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EMPLOYEE BENEFITS DEVELOPMENTS APRIL 2013

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Employee Benefits

RULINGS, OPINIONS, ETC.

Now is the Time to "Play or Pay."

The so-called play-or-pay mandate becomes effective January 1, 2014. For calendar year plans, 2014 open enrollment is fast approaching, so now is the time for employers to begin formulating play-or-pay mandate compliance plans. Union employers and employers that sponsor non-calendar year plans have unique issues that require evaluation. Employers may find the following checklist useful for this purpose.

Is the "employer" an "applicable large employer?"

To be exposed to play-or-pay penalties, an employer must have 50 or more full-time employees (30 or more hours on average per week, or 130 hours per month), including full-time equivalent employees. For this purpose, related employers (i.e., members of controlled groups and members of an affiliated service group) are treated as a single employer; therefore, the full-time employees of each member are aggregated for purposes of determining applicable large employer status. If the related group of employers has 50 or more full-time employees, each member of the group (i. e., each "applicable large employer member") faces penalty exposure. As the guidance currently stands, independent contractors and full-time workers who are "leased" from PEOs and other employee leasing entities must be counted as employees of the worksite employer if they are employees of the worksite employer under the so-called common law standard. Employers should carefully review independent contractor and leased employee relationships to determine a worker's status under this standard.

Threshold question: Should an employer play or pay?

This determination can be made only after carefully identifying all costs associated with each option. The "no coverage" option carries a number of potentially heavy costs: The $2,000 per employee, per year nondeductible "no coverage penalty," the additional income tax liability the employer is likely to incur as a result of payment of the nondeductible penalty; and the "make whole" payment (in cash or benefits)

the employer might need to provide to employees to compensate them for the loss of medical benefits. If the make-whole payment is in cash (i.e., additional taxable wages), the employer will need to consider the additional FICA tax payable on the make-whole payment. The impact on employee retention and recruitment needs to be considered in addition to the "hard" costs. This cost would then be compared to the cost of providing affordable coverage to substantially all full-time employees. As part of this analysis, employers must identify full-time employees, establish an affordability approach, and make certain assumptions about the percentage (or increased percentage) of employees who would elect coverage under a more affordable arrangement.

Does the applicable large employer member offer 95 percent of its full-time employees (and their dependents) the opportunity to enroll in an "eligible medical plan?"

If not, the applicable large employer member is exposed to the draconian "no coverage penalty" of up to $2,000 for each full-time employee if any full-time employee of the employer receives a subsidy for coverage purchased through the Exchange. The first 30 employees are not subject to the penalty. Employer members of a controlled or affiliated service group must share the 30-employee exclusion.

Eligible medical plans. Employer sponsored major medical plans, including self-insured and grandfathered plans, are eligible medical plans. Coverage under plans that provide excepted benefits, such as, for example, limited scope dental and vision benefits, "bona fide" hospital indemnity plans, and other arrangements that provide only ancillary medical benefits do not qualify as eligible medical coverage. Additional guidance on this issue may be forthcoming.

Identifying full-time employees. To avoid penalty assessments, employers must carefully identify their full-time employees, and must offer affordable, minimum value coverage to at least 95 percent of those employees. A full-time employee for a calendar month is any employee who is employed on average at least 30 hours of service per week (or 130 hours of service per month).

Employers should carefully review independent contractor and leased employee relationships to determine whether these workers should be treated as full-time employees. As previously noted, independent contractors and leased employees must be treated as employees of the worksite employer if they qualify as the worksite employer's employees under the common law standard. Additional agency guidance on the treatment of leased employees is likely to be forthcoming.

In addition, employers with employees who do not work a regular schedule (so-called variable hour employees and seasonal employees) will need to establish measurement periods (and related administrative and stability periods) to ensure that any variable hour or seasonal employee who meets the full-time standard is offered coverage during the 2014 open enrollment period and related stability period.

Does the applicable large employer member's plan provide "minimum value?"

Eligible medical plans that do not provide minimum value expose the employer to a penalty of up to $3,000 per year for each full-time employee who receives a subsidy for coverage purchased through the Exchange. To meet the minimum value requirement, the plan must have an actuarial value of at least 60 percent. Most fully insured plans will meet this requirement; however, employers should reach out to their insurer to determine who will bear the burden of proving minimum value. Employers that sponsor self-insured plans should begin a dialog with their TPAs, brokers, and attorneys for

guidance on establishing minimum value.

Is the employer's eligible medical plan "affordable?"

Eligible medical plans that are not affordable for a given full-time employee expose the employer to a penalty of up to $3,000 per year for that employee if he or she receives a subsidy for coverage purchased through the Exchange. Coverage is "affordable" if the employee is not required to pay more than 9.5 percent of pay toward premiums for self-only coverage under the employer's lowest cost plan. To eliminate or reduce exposure to the penalties, employers should begin to review their premium cost-sharing arrangements to determine whether self-only coverage is affordable. What are the estimated penalties if the employer's lowest cost, self-only coverage is not affordable? What would it cost the employer to ensure that the plan is affordable for all full-time employees? Which compensation safe harbor, if any, should the employer use to measure affordability?

Action Steps

Even though additional guidance is expected later this year, employers are well-advised to begin the planning process now.

These are just a few of the questions employers will need to address as part of the evaluation:

- In calculating hours of service for purposes of determining full-time employee status, are employers required to convert workers compensation or state-mandated disability payments into hours worked? If so, how?
- If an employer is a member of a related group of employers, does the employer have a procedure in place for tracking hours worked by an employee across the controlled group?
- How do wellness incentives factor into the determination of affordability?
- Is it clear that the definition of "dependent" includes only biological, adopted, and step children? What is the rule for dependents who are non-U.S. citizens residing outside of the United States?

There is no formal or informal public information indicating that the IRS (or Congress) is giving serious consideration to a delay in the effective date of the play-or-pay mandate or outright appeal of it. For some employers, the analysis outlined above is time-consuming, and with open enrollment around the corner, now is the time to build a compliance template. Building the compliance template now will enable employers to evaluate new legal developments and plan designs relatively quickly and efficiently.

DOL Offers Target Date Fund Tips for Fiduciaries

With the increasing popularity of target date retirement funds as an investment option in individual account retirement plans (e.g., 401(k) plans), the Department of Labor (DOL) recently published informal guidance intended to assist plan fiduciaries in selecting and monitoring those funds. Target date funds typically hold a mix of stocks, bonds, and other investments that automatically changes over time as the participant ages. The fund's initial asset allocation, when the target retirement date is a number of years away, usually consists mostly of stocks or equity investments, which often are higher-return, higher-risk investments. As the target retirement date approaches, the fund's asset allocation shifts to include a greater proportion of conservative investments (e.g., bonds and cash instruments), which generally are lower-return, lower-risk investments. In other words, these funds automatically rebalance to become more conservative as an employee gets

closer to retirement. Target date retirement funds can be attractive options for employees who do not want to actively manage their retirement savings. The DOL guidance reminds plan fiduciaries that there can be considerable differences among different target date retirement fund products offered in the market. Plan fiduciaries need to be engaged in a prudent and documented process for evaluating, selecting, and monitoring target date funds that focuses on matters such as the performance of the funds, the principal investment strategy and risks associated with the funds, and the investment fees and expenses that are charged by the funds. The DOL's guidance can be found here.

Agencies Issue New FAQs Regarding Affordable Care Act Preventive Care Issues

The Departments of Labor, Health, and Human Services and the Treasury have once again issued a set of FAQs regarding the implementation of the Patient Protection and Affordable Care Act (ACA). This recent guidance, the 12th in a series of FAQs that the agencies have published, focuses primarily on preventive care issues. Below is a summary of some of the issues addressed by the recent guidance.

Out-of-network coverage of preventive care services. Under the ACA, non-grandfathered group health plans are required to provide first dollar coverage of certain preventive care services. One of the recent FAQs clarifies that this no cost-sharing requirement applies to preventive services provided by an out-of-network provider when the plan does not have any in-network provider that offers the particular required preventive service.

Aspirin as preventive care. The U.S. Preventive Services Task Force recommends the use of aspirin for certain patients to reduce the risk of heart attacks. An FAQ in the recent guidance states that, when prescribed by a health care provider, aspirin must be covered without cost-sharing.

Polyp removal during a colonoscopy screening. If a polyp is discovered and removed during a colonoscopy that was performed as part of a screening procedure, a plan cannot impose cost-sharing on a participant. This is because the medical community regards polyp removal as an integral part of a colonoscopy. The FAQ notes, however, that cost-sharing may be imposed where a treatment is not a recommended preventive service, even if the treatment results from a preventive service.

First dollar coverage of contraceptives. As mentioned, non-grandfathered group health plans are prohibited from imposing cost-sharing on certain preventive care services, including all Food and Drug Administration approved contraceptive methods. Accordingly, a plan may not limit coverage to only oral contraceptives. However, plans may use reasonable medical management techniques to control costs. For example, a plan may cover a generic drug without cost-sharing and impose cost-sharing for an equivalent branded drug. In this instance, however, a plan must have a mechanism for waiving the cost-sharing for a branded drug if an individual's health care provider determines the generic drug would be medically inappropriate.

All the DOL FAQs on the new health care law can be found by clicking on the FAQs tab on the left side of the DOL Employee Benefit Security Administration website. You can go directly to this recent release by clicking here.

CASES

Discounted Stock Options Subject to Section 409A Penalties

Ruling in favor of the IRS, the U.S. Court of Federal Claims confirmed in a recent case that discounted stock options are deferred compensation subject to the requirements of Section 409A of the Internal Revenue Code. Under the Section 409A regulations, incentive stock options are exempt from coverage. Nonqualified stock options are also exempt from Section 409A, if, among other requirements, the options are granted with an exercise price that may never be less than the fair market value of the underlying stock on the date of grant. If the options are discounted, the Section 409A regulations provide that the options are treated as deferred compensation. If the terms of the discounted options fail to comply with the requirements of Section 409A, the options are subject to taxation upon vesting, interest at a premium rate, and a 20 percent additional tax. As a practical matter, because stock options are typically structured to be exercisable over a period of multiple years following vesting, options that are not exempt from Section 409A are unlikely to be compliant with Section 409A.

The case at hand arises from a determination by the IRS that stock options granted to a CEO of a company were issued with a discounted exercise price, resulting in a violation of Section 409A. On December 26, 2003, the company's executive compensation committee approved a grant of nonqualified stock options to its CEO. The options had an exercise price equal to the trading price of the company stock on that date. The grant was not ratified, however, until January 16, 2004, at which time the stock had risen in value. Following the executive's exercise of a portion of his options in 2006, the company's board of directors conducted an internal review of its option granting practices. The reviewing committee found that the appropriate measurement date for the grant of the CEO's options was not December 26, 2003, but January 16, 2004, the date on which the compensation committee ratified the grant. The company and the CEO entered into a reformation of the stock option agreement, and the CEO paid an additional $5.3 million to the company, representing the difference between the amended and the original exercise prices. In 2010, the IRS issued a Notice of Deficiency to the CEO and his wife for the 2006 tax year due to a violation of Section 409A, assessing additional taxes and interest of over $3.4 million. An additional $704,883 of interest was assessed in 2011. The couple paid the assessed amounts and filed suit for a refund. Both sides filed for partial summary judgment.

The CEO and his wife claimed that Section 409A did not apply to the stock options, advancing several legal arguments for their exemption: that options are not taxable until exercise; that options are not deferred compensation under the Code Section 3121(v) regulations; that the option income should be exempt under the short-term deferral exception; and that there was no deferral to a later year, because there was no legally binding right to option compensation until actual exercise of the options. The court rejected each argument, holding that discounted options are deferred compensation subject to Section 409A and granting partial summary judgment to the IRS. The case was set for trial on the factual issue of whether the options were issued at a discounted price on the grant date.

This case underscores the importance of establishing a methodology for determining the fair market value of stock options (and stock appreciation rights) that will satisfy Section 409A and stand up to IRS scrutiny on audit. Companies should establish and consistently follow a 409A-compliant process for determining the exercise price and be prepared to support their determinations through careful documentation. *Sutardja v. United States* (Fed. Cl. 2013)

Second Circuit Revisits Application of *Moench* Presumption

"What does the plan document say?," is a popular refrain heard from ERISA attorneys. That, it turns out, is the same question the Second Circuit would pose in deciding whether the *Moench* presumption applies to a plan sponsor's decision to offer employer securities in an eligible individual account plan.

Pension plans generally may not acquire qualifying employer securities if acquiring those securities would result in more than 10 percent of the plan's assets being invested in employer securities or employer real property. This restriction generally does not apply to eligible individual account plans (EIAPs). Recognizing the tension between ERISA's competing values of protecting retirement assets and encouraging investment in employer stock, courts have developed the *Moench* presumption that an ERISA fiduciary of an EIAP who makes employer stock available as an investment option is entitled to a presumption that it acted consistently with its fiduciary duties of prudence and loyalty. A court applying the presumption reviews the decision to make employer stock available as an investment option for abuse of discretion. Under this deferential standard, the Second Circuit previously held that an ERISA fiduciary may be found to have abused its discretion only where it knew or should have known that the employer, and therefore its stock, was in a dire situation.

In *Taveras v. UBS, AG*, (2d Cir. Feb. 27, 2013), UBS was the sponsor of two EIAPs, the Savings and Investment Plan (SIP) and the Plus Plan. Each plan allowed participants to direct their own investments among the various funds available under the plan, which included a UBS Stock Fund. Between April 26, 2007, through October 16, 2008, the plaintiffs' amended complaint alleged the UBS Stock Fund lost 74 percent of its value, though the plaintiffs' opposition to the defendants' motion to dismiss revised that figure down to 69 percent.

The Plus Plan's stated purpose was to attract and retain qualified individuals by providing them with an opportunity to accumulate assets for their retirement and to acquire UBS stock. Toward this goal, the Plus Plan required that the UBS Stock Fund be one of the investment options available under the plan. On the other hand, the SIP contained no language mandating or even encouraging that SIP participants be permitted to invest in the UBS Stock Fund.

The court noted that judicial scrutiny of an ERISA fiduciary's decision to offer employer stock as an investment option increases with the degree of discretion a plan allows that fiduciary to exercise in making that investment option available. Conversely, an ERISA fiduciary's failure to divest from employer stock is less likely to constitute an abuse of discretion if the plan's terms require investment in employer stock.

In view of this sliding scale, the court found that defendants were entitled to the benefit of the *Moench* presumption under the Plus Plan in that the plan's fiduciaries were directed to offer the UBS Stock Fund as an investment option by the Plus Plan document. With respect to the SIP, however, the court held that the decision to offer the UBS Stock Fund was one made pursuant to the plan fiduciaries' discretion and, thus, not entitled to a presumption of prudence. As a result, the fiduciaries' decision to make the UBS Stock Fund available as an investment option under the SIP becomes subject to heightened judicial scrutiny.

Although the *Taveras* decision refines the contours of when the *Moench* presumption applies in the first instance, it does little to answer the question of when an employer's situation – short of insolvency – becomes so dire that the presumption can be overcome.

Rental Property Sufficient to Find Personal Liability for Multiemployer Plan Withdrawal

Messina Trucking was a contributing employer to the Central States, Southeast and Southwest Areas Pension Fund. In October 2007, Messina Trucking withdrew from the fund. The fund determined that the withdrawal liability was slightly under $3.1 million and that all commonly controlled trades and businesses were jointly and severally liable. In January 2010, Messina Trucking defaulted on its withdrawal liability obligation. The fund filed a lawsuit against Messina Trucking, several entities that were under common control, Stephen Messina and Florence Messina personally, and a limited liability company owned by the Messinas formed to hold an investment. The basis on which to access liability against the Messinas personally was that the Messinas owned and leased the property from which Messina Trucking operated. The Messinas argued that they were not engaged in a trade or business and thus not liable for the withdrawal liability. The dispute in the case was not whether common control existed, but rather were the Messinas engaged in a trade or business. The Seventh Circuit Court of Appeals reversed the district court and held that the Messinas were engaged in a trade or business because of their ownership of the property used by Messina Trucking. The Seventh Circuit relied on a more recent decision also issued by the Seventh Circuit, which held that renting property to a withdrawing employer is "categorically" a trade or business. The Seventh Circuit determined that allowing Messina Trucking to operate on the property without paying rent for several years and the provision of property maintenance activities performed by Messina Trucking employees must be imputed to the Messinas. The court also held that the LLC owned by the Messinas was also a trade or business. The LLC's sole asset was a 50 percent partnership interest in another limited liability company that owned rental properties. The Messinas argued that the LLC was a passive investment vehicle and was not a trade or business. The Seventh Circuit found it was a trade or business because the intention of forming a business entity is highly relevant to the existence of a trade or business, and the LLC filed a Form 1065 tax return, which showed trade or business income, and declared on that tax return that its principal business trade or activity was real estate rental.

This case, along with several other recent cases, shows that multiemployer funds are undertaking aggressive action in order to collect withdrawal liability from every possible party and that possible claims against related entities and persons should be reviewed whenever an employer considers withdrawing from a multiemployer plan. (*Central States Southeast and Southwest Areas Pension Fund v. Messina Products LLC*, 7th Cir., 2013).

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