 1-119

 [i] The Duty of Loyalty. 1-119

 [ii] The Duty of Prudence 1-120

 [iii] The Duty to Inform 1-120

 [iv] Co-Fiduciary Liability 1-120

 [v] The Duty Not To

 Discriminate 1-120

 [vi] Non-Fiduciary Liability 1-122

 [d] Defendants Breached Their Duties 1-122

 [e] Allegations 1-123

 [i] For Violations of ERISA

 § 502(a)(1)(B) 1-123

 [ii] ERISA § 502(a)(3) for Violations

 of ERISA § 406(a)(1)(C). 1-123

 [iii] ERISA § 502(a)(2) and (3),

 for Violations of ERISA

 § 406(b) 1-124

 [iv] ERISA § 502(a)(2) and (3)

 for Violations of ERISA

 § 404 1-125

 [v] ERISA § 502(a)(3)for Violations

 of ERISA § 702 1-126

 [vi] ERISA § 502(a)(3), for Violations

 of ERISA § 405(a). 1-128

HEALTH CARE BENEFITS LAW**CHAPTER 2****Tax Treatment of Health Benefits**

§ 2.01	Introduction	2-4.1
§ 2.02	General Rules for Health Plans	2-4.2
	[1] Exclusion From Taxation of Premiums and Benefits	2-4.2
	[2] Eligible Medical Expenses	2-4.2
	[3] Employer Tax Deduction	2-4.3
	[4] Federal Tax Withholding	2-4.3
	[5] Disability Income Benefits Taxed as Deferred Compensation	2-4.3
	[a] Facts	2-4.4
	[b] Decision	2-4.5
§ 2.03	Health Plan Qualification Requirements	2-5
	[1] Written Plan	2-5
	[2] Employees vs. Self-Employed Individual	2-5
	[3] Coverage of Dependents	2-6
	[a] Old Rule	2-6
	[b] New Rule	2-6
§ 2.04	Nondiscrimination Tests for Health Plans	2-7
	[1] Identification of Self-Insured Arrangement	2-7
	[2] Highly Compensated Individuals	2-8
	[3] Eligibility Testing	2-8
	[a] Applying the Tests	2-9
	[b] Plan Aggregation	2-9
	[4] Nondiscriminatory Benefits	2-9
	[a] Type of Benefits	2-10
	[b] Amount of Benefits	2-10
	[c] Nondiscriminatory Operation	2-10
	[d] Special Rule for Retirees	2-10
	[5] Taxation of Excess Reimbursements Under a Discriminatory Health Plan	2-10
§ 2.05	Cafeteria Plans	2-12
	[1] Qualification Requirements	2-12
	[a] Written Plan	2-13
	[b] Participation by Employees Only	2-15
	[c] Use-It-or-Lose-It Rule	2-16
	[d] Period of Coverage	2-20.1
	[e] Election Procedures	2-20.1
	[f] Permissible Reimbursements	2-22
	[g] IRS Relaxes Rules for Cafeteria Plan Mid-Year Election Changes	2-23
	[2] Flexible Spending Accounts	2-24
	[a] Type of Reimbursements	2-24

TABLE OF CONTENTS

	[b]	Period of Coverage	2-24.1
		[i] Grace-Period Requirements	2-24.1
		[ii] Run-Out Period Requirements.	2-25
	[c]	Uniform Coverage	2-25
	[d]	Claims Substantiation	2-26
		[i] Health FSAs	2-26
		[ii] Dependent Care Assistance Plans (DCAPS)	2-26
	[e]	Experience Gains	2-27
	[f]	Smart Cards and Terminal-Restricted Debit Cards.	2-27
	[g]	Dependent Care Assistance Programs	2-27
[3]		Nondiscrimination Tests	2-27
	[a]	Highly Compensated Individual	2-28
	[b]	Eligibility	2-29
	[c]	Benefits and Contributions	2-29
	[d]	25 Percent Concentration Test	2-30
	[e]	Key Employee Concentration Test	2-30
	[f]	Safe Harbors	2-30
	[g]	Other Rules	2-31
	[h]	Taxation Under a Discriminatory Cafeteria Plan	2-31
[4]		Effect of the Family and Medical Leave Act on the Operation of Cafeteria Plans	2-31
	[a]	Introduction.	2-31
	[b]	Obligation to Offer Coverage During FMLA Leave	2-32
	[c]	Responsibility for Making Cafeteria Plan Premium Payments When an Employee on FMLA Leave Continues Group Health Plan Coverage	2-32.1
	[d]	Payment Options Required or Permitted While on Unpaid FMLA Leave	2-32.2
		[i] In General.	2-32.2
		[ii] Exceptions	2-32.4
		[iii] Voluntary Waiver of Employee Payments	2-32.4
		[iv] Example	2-32.4
	[e]	Payment of Premiums by Employees on Paid FMLA Leave.	2-32.5
	[f]	Restrictions Applicable to Contributions When an Employee’s FMLA Leave Spans Two Cafeteria Plan Years.	2-32.5

HEALTH CARE BENEFITS LAW

		[g] Special Rules Concerning Employees Taking FMLA Leave Who Participate in Health FSAs Offered Under a Cafeteria Plan	2-32.6
		[i] In General	2-32.6
		[ii] Coverage	2-32.6
		[iii] Examples	2-32.7
		[h] Entitlement to Non-Health Benefits on FMLA Leave	2-32.9
	[5]	IRS Modifies FSA “Use-or-Lose” Rule	2-32.9
		[a] Purpose of IRS Notice 2013-71	2-32.9
		[b] Background	2-32.10
		[c] Further Modification of “Use-or-Lose” Rule	2-32.11
		[d] Written § 125 Cafeteria Plan	2-32.13
		[e] IRS Examples	2-32.13
§ 2.06	Health	Reimbursement Accounts	2-32.16
		[1] Basic Design and Rules	2-32.16
		[2] Advantages of HRAs	2-35
		[3] Disadvantages of HRAs	2-37
		[4] Design Considerations	2-37
		[a] Coverage Under an HRA	2-38
		[b] COBRA Issues	2-38
		[c] Coordination Between an HRA and a Cafeteria Plan	2-38
		[d] Priority of Payments from HRA and an FSA	2-39
		[e] Code Section 105 Nondiscrimination Rules	2-39
		[5] Other Important Considerations	2-40
		[a] HIPAA Issues	2-40
		[b] ERISA Issues	2-40
		[c] Domestic Partner Coverage	2-41
		[d] Funding	2-41
		[e] Accounting Treatment of HRAs	2-41
		[f] IRS Guidance on Substantiation of Medical Expenses	2-42
		[6] Private Letter Rulings	2-44
		[7] Summary	2-44.3
§ 2.07	Health	Savings Accounts	2-45
		[1] IRS Guidance	2-45
		[a] Eligibility for HSAs	2-45
		[i] Definition of “High-Deductible Health Plan” (HDHP)	2-45
		[ii] Special Rules for Determining Whether a Health Plan That is a Network Plan Meets the Requirements of an HDHP.	2-46

TABLE OF CONTENTS

xvii

	[iii] Other Health Coverage Makes an Individual Ineligible	2-47
	[b] Establishing an HSA	2-47
	[c] Contributions to HSAs	2-48
	[d] Distributions from HSAs	2-52
	[e] Discrimination Rules	2-54
[2]	DOL Guidance	2-59
[3]	Interaction of Health Savings Accounts with Other Employer-Provided Health Reimbursement Plans	2-60
	[a] Situations Examined by Revenue Ruling 2004-45	2-61
	[b] IRS Analysis	2-62
	[i] Limited-Purpose Health FSA or HRA or Suspended HRA.	2-64
	[ii] Post-Deductible Health FSA or HRA	2-65
	[iii] Retirement HRA	2-66
	[c] Revenue Ruling 2004-45 Holdings Regarding Situations Examined.	2-66
[4]	The Tax Relief and Health Care Act of 2006	2-67
	[a] FSA and HRA Terminations to Fund HSAs	2-68
	[b] Repeal of Annual Deductible Limitation on HSA Contributions	2-68
	[c] Modification of Cost-of-Living Adjustment	2-68
	[d] Contribution Limitation Not Reduced for Part-Year Coverage.	2-68
	[e] Exception to Requirement That Employers Make Comparable Health Savings Account Contributions	2-68
	[f] One-Time Distribution from Individual Retirement Plans to Fund HSAs	2-69
	[g] Implications.	2-69
[5]	Employer Comparable Contributions to Health Savings Accounts and the Requirement of Filing Return for the Excise Tax—IRS Regulations.	2-69
	[a] Introduction.	2-70
	[b] Explanation of Provisions.	2-71
§ 2.08	Defense of Marriage Act (DOMA) Supreme Court Decision	2-74
[1]	Introduction	2-74
	[a] Effect On Health Care Benefit Plans.	2-75

HEALTH CARE BENEFITS LAW

	[b]	Open Questions	2-76
	[c]	Action Steps for Employers	2-77
[2]		Background	2-77
[3]		Majority Decision	2-78
	[a]	Jurisdictional Holding	2-78
	[b]	Decision on the Merits	2-80
[4]		Dissenting Opinions.	2-83
	[a]	Scalia Dissent	2-83
	[b]	Roberts Dissent	2-87
	[c]	Justice Alito and Justice Thomas Dissenting Opinions	2-87
§ 2.09		All Legal Same-Sex Marriages Recognized for Federal Tax Purposes	2-91
	[1]	Introduction	2-91
	[2]	Details of Revenue Ruling 2013-17	2-91
	[a]	Issues Considered	2-91
	[b]	Law and Analysis	2-92
		[i] Background	2-92
		[ii] Recognition of Same-Sex Marriages.	2-93
		[iii] Martial Status Based on the Laws of the State Where a Marriage is Initially Established.	2-96
		[iv] Registered Domestic Partnerships, Civil Unions, or Other Similar Formal Relationships Not Denominated as Marriage	2-97
	[c]	Holdings	2-97
	[d]	Prospective Application	2-98

CHAPTER 3

**Health Benefit Plans and
ERISA Preemption**

§ 3.01		Introduction	3-2
§ 3.02		ERISA Preemption	3-3
§ 3.03		Court Decisions Interpreting Preemption	3-5
	[1]	State-Mandated Benefits	3-5
		[a] Insured Plans.	3-5
		[b] Application of State-Mandated Laws.	3-6
		[c] Self-Insured Plans.	3-7
		[d] State Insurance Statute Preempted	3-7
		[e] ERISA Preemption Upheld.	3-8
	[2]	Plan Administration	3-9

TABLE OF CONTENTS

	[a]	Damages that Involve Benefits Disputes	3-9
	[b]	“Bad Faith” Denial	3-10
	[c]	Elective-Surgery Dispute	3-10
	[d]	Removal From State to Federal Court	3-11
	[e]	Subrogation Claims.	3-12
		[i] Preemption to State Antisubrogation.	3-12
		[ii] State Statute Not Preempted.	3-13
	[3]	Workers’ Compensation Statute Preempted	3-14
	[4]	State Surcharges Not Preempted	3-14
§ 3.04		Health Plan Funding Alternatives and Preemption	3-17
	[1]	Conventional Insurance	3-17
	[2]	Minimum Premium Plans	3-17
		[a] Advantage of a Minimum Premium Plan	3-18
		[b] Meaning of “Premium”.	3-19
	[3]	Self-Insurance	3-19
		[a] Administrative-Services-Only Arrangements	3-20
		[b] Administration and Services	3-20
	[4]	Stop-Loss Coverage.	3-21
		[a] Stop-Loss Preemption Upheld	3-22
		[b] Exception to Stop-Loss Preemption	3-22
		[c] State Cannot Regulate Stop-Loss Levels	3-23
§ 3.05		U.S. Supreme Court: ERISA Preempts Vermont Law Requiring Health Data Reporting	3-24
	[1]	Summary	3-24
	[2]	District Court Opinion	3-26
		[a] Overview.	3-26
		[b] Opinion	3-27
		[i] Standing	3-30
		[ii] Preemption	3-31
	[3]	Second Circuit Opinion	3-39
	[4]	Supreme Court Decision	3-44
§ 3.06		State Law Claims of Fraud and Misrepresentation Not Preempted by ERISA.	3-47
	[1]	Summary	3-47
	[2]	Background	3-48
		[a] Factual Background	3-48
		[b] Procedural History	3-49
	[3]	ERISA Claims	3-50
		[a] Breach of Fiduciary Duty Claim.	3-50

HEALTH CARE BENEFITS LAW

	[i]	Discretion over Plan Management	3-51
	[ii]	Control over Plan Assets	3-54
	[b]	Prohibited Transaction Claim	3-56
	[i]	Restitution	3-58
	[ii]	Disgorgement	3-59
[4]		State Law Claims	3-59
	[a]	Preemption	3-59
	[i]	Express Preemption	3-59
	[ii]	Conflict Preemption	3-61
§ 3.07		ERISA Does Not Preempt State's Unfair Trade Practices and Mental Health Parity Laws	3-63
	[1]	Summary	3-63
	[2]	Background	3-63
	[3]	Decision	3-64

CHAPTER 4**Employer Liability in Managed Care**

§ 4.01		Introduction	4-2
	[1]	Elements of Managed Care	4-3
	[a]	Plan Design	4-3
	[b]	Health Care Delivery Systems	4-3
	[i]	Health Maintenance Organizations	4-3
	[ii]	Preferred Provider Organizations	4-3
	[iii]	Point-of-Service Plans	4-4
	[iv]	Employer Direct Contracting	4-4
	[v]	Utilization Review	4-4
§ 4.02		Theories of Liability Arising from Managed Care	4-5
	[1]	Liability Arising from Selection or Retention of Health Care Providers	4-5
	[a]	Actual Agency	4-5
	[b]	Ostensible or Apparent Agency	4-6
	[c]	Corporate Negligence	4-7
	[d]	Contract and Warranty Claims	4-9
	[e]	Ambiguous Contract Terms	4-9
	[f]	Liability Arising from Utilization Review or Case Management	4-10
	[g]	Improper Provider Incentives	4-11
	[h]	Liability Arising From Negligence of Utilization Review Personnel	4-11

TABLE OF CONTENTS

xxi

§ 4.03	Impact of ERISA on Employer Liability for Managed Care	4-13
	[1] Preemption of State Laws	4-13
	[2] Limitation of the Preemption Doctrine	4-15
	[3] Impact of ERISA on Potential Damage Awards	4-16
§ 4.04	Potential Employer Liability Under ERISA	4-17
	[1] Plan Requirements	4-17
	[2] Employer Guidelines	4-17
	[3] Communication of Plan Provisions	4-18
	[4] Employer Guidelines	4-18
	[5] Claims Procedures	4-19
	[a] Employer Guidelines	4-19
	[b] Standard of Review	4-20
	[6] Fiduciary Standards	4-20
	[a] Prudent Selection of Managed Care Providers	4-21
	[b] Prohibited-Transaction Rules	4-22
	[c] Remedies	4-22
§ 4.05	Employer Contracting Strategies to Avoid Liability	4-23
	[1] Selecting and Contracting with a Managed Care Vendor	4-23
	[a] Selecting a Managed Care Entity	4-23
	[b] Contracting With a Utilization Review Organization	4-24

CHAPTER 5

Plan Administration

§ 5.01	Auditing Claims Administration Performance	5-5
	[1] Introduction	5-5
	[2] Defining Audit Objectives	5-6
	[a] Focused Audits	5-6
	[b] Comprehensive Audits	5-6
	[3] Auditing Claims	5-6
	[a] Accuracy and Timeliness	5-7
	[b] Audit Steps	5-7
	[c] Elements of a Sample Claim Review	5-9
	[d] Standards of Performance	5-10
	[e] Computerized Audit Checks	5-11
	[4] Assessing the Claims Office and Reviewing Procedures	5-11
	[a] Location of Claims Offices	5-11
	[b] Size and Experience Levels of Staff	5-11

HEALTH CARE BENEFITS LAW

	[c]	Organizational Structure	5-12
	[d]	Coordination with Vendors of Adjunct Services	5-12
	[e]	Effective Integration	5-12
	[f]	Flexibility and Responsiveness	5-13
	[g]	Quality Control and Security	5-13
[5]		Evaluating Claims Systems	5-14
	[a]	Input	5-14
	[b]	Adjudication Capabilities	5-15
	[c]	Output	5-15
	[d]	Other Items	5-16
[6]		Managed Care Program Integration	5-16
	[a]	Utilization Review	5-16
	[b]	Specialty Utilization Review	5-17
	[c]	Preferred Provider Organizations	5-17
	[d]	Employee Assistance and Wellness Programs	5-17
[7]		Improving Administrator Performance	5-18
	[a]	Financial Recovery	5-18
	[b]	System Changes and Reprogramming	5-18
	[c]	Retraining	5-18
	[d]	Specialized Audits and Reports	5-18
	[e]	Coordinating Vendors	5-18
	[f]	Follow-up Reviews	5-18
	[g]	Performance Contracts	5-19
	[h]	Changing Administrators	5-19
§ 5.02		Negotiating Administrative-Services-Only Contracts	5-20
	[1]	Introduction	5-20
	[a]	Important Issues	5-20
	[b]	Overview of Administrative- Services-Only Contracts	5-20
	[2]	ERISA Considerations	5-21
	[a]	Prudent-Man Rule	5-21
	[b]	Value of Services	5-22
	[c]	Determining Fees	5-23
	[d]	Fixed-Dollar Amount	5-23
	[e]	Fixed Amount Per Claim	5-24
	[f]	Fee for Service	5-24
	[3]	Common Provisions in Administrative- Services-Only Contracts	5-24
	[a]	Services (Obligations)	5-24
	[b]	Appeals	5-25
	[c]	Other Services	5-25
	[d]	Banking/Payment of Claims	5-26
	[e]	Financial Stability	5-26
	[f]	Overdrafts	5-27

TABLE OF CONTENTS

xxiii

	[g]	Costs and Fees	5-27
	[h]	Record Maintenance and Examination	5-28
	[i]	Indemnification	5-28
	[j]	Plan Prohibition	5-28
	[k]	Clauses Will Vary	5-29
	[l]	Managed Care Liabilities	5-29
	[m]	Erroneous Payments	5-30
	[n]	Overpayments	5-30
	[o]	Gross Negligence	5-31
	[p]	Agency/Fiduciary Status	5-31
		[i] Claims Review	5-31
		[ii] Claims Processing	5-34
	[q]	Defining a Service Provider as a Fiduciary	5-34
	[r]	Ministerial Functions	5-35
	[s]	Term of Agreement/Termination	5-35
	[t]	Guaranteed Rates	5-36
	[u]	Managed Care Networks	5-36
	[v]	Miscellaneous	5-37
[4]		Less Common Features in Administrative- Services-Only Contracts	5-37
	[a]	Definitions	5-37
	[b]	Reports to Employers	5-37
	[c]	Performance Guarantees and Incentives	5-38
	[d]	Noninsurer TPAs	5-38
	[e]	Stop-Loss Insurance	5-39
	[f]	Right to Audit	5-39
	[g]	Claims Processing Disruption	5-39
	[h]	Delegation	5-40
	[i]	Notice of Litigation or Governmental Inquiry	5-40
	[j]	Other Provisions	5-41
§ 5.03	[Reserved]	5-42
§ 5.04		Auditing Utilization Review and ERISA Compliance	5-43
	[1]	Introduction	5-43
	[2]	Agency Theory	5-43
		[a] Agency Liability	5-43
		[b] Ostensible Agency Liability	5-43
		[c] Enhanced Risk	5-65
		[d] Court Decisions	5-65
		[e] Risk Management Steps	5-66
	[3]	Corporate Negligence Theory	5-67
		[a] Hospital Liability	5-67
		[b] Employer Liability	5-68
		[c] Risk Management Steps	5-68

HEALTH CARE BENEFITS LAW

	[4]	Medical Management Liability	5-70
		[a] The Wickline Case	5-70
		[b] The Wilson Case	5-71
		[c] Risk Management Steps	5-71
	[5]	Liability Based on Provider Incentives	5-72
		[a] Potential Conflict	5-72
		[b] Steps to Reduce Utilization Management Liability	5-72
	[6]	ERISA Liability	5-73
		[a] Fiduciary Liability	5-73
		[b] ERISA Claims Denial	5-74
		[c] ERISA Preemption and its Application to Managed Care	5-74
		[d] Claims that “Relate To” Plan Administration Are Preempted.	5-74
		[e] Settlor Functions	5-76
		[f] Risk Management Steps	5-76
		[g] Managed Care Contract	5-78
		[h] Managed Care Liability Audit	5-78
§ 5.05		Subrogation: The Plan Administrator’s Duty to Recover Plan Assets from Tortfeasors	5-82
	[1]	Introduction	5-82
	[2]	The Right of Subrogation: How Health Care Plans Recover from Tortfeasors	5-83
		[a] Enforcement of Subrogation and ERISA Plan Reimbursement Claims	5-84
		[b] Equitable Lien by Agreement	5-84
		[c] Plan Terms Govern ERISA Reimbursement Action Based On Equitable Lien	5-85
		[i] Background	5-86
		[ii] Plan Arguments	5-86
		[iii] Participant Arguments	5-87
		[iv] Supreme Court Opinion	5-87
		[d] ERISA Equitable Relief Case Involving Dissipated Funds	5-88
	[3]	Some Practical Issues in a Recovery Program	5-90.1
		[a] Identifying Cases Where Recovery Is Possible.	5-90.1
		[b] Determining When Recovery Is Probable	5-90.2
		[c] Estimating Damages and Costs of Recovery	5-90.3
	[4]	Reasonable Expectations of an Effective Recovery Program	5-90.4

TABLE OF CONTENTS

xxv

[5]	Background on Legal History	5-90.5
[6]	Restrictions on Tort Recovery	5-90.6
	[a] Contributory Negligence.	5-90.6
	[b] Partial Comparative Negligence.	5-90.6
	[c] Pure Comparative Negligence	5-90.7
[7]	Restrictions on Subrogation.	5-90.7
	[a] The Made Whole Rule	5-90.7
	[b] The Collateral Source Rule.	5-90.8
	[c] Anti-Subrogation Statutes.	5-92
[8]	ERISA and Federal Common Law	5-92
[9]	Significance of the Legal Principles	5-93
[10]	Well-Designed Plan Language.	5-94
	[a] Exclusion of Expenses Paid or Payable by a Third Party	5-95
	[b] Recovery and Subrogation Provisions.	5-97
	[i] Provisions Related to Payment Prior to Determination of Responsibility of a Third Party.	5-97
	[ii] Provisions Related to Subrogation	5-98
	[iii] Provisions Regarding a Reimbursement and/or Subrogation Agreement.	5-99
	[iv] Provisions Relating to Cooperation by Covered Individuals.	5-100
	[v] Provisions Stating that All Recovered Proceeds Are to Go Toward Reimbursement of the Plan	5-101
[11]	The Reimbursement Agreement	5-102
[12]	Are these Plan Provisions Effective?.	5-103
[13]	A Program for Effective Administration of Third-Party Recoveries.	5-106
	[a] Elements of a Cost-Effective Third-Party Recovery Program	5-107
	[i] The First Step: Find Cases that Afford Potential Recovery.	5-107
	[ii] The Second Step: The First Contact with the Covered Person	5-108
	[iii] The Third Step: Contact the Third Party's Insurer or Attorney.	5-111

HEALTH CARE BENEFITS LAW

[iv]	The Fourth Step: Follow Up, Follow Up, and Follow Up. . .	5-111
[v]	The Fifth Step: Negotiate in Good Faith.	5-112
[b]	An Important Reminder: Remember Whose Money Is at Stake.	5-115

CHAPTER 6**Qualified Medical Child Support Orders**

§ 6.01	QMCSO	6-2
	[1] Definition	6-3
	[2] Required Information.	6-3
§ 6.02	The Plan Administrator's Responsibilities	6-5
§ 6.03	Rights of Alternative Recipients	6-7
§ 6.04	Enforcement.	6-8
§ 6.05	SSA Amendments Enabling State Enforcement	6-9
	[1] Requirements for Insurers	6-9
	[2] Requirements for Employers	6-10
	[3] Additional Requirements.	6-10
§ 6.06	Unanswered Questions	6-11
	[1] Preexisting Conditions.	6-11
	[2] Open Enrollment	6-11
	[3] Interim Coverage	6-11
	[4] COBRA	6-12
	[5] Nonparticipating Employees	6-12
§ 6.07	What Employers Should Do	6-13
§ 6.08	Procedures	6-14
	[1] Determining If a Medical Child Support Order Is Qualified	6-14
	[a] Receipt of Order	6-14
	[b] Parties to Be Notified	6-14
	[c] Content of Notice	6-15
	[d] Determination of Status of Order	6-15
	[e] Requirements for Qualification.	6-16
	[f] Direct Payment of Benefits.	6-16
	[g] Modifications and Redeterminations.	6-17
	[h] Determination by Another Entity	6-17
	[i] Application of Plan to Alternate Recipients.	6-17
	[j] Information Required from Alternate Recipients.	6-18
	[k] Determinations Binding	6-19
	[l] Disputes.	6-19

TABLE OF CONTENTS

xxvii

CHAPTER 7

COBRA

§ 7.01	COBRA Continuation Coverage	7-6
	[1] Overview	7-6
	[2] Penalties for Failure to Comply with COBRA	7-7
§ 7.02	Plans that Are (and Are Not) Subject to COBRA	7-9
	[1] What is a Group Health Plan?	7-9
	[a] Definitions	7-9
	[b] Plans Subject to COBRA	7-10
	[c] Plans Not Subject to COBRA	7-11
	[2] What is a Small-Employer Group Health Plan?	7-12
	[3] How Many Plans Does a Plan Sponsor?	7-13
	[4] “Packaged” Health Care Plans	7-14
	[5] COBRA and Cafeteria Plans	7-14
	[a] What Cafeteria Plans Are	7-14
	[b] COBRA and Cafeteria Choices	7-15
	[c] COBRA and Health Care FSAs	7-15
	[d] COBRA and Premium Conversion Arrangements	7-17
§ 7.03	Qualified Beneficiaries and Qualifying Events	7-18
	[1] Who Is Entitled to COBRA Continuation Coverage, Why and for How Long	7-18
	[2] Employees and 18-Month Qualifying Events	7-21
	[3] “Renegade Dependents” and 36-Month Qualifying Events	7-22
	[a] Dependents Who Have Their Own Qualifying Events	7-22
	[b] The Unique Status of “Renegade Dependents”	7-23
	[c] Divorce or Legal Separation as a Qualifying Event	7-25
	[4] Multiple Qualifying Events	7-27
	[5] Disabled Individuals and 29-Month Qualifying Events	7-27
	[a] Disability and COBRA	7-27
	[b] The Plan’s Disability Extension as an Alternative to COBRA Continuation Coverage	7-28
	[6] Retirees, Bankruptcy and Unlimited COBRA Continuation Coverage	7-29
	[7] Dates When the Qualifying Event Occurs and Coverage Ends	7-30
§ 7.04	The Charge for COBRA Continuation Coverage	7-32

HEALTH CARE BENEFITS LAW

	[1]	Amount of the Charge for COBRA Continuation Coverage	7-32
	[2]	Determining the Amount Insured Plans May Charge.	7-33
	[3]	Determining the Amount Self-Insured Plans May Charge.	7-34
	[4]	Increases and Decreases of the Amount Charged.	7-35
	[5]	Grace Periods.	7-36
	[6]	Who Loses if the COBRA Participant Does Not Pay the Amount Charged?	7-37
	[7]	Difference Between the Premium and the Amount Charged	7-38
§ 7.05		COBRA and USERRA Notices.	7-40
	[1]	Multiple COBRA Notice Requirements	7-40
	[2]	The General (or Initial) COBRA Notice	7-41
	[a]	When and How a General COBRA Notice Must Be Given	7-41
	[b]	Information in the General COBRA Notice.	7-43
	[c]	Method of Delivery of a General COBRA Notice.	7-45
	[d]	Consequences of Delay or Failure to Give a General COBRA Notice.	7-46
	[e]	Starting a New Employment Relationship with a General COBRA Notice.	7-46
	[3]	The COBRA Election Notice.	7-47
	[a]	When and How a COBRA Election Notice Must Be Given	7-47
	[b]	Information the COBRA Election Notice Must Contain	7-48
	[c]	Method of Delivery of a COBRA Election Notice.	7-52
	[d]	Consequences of Delay or Failure to Give a COBRA Election Notice.	7-52.1
	[e]	COBRA Continuation Coverage and Divorce.	7-52.1
	[i]	What COBRA Requires	7-52.2
	[ii]	Judicial Interpretation of COBRA Requirements	7-52.3
	[4]	Notice of Unavailability of COBRA Coverage	7-52.5
	[5]	Notice of Early Termination of COBRA Continuation Coverage	7-52.5

TABLE OF CONTENTS

xxix

[6]	Notice of Termination of COBRA Continuation Coverage at the End of the 18-Month or 36-Month COBRA Period . . .	7-52.7
[7]	Other COBRA Notices that the Employer Should Provide	7-52.8
[a]	Second Qualifying Event Notices.	7-52.9
[i]	Why a Second COBRA Qualifying Event Notice May Be Needed.	7-52.9
[ii]	Texts of Second COBRA Qualifying Event Notices . . .	7-52.10
[iii]	Notice When a Child Ceases to Be a Dependent	7-52.11
[iv]	Notice When a Second Qualifying Event is Death, Divorce, Legal Separation or Medicare Eligibility	7-52.12
[b]	Notice of an 11-Month Extension of COBRA Continuation Coverage Due to Disability	7-52.13
[8]	COBRA Notices that Plan or COBRA Participants Must Provide	7-52.15
[a]	Why Plan Participants and COBRA Participants Must Provide Notices to the Plan.	7-52.16
[b]	Notice of the Plan Participant's or COBRA Participant's Death.	7-52.16
[c]	When Those Notices Must Be Provided	7-52.17
[d]	Procedures for Providing Those Notices	7-52.18
[i]	Use of Company Forms	7-52.18
[ii]	Oral Notice	7-52.18
[iii]	Written Notice	7-52.20
[iv]	Notice of a Determination that Disability Has Ended.	7-52.20
[v]	What Employers Need to Know to Provide a COBRA Election Notice	7-52.21
[vi]	Dealing with Incomplete Notices from Plan Participants or COBRA Participants	7-52.22
[vii]	Use of Model Notice Forms.	7-52.22
[e]	Second COBRA Notice Under the Trade Act of 2002.	7-52.23
[9]	Judicial Interpretation of COBRA Notice Requirements	7-52.23

HEALTH CARE BENEFITS LAW

	[a]	Failure to Give a COBRA Qualifying Event Notice	7-52.24
	[b]	Reliance on Incompetent Administrators	7-52.26
	[c]	Notices to Disabled Employees	7-52.26
	[d]	Notices to Dependent Children	7-52.28
	[e]	Termination of COBRA Continuation Coverage for Nonpayment of COBRA Premiums	7-52.29
	[10]	Dealing with COBRA and USERRA Notice	7-52.30
	[a]	Background	7-52.30
	[b]	USERRA Rights Notice	7-52.30
	[c]	Health Plans Must Provide Extended USERRA Continuation Coverage Under COBRA	7-52.31
§ 7.06		Day-to-Day Administration of COBRA Continuation Coverage	7-53
	[1]	Basic Day-to-Day Administration	7-53
	[2]	Enrollment in COBRA Continuation Coverage	7-54
	[a]	The Gap Between the Qualifying Event and COBRA Enrollment	7-55
	[b]	Managing the Gap Between the Qualifying Event and COBRA Enrollment	7-55
	[c]	Waivers of COBRA Continuation Coverage	7-57
	[3]	Billing the Charge for COBRA Continuation Coverage	7-57
	[a]	Billing for the Initial Payment	7-58
	[b]	Billing for Monthly Payments	7-59
	[c]	Increases in the Monthly Charge for COBRA Continuation Coverage	7-60
	[4]	Collecting the Charge for COBRA Continuation Coverage	7-61
	[5]	Maintaining Rights of COBRA Participants	7-61
	[a]	Processing Special Enrollments	7-62
	[b]	Cafeteria Plan Open Enrollments	7-62
	[c]	Offering COBRA Participants Enrollment in New Health Programs	7-63
	[d]	Providing the Plan's Disability Extension	7-63
	[e]	Conversion Notices When COBRA Continuation Coverage Expires	7-64

TABLE OF CONTENTS

xxxi

	[6] Monitoring COBRA Administration	7-65
	[a] Integrating COBRA with Employer-Paid Continuation Coverage	7-65
	[b] Monitoring Procedures for Sending COBRA Notices	7-67
	[c] Processing Change of Family Status Notices	7-67
	[d] Monitoring Social Security Disability Income Benefits Awards	7-67
	[e] Tracking COBRA Claim Experience	7-69
§ 7.07	COBRA and Alternative or Duplicate Coverage	7-70
	[1] Alternatives to COBRA Continuation Coverage	7-70
	[a] Conversion as an Alternative to COBRA Continuation Coverage	7-70
	[b] Disability Extension as an Alternative to COBRA Continuation Coverage	7-71
	[2] COBRA and Duplicate Coverage	7-72
	[a] Impact of HIPAA	7-76
	[b] A Practical Approach to COBRA and Duplicate Coverage	7-76
	[3] Who Pays First When COBRA and Other Coverage Coexist	7-77
	[a] COBRA and Other Group Health Coverage	7-77
	[b] COBRA and Medicare	7-78
§ 7.08	When COBRA Continuation Coverage Ends Early (and When It Doesn't)	7-79
	[1] Terminating Events	7-79
	[2] Termination of All Health Care Plans	7-79
	[3] Failure to Pay the Charge for COBRA Continuation Coverage	7-80
	[a] Initial Payment	7-80
	[b] Monthly Payment	7-82
	[4] Obtaining Other Group Health Coverage	7-83
	[5] Becoming Entitled to Medicare	7-84
	[6] Termination of Coverage for Cause	7-85
	[7] Ceasing to Be Disabled During the 11-Month Extended COBRA Period	7-86
	[8] Notice Requirements When COBRA Continuation Coverage Ends	7-86
	[a] Notices Related to Terminating Events	7-86
	[b] Notices When COBRA Continuation Coverage Expires	7-88
§ 7.09	COBRA and Purchases and Sales of Businesses	7-90

HEALTH CARE BENEFITS LAW

	[1]	COBRA Continuation Coverage When Businesses Are Sold	7-90
	[2]	Basic Principles When Businesses Are Sold	7-91
	[3]	When the Seller Goes Out of Business	7-92
	[4]	When the Seller Remains in Business	7-93
	[a]	Transactions Relevant to Sales of Businesses	7-93
	[b]	Parties Relevant to Sales of Businesses	7-93
	[c]	Summary of Responsibilities for Providing COBRA Continuation Coverage	7-94
	[d]	Seller's Employees Hired by the Buyer	7-95
§ 7.10		How COBRA Affects Multiemployer Plans and Interacts with Other Laws	7-96
	[1]	COBRA and Multiemployer Plans	7-96
	[a]	Small and Large Employers Contributing to Multiemployer Plans	7-96
	[b]	Cessation of Contributions by an Employer	7-97
	[2]	FMLA (Family and Medical Leave Act) and COBRA	7-98
	[a]	When a COBRA Qualifying Event Occurs	7-98
	[b]	Practical Approach to the Interaction of COBRA and the FMLA	7-100
	[3]	USERRA (Uniformed Services Employment and Reemployment Rights Act) and COBRA	7-100
	[4]	State Continuation of Coverage Laws	7-101
	[a]	State Laws Covering Overlapping Periods and Qualifying Events	7-101
	[b]	Notices if COBRA and State Continuation Coverage Laws Overlap	7-102
	[c]	Giving the Person a Choice of State or COBRA Coverages	7-102
	[d]	State Laws With Longer Periods for Divorced or Widowed Spouses	7-103
	[e]	State Laws with Longer Periods for Employees or Dependents	7-105
	[f]	Notices When Coverage State- Mandated Coverage Is Required After COBRA	7-107

TABLE OF CONTENTS

xxxiii

§ 7.11	COBRA Election and Enrollment Deadlines Extended During COVID-19 “Outbreak Period”	7-108
	[1] Summary	7-108
	[2] Duration of “Outbreak Period”	7-108
	[3] Planning for Longer Special Enrollment Periods	7-109
	[4] Planning for Longer COBRA Election Periods	7-109

CHAPTER 8

ERISA Reporting and Disclosure

§ 8.01	Requirements in General	8-3
§ 8.02	Covered Plans	8-4
	[1] Statutory Exemptions	8-4
	[2] Practices and Arrangements	8-4
	[3] Trust Requirement	8-5
	[4] Limited Exemptions	8-5
	[a] Small, Unfunded Welfare Benefit Plans	8-6
	[b] Group Insurance Arrangements for Small Plans	8-6
	[c] Unfunded Plans for Management or Highly Compensated Employees	8-7
§ 8.03	Reporting to Government Agencies	8-9
	[1] Filing the SPD with the DOL	8-9
	[a] General Format	8-9
	[b] Eliminate Jargon	8-9
	[c] Contents of the Summary Plan Description	8-10
	[2] Filing Form 5500 with the DOL	8-12
	[a] Related Schedules and Forms	8-13
	[i] Pre-1999	8-13
	[ii] 1999 and Later	8-14
	[iii] Schedule F, Fringe Benefit Plan Annual Information	8-15
	[b] Annual Reports	8-15
	[c] Penalty for Failure to File	8-17
	[d] Reasonable Cause	8-18
	[e] Special Event Reporting	8-18
	[f] Voluntary Correction Program of IRS for Late or Non-Filers	8-18.1
§ 8.04	Disclosure to Participants	8-19
	[1] Administrator Obligations	8-19

HEALTH CARE BENEFITS LAW

	[a]	Mail Distribution	8-19
	[b]	Electronic Notices	8-20
	[c]	Rules for Examining Documents	8-22
	[d]	Other Plans	8-22
	[e]	Participants Covered Under the Plan	8-23
	[f]	Disclosure Requirements	8-23
	[2]	Automatic Disclosure of SPD	8-24
		[a] Multiple Classes of Participants	8-24
		[b] Health Maintenance Organizations	8-25
	[3]	Automatic Disclosure of SMM	8-25
	[4]	Automatic Disclosure of Summary Annual Report	8-25
	[5]	Other Automatic Disclosures	8-26
	[6]	Written Explanation of Claim Denial	8-26
	[7]	Disclosure Upon Request	8-26
	[8]	Disclosure Upon Examination	8-26.1
	[9]	Charges for Documents	8-26.1
	[10]	Who Can Examine Plan Documents	8-26.2
	[11]	Where Documents Must Be Made Available	8-26.2
§ 8.05		Liability for Inaccurate Disclosure	8-26.4
	[1]	Potential Liability	8-26.4
	[2]	Disclaimer as Protection	8-26.4
	[3]	Other Trouble Spots	8-27
	[4]	Employee Communication Guidelines	8-28
	[5]	Disclosure of Usual and Customary Fee Schedules	8-28
§ 8.06		Claims Procedures for Employee Benefit Plans	8-31
	[1]	Who May Represent a Claimant	8-32
	[2]	Structure and Scope of the Final Regulation	8-33
		[a] Structure	8-33
		[b] Obligation to Establish and Maintain Reasonable Claims Procedures	8-33
	[3]	Limitations on Arbitration and Multiple Appeals	8-36
	[4]	Claim Determinations and Appeals	8-38
		[a] Overview	8-38
		[b] Urgent Care Claims	8-39
		[c] Concurrent Care Claims	8-39
		[d] Pre-Service Claims	8-40
		[e] Post-Service Claims	8-41
		[f] Disability Claims	8-42
	[5]	Content of Notices of Adverse Benefit Determinations	8-43
		[a] Initial Health Care or Disability Benefit Claim Determinations	8-43

TABLE OF CONTENTS

xxxv

	[b] Notification of Benefit Determination on Review	8-43
	[6] Preemption of State Law	8-44
§ 8.07	Retention of Records Under ERISA for Employee Benefit Plans	8-46
	[1] Statutory Provisions	8-46
	[2] Records Retention Generally	8-47
	[3] Electronic Records Retention	8-48

CHAPTER 9

Retiree Medical Benefits

§ 9.01	Postretirement Health Care	9-4.3
	[1] Overview of Retiree Benefits	9-4.3
	[2] Integration with Medicare	9-5
	[a] Coordination of Benefits	9-6
	[b] Maintenance of Benefits	9-7
	[c] Carveout	9-7
	[d] Charges Not Eligible for Medicare	9-8
	[3] Financial Accounting Standards Board's Standard	9-9
	[4] Valuation of Retiree Medical Benefits	9-9
	[5] Funding	9-9
	[a] Direct Funding	9-9
	[i] 401(h) Plans	9-9
	[ii] 501(c) Trusts	9-10
	[b] Indirect Funding	9-10
	[i] Defined Benefit Pension Plans	9-10
	[ii] Company-owned Life Insurance	9-11
	[6] Future Plan Designs End Benefits	9-11
	[a] Defined-Dollar Plans	9-11
	[b] Defined Contribution Plans	9-11
	[c] Long-Term Care	9-12
§ 9.02	Postretirement Health Benefits Obligation	9-13
	[1] Statement of Financial Accounting Standards No. 106: Overview of Issues	9-13
	[a] Summary of the Rules	9-13
	[b] Liability Buyouts	9-14
	[c] Application of the Rules	9-14
	[2] Recognizing and Measuring Liability	9-15
	[3] Transition Rules	9-16
	[4] Funding the Plan	9-16
	[5] Insured Liability Buyouts	9-17
	[6] Disclosure Requirements	9-17

HEALTH CARE BENEFITS LAW

§ 9.03	Measuring the Postretirement Obligation	9-20
	[1] Ongoing Issues After Adopting Statement of Financial Accounting Standards No. 106.	9-20
	[a] Determining the Substantive Plan.	9-20
	[b] Measurement of Obligations and Periodic Cost	9-21
	[c] Health Care Claims.	9-21
	[d] The Ongoing Impact of Transition	9-22
	[2] Analysis of Actuarial Assumptions	9-23
	[a] Health Care Cost Trend Assumption.	9-23
	[b] Discount Rate	9-24
	[c] Assess Other Assumptions	9-24
	[3] Measuring the Obligation	9-25
	[4] SOP 94-6 Adds New Benefits-Related Disclosures	9-26
	[5] Accounting for Plan Events.	9-26
	[a] Plan Amendments	9-27
	[b] Curtailments	9-27
	[c] Difference Between Curtailments and Plan Amendments.	9-27
	[d] Measuring the Impact of a Curtailment	9-28
	[e] Special Termination Benefits	9-28
	[f] Settlements	9-29
	[6] Auditing Considerations	9-29
§ 9.04	Prefunding Postretirement Health Plans	9-31
	[1] Informal Funding Vehicles.	9-31
	[a] Pay-as-You-Go Arrangements	9-31
	[b] Corporate-Owned Life Insurance	9-32
	[c] Rabbi Trusts	9-32
	[d] Timing of the Deduction	9-32
	[i] Multiple Payments	9-33
	[ii] Multiple Years	9-33
	[e] Deduction Rules in General	9-33
	[i] Deferred Benefits	9-34
	[ii] Funded vs. Unfunded.	9-34
	[f] Unfunded, Uninsured Deferred Benefits.	9-34
	[i] Deferred Compensation	9-34
	[ii] Medical Benefits.	9-35
	[iii] Determining the Proper Tax Year.	9-35
	[g] Unfunded, Insured Arrangements.	9-36
	[i] Qualified Nonguaranteed Contracts	9-37

TABLE OF CONTENTS

xxxvii

	[ii]	Premium Stabilization Reserves	9-38
	[iii]	Unfunded, Partially Insured Arrangements	9-39
[2]		Formal Funding Vehicles	9-39
	[a]	Differences in Formal Approaches	9-40
	[b]	Voluntary Employee Beneficiary Association	9-40
	[c]	Accounts Held Pursuant to Regulations	9-41
	[i]	Certain Retired Lives Reserves	9-41
	[ii]	Certain Administrative-Services-Only Arrangements	9-41
	[iii]	Arrangements Involving a Contractual Refund Right Based Solely on the Employer's Experience	9-42
	[iv]	Other Arrangements	9-42
	[d]	401(h) Accounts	9-42
	[e]	Taxable Trusts, Corporations, Joint Ventures, and Partnerships	9-43
	[i]	Taxable Trusts	9-43
	[ii]	Corporations	9-44
	[iii]	Joint Ventures and Partnerships	9-44
§ 9.05		Tax and Other Prefunding Considerations	9-45
	[1]	Tax Deductions for Contributions to Formal Funds	9-45
	[a]	Qualified Cost	9-46
	[b]	Qualified Direct Costs	9-46
	[c]	Additions to a Qualified Asset Account	9-47
	[i]	Account Limit	9-47
	[ii]	Incurred but Unpaid Claims	9-48
	[iii]	Retiree Medical Benefits	9-48
	[iv]	Actuarial Assumptions and Certifications	9-49
	[v]	Safe-Harbor Limits	9-50
	[vi]	Collectively Bargained Plans	9-50
	[vii]	Employee-Pay-All Plans	9-51
	[d]	Plans Exclusively for Retirees	9-51
	[e]	Key Employee Separate Account Requirements	9-52
	[f]	Income Taxes on Excess Reserves	9-53
	[g]	Unrelated Business Income Taxes	9-53
	[h]	Deemed Unrelated Income	9-53

HEALTH CARE BENEFITS LAW

	[i]	Excise Taxes on Disqualified Benefits	9-54
		[i]	Key Employees 9-54
		[ii]	Discriminatory Benefits 9-54
	[j]	Employer Reversions	9-54
	[k]	Employee Pay-All Plans	9-54
	[2]	Prefunded Plans	9-54
		[a]	Tax Benefits 9-55
		[b]	Earnings and Balance Sheet Benefits 9-55
		[c]	Increased Flexibility and Reduced Risk 9-55
		[d]	Financial Benefits 9-56
		[e]	Human Resources Benefit 9-57
	[3]	Court Decisions Affecting Plan Termination	9-57
		[a]	Importance of Plan Document 9-57
		[b]	Ensuring Plan Flexibility 9-59
§ 9.06		Modifying or Terminating Retiree Medical Benefits	9-60
	[1]	Factors Influencing Changes in Retiree Health Benefits	9-60
		[a]	Employer Reaction to Increased Costs 9-60
		[b]	Federal Court Decisions 9-61
	[2]	Legal Context of Retiree Medical Plans	9-61
		[a]	ERISA 9-61
		[b]	Written Documents 9-62
		[c]	Standard of Review 9-62
		[d]	ERISA Preemption 9-63
		[e]	Statutes Giving Rise to Retiree Complaints 9-63
	[3]	Contract Analysis Under ERISA Plans	9-63
		[a]	General Rule 9-63
		[b]	Ambiguous Language 9-64
		[c]	“Status Benefits” or Vesting Theory 9-65
		[d]	Retiree Benefits in Nonbargaining Cases 9-66
		[e]	Retiree Benefits in Collectively Bargained Plans 9-67
	[4]	Interpretation of Ambiguous Contract Provisions	9-67
		[a]	Representations by the Employer 9-68
		[b]	Bilateral Contract Claims 9-69
	[5]	ERISA Fiduciary Claims	9-71
	[6]	Special Circumstances Affecting Plan Modification or Termination	9-72
		[a]	Multiemployer Plans 9-72

TABLE OF CONTENTS

xxxix

	[b]	Plant Dispositions and Bankruptcies . . .	9-72
	[c]	Successor Employer’s Obligations	9-73
[7]		Position of the Courts on Retirees’ Right to Benefits	9-75
	[a]	Reservation of Rights Provision	9-75
	[b]	Commitment to Vest Benefits Must Be Clearly Expressed	9-76
[8]		Sixth Circuit Clarifies Prior Decisions	9-77
[9]		Supreme Court Rejects Yard-Man Inference Under “Ordinary Principles of Contract Law”	9-89
	[a]	Summary	9-89
	[b]	Sixth Circuit Decision	9-90
	[c]	Supreme Court Decision	9-98
		[i] Majority Opinion	9-98
		[ii] Concurring Opinion	9-107
[10]		District Court Rules Johnson Controls Retirees Not Entitled to Lifetime Health Benefits	9-108
	[a]	Summary	9-108
	[b]	Decision	9-109
		[i] Background	9-109
		[ii] The Agreements	9-110
		[iii] Procedural Background	9-116
		[iv] Vesting of Welfare Benefits	9-116
		[v] Interpreting the Language of the CBAs	9-123
	[c]	Subclasses B and F	9-130
[11]		District Court Rules Honeywell Retirees Entitled to Lifetime Health Benefits	9-131
	[a]	Facts	9-131
		[i] Pre-2000 CBAs	9-132
		[ii] 2000-2003 CBA	9-133
		[iii] 2000-2003 CBA Retiree Healthcare Provision	9-135
	[b]	Decision	9-135
		[i] 2003 and 2008 Negotiations.	9-139
		[ii] 2011 Negotiations	9-142
		[iii] Post-2014 Course of Conduct.	9-144
		[iv] Conclusion of Law	9-145
[12]		General Electric Wins Retirees’ Challenge of Termination of Health Benefits Coverage	9-146
	[a]	Background	9-146
	[b]	Discussion	9-147
	[c]	Decision	9-149

HEALTH CARE BENEFITS LAW

[13]	Michigan District Court Rejects Retirees’ Claim for Lifetime Healthcare Benefits	9-149
[14]	Sixth Circuit Decision on Retiree Medical Coverage After Tackett	9-150
	[a] Background	9-150
	[b] Decision	9-151
[15]	U.S. Supreme Court Rejection of Sixth Circuit Decision	9-156
	[a] Background	9-157
	[b] Supreme Court Decision	9-158
[16]	Weyerhaeuser Wins Class Action Over Retiree Benefit Cuts	9-160
	[a] Background	9-160
	[b] Discussion	9-161
	[i] Claim for Contractually Vested Healthcare Benefits	9-161
	[ii] Claim for Promissory Estoppel	9-165
[17]	Gerdau Ameristell Reaches \$16M Settlement with Retirees Over Health Care Cuts	9-165
	[a] Background	9-165
	[b] Key Terms of the Proposed Settlement	9-166
	[i] Class Members who are age 65 or Older	9-166
	[ii] Class Members who are younger than age 65 and eligible for Medicare due to disability	9-166
	[iii] Class Members Who are Younger than Sixty-five and Not On Medicare Due to Disability	9-167
	[iv] Open Enrollment	9-167
	[v] Lump Sum Payment	9-168
	[vi] Life Insurance	9-168
	[viii] Attorneys’ Fees	9-168
[18]	FreightCar America To Pay Retirees \$30M To Settle Health Care Benefits Dispute	9-168
	[a] Background	9-169
	[b] Settlement Agreement	9-169
[19]	Ohio District Court Approves Retiree Class Action Settlement	9-172
	[a] Background	9-172
	[b] Settlement Terms	9-172

TABLE OF CONTENTS

xli

	<p>[20] Honeywell Cannot Cut Retiree Health Benefits in Minnesota for Now</p> <p style="padding-left: 20px;">[a] Background</p> <p style="padding-left: 40px;">[i] Factual History</p> <p style="padding-left: 40px;">[ii] Procedural History</p> <p style="padding-left: 20px;">[b] Decision</p> <p style="padding-left: 40px;">[i] Irreparable harm</p> <p style="padding-left: 40px;">[ii] Likelihood of Success</p> <p style="padding-left: 40px;">[iii] Balance Between Harm and Injunctive Relief; Public Interest</p> <p>[21] Union and Retirees Unable to Challenge Benefit Cutback Decision</p> <p style="padding-left: 20px;">[a] Background</p> <p style="padding-left: 20px;">[b] Plaintiffs' Standing to Bring ERISA Claim</p> <p style="padding-left: 40px;">[i] UMW Association Standing</p> <p style="padding-left: 40px;">[ii] Retiree-Plaintiffs' standing</p> <p>§ 9.07 Retiree Drug Subsidy Program</p> <p>§ 9.08 Reimbursement of Retiree Health Premiums or Expenses Utilizing a § 401(h) Account</p> <p style="padding-left: 20px;">[1] Facts</p> <p style="padding-left: 20px;">[2] Rulings Requested</p> <p style="padding-left: 20px;">[3] Legal Analysis</p> <p style="padding-left: 20px;">[4] Conclusion</p>	<p>9-173</p> <p>9-173</p> <p>9-174</p> <p>9-178</p> <p>9-179</p> <p>9-179</p> <p>9-182</p> <p>9-189</p> <p>9-189</p> <p>9-189</p> <p>9-190</p> <p>9-190</p> <p>9-190.2</p> <p>9-190.5</p> <p>9-191</p> <p>9-191</p> <p>9-194</p> <p>9-194</p> <p>9-196</p>
--	---	--

CHAPTER 10

Health Maintenance Organization Act

§ 10.01	Development of HMOs	10-1
§ 10.02	Implications for Employers	10-3
	[1] Mandatory Dual Choice	10-3
	[a] Two Classes of HMOs	10-3
	[b] Open Enrollment Period Required	10-5
	[2] Community Rating	10-5
	[a] Rating by Class	10-6
	[b] Adjusted Community Rating	10-6
	[c] Adjusted Community Rating vs. Experience Rating	10-7
	[3] Employer Contributions	10-7
	[4] State Insurance Laws	10-8

HEALTH CARE BENEFITS LAW**CHAPTER 11****Medicare Secondary Payer Issues**

§ 11.01	Medicare Secondary Payer (MSP) Laws	11-4.1
	[1] Employer Responsibilities Under MSP	11-4.2
	[2] Medigap Policies	11-4.3
§ 11.02	Enforcement of Medicare Secondary Payer Laws	11-5
	[1] Private Cause of Action	11-5
	[2] Excise Tax for Nonconforming Group Health Plans	11-5
	[a] Aggregation Rules	11-5
	[b] Disabled Employees	11-5
	[3] Prohibition of Financial Incentives Not to Enroll in a Group Health Plan	11-6
§ 11.03	Identifying Secondary Payer Situations	11-7
§ 11.04	Health Coverage Data Bank	11-9
§ 11.05	Recovery of Conditional Payments	11-10
	[1] State Laws Do Not Limit Recovery	11-12
	[2] Private Claims-Filing Requirements Do Not Limit Recovery	11-12
	[3] Recovery from Third-Party Administrators	11-13
	[4] Third-Party Administrators Not Liable	11-14
	[5] Problem of Double Liability	11-15
	[6] Restrictions on Governmental Rights of Recovery	11-15
	[7] Supreme Court Decision Regarding Subrogation Question	11-16
§ 11.06	Medicare + Choice: New Alternatives in Medicare	11-16.2
	[1] Introduction	11-16.2
	[2] Types of Medicare + Choice Plans	11-16.2
	[a] Coordinated Care Plans	11-16.3
	[b] HMO	11-17
	[c] POS	11-17
	[d] PPO	11-17
	[e] PSO	11-17
	[f] Medical Savings Accounts	11-18
	[g] Private Fee-for-Service Plans	11-18
	[h] Religious Fraternal Benefit Plans	11-18
	[3] Medigap	11-19
	[4] Eligibility and Enrollment	11-19
	[a] Limitations on Enrollment	11-19
	[b] Enrollment Requirements	11-20
	[i] Coordinated Open Enrollment	11-20

TABLE OF CONTENTS

xliii

		[ii] Lock-In	11-21
		[c] Beneficiary Education	11-22
[5]		Benefits	11-22
		[a] Additional Benefits	11-23
		[b] Supplemental Benefits	11-23
		[c] Premiums	11-23
		[i] Premiums for MSA Enrollees	11-24
		[ii] Calculation of Benefits	11-24
		[d] Cost Sharing	11-24
		[e] Point-of-Service (POS) Benefits	11-25
		[f] Coordination of Benefits	11-25
[6]		Beneficiary Protections	11-25
		[a] Access	11-25
		[b] Access to Services Under a Medicare + Choice Private Fee-for-Service (PFFS) Plan	11-26
		[c] Confidentiality	11-26
		[d] Prohibited Medicare + Choice Interference	11-27
		[e] Grievances and Appeals	11-27
		[f] Quality Assurance	11-28
		[i] Agreement with Review Organization	11-28
		[ii] Deemed Quality	11-28.1
[7]		Relationships with Providers	11-28.1
[8]		Payments to Plans	11-28.2
[9]		Risk Adjustment	11-28.3
[10]		Adjusted Community Rates	11-28.3
[11]		Declining Enrollment Rates in Medicare + Choice Plans	11-28.4
§ 11.07		Health Care Insolvency	11-28.5
		[1] Introduction	11-28.5
		[2] Executory Contracts	11-29
		[a] Definition of Executory Contract	11-29
		[b] Provider Agreements as Executory Contracts	11-29
		[i] Cases Holding That Provider Agreements Are Executory Contracts	11-30
		[ii] Cases Holding That Provider Agreements Are Not Executory Contracts	11-30
		[c] Assumption/Rejection of Provider Agreements	11-31
		[i] Cases Requiring Explicit Court Approval	11-31

HEALTH CARE BENEFITS LAW

	[ii]	Effect of Acceptance of Payments by Provider	11-32
	[iii]	When a Default Need Not Be Cured	11-33
	[iv]	Injunctive Relief from Provider Agreement	11-33
[3]		The Automatic Stay and Setoff/Recoupment of Prepetition Overpayments	11-34
	[a]	Setoff	11-34
	[b]	Recoupment	11-35
	[i]	Recoupment of Overpayments Not Authorized	11-36
	[ii]	Recoupment of Overpayments Authorized	11-38
[4]		Protection Against Discrimination by Governmental Units	11-39
	[a]	Protections Against Discriminatory Treatment	11-39
	[b]	Application of Section 525(a) to Medicare and Medicaid Providers.	11-40
[5]		Absolute Priority Rule	11-40
[6]		Jurisdiction	11-42
[7]		Eligibility Issues in Health Care Bankruptcies	11-43
	[a]	When HMOs Are Eligible for Relief Under the Bankruptcy Code	11-44
	[b]	HMOs as Domestic Insurers	11-45
	[c]	Other Considerations	11-45
§ 11.08		Public Funding of Medical Services and Drugs and Its Impact on the Private Sector	11-46
	[1]	Primary Public Programs That Support Medical Services	11-46
	[2]	How Federal Programs, Especially Medicare, Influence Private Insurance	11-46
	[3]	Overview of Medicare and Medicaid	11-46
	[a]	Medicare	11-47
	[i]	Overview	11-47
	[ii]	Who Qualifies?	11-47
	[iii]	Funding	11-47
	[iv]	Premiums, Deductibles and Co-insurance	11-48
	[v]	What is Not Covered—Drugs.	11-48
	[b]	Medicaid	11-48
	[i]	State Participation	11-48
	[ii]	Eligibility	11-49
	[iii]	Prescription Drug Benefits and Rebate Program	11-49

TABLE OF CONTENTS

xliv

[4]	Administration of Medicare and Medicaid	11-49
	[a] Medicare	11-49
	[b] Medicaid	11-49
[5]	Hospital Payments Under Medicare	11-50
	[a] Cost Reimbursement System (Pre-1983)	11-50
	[b] Prospective Payment System (PPS)	11-50
[6]	Doctors Under Medicare	11-51
[7]	Drugs Under Medicare and Medicaid	11-52
	[a] Medicare—Limited Drug Benefits	11-52
	[b] Medicaid	11-52
	[i] Outpatient Drugs	11-52
	[ii] Inpatient Drugs	11-52
	[c] Medicare Modernization Act	11-53
	[i] Employer or Union Coverage	11-53
	[ii] Limited Incomes and Resources	11-54
	[iii] Automatic and Facilitated Enrollment	11-55
	[iv] Dual-Eligible Beneficiaries with Retiree Drug Coverage	11-55
[8]	Anti-Kickback and Anti-Referral Laws	11-58
	[a] Anti-Kickback Laws	11-58
	[i] Scope of Anti-Kickback Law	11-58
	[ii] Safe Harbor Regulation— In General	11-59
	[iii] Marketing and Advertising— Personal Services Safe Harbor	11-59
	[b] Stark Anti-Referral Provision	11-63
[9]	Carrier Responsibilities—Review of Services and Payment for Services	11-63
	[a] Coverage	11-64
	[i] Part A Versus Part B	11-64
	[ii] Overutilization	11-64
	[iii] Fraudulent Billing	11-65

CHAPTER 12

Family and Medical Leave Act

§ 12.01	Overview	12-2
§ 12.02	Coverage	12-4
§ 12.03	Eligibility for Leave	12-5

HEALTH CARE BENEFITS LAW

	[1]	Eligibility Requirements	12-5
	[2]	Qualifying Events for FMLA Leave	12-6
	[3]	Adoption and Foster Care	12-6
	[4]	Domestic Partners	12-6
	[5]	Family Care	12-6
	[6]	Serious Health Condition.	12-6
	[7]	Doctor Visits or Therapy	12-7
	[8]	Voluntary or Cosmetic Treatments	12-7
	[9]	Substance Abuse	12-8
	[10]	Continuing-Treatment Requirement	12-8
	[11]	Inability to Perform the Job.	12-8
	[12]	Support for Leave Request for Family Care.	12-9
	[13]	Intermittent or Reduced Leave Schedule for a Serious Health Condition	12-9
	[14]	Health Care Provider	12-10
§ 12.04		Definition of “Leave”	12-11
	[1]	Working Spouses	12-11
	[2]	Reduced Workweek or Intermittent Leaves	12-11
	[3]	Transfer to an Alternative Position	12-12
	[4]	Calculation of Leave Taken	12-12
§ 12.05		Paid Leave	12-13
	[1]	Paid Family Leave	12-13
	[2]	Paid Vacation or Personal Leave	12-13
	[3]	Using Paid Leave for FMLA Purposes	12-14
	[4]	Qualifying Reason Needed to Grant Leave.	12-14
	[5]	Designating FMLA Leave	12-15
§ 12.06		Benefits Coverage	12-16
	[1]	Same Benefits Required.	12-16
	[2]	When Coverage Ceases	12-16
	[3]	Payment of Premiums	12-17
	[4]	Methods of Payment	12-17
	[5]	Multiemployer Plans	12-18
	[6]	Failure to Make Timely Premium Payments	12-18
	[7]	Recovering Employer Premiums	12-19
	[8]	Medical Emergency Exceptions	12-19
	[9]	Guidelines for Recovering Premiums	12-20
	[10]	Employee’s Rights on Returning to Work	12-21
	[11]	Protection of Employees	12-21
§ 12.07		Notice.	12-23
	[1]	Posting Requirements	12-23
	[2]	Employee Notice	12-23
	[3]	Actions Taken Against Employees	12-24

TABLE OF CONTENTS

xlvii

[4]	Medical Certification	12-24
[5]	Required Information.	12-24
[6]	Second and Third Opinions	12-25
[7]	Employee Status Reports.	12-25
[8]	Fitness-for-Duty Report.	12-26

CHAPTER 13

ADA's Impact on Employee Benefit Plans

§ 13.01	Statutory and Regulatory Framework	13-4
	[1] Terms and Definitions	13-4
	[2] Discrimination	13-5
	[3] EEOC's Interim Enforcement Guidelines	13-6
	[a] Burden Shifts to Employers	13-6
	[b] Subterfuge Analysis	13-6
	[4] Application to Employee Health Benefits Plans	13-6.1
§ 13.02	General Standards for Insured and Self-Insured Plans	13-6.2
	[1] Family Health Coverage Not an ADA Issue	13-6.2
	[2] Curtailing Coverage.	13-6.2
	[3] Denial of Experimental Treatment Violates ADA	13-7
	[4] Similarities to the Age Discrimination in Employment Act	13-8
	[5] Interpreting "Bona Fide" and "Subterfuge" in the ADA	13-9
	[6] Insured Plans and Risk Classifications	13-9
	[7] Discrimination in Benefits.	13-10
	[8] Equal Employment Opportunity Commission Interpretation.	13-11
§ 13.03	Determining the Meaning of "Subterfuge"	13-13
	[1] Cost Justification	13-13
	[2] Business Purpose	13-13
	[3] Data Collection	13-14
	[a] Question of Cost	13-14
	[b] A Key Example	13-14
	[c] Time Limitation Not Discriminatory	13-15
§ 13.04	Enforcement.	13-16
	[1] Time Limits	13-16
	[2] Attorney Fees.	13-16
	[3] Dispute Resolution.	13-16
§ 13.05	EEOC Regulations on ADA and GINA Compliance for Wellness Programs	13-17

HEALTH CARE BENEFITS LAW

[1]	Introduction	13-17
	[a] Application of the ADA to Wellness Programs	13-18
	[b] Application of Title II of GINA to Wellness Programs	13-19
[2]	ADA Final Wellness Regulation	13-19
	[a] Definition of Employee Health Program	13-19
	[b] Employee Health Program Must be “Voluntary”	13-20
	[c] Qualification as an Employee Health Program	13-21
	[d] Reasonable Design	13-21
	[e] Voluntary Participation and Notice.	13-22
	[f] Confidentiality of Medical Information.	13-23
	[g] Incentive Limits	13-23
	[h] Limit Applies to Stand-Alone Wellness Programs and Wellness Programs that are Part of Group Health Plan.	13-25
	[i] “Employee Health Programs” Involving a Disability-Related Inquiry or Medical Examination Are Subject to the final regulation.	13-25
	[j] Application to Tobacco Cessation Programs	13-26
	[k] Employers Must Satisfy Certain Notice Requirements	13-26
[3]	GINA Final Wellness Regulation.	13-26
	[a] Employer May Offer Inducement to Employee for Employee’s Spouse to Provide Information About Spouse’s Manifestation of Disease or Disorder as Part of HRA	13-26
	[b] GINA Regulation Applies Broadly to Wellness Programs, Whether or Not Offered as Part of a Group Health Plan.	13-27
	[c] GINA Subject Programs Must Satisfy a Reasonable Design Requirement.	13-27
	[d] Confidentiality, Notice and Authorization	13-27
	[e] GINA-Subject Programs Must Limit Incentives (Maximum Incentive Limitations Mirror ADA).	13-28

TABLE OF CONTENTS

xlix

	[f]	GINA-Subject Programs Cannot Deny Access to Group Health Plan Coverage (or a Particular Benefits Package Within a Group Health Plan) Solely for Failure to Complete an HRA	13-28
	[g]	GINA-Subject Programs Cannot Provide Any Financial Incentives for Use with Child HRAs.	13-28
	[h]	GINA-Subject Programs Cannot Provide Financial Inducement for Spouse to Provide His or Her Genetic Information, Including Genetic Tests	13-29
	[i]	Information Regarding Tobacco Use Is Not Genetic Information	13-29
	[j]	Authorization Requirement Applies to Spouses.	13-29
	[k]	GINA-Subject Programs Cannot Condition Receipt of Inducement on Waiver of Confidentiality Protections	13-29
	[4]	Applying ADA, GINA AND HIPAA/ACA Incentive Limits	13-29
§ 13.06		District Court Rules that Wellness Program Health Risk Assessment Does Not Violate the ADA.	13-31
	[1]	Summary	13-31
	[2]	Background	13-32
	[3]	Decision.	13-34
	[4]	Legal Analysis	13-35
	[a]	Safe Harbor Provision.	13-35
	[b]	Voluntary Examination and Inquiry	13-40
	[c]	Retaliation and Interference Claims	13-41
§ 13.07		Yale University Sued Over Workplace Wellness Penalties	13-43
	[1]	Summary	13-43
	[2]	Background	13-44
	[a]	General	13-44
	[b]	The ADA’s “Voluntary” Requirement for Employee Wellness Programs	13-44
	[c]	GINA’s “Voluntary” and Nondisclosure Requirements for Employee Wellness Programs	13-45
	[d]	2016 EEOC Regulations Governing Employee Wellness Programs under the ADA and GINA	13-45

HEALTH CARE BENEFITS LAW

[3]	Allegations	13-46
[4]	Causes of Action	13-48
	[a] Violation of the ADA	13-48
	[b] Violation of GINA	13-49
[5]	Relief Requested	13-49
[6]	District of Columbia District Court Vacates the Penalty and Incentive Provisions of the 2016 EEOC Rules as Arbitrary and Capricious	13-50
	[a] Summary of 2017 Decision	13-50
	[b] Background of 2017 Decision	13-51
	[c] 2016 EEOC Rules	13-52
	[i] The ADA Rule	13-53
	[ii] Consistency with HIPAA	13-54
	[iii] Current Insurance Rates	13-55
	[iv] Failure to Consider Relevant Factors	13-56
	[v] The GINA Rule	13-57

CHAPTER 14**[Reserved]****CHAPTER 15****Regulation of Multiple Employer
Welfare Arrangements**

§ 15.01	Introduction	15-2.1
§ 15.02	The Basis for MEWAs	15-3
§ 15.03	Federal Regulation	15-4
	[1] Fully Insured Plans	15-4
	[2] Plans Not Fully Insured	15-4
	[3] Non-ERISA Plans	15-4
§ 15.04	Department of Labor Involvement	15-5
§ 15.05	Defining the Scope of Federal Preemption	15-6
	[1] Taft-Hartley Plans	15-6
	[2] Single Employer Plans	15-7
§ 15.06	Compliance with State Insurance Law	15-8
	[1] Reserves	15-8
	[2] DOL's Deference to States	15-9
§ 15.07	Compliance with ERISA	15-11
§ 15.08	IRS Compliance	15-13
§ 15.09	Compliance with COBRA	15-14
§ 15.10	ERISA and Workers' Compensation	15-15

TABLE OF CONTENTS

li

§ 15.11	Expanded Reporting Requirements	15-16
	[1] DOL Rule	15-16
	[2] What a MEWA Is	15-17
	[3] How MEWAs Are Regulated	15-18
	[4] Information to Be Disclosed on DOL Form M-1	15-19
	[a] Disclosure Requirements	15-19
	[b] Guidance on Compliance with the Filing Requirements	15-19
	[c] Demonstrating a Good Faith Effort to Comply	15-19
	[d] Consequences that Flow From Completion of the Form	15-20
§ 15.12	DOL Finalizes Association Health Plan Rule	15-21
	[1] Background	15-21
	[2] Overview of the Final Rule	15-25
	[a] Continued Availability of “Bona Fide Group or Association of Employers”	15-25
	[b] Bona Fide Groups or Associations of Employers under the Final Rule	15-26
	[i] Purpose of the Association	15-27
	[ii] The Group or Association Must Have an Organizational Structure	15-28
	[iii] Participating Employer Control Over the Group or Association and the AHP	15-28
	[iv] Definition of Eligible Participant	15-29
	[v] Health Insurance Issuer Cannot Sponsor an AHP	15-29
	[vi] Commonality of Interest	15-30
	[vii] Nondiscrimination	15-30
	[c] Working Owner Provision	15-31
	[i] Treatment of Working Owners as Employers and Employees	15-31
	[ii] Working Owner Definition and Verification of Owner Status	15-32
	[d] Application of ERISA Group Health Plan Requirements to AHPs	15-33
	[e] ERISA Fiduciary Status and Responsibilities of AHP Sponsors	15-33
	[3] DOL Final Rule Adopts New Regulation	15-35

HEALTH CARE BENEFITS LAW

§ 15.13 District Court Rules that DOL AHP Regulations Are An Unreasonable Interpretation of ERISA . . . 15-43

[1] Summary 15-43

[2] Background 15-44

[a] ERISA and the ACA 15-45

[b] Association Health Plans and the Final Rule 15-45

[c] Procedural History 15-47

[3] Decision 15-47

[a] The Chevron Framework Applies to DOL’s Interpretation of ERISA 15-48

[b] DOL’s Regulatory Interpretation of ERISA Is Not Reasonable 15-49

[i] ERISA Is Limited to Employee Benefit Plans Arising from Employment Relationships. 15-49

[ii] ERISA Extends the Definition of Employer Only to Associations Acting in the Interest of Employers 15-50

[iii] The Final Rule’s Expansive Test for Bona Fide Associations is Not Reasonable. 15-51

[iv] The Final Rule’s Expansion of “Employer” to Include Working Owners without Employees Is Not Reasonable. 15-57

CHAPTER 16

Health Insurance Portability and Accountability Act of 1996

§ 16.01 Statute Policy 16-6.3

§ 16.02 Group Health Plan Portability, Access and Health Status Nondiscrimination 16-7

[1] General Restrictions on Preexisting Condition Exclusions 16-7

[2] “Creditable Coverage” Defined 16-8

[3] “Excepted Benefits” 16-8

[4] Certifications of Creditable Coverage 16-8

[5] 63-day Breaks in Creditable Coverage 16-8

[6] Standard and Alternative Methods for Crediting Prior Coverage 16-9

TABLE OF CONTENTS

liii

	[7]	No Preexisting Condition Exclusions for Newborns and Adopted Children	16-9
	[8]	No Preexisting Condition Exclusions for Pregnancy	16-10
	[9]	Special Enrollment Periods Due to Loss of Other Coverage	16-10
	[10]	Special Enrollment Periods for Dependents	16-10
	[11]	HMO Affiliation Periods	16-10
	[12]	Health Status Nondiscrimination	16-11
	[13]	New Participant Disclosure Deadlines for Material Reductions in Group Health Plans	16-11
	[14]	Additional Information That Must Be Included in Plan Documents and SPDs	16-12
	[15]	Guaranteed Renewability in Multi-Employer Plans and MEWAs	16-12
	[16]	MEWA Reporting Requirement	16-12
	[17]	State Flexibility and Preemption	16-12
	[18]	Effective Dates	16-12
	[19]	Penalties	16-13
	[20]	Implications	16-13
§ 16.03		Group Health Insurer Requirements	16-16
	[1]	Guaranteed Issue Not Required in the Large Group Market	16-16
	[2]	Guaranteed Issue in the Small Group Market	16-16
	[3]	Insurers May Use Certain Underwriting Requirements to Deny Coverage	16-16
	[4]	Denial of Coverage May Result in a Suspension of New Business Activity in a Service Area	16-17
	[5]	Guaranteed Renewal Requirements	16-17
	[6]	Rules Regarding a Health Insurer’s Exit from a Market	16-17
	[7]	Disclosure Requirements	16-18
	[8]	Special Rules Regarding Association Coverage	16-18
	[9]	Study of Conditions in the Large Group Market	16-18
	[10]	Preemption/State Flexibility	16-19
	[11]	Penalties	16-19
	[12]	Implications	16-19
§ 16.04		Individual Health Insurer Requirements	16-20
	[1]	Guaranteed Issue to Eligible Individuals	16-20

HEALTH CARE BENEFITS LAW

	[a]	Eligible Individuals	16-20
	[b]	Guaranteed Renewal	16-20
	[2]	Coverage Requirements	16-20
	[3]	Optional State Programs/State Flexibility	16-22
	[4]	Discontinuation of Health Coverage/Exit from the Market	16-22
	[5]	Federal Preemption of State Insurance Laws	16-22
	[6]	Penalties	16-23
	[7]	Implications	16-23
§ 16.05		COBRA Amendments	16-24
	[1]	Disability May Arise Within First 60-Days of COBRA Continuation.	16-24
	[2]	Any Disabled Qualified Beneficiary May Become Entitled to Up to 29 Months COBRA Continuation	16-24
	[3]	Newborns and Adopted Children Are Qualified Beneficiaries	16-24
	[4]	Coverage Under Another Group Health Plan	16-25
	[5]	Medicare Entitlement Followed by Qualifying Event.	16-25
	[6]	Effective Dates.	16-25
	[7]	Penalties	16-26
	[8]	Implications	16-26
§ 16.06		Long-Term Care	16-28
	[1]	Federal Tax Treatment of Long-Term Care Clarified.	16-28
	[a]	What is a “Qualified Long-Term Care Insurance Contract”?	16-28
	[b]	What Are Qualified Long-Term Care Services?	16-29
	[i]	Per Diem Limitations	16-29
	[ii]	Taxation of Payments in Excess of the Per Diem Limits	16-29
	[c]	Treatment of Long-Term Care Services as Medical Care for Federal Tax Purposes	16-30
	[2]	Long-Term Care Insurance Not Permitted Under Cafeteria Plans or Flexible Spending Accounts	16-30
	[3]	COBRA Exclusion.	16-30
	[4]	Long-Term Care Insurance Coverage Provided by a Rider to a Life Insurance Contract.	16-30
	[5]	Treatment of Certain State-Maintained Plans	16-31

TABLE OF CONTENTS

	[6] Annual Reporting Requirement for Long-Term Care Benefits Payers	16-31
	[7] Long-Term Care Study	16-31
	[8] Consumer Protection Provisions	16-31
	[9] Life Insurance Company Reserves	16-31
	[10] Effective Dates	16-32
	[11] Penalties	16-32
	[12] Implications	16-32
§ 16.07	Administrative Simplification	16-34
	[1] National Standards for Electronic Transmission of All Health Care Coverage Information	16-34
	[2] Individual Health Identifiers	16-34
	[3] Electronic Authentication of Signatures	16-35
	[4] Coordination of Benefits	16-35
	[5] Protection of Privacy	16-35
	[6] Effect of State Law	16-35
	[7] Penalties	16-35
	[8] Implications	16-36
	[9] HIPAA Administrative Enforcement Regulations to Conform to the HITECH Act	16-36
	[a] Introduction	16-36
	[b] Statutory and Regulatory Background	16-36.1
	[c] The Final Rule	16-36.4
	[10] Significant Financial Penalties Imposed by the Department of Health and Human Services	16-36.7
	[a] Civil Penalties Imposed on Covered Entities	16-36.7
	[b] Expanded Enforcement for Business Associates	16-36.8
	[c] HHS Reduces Maximum Penalty Amounts for Certain HIPAA Violations	16-36.8
	[i] Background	16-36.9
	[ii] Revised Maximum Penalty Amounts	16-36.9
§ 16.08	Health Care Fraud and Abuse	16-37
	[1] Federal Initiative to Combat Health Care Fraud in Public and Private Health Plans	16-37
	[2] Expulsion from Medicare and Medicaid for Health Care Fraud	16-37
	[3] National Fraud Data Bank	16-37
	[4] Medicare Beneficiary Incentive Program	16-38

HEALTH CARE BENEFITS LAW

	[5]	Intermediate Sanctions on Medicare HMOs	16-38
	[6]	Exception to Anti-Kickback Penalties for Medicare HMOs' Risk-Sharing Arrangements	16-38
	[7]	Advisory Opinions Required Under the Medicare/Medicaid Anti-Kickback Law	16-39
	[8]	Penalties	16-39
	[9]	Fraud Against "Federal Health Care Programs"	16-39
	[10]	Implications	16-40
§ 16.09		Accelerated Death Benefits	16-41
	[1]	Terminally Ill Insureds	16-41
	[2]	Chronically Ill Insureds	16-41
	[3]	Qualified Accelerated Death Benefit Riders Treated as Life Insurance	16-42
	[4]	Viatical Settlement Agreements	16-42
	[5]	IRS Reporting Requirements	16-43
	[6]	Penalties	16-43
	[7]	Implications	16-43
§ 16.10		Medical Savings Accounts	16-44
	[1]	Tax-Favored MSA Available to the Self-Employed and to Employees of Small Employers	16-44
	[2]	A High-Deductible Health Plan Must Accompany an MSA	16-44
	[3]	No Income Tax on MSA Earnings or Distributions for Medical Expenses	16-44
	[4]	Limited Number of MSAs Permitted During Four-Year Experiment	16-45
	[5]	HMOs May Offer MSA-Related Products	16-45
	[6]	Penalties	16-45
	[7]	Implications	16-46
§ 16.11		Interim Final Rules Under the Health Insurance Portability and Accountability Act of 1996	16-47
	[1]	In General	16-47
	[2]	Preexisting Condition Exclusion	16-48
	[a]	Limitations on Preexisting Condition Exclusions	16-48
	[b]	Length of Preexisting Condition Exclusion Period	16-49
	[c]	Reduction of Preexisting Condition Exclusion by Prior Coverage	16-50
	[d]	Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children	16-50

TABLE OF CONTENTS

lvii

	[e] Notice of Preexisting Condition Exclusion	16-50
	[f] HMO Affiliation Period as Alternative to Preexisting Condition Exclusion	16-50
[3]	Excepted Plans and Excepted Benefits	16-51
	[a] Very Small Plans	16-51
	[b] Excepted Benefits	16-51
[4]	Rules Relating to Creditable Coverage	16-53
	[a] Method of Crediting Coverage	16-53
	[b] Standard Method	16-53
	[c] Alternative Method	16-54
	[d] Determination Period Under Both Methods	16-55
[5]	Certificates and Disclosure of Previous Coverage	16-55
	[a] Form of Certificate	16-55
	[b] Information in Certificate	16-55
	[c] Certification Events and Timing	16-56
	[d] Responsibilities of Plans and Issuers	16-57
	[e] Other Entities Issuing Certificates	16-58
	[f] Dependent Coverage Information	16-58
	[g] Information for Alternative Method of Counting Creditable Coverage	16-59
	[h] Demonstration of Coverage if Certificate is Not Provided	16-59
	[i] Notice to Individual of Determination of Period of Preexisting Condition Exclusion	16-60
[6]	Special Enrollment Periods	16-60
	[a] Special Enrollment for Loss of Other Coverage	16-61
	[b] Special Enrollment for New Dependents	16-62
	[c] Additional Special Enrollment Rights, Notice and Disclosure Obligations for Group Health Plans	16-62
[7]	Nondiscrimination in Eligibility	16-62.2
[8]	Preemption of State Laws: State Flexibility	16-64
[9]	Expansion of ERISA Reporting and Disclosure Requirements	16-65
	[a] SPD Content Requirements	16-65
	[b] Accelerated Disclosure	16-66
	[c] Alternative Delivery Methods	16-66
[10]	Post-Interim Rules on Guidance Under HIPAA and Related Laws	16-66

HEALTH CARE BENEFITS LAW

	[a]	Flexible Health Spending Accounts (FSAs)	16-66
	[b]	HIPAA and Health FSA Plans.	16-67
	[c]	HIPAA Special Enrollment Rights and COBRA	16-68
§ 16.12		Mental Health Parity and Minimum Maternity Stay Benefits	16-77
	[1]	Mental Health Parity	16-77
		[a] Exemptions	16-78
		[b] Effective Date	16-79
	[2]	Implications	16-79
	[3]	Amendments to Mental Health Parity Provisions	16-80
	[4]	Minimum Maternity Stay Benefits	16-81
		[a] Special Notice Requirement	16-82
		[b] Preemption	16-83
		[c] Effective Date	16-83
		[d] Implications.	16-83
	[5]	The Effect on Employers of ERISA's Mandated Welfare Benefits	16-84
	[6]	What Might Be Next?	16-85
§ 16.13		Temporary Regulations Under the Mental Health Parity Act	16-86
	[1]	Introduction	16-86
	[2]	Increased Cost Exemption	16-86.1
	[3]	Penalties for Noncompliance	16-86.2
§ 16.13A		The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	16-86.3
§ 16.14		Interim Rules Governing the Newborns' and Mothers' Health Protection Act of 1996.	16-87
	[1]	Introduction	16-87
		[a] Background	16-87
		[b] Application	16-88
	[2]	The General Rule for Hospital Lengths of Stay	16-89
	[3]	Prohibitions	16-91
	[4]	Construction.	16-92
	[5]	Notice Requirements Under ERISA and the PHS Act.	16-94
	[6]	Applicability in Certain States.	16-95
§ 16.14A		Final Rules Governing the Newborns' and Mothers' Health Protection Act of 1996	16-96
	[1]	Generally	16-96
	[2]	Hospital Length of Stay	16-96
		[a] Generally.	16-96
		[b] Definition of Attending Provider	16-96
		[c] Authorization and Precertification	16-96.1

TABLE OF CONTENTS

lix

	[3]	Notice Requirements Under ERISA and the Public Health Services (PHS) Act	16-96.1
		[a] Notice Requirements Under ERISA	16-96.2
		[b] Notice Requirements for Nonfederal Governmental Plans	16-96.2
		[c] Notice Requirements for Health Insurance Issuers in the Individual Market	16-96.3
	[4]	Applicability in States	16-96.3
	[5]	Applicability Date	16-96.3
§ 16.15		Compliance with Privacy Requirements Protecting Personal Medical Records Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).	16-96.4
	[1]	Effective Dates	16-97
	[2]	Covered Entities and Related Definitions	16-98
		[a] Covered Entity	16-98
		[b] Excepted Benefits	16-98
		[c] Health Care Provider	16-98
		[d] Health Plan	16-99
		[e] Group Health Plan	16-99
		[f] Health Care Clearinghouse	16-100
		[g] Health Information	16-100
		[h] Business Associate	16-100
	[3]	Disclosure of Protected Health Information	16-100
		[a] What is Protected?	16-100
		[b] De-Identified Information	16-101
		[c] Permitted Uses and Disclosures	16-101
		[d] Minimum Necessary Standard	16-101
		[e] Required Disclosures	16-102.4
		[f] Consent versus Authorization	16-102.4
		[i] General Rule for Consents	16-102.4
		[ii] General Rule for Authorizations	16-103
		[g] Representatives	16-105
		[h] Access, Amendment, and Accounting	16-105
		[i] Right to Request Additional Protection of PHI	16-105
		[j] Notice of HIPAA Privacy Rule Rights	16-105
		[k] Psychotherapy Notes	16-105
		[l] Directories, Marketing, and Fundraising	16-106
		[m] Business Associates	16-106
		[n] Disclosure to Employers and Other Plan Sponsors of Group Health Plans	16-107

HEALTH CARE BENEFITS LAW

	[o]	Disclosure to Worker’s Compensation Carriers and Other Non-Covered Entities	16-107
	[p]	Research	16-108
	[4]	Mergers and Acquisitions	16-109
	[5]	Enforcement/Penalties	16-109
	[6]	State Law Preemption	16-109
	[7]	Compliance with Other Federal Laws	16-110
	[8]	HIPAA Compliance Action Plan	16-112
§ 16.16		Final Modifications to HIPAA Privacy Rule	16-115
	[1]	Patient Consent	16-115
	[a]	Limitation on Obtaining Consent	16-115
	[b]	Facilitation of PTO	16-115
	[2]	Written Acknowledgment of Privacy Notice’s Receipt	16-116
	[3]	Modification of Minimum Necessary Requirement	16-117
	[a]	Incidental Uses or Disclosures	16-117
	[b]	Authorization Not Subject to Minimum Necessary Standard	16-117
	[4]	Business Associate Contracts	16-117
	[a]	Deferral of Contract Deadline.	16-117
	[b]	Sample Contract Language.	16-118
	[5]	Marketing.	16-118
	[a]	Authorization Necessary for Disclosure.	16-118
	[b]	Clarification of Marketing Definition	16-118
	[6]	Disclosure of a Minor’s PHI	16-119
	[7]	Research Use and Disclosure.	16-119
	[a]	Institutional Review Board Requirement	16-119
	[b]	Research in Connection with Treatment	16-120
	[c]	Transition Procedures	16-120
	[d]	Revocation of Authorization after Commencement of Research	16-120
	[8]	Authorization Forms: Core Elements and Other Requirements	16-121
	[9]	De-Identification of Protected Health Information	16-121
	[10]	Other Clarifications	16-121
	[11]	2005 HIPAA Regulations Regarding Notice and Creditable Coverage.	16-122
§ 16.17		Employer Obligations to Protect the Privacy of Medical Records Under Group Health Plans	16-123

TABLE OF CONTENTS

lxi

	[1] Consequence of Non-Compliance with HIPAA	16-124
	[2] Comparison of GHP Requirements Based on Type of Group Health Plan	16-125
	[3] Exchange of Information Between the GHP and the Employer	16-127
	[4] Implementation	16-129
	[5] Organized Health Care Arrangements (“OHCAs”)	16-131
	[6] Employer as Covered Entity and GHP Sponsor	16-133
	[7] Conclusion	16-133
§ 16.18	HIPAA Security Standards	16-134
	[1] Introduction	16-134
	[2] Security Requirements and Implementation Features	16-134
	[3] Implementation of a HIPAA Security Compliance Plan	16-135
	[4] Civil and Criminal Penalties for HIPAA Security Noncompliance	16-135
	[5] Conclusion	16-136
§ 16.19	Final Rules on Health Plan Nondiscrimination	16-137
	[1] Background	16-137
	[2] Clarifications	16-137
	[3] Wellness Programs	16-138
	[4] Relationship with Other Laws	16-139
§ 16.19A	Genetic Information Nondiscrimination Act	16-140
	[1] Title I: Genetic Nondiscrimination in Health Insurance	16-140
	[2] Title II: Prohibiting Employment Discrimination on the Basis of Genetic Information	16-141
	[3] EEOC Proposed Regulations Under GINA’s Employment Nondiscrimination Requirements	16-142
	[a] Definitions	16-142
	[i] Employee	16-142
	[ii] Covered Entity	16-142
	[iii] Family Member	16-142
	[iv] Family Medical History	16-143
	[v] Genetic Information	16-143
	[vi] Genetic Monitoring	16-143
	[vii] Genetic Services	16-144
	[viii] Genetic Test	16-144
	[ix] Manifestation or Manifested	16-144
	[b] Prohibited Practices	16-145
	[c] Acquisition of Genetic Information	16-145

HEALTH CARE BENEFITS LAW

	[d]	Confidentiality	16-147
	[e]	Limitations on Disclosure	16-147
	[f]	Relationship to HIPAA Privacy Regulations.	16-148
	[g]	Relationship to Other Laws Regarding Discrimination or Genetic Information.	16-148
	[h]	Relationship to Other Federal Laws Governing Health Coverage.	16-148
	[i]	Medical Information	16-149
§ 16.20	Part 7	Audits	16-150
	[1]	General Investigative Powers	16-150
		[a] ERISA Section 504	16-150
		[b] ERISA Section 104	16-150
	[2]	Investigations of Health and Welfare Plans— DOL Compliance Project	16-150
	[3]	Who to Investigate	16-151
	[4]	Steps in the Investigation Process	16-151
		[a] Initial Document Request	16-151
		[b] On-Site Review	16-152
		[c] DOL Interview	16-153
		[d] Voluntary Compliance Notice Letter	16-153
		[e] Settlement Agreement	16-153
	[5]	Part 7 Self-Compliance Assistance	16-153

CHAPTER 17

Welfare Benefits Provided by PEOs

§ 17.01	Introduction	17-2
	[1] The PEO Industry	17-2
	[2] Why PEOs Cause Concern	17-4
	[3] Overview	17-4
§ 17.02	Welfare Benefits	17-6
§ 17.03	Who is the Employer?	17-7
	[1] Co-Employment Under Agency Principles.	17-9
	[2] Co-Employment Under the Code	17-11
	[3] Microsoft III.	17-12
§ 17.04	Federal Tax Issues	17-15
	[1] Excludability of PEO-Provided Welfare Benefits	17-15
	[2] Welfare Benefits Nondiscrimination Rules	17-16
	[3] “Leased Employees”	17-18
	[4] METs, MEWAs and VEBAs	17-22

TABLE OF CONTENTS

lxiii

	[5]	Section 419 Deduction Issues	17-22
		[a] Qualified Non-Guaranteed Insurance Contracts	17-25
		[b] Ten or More Employer Plans	17-25
		[c] Employee Pay-All Plans	17-27
	[6]	VEBAs	17-27
	[7]	Taxation of Non-Exempt Trusts and Exempt VEBAs	17-31
	[8]	VEBA and Non-Exempt Trust Reporting Requirements	17-32
	[9]	Proposed PEO Legislation	17-33
§ 17.05		PEO Welfare Benefits Under ERISA	17-36
	[1]	Whether a Worker Is Entitled to Welfare Benefits Under a Client Company’s Plan	17-36
		[a] Welfare Benefit Plan Language	17-37
		[b] Waiver of ERISA Rights	17-42
	[2]	Potential Client Company Liability Under ERISA for Interference With Rights Under a Welfare Plan	17-43
	[3]	Welfare Plan Amendments	17-46
	[4]	ERISA-Covered Welfare Plan ERISA Obligations	17-50
		[a] Requirements Under ERISA Part 1	17-50
		[b] Requirements Under ERISA Part IV	17-51
		[c] Requirements Under ERISA Part V	17-52
	[5]	Whether PEOs Maintain Single-Employer Welfare Benefit Plans	17-52
		[a] A Group or Association of Employers	17-54
		[b] Could a PEO’s Welfare Benefit Plan Be an ERISA-Covered Plan?	17-58
	[6]	Whether a Client Company Establishes or Maintains an ERISA-Covered Welfare Plan	17-60
	[7]	MEWAs and State Insurance Laws	17-64
		[a] Scope of ERISA Preemption	17-65
		[b] State Regulation of MEWAs	17-66
§ 17.06		COBRA and HIPAA	17-71
	[1]	COBRA	17-71
		[a] Impact of a PEO Arrangement	17-73
		[b] Proposed Legislation	17-75
	[2]	HIPAA	17-76
		[a] Application of HIPAA Requirements to a PEO Arrangement	17-78
		[b] MEWA Reporting	17-79
§ 17.07		Conclusion	17-81

HEALTH CARE BENEFITS LAW**CHAPTER 18****Bankruptcy Abuse Prevention and Consumer Protection Act of 2005—Title XI Health Care and Employee Benefits**

§ 18.01	Introduction	18-1
§ 18.02	Disposal of Patient Records	18-3
§ 18.03	Appointment of Ombudsman to Act as Patient Advocate	18-4
§ 18.04	Duty of Trustee to Transfer Patients	18-5
§ 18.05	Administrative Expense Claim for Costs of Closing a Health Care Business and Other Administrative Expenses	18-6
§ 18.06	“Health Care Businesses”—Definition	18-8
§ 18.07	Exclusion from Program Participation Not Subject to Automatic Stay	18-9
§ 18.08	Miscellaneous Changes to Health Care Laws	18-10
	[1] Health Savings Accounts	18-10
	[2] Unsecured Benefit Plan Contributions	18-10
	[3] Duties of Debtor That is a Plan Administrator	18-10
	[4] Restrictions on Modifying Retiree Benefits	18-10
§ 18.09	Conclusion	18-11

CHAPTER 19**[Reserved]****CHAPTER 20****2010 Health Care Reform:
The Patient Protection and Affordable Care Act &
The Health Care and Education Reconciliation Act**

§ 20.01	Introduction to 2010 Legislation	20-8.3
	[1] Generally	20-8.3
	[2] Timeline of Changes	20-9
	[a] Effective During 2010	20-9
	[b] Effective in 2011	20-10
	[c] Effective in 2012	20-10
	[d] Effective in 2013	20-11
	[e] Effective by 2014	20-11

TABLE OF CONTENTS

lxv

	[f] Effective in 2015.....	20-13
	[g] Effective in 2016.....	20-13
	[h] Effective by 2017.....	20-13
	[i] Effective by 2018.....	20-13
	[j] Effective in 2019-2020.....	20-14
§ 20.02	Small Employer Health Insurance Expense Tax Credit.....	20-15
	[1] Generally.....	20-15
	[2] Employers Eligible for Section 45R Tax Credit.....	20-15
	[3] Calculation of Section 45R Tax Credit.....	20-17
	[4] Claiming a Section 45R Tax Credit.....	20-18
	[5] Transitional Relief for Taxable Years Beginning in 2010.....	20-19
	[6] Issues Not Addressed by IRS Notice 2010-44.....	20-19
§ 20.03	Early Retiree Reinsurance Program.....	20-20
§ 20.04	Health Care Reform’s Impact on Hospitals.....	20-20.1
§ 20.05	Regulations to Implement the Affordable Care Act.....	20-20.3
	[1] Generally.....	20-20.3
	[2] Required Coverage of Adult Children to Age Twenty-Six.....	20-20.3
	[a] Generally.....	20-20.3
	[b] IRS Notice 2010-38.....	20-20.5
	[c] Interim Final Regulations.....	20-21
	[d] Tax Consequences in Certain States...	20-21
	[3] Status as a Grandfathered Health Plan.....	20-22
	[a] Definition of Grandfathered Health Plan Coverage.....	20-23
	[i] Maintenance of Grandfather Status.....	20-23
	[ii] Adding New Employees.....	20-25
	[iii] Health Insurance Coverage Maintained Pursuant to a Collective Bargaining Agreement.....	20-25
	[b] Rules Applicable to Grandfathered Plans.....	20-25
	[4] Prohibition on Preexisting Condition Exclusions, Lifetime and Annual Dollar Limits on Benefits, Restrictions on Rescissions, and Patient Protections.....	20-26
	[a] Prohibition on Preexisting Condition Exclusions.....	20-26
	[b] Lifetime and Annual Limits.....	20-27
	[c] Prohibition on Rescissions.....	20-27

HEALTH CARE BENEFITS LAW

	[d] Patient Protections	20-28
[5]	Coverage for Preventative Services.	20-28
	[a] Recommended Preventative Services Subject to Cost-Sharing Limitations	20-28
	[b] Preventative Services Not Required to Be Covered.	20-29
[6]	Internal Claims and Appeals and External Review Processes (PHS Act Section 2719)	20-30
	[a] Internal Reviews and Appeals Processes	20-39
	[b] External Review Process.	20-40
	[i] State Standard for External Review.	20-41
	[ii] Federal External Review Process.	20-42
	[c] Culturally and Linguistically Appropriate Notices	20-42
[7]	Health Insurance Coverage of College and University Students.	20-43
	[a] Proposed Definition of “Student Health Insurance Plan”	20-44
	[b] Provisions of the PHS Act and ACA Inapplicable to Student Health Insurance Plans.	20-45
	[i] Guaranteed Availability and Guaranteed Renewability	20-46
	[ii] Annual Limits.	20-46
	[iii] Coverage of Preventive Services	20-47
	[c] Notice	20-47
[8]	Final Regulations on ACA’s Summary of Benefits and Coverage	20-47
[9]	DOL FAQs on Summary of Benefits and Coverage	20-49
[10]	DOL Rules on ACA’s Medical Loss Ratio Provision.	20-49
[11]	DOL Responds to Questions on ACA	20-50
[12]	Agencies Issue New Guidance on Mental Health Parity Requirements	20-51
[13]	DOL Proposes New Enforcement Procedures and Reporting Requirements for MEWAs.	20-52
	[a] Proposed Regulations	20-52
	[b] Final Rules	20-52.1

TABLE OF CONTENTS

lxvii

§ 20.06	Changes to Tax-Favored Arrangements Under ACA	20-53
	[1] Generally	20-53
	[2] Changes to Definitions of “Medical Expenses” for FSAs and HRAs for 2011	20-54
	[3] Changes to Definition of “Qualified Medical Expenses” for HSAs and Archer MSAs for 2011	20-54
	[4] Use of Health FSA and HRA Debit Cards for Over-the-Counter Drug Expenses	20-54
	[5] Transition Rule for Cafeteria Plan Amendments	20-55
	[6] Revenue Ruling 2003-102 Obsolete	20-55
	[7] Notice 2013-54—Application of Market Reform and other Provisions of the ACA to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements	20-55
	[a] Background	20-56
	[i] Health Reimbursement Arrangements	20-56
	[ii] Employer Payment Plans	20-56
	[iii] Health Flexible Spending Arrangements (Health FSAs)	20-56
	[iv] Affordable Care Act Guidance	20-57
	[b] Department Guidance	20-58.2
§ 20.07	Shared Responsibility for Employers Regarding Health Coverage	20-58.3
	[1] Guidance on Determining Whether Worker is “Full-Time Employee”	20-58.13
	[a] Overview	20-58.14
	[b] Background	20-58.15
	[i] Notice 2011-36	20-58.17
	[ii] Notice 2011-73	20-58.17
	[iii] Notice 2012-17	20-58.18
	[c] Determining Full-Time Status of Employees	20-58.19
	[i] Ongoing Employees: Safe Harbor	20-58.19
	[ii] Ongoing Employees: Option to Use Administrative Period Under Safe Harbor	20-58.20
	[iii] New Employees: Reasonably Expected to Work Full-Time	20-58.21

HEALTH CARE BENEFITS LAW

- [iv] New Employees: Safe Harbor
for Variable Hour and
Seasonal Employees 20-58.21
- [2] Calculating an Employee’s Hours
of Service 20-58.25
- [3] Ninety-Day Waiting Period Limitation 20-58.31
 - [a] Overview 20-58.32
 - [b] Guidance 20-58.32
 - [i] “Waiting Period” Defined 20-58.33
 - [ii] Application to Variable Hour
Employees When a Specified
Number of Hours of Service
Per Period is a Plan Eligibility
Condition 20-58.33
 - [c] Examples 20-58.34
- [4] Method for Determining Whether an
Employer is an “Applicable Large
Employer” for a Calendar Year 20-58.35
- [5] Reporting by Applicable Large Employers
on Health Insurance Coverage Under
Employer-Sponsored Plans 20-58.36
 - [a] Background 20-58.36
 - [i] Reporting to the IRS 20-58.36
 - [ii] Reporting to Employees 20-58.37
 - [b] Notice 2012-33 20-58.37
 - [c] Final Regulations on Information
Reporting by Applicable Large
Employers on Health Insurance
Coverage Offered Under
Employer-Sponsored Plans 20-58.38
 - [i] Background 20-58.38
 - [ii] Information Reporting to the
IRS 20-58.41
- [6] Minimum Value of an Employer-Sponsored
Health Plan 20-58.45
 - [a] Overview 20-58.45
 - [b] Actuarial Value of Existing
Employer-Sponsored Plans 20-58.47
 - [c] Statutory Background 20-58.47
 - [d] HHS Intentions with Respect to
Actuarial Value for Qualified
Health Plans 20-58.48
 - [e] Assumptions to Be Used in the
Minimum Value Determination 20-58.49
 - [i] Standard Population and
Utilization 20-58.50

TABLE OF CONTENTS

- [ii] Treatment of HSAs and HRAs
in Calculating Minimum
Value 20-58.51
 - [f] Options for Determining Minimum
Value. 20-58.51
 - [i] AV and MV Calculators 20-58.51
 - [ii] Design-Based Safe Harbor
Checklists 20-58.52
 - [iii] Actuarial Certification 20-58.52
- [7] Individual and Employer Mandates. 20-58.53
 - [a] Repeal of Individual Mandate. 20-58.53
 - [b] Employer Mandate Remains in Force . . . 20-58.53
 - [c] “Cadillac Tax” Delayed Until 2022. . . . 20-58.54
 - [d] ACA Out-of-Pocket Limit and PCORI
Fee Announced 20-58.54
 - [i] OOP Limits 20-58.54
 - [ii] PCORI Fees 20-58.55
- [8] Notice to Employees About Health Insurance
Exchanges 20-58.55
 - [a] Application 20-58.55
 - [b] Required Information 20-58.55
 - [c] Model Notice 20-58.56
 - [d] Who Must Receive the Notice 20-58.56
 - [e] Due Date 20-58.56
- [9] IRS Final Regulations on Employer Shared
Responsibility Requirements 20-58.56
 - [a] Overview. 20-58.56
 - [b] Coverage of Dependents. 20-58.58
 - [i] Transitional Relief Extended
for 2015 Plan Year 20-58.58
 - [ii] Exclusions for Stepchildren,
Foster Children and
non-U.S. Citizens 20-58.58
 - [c] Contingent Worker Issues. 20-58.58
 - [d] Calculation of Employer Shared
Responsibility Payment 20-58.60
 - [i] Assessable payments under
Code section 4980H(a) 20-58.60
 - [ii] Assessable payments under
section 4980H(b). 20-58.61
 - [e] IRS Questions and Answers on ACA
Employer Shared Responsibility
Provisions. 20-58.61
 - [i] Basics of the Employer Shared
Responsibility Provisions . . . 20-58.62

HEALTH CARE BENEFITS LAW

	[ii]	Which Employers Are Subject to the Employer Shared Responsibility Provisions . . .	20-58.62
	[iii]	Identification of Full-Time Employees	20-58.64
	[iv]	Liability for the Employer Shared Responsibility Payment	20-58.65
	[v]	Calculation of the Employer Shared Responsibility Payment	20-58.67
	[vi]	Making an Employer Shared Responsibility Payment	20-58.68
	[vii]	Transition Relief	20-58.68
	[viii]	Basics for Small Employers	20-58.72
	[ix]	Premium Tax Credit	20-58.73
	[f]	ACA Out-of-Pocket Limit and PCORI Fee Announced	20-58.74
	[i]	OOP Limits	20-58.74
	[ii]	Patient-Centered Outcomes Research Institute Fees	20-58.74
§ 20.07A		ACA Employer Wellness Program Provisions	20-58.75
	[1]	Background	20-58.75
	[2]	Categories of Wellness Programs	20-58.76
	[a]	Participatory Wellness Programs	20-58.76
	[b]	Health-Contingent Wellness Programs	20-58.77
	[3]	Standards Applicable to Health-Contingent Wellness Programs	20-58.77
	[4]	Compliance with Other Laws	20-58.80
	[a]	Background	20-58.80
	[b]	ERISA	20-58.80
	[c]	COBRA Continuation Coverage	20-58.81
	[d]	HIPAA Privacy and Security Rule	20-58.81
	[e]	Americans with Disabilities Act (ADA)	20-58.81
	[f]	Internal Revenue Code (Code)	20-58.81
	[5]	EEOC Proposed Rule on Worksite Wellness Programs Using Financial Incentives	20-58.82
	[a]	Background	20-58.82
	[b]	The Proposed Rule	20-58.83
	[i]	Laws Relevant to the Proposed Rule	20-58.84
	[ii]	Summary of Proposed Revisions	20-58.89
	[6]	EEOC Litigation Against Employer Wellness Programs	20-58.92

TABLE OF CONTENTS

lxxi

	[a]	EEOC v Orion Energy Systems, Inc. . . .	20-58.92
	[b]	<i>EEOC v. Flambeau Inc.</i>	20-58.93
	[c]	<i>EEOC v. Honeywell International, Inc.</i>	20-58.94
	[i]	Overview	20-58.94
	[ii]	Statement of Facts	20-58.95
	[iii]	EEOC Complaint	20-58.96
	[iv]	Prayer for Relief.	20-58.97
	[v]	Decision	20-58.98
§ 20.08		Patient Protection and Affordable Care Act in the Courts	20-58.99
	[1]	Generally	20-58.99
	[2]	Court Cases Considering the PPACA	20-58.100
	[a]	Sixth Circuit Court of Appeals	20-58.100
	[b]	Eleventh Circuit Trial Court Decision	20-64
	[c]	Eleventh Circuit Court of Appeals	20-92
	[i]	Medicaid Expansion.	20-92
	[ii]	Individual Mandate and Severability	20-95
	[d]	Fourth Circuit Court of Appeals	20-107
	[e]	Third Circuit Trial Court Decision	20-109
	[f]	District of Columbia Circuit Court of Appeals.	20-110
	[3]	Practicality of the PPACA Assuming Severability	20-118
	[4]	Supreme Court Accepts Appeal.	20-120
	[5]	Supreme Court Upholds Affordable Care Act	20-121
	[6]	Challenges to ACA Contraceptive Mandate.	20-126
	[a]	Appeals Court Faults Birth-Control Mandate	20-126
	[b]	ACA Accommodation for Religious Organizations Places Substantial Burden on Exercise of Religion.	20-126.3
	[c]	Supreme Court Grants Review	20-126.5
	[d]	Supreme Court Decision.	20-126.5
	[i]	Facts of the Case	20-126.6
	[ii]	Opinion of the Court	20-126.6
	[7]	Constitutionality of Subsidies for Federally- Run Health Insurance Exchanges	20-126.15
	[a]	Background.	20-126.16
	[b]	King v. Burwell.	20-126.17
	[c]	Halbig v. Burwell	20-126.22
	[8]	U.S. Supreme Court To Decide Constitutionality of ACA	20-126.28

HEALTH CARE BENEFITS LAW

	[a]	Background	20-126.29
		[i] Individual Mandate	20-126.29
		[ii] Severability Analysis	20-126.30
	[b]	Questions Presented	20-126.31
	[c]	Practical Impact	20-126.32
§ 20.09		DOL’s ACA Self-Compliance Tool Kit	20-127
	[1]	Determining Grandfather Status Under ACA.	20-127
		[a] Generally.	20-127
		[b] DOL Questions	20-128
	[2]	Determining Compliance with the Affordable Care Act Extension of Dependent Coverage of Children to Age 26 Provisions.	20-132
		[a] Generally.	20-132
		[b] DOL Questions	20-132
	[3]	Determining Compliance with ACA Rescission Provisions.	20-134
		[a] Generally.	20-134
		[b] DOL Questions	20-134
	[4]	Determining Compliance with ACA Prohibitions on Lifetime Limits and Restrictions on Annual Limits	20-135
		[a] Generally.	20-135
		[b] Lifetime Limits—DOL Questions	20-135
		[c] Annual Limits—DOL Questions	20-137
	[5]	Determining Compliance with the ACA Prohibition on Preexisting Condition Exclusion for Individuals Under 19	20-138
		[a] Generally.	20-138
		[b] DOL Questions	20-138
	[6]	Determining Compliance with the ACA Provisions Regarding the Provision of the Summary of Benefits and Coverage (SBC) and Uniform Glossary	20-139
		[a] Generally.	20-139
		[b] Transitional Relief Providing Flexibility and Emphasizing Good Faith Progress Towards Compliance	20-139
		[c] DOL Questions	20-140
	[7]	Determining Compliance with the Patient Protection Provisions of the Affordable Care Act	20-143
		[a] Choice of Healthcare Professional	20-143
		[b] Coverage of Emergency Services	20-146

TABLE OF CONTENTS

lxxiii

	[8] Determining Compliance with ACA Coverage of Preventive Services Provisions.	20-148
	[9] Determining Compliance with the Affordable Care Act Provisions Regarding Internal Claims and Appeals and External Review.	20-151
	[a] Internal Claims and Appeals	20-151
	[b] External Review	20-156
§ 20.10	Risks to Realigning a Workforce.	20-159
	[1] ERISA 510 Claims and Work Force Structuring.	20-159
	[a] Background.	20-159
	[b] ERISA 510 Claims	20-159
	[2] ACA Retaliation Protections	20-159
	[a] Background.	20-159
	[b] Who is Protected?	20-160
	[c] Burden of Proof.	20-161
§ 20.11	Report on ACA Employer Mandate	20-163
	[1] Summary	20-163
	[2] Employer Shared Responsibility Determinations	20-164
	[a] Applies to All Employers	20-164
	[b] Potential Employer Penalty Requirements	20-164
	[c] Large Employers, Shared Responsibility Provisions, and Potential Penalty Determinations.	20-165
	[d] Large Employer Status: Determined by Full-Time Equivalent Calculation	20-165
	[e] Employers Such as Franchise Owners or Multiple Business Owners.	20-166
	[f] Independent Contractors.	20-166
	[g] Temporary Staffing Firm Workers	20-167
	[h] Calculating Large Employer Status When the Firm Employs Workers Covered by TRICARE or Veterans Assistance.	20-167
	[i] Calculating Large Employer Status When the Firm Employs Seasonal Workers	20-167
	[3] Potential Penalties on Large Employers	20-167
	[a] Large Employers Determined to Not Offer Health Coverage.	20-168
	[b] Large Employers Determined to Offer Health Coverage.	20-168

HEALTH CARE BENEFITS LAW

[c]	How to Determine an Employee's Full-Time Status	20-169
[d]	Ongoing Employees	20-170
[e]	New Employees Reasonably Expected to Work Full-Time	20-170
[f]	Full-Time Status Determination of Variable Hour Work and Seasonal Workers	20-171
	[i] Variable Hour Employees	20-171
	[ii] Seasonal Workers	20-171
	[iii] Determining Full-Time Worker Status for Seasonal Workers	20-171
[g]	Full-Time Status Determination of Adjunct Faculty, Employees with Layover Hours or On-Call Hours, Employees with Difficult to Identify or Track Hours	20-171
[h]	Exclusions from Definition of Hour of Service: Volunteers, Student Workers in Certain Types of Employment, and Members of Religious Orders	20-172
	[i] Volunteers (Including Some Volunteer Firefighters)	20-172
	[ii] Student Workers	20-172
	[iii] Religious Orders	20-173
[4]	Health Insurance Coverage Requirements for Employer Plans	20-173
	[a] Dependent Coverage: Children Under 26 but Not Spouse	20-173
	[b] Affordable Coverage	20-173
	[c] Adequate Coverage (Minimum Value)	20-173
[5]	Implementation and Transition Relief Through 2015	20-174
	[a] Measurement Period	20-174
	[b] Dependent Coverage	20-175
	[c] Employers with Fewer Than 100 FTEs	20-175
	[d] Limited Workforce Size	20-175
	[e] Maintenance of Workforce and Aggregate Hours of Service	20-175
	[f] Maintenance of Previously Offered Health Coverage	20-175
[6]	Employer Reporting and Other Requirements	20-176

TABLE OF CONTENTS

lxxv

[7]	ACA Outlook for 2016 and Beyond	20-177
	[a] Cadillac Tax Delay	20-177
	[b] Repeal of Automatic Enrollment	20-178
	[c] Pace Act	20-178
	[d] Section 4980H – Employer “Play-or-Pay” Mandate To Become Fully Effective	20-178
	[e] Recordkeeping Requirements	20-180
[8]	IRS Releases ACA Affordability Rates for 2017	20-182
	[a] Overview	20-182
	[b] Revenue Procedure 2016-24	20-182
	[i] Employer Shared Responsibility	20-182
	[ii] Individual Mandate	20-183
	[iii] Premium Tax Credit	20-183
[9]	IRS Issues ACA Reporting Extension and Transition Relief	20-183
	[a] Background	20-184
	[b] Transition Relief	20-186
	[i] Extension of Due Date for Furnishing to Individuals under Sections 6055 and 6056 for 2016	20-186
	[ii] Extension of Good Faith Transition Relief from Section 6721 and 6722 Penalties for 2016	20-187
	[iii] Future Years	20-188

CHAPTER 21

The Coronavirus Aid, Relief, and Economic Security (CARES) Act

§ 21.01	Introduction to Legislation	21-2.1
§ 21.02	Overview	21-3
§ 21.03	Business Provisions	21-4
	[1] Government Loans for Struggling Industries & Related Transparency Measures	21-4
	[2] Other Aviation Industry Provisions	21-5
	[3] Payroll Tax Credit	21-5
	[4] Other Business Provisions	21-5
	[5] Small Business Assistance	21-6

	[6] Paid Leave	21-7
§ 21.04	Unemployment	21-8
	[1] Unemployment Insurance	21-8
	[2] Short-Time Compensation	21-8
§ 21.05	Cash to Americans through Direct Payments and Retirement Provisions	21-9
	[1] Direct Payments to American Workers	21-9
	[2] Retirement Accounts	21-9
§ 21.06	Health Care	21-10
	[1] “Marshall Plan” for Health Care Systems	21-10
	[a] COVID-19 Testing	21-10
	[b] Reauthorization of Programs	21-10
	[2] Medicare and Medicaid Provisions	21-10
	[a] Medicare	21-10
	[b] Medicaid	21-11
§ 21.07	Education Provisions	21-12
	[1] Education	21-12
	[2] Student Loans	21-12
§ 21.08	Miscellaneous CARES Act Provisions	21-13
	[1] State and Local Expenditures Fund	21-13
	[2] Postal Service	21-13
§ 21.09	Emergency Discretionary Appropriations	21-14
§ 21.10	Applicable Sections of the Final COVID-19 Stimulus Package	21-16
§ 21.11	COBRA Election and Enrollment Deadlines Extended During COVID-19 “Outbreak Period”	21-26
	[1] Introduction	21-26
	[2] Statutory Periods	21-26
	[3] Duration of “Outbreak Period”	21-26
	[4] Planning for Longer Special Enrollment Periods	21-27
	[5] Planning for Longer COBRA Election Periods	21-27
§ 21.12	CARES Act Provisions Impacting Employer-Sponsored Group Health Plans	21-29
	[1] Summary	21-29
	[2] Telehealth and HDHPs	21-29
	[3] COVID-19 Diagnostic Testing Without Cost Sharing	21-29
	[4] COVID-19-Related Preventive Services	21-29
	[5] Over-the-Counter Products and Medications	21-30
	[6] Planning for “Outbreak Period” Extended Deadlines	21-30
	[a] Applicable to Welfare Plan Participants and Beneficiaries	21-30
	[b] Applicable to Welfare Plans	21-31

TABLE OF CONTENTS

lxxvii

§ 21.13	Legal Issues in COVID-19 Vaccine	
	Development and Deployment	21-32
	[1] Summary	21-32
	[2] Background	21-33
	[3] FDA Law Considerations: Bringing a New Vaccine to Market.	21-35
	[a] Clinical Trials of Investigational New Drugs	21-35
	[i] Using Clinical Trials to Collect Substantial Evidence	21-35
	[ii] Submitting an Investigational New Drug Application to FDA	21-37
	[iii] Institutional Review Board Review and Approval	21-38
	[iv] Clinical Trial Phases.	21-38
	[v] Considerations for Congress	21-40
	[b] FDA Approval and Options for Bringing a New Vaccine to Market Faster	21-41
	[i] Shortening the Development and Review Processes	21-41
	[ii] Emergency Use Authorizations Before Approval	21-45
	[iii] Considerations for Congress	21-47
	[4] Patent Rights in COVID-19 Vaccines: Incentives, Access, and Affordability	21-48
	[a] Patent Basics	21-50
	[b] Patent Rights in Inventions Made with Federal Assistance	21-53
	[c] Governmental Compulsory Patent Licenses.	21-56
	[i] March-In Rights Under the Bayh-Dole Act.	21-56
	[ii] Governmental Use Rights	21-57
	[d] Targeted Legislation and the Takings Clause	21-58
	[5] State and Federal Authority to Mandate Vaccination	21-60
	[a] State and Local Authority to Mandate Vaccination	21-62
	[b] Federal Authority to Mandate Vaccination.	21-65
	[i] Executive Branch Authority to Mandate Vaccination.	21-65
	[ii] Congress’s Authority to Mandate Vaccination	21-67

HEALTH CARE BENEFITS LAW

[6]	Liability and Compensation for COVID-19 Vaccine Injuries	21-70
[a]	The Public Readiness and Emergency Preparedness Act	21-71
[i]	Scope of Immunity from Liability	21-71
[ii]	The Willful Misconduct Exception	21-74
[b]	The Countermeasures Injury Compensation Program	21-76
[c]	The COVID-19 PREP Act Declaration	21-77
	TABLE OF ABBREVIATIONS	TA-1
	INDEX	I-1