EMPLOYEE BENEFITS DEVELOPMENTS NOVEMBER 2013

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RULINGS, OPINIONS, ETC.

Religious Employers and the Women's Contraceptive Mandate

Background

This past July, the U.S. Departments of Labor, Health and Human Services, and the Treasury released final regulations regarding health plan coverage of certain preventive services for women, including female sterilization and FDA-approved contraceptives (the "contraceptive mandate"). The regulations are generally effective for plan years beginning on or after January 1, 2014. The final regulations seek to ensure that *non-grandfathered* health plans and issuers provide women with access to contraceptive coverage without cost sharing. The regulations purport to accomplish this objective in a fashion that protects certain nonprofit religious organizations with religious objections to providing contraceptive coverage from having to contract, arrange, pay, or refer for such coverage.

The Religious Employer Exemption

Under the regulations, "religious employers" are not required to comply with the contraceptive mandate. Under the final regulation, a "religious employer" is a nonprofit entity that is referred to in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. These sections of the code refer to churches; integrated auxiliaries, conventions, or associations of churches; and the exclusively religious activities of religious orders. This narrow definition would probably not include most church-related institutions (e.g., faith-based colleges, universities, or hospitals). However, the final regulations provide an accommodation for certain nonprofit entities that qualify as "eligible organizations."

Accommodations for Eligible Organizations

As noted above, the final regulations establish accommodations for eligible organizations, such as faith-based colleges, universities, and hospitals, that meet a self-certification standard. These organizations can avoid contracting, arranging, paying for, or referring to contraceptive coverage if certain requirements are met, as more fully discussed below.

Definition of an Eligible Organization: An “eligible organization” is an organization that (1) opposes providing coverage for some or all of the contraceptive services required to be covered under the contraceptive mandate due to religious objections, (2) is organized and operates as a nonprofit entity, (3) holds itself out as a religious organization, and (4) self-certifies that it satisfies the first three criteria. The final rule makes no accommodation for secular or for-profit employers.

Self-Certification Generally: Each organization seeking to be treated as an eligible organization under the final regulations must self-certify prior to the beginning of the first plan year to which an accommodation is to apply. *This means that eligible organizations that sponsor calendar year plans must satisfy the self-certification requirement by January 1, 2014*. To be effective, a copy of the self-certification must be provided to the plan’s health insurance issuers or, if the plan is self-insured, the plan’s third-party administrators. An issuer or third-party administrator may not require any documentation from the organization beyond its self-certification as to its status as an eligible organization. Form 700, published by the Employee Benefits Security Administration, should be used for the self-certification.

Self-Certification for Insured Plans: If an eligible organization provides Form 700 to its health insurance plan, the health insurance issuer must exclude contraceptive coverage from the eligible organization’s group health coverage. Upon receipt of the certification, the health insurance issuer must:

• Expressly exclude contraceptive coverage from the eligible organization’s group health insurance coverage,

• Notify plan participants and beneficiaries, contemporaneous with but separate from a group health plan’s enrollment materials, that the issuer provides payments for contraceptive services at no cost separate from the group health plan for as long as the participant or beneficiary remains enrolled in the plan, and

• Provide payments for contraceptive services for plan participants and beneficiaries, separate from the group health plan, without the imposition of cost sharing, premium, fee, or other charge on plan participants or beneficiaries or on the eligible organization or its plan.

An eligible organization and its group health plan are considered to comply with the contraceptive coverage requirement even if the issuer fails to comply with the requirement to provide separate payments for contraceptive services for plan participants and beneficiaries at no cost.

Self-Insured Plans: An eligible organization is considered to comply with the contraceptive mandate if it provides a copy of its self-certification to all third-party administrators with which it or its plan has contracted.

The self-certification for a self-insured plan must state that the eligible organization will not act as the plan administrator or claims administrator with respect to contraceptive services or contribute to the funding of contraceptive services and must cite the relevant provision of ERISA regulations that explains the obligations of the third-party administrator with respect to the coverage.

Upon receipt of a copy of the self-certification, the third-party administrator has the right to decide not to enter into or remain in a contractual relationship with the eligible organization to provide administrative services for the plan.

If the third-party administrator agrees to enter into or remain in the contractual relationship with the eligible organization, the third-party administrator must then provide or arrange separate payments for contraceptive services without cost-sharing, premium, fee, or other charge to plan participants or their covered dependents or to the eligible organization or its plan. The third-party administrator must also provide plan participants and beneficiaries with notice of the availability of the separate payments for contraceptive services contemporaneous with (to the extent possible), but separate from, the group health plan's enrollment materials.

Immediate Employer Action May Be Required

Religious employers that object to some or all of the services and drugs that are required to be covered under the contraceptive mandate should review their plan documents and insurance contracts to determine whether these services and drugs are covered and take action accordingly. Eligible organizations that have religious-based objections to this coverage will need to engage their insurance issuer (or third-party administrator) in a discussion of the self-certification procedure and provide a self-certification form (EBSA Form 700) to the health insurance issuer or third-party administrator (under a self-insured plan) as soon as reasonably possible, but not later than the first day of the 2014 plan year. EBSA Form 700 may be found here.

Guidance on HRAs and Other Employer Payment Plans

Under ACA for 2014. The Treasury and Department of Labor recently published guidance on the application of the Affordable Care Act Market Reforms on certain health care arrangements, such as Health Reimbursement Accounts (HRAs). Importantly, this guidance provides that, beginning with the 2014 plan year, employers may no longer utilize stand-alone general purpose HRAs for current employees. Starting next year, an HRA will generally not be permitted unless it is integrated with a group health plan that does not have annual dollar limits. To be integrated: (i) the employer must offer coverage under a group health plan, (ii) the employee receiving the HRA must actually enroll in a group health plan, (iii) the employee must be permitted to permanently opt-out of and waive future reimbursements from the HRA at least annually, and (iv) upon termination of employment, either the remaining amounts are forfeited or the employee is permitted to permanently opt-out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage and will preclude a covered individual from claiming a premium tax credit under the marketplace exchange. Significantly, the guidance points out that, although an individual is required to enroll in group health plan coverage, the individual may enroll in a group health plan other than the plan offered by his or her employer. For example, an individual may be considered to participate in an integrated HRA if he or she declines coverage under his or her employer's plan and instead enrolls for coverage under a spouse's employer's group health plan. However, an HRA paired with an individual health insurance policy would not be considered integrated. If at some point in the future an employee ceases coverage under a group health plan, he or she would still be permitted to be reimbursed from an existing HRA balance under the terms of the HRA but would not be eligible for new employer contributions. Along with integrated HRAs, employers will also be permitted to continue or

establish HRAs for retirees. In addition to HRAs, this guidance addresses employer payment plans. Starting next year, employers may not allow employees to purchase individual coverage on a pre-tax basis through a cafeteria plan. However, the purchase of excepted benefits on a pre-tax basis under a cafeteria plan will be permitted. Employers should review their HRAs, cafeteria plans, and other employer payment plans and amend them as necessary before the first day of the plan year in 2014. (IRS Notice 2013-54; DOL Technical Release No. 2013-03)

IRS Says Plan May Not Automatically Revoke Spouse as Beneficiary Upon Legal Separation

Some qualified retirement plans, including some retirement plans preapproved by the IRS, contain provisions that automatically revoke a spouse as a participant's beneficiary upon the participant and spouse becoming legally separated. The IRS recently released guidance stating that such a plan provision causes a plan to be noncompliant with the spousal waiver rules.

The confusion lies in IRS regulations that do not require spousal consent in certain circumstances, including where the participant becomes legally separated from his or her spouse. However, the IRS's recent guidance makes clear that while a participant may affirmatively elect to name a beneficiary other than his or her legally separated spouse (or affirmatively waive any qualified pre-retirement survivor annuity (QPSA) available under a plan) without obtaining spousal consent, the plan's terms may not automatically revoke the participant's legally separated spouse as the participant's beneficiary (or treat the participant as being unmarried for purposes of any QPSA available under the plan).

Plans may still contain provisions that automatically revoke a participant's designation of his or her former spouse as beneficiary following the participant's divorce from the former spouse.

Plan sponsors should review their plan documents to determine whether their plan automatically revokes a participant's legally separated spouse as the participant's beneficiary in order to determine whether their operational procedures and/or plan document need to be amended.

CASE

SunTrust Stock Drop Case Dismissed

A federal district court recently dismissed a lawsuit brought against the fiduciaries of the SunTrust 401(k) plan for breaches of ERISA fiduciary duties in connection with a loss of significant value in 401(k) plan account balances that were invested in SunTrust stock. SunTrust's share price plummeted during the subprime mortgage crisis. The lawsuit alleges plan fiduciaries knew or should have known the stock was an imprudent plan investment and that maintaining the plan's heavy investment in the stock violated the ERISA duty of prudence. Relying on the holding in *Lanfear v. Home Depot, Inc.* (11th Cir. 2012), the district court ruled that in order for the plaintiffs to state a claim that plan fiduciaries violated their duty of prudence, they must allege the settlor, under the circumstances faced by the plan fiduciaries, would have intended the fiduciaries sell off the plan's investments in SunTrust stock. While the court noted the complaint failed to make the

necessary specific allegations and therefore failed on its face to state a prudence claim under ERISA, the court nevertheless considered the prudence claim. The court reviewed various plan documents, including the investment policy statement, and could find no indication that the settlor (i.e., SunTrust) contemplated the sale of the plan's SunTrust shares, even in the face of dire financial circumstances. The plan documents reviewed by the court also indicate the settlor fully understood and approved of the fact that the company stock fund was a high-risk investment for plan participants. For these and other reasons, the court granted defendants' motion to dismiss plaintiffs' prudence claim. *In re SunTrust Bank, Inc., ERISA Litig.* (N.D. Ga. 2013)

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