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EMPLOYEE BENEFITS DEVELOPMENTS MAY 2013

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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Agencies Issue Regulations Regarding 90-Day Waiting Period for Group Health Plans

The Departments of Health and Human Services, Labor, and the Treasury issued proposed regulations regarding the Patient Protection and Affordable Care Act's (ACA's) 90-day waiting period limitation. Under this provision of the ACA, group health plans cannot impose a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage can become effective for an employee or dependent who is otherwise eligible to enroll under the terms of the health plan. This 90-day waiting period limitation becomes effective for plan years beginning on or after January 1, 2014. For purposes of counting days during a waiting period, all calendar days are counted. The waiting period cannot be extended beyond 90 days even if the 91st day happens to fall on a weekend or a holiday. Although the regulations clarify that eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days, a plan may impose other eligibility requirements not based on elapsed time so long as they are not designed to avoid compliance with the 90-day waiting period limitation. For example, requiring a participant to be in an eligible job classification or achieve job-related licensure requirements would not generally be considered a violation of the 90-day waiting period limitation. The regulations also provide guidance on the imposition of waiting periods on variable hour employees. Plans that condition a variable hour employee's eligibility on meeting certain hour requirements may utilize a measurement period similar to the measurement period used for determining a variable hour employee's full-time status under the ACA's shared responsibility provisions. Under these provisions, an employer may track a variable hour employee's hours during a reasonable measurement period of no more than 12 months. Assuming the variable hour employee worked a sufficient number of hours during the measurement period, the employee's coverage would have to become effective the earlier of 13 months from the date of hire (plus if the employee's date of

hire is not the first day of the month, the time remaining until the first day of the next calendar month), or 90 days following the end of the measurement period. In light of these regulations, employers should review the eligibility provisions for their health plans to confirm that any waiting period does not exceed 90 days.

Administrative Tip: QDROs and Fee Disclosures

We are quickly approaching the first anniversary of participant fee disclosures being required to be provided for ERISA-covered defined contribution plans that allow participants to direct the investment of their account balance. It is important for plan administrators to recognize that not only must the fee disclosure be provided to participants, but it must also be provided to beneficiaries under the plan. When all or a portion of a participant's benefit in a plan is assigned to an alternate payee under a qualified domestic relations order (or QDRO), the alternate payee is considered to be a beneficiary under the plan. As a result, the alternate payee must be provided the plan's fee disclosure on or before the date he or she may first direct his or her investments in the plan.

Final Rules: Essential Health Benefits, Cost-Sharing, and Actuarial Value

Beginning in 2014, non-grandfathered *individual* health insurance policies and policies issued to *small* employers must provide "essential health benefits;" adhere to federally defined dollar limits on deductibles and out-of-pocket maximums; and have an actuarial value of at least 60 percent. Final regulations recently issued by the Department of Health and Human Services (HHS) (78 Fed. Reg. 12834) and Frequently Asked Questions (FAQs) recently issued by HHS, the Department of Labor, and the Treasury clarify the extent to which these requirements apply to *self-funded* plans and health insurance policies sold to *large* employers.

Essential Health Benefits

Essential health benefits include medical items and services in 10 federally defined benefit categories, including hospitalization, prescription drugs, mental health and substance use disorder services, and maternity and newborn care. Each state has some discretion in determining which specific health care items and services within the 10 mandated categories qualify as "essential;" therefore, no one state's list is likely to be identical to the lists developed by the others.

Self-funded medical plans and health insurance policies sold to *large* employers are not required to provide essential health benefits, but are prohibited from imposing lifetime and annual dollar limits on these benefits. For example, a plan that limits hospitalization benefits or benefits for prescription drugs to a dollar amount per day or year would violate this requirement. A plan may limit the number of visits or days for which it will pay, provided there is no dollar cap on the amount it will pay per day/visit.

Action Steps. Sponsors of self-funded and large group insurance plans should review their plan designs to ensure that there are no impermissible annual or lifetime dollar limits on essential health benefits. Because the final regulations do not address essential health benefits for self-funded and large group policies, employers will need to adopt a good-faith definition of their own, perhaps based on the essential health benefits package of the state where most of the employer's employees reside. For example, self-funded plans covering only New York residents may reasonably choose to reference New York's

essential health benefits package for this purpose.

Deductibles and Out-of-Pocket Maximums

Beginning in 2014, deductibles in the *individual* and *small* group insurance markets generally cannot exceed $2,000 for self-only coverage and $4,000 for family coverage. In the recent guidance, the departments confirmed that the deductible limits described above *do not* apply to self-funded plans and insurance sold to large employer groups.

Beginning in 2014, out-of-pocket maximums (including, for this purpose, co-pays, deductibles, and coinsurance for in-network providers) would be tied to the enrollee out-of-pocket limit for high deductible health plans that qualify for use with health savings accounts (HSAs). The cost sharing limits do not include premiums, items and services that are excluded from coverage, limits pertaining to items and services that are not essential health benefits, amounts that are balance-billed, and cost sharing amounts for out-of-network providers. For 2014, this amount would be $6,350 for self-only coverage and $12,700 for family coverage. Unlike the limit on deductibles, the final regulations confirm that non-grandfathered self-funded and large group health plans are subject to the out-of-pocket maximums described above.

Action Steps. Plan sponsors will need to review their health plans to insure that the maximum out-of-pocket exposure for self-only and family coverage does not exceed the dollar amounts referenced above for plan years beginning in 2014.

Plans that have multiple service providers (such as, for example, sponsors that have one service provider for major medical coverage, a separate pharmacy benefit manager for prescription drug benefits, and a separate managed behavioral health organization) will need to ensure that there is a procedure in place to coordinate the separate service providers to ensure the out-of-pocket maximums are not exceeded. Fortunately, there is a transition rule in Q2 of the recent FAQ guidance that applies only for the first plan year beginning on or after January 1, 2014. Under the transition rule, the departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

1) The plan complies with the requirements with respect to the major medical coverage (excluding, for example, prescription drug coverage) and

2) If the coverage other than major medical coverage (e.g., prescription drug coverage) includes a separate out-of-pocket maximum, the out-of-pocket maximum does not exceed the applicable dollar limits.

Actuarial Value

Beginning in 2014, if an applicable large employer maintains a medical plan that does not have an actuarial value of at least 60 percent full-time employees who enroll in a plan through the Exchange may qualify for premium or cost-sharing assistance. This, in turn, exposes the employer to a penalty under the so-called play-or-pay mandate.

The final regulation confirms that employers will be able to determine minimum value using one or more of the following methods:

1) MV Calculator. HHS has developed a minimum value calculator based on claims data for typical self-funded employer plans. The calculator is available on the HHS website.
2. Design-based safe harbor checklists. These are not yet available.

3. Actuarial Certification.

Action Steps. We strongly encourage plan sponsors, particularly sponsors of self-insured plans, to begin a dialogue with insurers and third party administrators for the purposes of determining whether their plans meet the minimum value requirement.

All FAQs on the new health care law can be found by clicking on the FAQs tab on the left side of the DOL's website (www.dol.gov/ebsa).

IRS Establishes Preapproved 403(b) Plan Program

The IRS has announced a pre-approved 403(b) plan document program. Under this program, 403(b) plan sponsors will be able to adopt a 403(b) plan document that has received an IRS opinion or advisory letter stating the terms of the written plan document conform to the requirements of Internal Revenue Code § 403(b). Plan sponsors may soon see their brokers, insurance companies, and third party record keepers begin to offer a pre-approved plan document product to use in complying with the written plan document requirement. Of course, to maintain its tax-favored status, a preapproved 403(b) plan must still be operated in accordance with its written terms. It is expected that the first round of IRS 403(b) opinion and advisory letters for pre-approved 403(b) plans will be issued in approximately two years. The IRS still has not announced a program for an employer to obtain an individual IRS determination letter with respect to a 403(b) plan.

CASES

Offering Retail-Class Investment Fund Options Can Trigger Breach of Fiduciary Duties

The Court of Appeals for the Ninth Circuit recently affirmed the ruling of a federal district court that fiduciaries for a 401(k) plan were imprudent in deciding to include retail-class shares of three specific mutual funds in the plan menu of investment fund options because they failed to investigate the possibility of institutional-share class alternatives. The unchallenged findings in this case with respect to the fiduciary breach are that during the relevant time period (1) all three of the litigated fund options offered institutional-class options in which the 401(k) plan almost certainly could have participated, (2) the institutional-class fund options for those funds were in the range of 24 to 40 basis points cheaper than the retail class options the 401(k) plan offered to participants, and (3) there were no salient differences in the investment quality or management of the institutional-class options and the retail class options. Despite strenuous arguments from the plan fiduciaries that they reasonably depended on their investment consultant for advice about which mutual fund share classes should be selected for the plan, the court held the plan fiduciaries cannot reflexively and uncritically adopt investment recommendations. In the absence of evidence that the plan fiduciaries themselves considered the possibility of institutional classes for the funds litigated, or that the investment consultant engaged in a prudent process that considered different share classes, the Ninth Circuit had little difficulty agreeing with the district court that the plan fiduciaries did not exercise the "care, skill, prudence, and diligence under the circumstances" that ERISA demands in the selection of the

retail mutual funds.

To be clear, the court's ruling does not go so far as to suggest that retail-class investment fund options should never be offered. In fact, the court specifically declined to endorse such a bright-line rule. Nonetheless, plan fiduciaries must be engaged in a prudent process that critically evaluates institutional-class alternatives for the investment funds selected for the plan. Various performance factors can come into play in deciding between different share classes, and sometimes offering retail-class shares is appropriate. But a failure to investigate and evaluate the availability, performance, expenses, etc. associated with different share classes is not prudent. (*Tibble v. Edison Int'l*, 9th Cir. 2013)

Duty of Prudence Applies to Decision to Offer Employer Stock as Investment Option; Fiduciaries Not Required to Disclose Nonpublic Information Concerning Employer Stock

In an appeal, the Eleventh Circuit was asked to answer (1) whether ERISA requires fiduciaries of an eligible individual account plan that offers employer stock as an investment option to divulge material, nonpublic financial information concerning the employer, and (2) whether the exemption from the diversification requirement under ERISA § 404(a)(2) that applies to the acquisition (or holding) of employer stock in an individual account plan similarly exempts a fiduciary from the duty of prudence in ERISA § 404(a)(1)(B) when employer stock is offered as an investment option.

Relying on its 2012 decision in *Lanfear v. Home Depot, Inc.*, (11th Cir. 2012), the court answered both questions in the negative. With respect to the first question, the court held that ERISA does not require the disclosure of nonpublic, material information that may affect the value of employer stock. As to the second question, the court held ERISA § 404(a)(2) does not absolve a fiduciary from his or her duty to act prudently in deciding to offer employer stock as an investment option.

Of course, a fiduciary's decision to offer employer securities as an investment option within an eligible individual account plan may be entitled to a presumption of prudence (i.e., the so-called *Moench* presumption), if the plan document requires or strongly encourages employer stock to be offered as an investment option. (*Fisch v. Suntrust Banks, Inc.*,11th Cir., 2013).

Post-Distribution Enforcement of Benefit Waivers Not Preempted by ERISA

In 2009, plan administrators generally applauded a decision by the U.S. Supreme Court holding that ERISA requires distribution of benefits to the named beneficiary in an ERISA plan, regardless of any state law waiver purporting to divest that beneficiary of his or her right to the benefits. In reaching this decision, the Court in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan* focused on three key objectives of ERISA: (1) simple administration, (2) avoiding double liability for plan administrators, and (3) ensuring that beneficiaries get their benefits quickly. Addressing an issue that the Supreme Court had explicitly left unanswered in the earlier case, the U.S. Court of Appeals for the Fourth Circuit recently ruled that ERISA does not, however, prohibit a state court from enforcing a former spouse's waiver of his interest in his ex-wife's ERISA plan benefits *after* benefits have been distributed.

As so often happens, the ex-wife in this case neglected to change the beneficiary designations for her 401(k) and life insurance plans following her divorce, even though her ex-husband had executed a waiver of his rights under the plans. On the participant's death in 2011, the ex-husband was still the named beneficiary of the participant's ERISA benefits. Consequently, the plan administrators of both plans correctly determined that the benefits should be paid to the ex-husband. The participant's parents appealed the administrators' decisions and filed suit directly against the ex-husband for breach of his marital settlement agreement. The ex-husband countered with an action asserting that ERISA preempted the waiver provisions in the settlement agreement. Litigation ensued, eventually resulting in the Fourth Circuit's affirmation of a lower court decision dismissing the ERISA preemption claim and holding that, although the plan administrators must distribute benefits to the ex-husband as named beneficiary, the ex-husband must then waive his rights to the funds following that distribution and turn the funds over to his ex-wife's estate. Noting that "allowing post-distribution suits to enforce state-law waivers" does not interfere with the objectives of ERISA, the appeals court found that ERISA does not preempt post-distribution suits against beneficiaries. (*Andochick v. Byrd*, 4th Cir. 2012)

Modification of Discount Rates Not Cutback for Plan Lump-Sum Benefits

Mutual of New York's Insurance Company (MONY) sponsored a tax qualified defined benefit retirement plan and also an excess benefit plan, a defined benefit non-qualified plan. Both plans allowed for a lump sum distribution to be taken in lieu of the normal form annuity payment. Mr. Dennison, a participant in both plans, left MONY in 1996. In 2009, 13 years after leaving MONY, Mr. Denison attained age 55 and was eligible to commence receiving benefits from both plans. Mr. Dennison requested lump sum payments from both plans.

The qualified plan had recently been amended to provide that lump sum benefits were no longer calculated using a discount rate based on so called "PBGC interest rates" and instead used so called "segment interest rates." The use of the segment interest rates was a change required by the Pension Protection Act (PPA). The use of the segment interest rates results in a lower lump sum benefit payment than the old PBGC interest rates would have produced. Mr. Dennison argued that the amendment of the discount rate factors was an impermissible cut-back in his accrued benefit.

The Seventh Circuit upheld the plan's decision that no cut back benefits had occurred. The court found that the protected accrued benefit under the qualified defined benefit plan was the annuity form of benefit, which had not changed as a result of the amendment. The adoption of the PPA segment interest rates was a change required by law and, under the law and regulations, was a permissible cutback in benefits.

Mr. Dennison had also argued that the terms of the qualified defined benefit plan at the time he separated from employment in 1996 should govern. The court rejected that argument, finding that the amendment to add the PPA segment rates was clearly drafted to apply to people who had terminated at an earlier date.

With respect to the non-qualified excess benefit plan, Mr. Dennison challenged the use of the stated of 7.5 percent discount rate. Again, the 7.5 percent discount rate produced a smaller lump sum benefit than use of a lower rate, such as PBGC interest rates, would produce. The terms of the excess benefit plan did not provide for a specific rate, but rather referred to the terms of the qualified plan. The Seventh Circuit looked at the terms of the qualified defined benefit plan and determined that the document discussed the use of PBGC rates and segment rates for benefits subject to IRC § 417(e). IRC

§ 417(e) provides for a floor on the amount that can be paid as a lump sum benefit in a qualified plan. The court rejected Mr. Dennison's position, finding that because the excess plan was a non-qualified plan, it was not subject to the rules of IRC § 417(e). Thus, the default interest rate under the qualified plan of 7.5 percent was the rate that was appropriate to use. The court also found that the plan had used this rate consistently over many plan years and therefore any ambiguity in the plan was resolved by the administrator's consistent use of the 7.5 percent interest rate. (*Dennison v. MONY Life Retirement Income Security Plan for Employees*, 7th Cir., 2013).

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