



Employee Benefits Bulletin

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SUPREME COURT CONSIDERS TWO SIGNIFICANT BENEFIT CASES

The United States Supreme Court will decide two important employee benefit cases this term. One of the cases, *Kentucky Association of Health Plans v. Miller*, will decide whether an employer-sponsored health care plan has to honor a state's "any willing provider" law. The other case, *Black & Decker Disability Plan v. Nord*, considers how much consideration a disability plan must give to a finding of disability made by an employee's own physicians. This latter case may also provide guidance more generally on how much discretion courts should give to plan administrators when they deny benefits under any type of employee benefit plan.

The Any-Willing-Provider Case

Kentucky, along with a dozen or so other states, has an "any-willing provider" law. These laws generally prohibit health care plans from discriminating against any health care provider that is located within the plan's coverage area if the provider is willing to meet the terms and conditions for participation in the plan. In other words, health plans have to let patients choose their own providers, even if the provider is not part of the plan's network, so long as the provider is willing to accept the terms offered by the plan to providers in its network.

Health care plans say that such laws increase their costs, since they can negotiate low rates with network providers only because of the providers' expectation that they will have a steady stream of patients (who must use network providers). If the patient can choose providers outside the network, the network providers will not expect the high patient volume and thus will not agree to low rates. And the increased costs to health care plans will result in higher medical premiums for employers who sponsor health care plans. Indeed, some studies suggest that health care costs do rise when states adopt "any-willing-provider" laws.

OUR MERGER

On January 1, 2003, Adams and Reese LLP and Lange, Simpson, Robinson & Somerville LLP merged, creating the largest law firm in Alabama, Louisiana and Mississippi. With a total number of attorneys approaching 300, the firm has offices in Birmingham, Baton Rouge, Jackson, Houston, Mobile, New Orleans and Washington DC.

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On the other side of the issue are employees, who generally want to be able to choose whatever health care provider they want, and of course health care providers themselves. The Bush administration is siding with the employees and health care providers on this issue.

The Legal Issue

The legal issue before the Supreme Court is whether ERISA preempts--and thus invalidates--state "any-willing-provider" laws. ERISA's preemption section generally invalidates state laws that "relate" to employee benefit plans. But there are exceptions to ERISA preemption and one of the biggest exceptions is for state laws regulating insurance. The Supreme Court last year, commenting on the broad preemption provision and the almost-as-broad insurance exception, dryly noted that their combined effect is "simultaneously to preempt everything and hardly anything."

There does not appear to be any serious question that the Kentucky law "relates" to employee health benefit plans, since the law dictates who is eligible to provide medical services to employees under such plans. The key question, then, is whether the Kentucky any-willing-provider law is a law regulating insurance.

In deciding this issue, the Supreme Court will be guided by three questions about the law: 1) does it have the effect of transferring or spreading policyholder risk; 2) does it govern an integral part of the policy relationship between insured and insurer; and 3) is it limited to entities within the insurance industry. The oral argument before the Court suggests that the second question will be most important for resolving the case.

The lawyer for the health care plans argued that the Kentucky law governs not the *policy* relationship between the insurer and *insured*, but rather the *contractual* relationship between the insurer and the *providers*. Some of the Justices, however, seemed skeptical. And last year in a similar case, the Supreme Court upheld an Illinois state law that permitted an insured to obtain an independent review of an HMO's decision on whether a procedure was medically necessary.

But trying to predict how the Court will come down in a preemption case is akin to reading tea leaves. The case, though, is being closely watched (particularly in Louisiana, Texas, and Arkansas, where the Fifth Circuit has held that ERISA does preempt any-willing-provider laws). Alabama, by the way, has any-willing-provider laws applicable to dentists and pharmacists. A district court in 1996 held that ERISA preempted these laws.

The Treating Physician Opinion Case

Black & Decker sponsors a long-term disability benefit for its employees. The plan is funded directly by Black & Decker, which is also plan administrator. The plan provides up to 30 months of disability benefits for employees whose medical condition prevents them from performing their jobs with Black & Decker. (After 30 months, disability benefits continue only if the employee's medical condition prevents the employee from holding any gainful employment consistent with the employee's education and training.)

Kenneth Nord, a Black & Decker employee, was diagnosed by his physician as having degenerative disc disease. The physician also determined that Nord's condition prevented him from performing his job. Three other treating physicians concurred, as did a representative of Black & Decker's Human Resources Department to whom the case was referred for evaluation.

Black & Decker, however, denied Nord's claim for disability benefits. In doing so, it relied on a review of an independent medical examiner who was retained by the Plan to examine Nord on a one-time basis. The medical examiner agreed with the treating physicians' diagnosis that Nord suffered from degenerative disc disease but concluded that he could continue to work at his old job.

Nord brought a lawsuit (in California) challenging the denial of his benefits. Once in court the question became how closely the judge should look at Black & Decker's decision to deny benefits: should it look at all the evidence and decide whether Nord was unable to perform his job (in which case Nord would probably win, since the weight of the evidence supported him) or simply decide whether there was some evidence supporting Black & Decker's denial (in which case Black & Decker would probably win, because its physician said Nord could continue working at his job). In legal jargon, the former approach is known as *de novo* review, the latter approach as *deferential* review.

(Sometimes courts call *deferential* review "arbitrary and capricious" review, because a court using *deferential* review will uphold a benefit denial unless the plan acted "arbitrarily and capriciously.")

A dozen years ago the Supreme Court looked at these issues and decided whether *de novo* review or *deferential* review should be the rule under ERISA. (The case was *Firestone Tire & Rubber Co. v. Bruch*.) What the Court said then was this: what kind of review is appropriate depends on what the plan itself says. Unless a plan says that an administrator has discretion in making benefit decisions, then a trial court should use *de novo* review. If the plan gives the administrator discretion, then a trial court should use *deferential* review.

Black & Decker's plan said that the plan manager had "sole and absolute discretion" in deciding whether a participant was disabled. Thus, the trial court hearing the case used *deferential* review and upheld Black & Decker's decision to deny benefits.

But the Supreme Court said something else in *Firestone*, which courts ever since have had trouble interpreting: a conflict of interest is a factor to be taken into consideration when a court engages in deferential review. And on appeal to the Ninth Circuit Court of Appeals this became the issue: did Black & Decker have a conflict of interest and if it did, how should that affect the result in the case.

The Court of Appeals said that Black & Decker had a conflict of interest, since it both funded the plan and resolved benefit disputes arising under the plan. When it rejected a claim for benefits, Black & Decker saved itself money. The Ninth Circuit also said that Black & Decker's rejection without explanation of the opinions of Nord's treating physicians and its own human resource employee demonstrated that the conflict actually affected Black & Decker's decision to deny the benefits. Thus, the Court of Appeals said the trial court should have used de novo review and ordered that Nord be awarded his benefits.

The Supreme Court now will have the final word on *Black & Decker*. And the Supreme Court has a choice: it can decide the case narrowly and simply consider how much weight a disability benefits plan must give to the opinion of an employee's treating physician when it differs from the opinion of a doctor hired by the plan to evaluate the case. If the Supreme Court takes this approach, the case will be important for disability benefits cases but may not do very much to clarify how courts should review denials of benefits in other types of employee benefit plans, such as pension or health benefit plans.

Or the Court may explain what it meant twelve years ago in *Firestone*, when it said that a conflict of interest is a factor that a trial court should consider in deciding whether a plan administrator acted arbitrarily and capriciously in denying benefits. If it takes this approach, it might tell us when a plan administrator has a conflict of interest and how a conflict, when it does exist, affects "deferential" review. If the Court does get into these issues, *Nord* may turn out to be the most significant employee benefit case since, well, since *Firestone*.

TID BITS, TRICKS & TRAPS

Small Business Tax Credit To Establish Retirement Plan. EGTRRA provided a tax credit for small employers to help them with the costs of starting up a retirement plan. The credit is equal to 50% of the costs of starting up or maintaining a plan, up to \$500 per year, for the plan's first three years. A small employer is defined as a firm with no more than 100 employees. The IRS will also, courtesy of EGTRRA, waive fees for small employers to obtain a determination letter that a new plan is qualified.

NEW GUIDANCE

Department of Labor and SEC Issue Sarbanes/Oxley 401(k) Blackout Period Final Regulations.

Department of Labor. The Department of Labor issued final regulations on the Sarbanes/Oxley rules governing blackout periods for defined contribution plans, which took effect on January 26, 2003. The DOL rules require that participants generally be given 30 days notice before periods in which they either cannot direct investments, or receive plan distributions, or obtain plan loans. The notice must include, among other things, reasons for the blackout, the rights suspended during the blackout period, the beginning and ending dates of the period, and a statement advising participants to evaluate their investments in light of their inability to make investment changes during the period. Penalties for failure to comply include \$100 per/day, per/participant fines.

SEC. Sarbanes/Oxley also included a related provision for blackout periods in plans in which participants are prevented from engaging in transactions involving employer stock held in their accounts. Under this provision, executive officers and directors of the company are prohibited during a blackout period from trading employer securities acquired in connection with their service or employment as officer or director. The SEC rules will only apply to blackout periods lasting more than three consecutive business days and which suspend the rights of at least 50% of the participants in defined contribution plans of the employer to trade in employer securities. NOTE: Issuers must timely notify directors, executive officers, and the SEC of an impending blackout period.

HIPAA Privacy Rule Compliance Deadline Is Approaching.

HIPAA's rules protecting the privacy of certain medical information goes into effect for many employers on April 14, 2003. The rules apply to firms that employ at least 50 people and offer health care benefits. The effective date is delayed one year for "small group health plans," which are plans with less than \$5,000,000 in total premiums paid or benefits paid out. IRS Issues Revenue Procedure on Deemed IRAs. The IRS issued Revenue Procedure 2003-13, which provides guidance for employers that want to take advantage of a provision in EGTRRA that permits qualified plans to accept voluntary IRA contributions from employees. The Revenue Procedure provides a sample amendment to graft a deemed IRA onto a plan.

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