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EMPLOYEE BENEFITS DEVELOPMENTS DECEMBER 2012

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Employee Benefits

RULINGS, OPINIONS, ETC.

New Proposed Regulation Relating to Wellness Programs

In late November, the Departments of Health and Human Services, Labor, and Treasury issued a proposed regulation that makes important changes in the HIPAA nondiscrimination rules governing wellness programs in group health coverage. The proposed regulation is expected to be issued in final form next year and is expected to apply to plan years beginning on and after January 1, 2014. In this article, we summarize some of the important new proposed changes.

Participatory Wellness Programs. Under the proposed regulation, a "participatory wellness program" is a program that either does not require an individual to meet a standard related to a health factor in order to obtain a reward or that does not offer a reward at all. Participatory wellness programs include fitness center reimbursement programs; diagnostic testing programs that reward participation (i.e., programs that do not base rewards on test outcomes); programs that waive co-pays or deductibles for prenatal or well-baby visits; programs that reimburse employees for the costs of smoking cessation programs, regardless of whether the employee quits smoking; and programs that reward employees for attending a free education seminar. The proposed rule does not change current law; as long as a participatory wellness program is made available to all similarly situated individuals, the program will comply with HIPAA's nondiscrimination rules without having to satisfy any additional standards. For example, under existing law, there is no limit on the financial incentives for participatory wellness programs. The proposed rule would not change this.

Health-Contingent Wellness Programs. A health-contingent wellness program is a wellness program that conditions the receipt of a reward on the satisfaction of a standard that is related to a health factor. The following are examples of health contingent wellness programs: Diagnostic screening programs that base rewards on outcomes (e.g., a testing program that provides a premium subsidy for employees who reduce their cholesterol levels); smoking surcharges for employees who use tobacco

products; and programs that waive cost-sharing requirements (i.e., co-pays and deductibles) for employees who run or walk at least 10 miles per week.

Under the current rules, health-contingent wellness programs must meet five requirements:

1) Individuals must be given the opportunity to qualify at least once per year.
2) The maximum reward cannot exceed 20 percent of the annual cost of employee-only coverage (20 percent of the cost of family coverage if, in addition to the employee, any class of dependents may participate in the wellness program).
3) The program must allow for a reasonable alternative standard (or waive the otherwise applicable standard) for obtaining a reward for any individual for whom it is either unreasonably difficult due to a medical condition or medically inadvisable to attempt to meet the otherwise-applicable standard.
4) The program must be reasonably designed to promote health or prevent disease.
5) All plan materials that describe the terms of the program must disclose the availability of other means of qualifying for the reward or the possibility of a waiver of the otherwise applicable standard.

The proposed regulation would maintain these requirements and make the following changes:

1) The proposed regulation reflects the increase in the maximum reward from 20 percent to 30 percent of the applicable cost of coverage, effective 2014, as mandated by the Affordable Care Act.
2) The maximum percentage (30 percent) would be increased an additional 20 percentage points to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.
3) With respect to the requirement that a program allow for a reasonable alternative standard, the proposed regulation provides as follows:

- If the reasonable alternative standard is completion of an educational program, the plan must specify the program or programs that are available, may not require an individual to find a program, and may not require the individual to pay for the program.
- If the reasonable alternative standard is a diet program, the plan must pay any membership or participation fee but is not required to pay for the cost of food.
- If the reasonable alternative standard is compliance with the recommendation of a medical professional engaged by the plan, and an individual's personal physician states that the plan's recommendation is not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the recommendation of the individual's personal physician.

4) Under the proposed regulations, an employer would be permitted to require an individual to obtain a statement from his or her physician that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for an individual to attempt to satisfy, the otherwise applicable standard only if reasonable under the circumstances. The proposed regulation provides that it would not be reasonable for an employer to seek verification of a claim that is "obviously valid based on the nature of the individual's medical condition that is known to the plan." Employers may seek verification in the case of claims for which it is reasonable to determine that medical judgment is required to evaluate the validity of the claim.

Employers should review their wellness programs and vendor contracts in light of the proposed regulation to determine whether any changes would be required and to ensure, to the extent possible, that the vendor is aware of the upcoming changes. Employers should be on the watch for the final wellness regulations, which are expected in 2013, effective for plan years beginning on and after January 1, 2014.

CASES

District Court Rejects Private Equity Fund Liability for Multiemployer Plan Withdrawal

A recent decision of the District Court for Massachusetts provides welcome news for private equity funds that invest in businesses that may have significant liability from multiemployer plans. Under the Employee Retirement Income Security Act of 1974 (ERISA), trades or businesses under common control are jointly and severally liable for certain pension plan liabilities, including withdrawal liability from a multiemployer pension plan. Generally, a company would be within the common control group rules if another entity held 80 percent or more of the interest in the company with liability. In the past, private equity funds felt they were not subject to this liability because they were not "a trade or business," and therefore not subject to the control group rules. In 2007, the Pension Benefit Guaranty Corporation (PBGC) issued an opinion letter indicating that a private equity fund could be a trade or business, finding that a private equity fund's stated purpose was to make a profit and that the private equity fund's investment activity was continuous and regular. In a recent case, the District Court for Massachusetts examined the liability of two private equity funds run by Sun Capital Partners. One fund owned 70 percent of the company, Scott Brass Inc., and another other fund owned 30 percent. The district court rejected control group liability, finding that the private equity funds were not a trade or business. The court rejected the rationale of the PBGC opinion and found that the funds were passive investment funds and that activities of the funds were not sufficiently continuous or regular in order to constitute a trade or business. The multiemployer plan had also argued that the private equity funds were liable under an "avoid or evade" theory, given that the ownership may have been split between the two funds based on advice provided to the funds that it would be prudent to keep the ownership interest of each fund below 80 percent. The court also rejected that argument, finding that it would be unlikely that an entity or person purchasing a business would do so with the intent, at the time of investment, that the business would fail or that the failure was imminent. While this decision is good news for private equity funds, it should be noted that the decision is on appeal to the First Circuit and merits further watching. Additionally, it may also be appropriate for private equity funds to limit ownership of the company in any one fund to below 80 percent in order to have a further position that the control group 80 percent ownership test is not satisfied. *Sun Capital Partners III L.P. v. New England Teamsters and Trucking Industry Pension Fund* (D. Mass., 2012)

Actual Receipt of COBRA Notice Not Required

The U.S. District Court for the Southern District of Florida recently held that an employer had satisfied its Consolidated Omnibus Budget Reconciliation Act (COBRA) election notice obligation, even though the employer's former employee never received the notice. In this case, the employer sent the COBRA notice via certified mail to the former employee's last

known address. However, the former employee claimed to never have received the COBRA notice. The former employee's claim is supported by a print-out from the U.S. Postal Service noting that the letter had been processed on August 27, 2011, and was unclaimed as of September 13, 2011. Under the COBRA and Department of Labor regulations, a plan administrator does not have to prove that a former employee actually receives a COBRA notice. Rather, the plan administrator must use a disclosure method that is "reasonably calculated to ensure actual receipt." In granting summary judgment in favor of the employer, the court noted that there was no evidence of bad faith on the part of the employer and that, by sending the COBRA notice to the former employee's last known address, the employer complied with its notice obligation. *Burden v. City of Opa Locka* (S.D. Fla., 2012)

Plan Cannot Exclude COLA From Lump Sum Payouts of Accrued Benefits

In 1991, the sponsor of a pension plan amended the plan to offer a lump sum distribution as an optional form of benefit, but excluded from the calculation of lump sums the actuarial value of cost-of-living adjustments (COLAs) that would have been applicable to the same pension benefit when distributed in the form of an annuity. Plan participants who received lump sum payouts and did not receive the economic value of the COLA in their lump sum distributions sued the plan sponsor, claiming that the failure to treat the COLA as part of the accrued benefit is a violation of ERISA. A federal district court, on the matter of liability, ruled in favor of the participants, holding that the lump sum must be actuarially equivalent to the accrued benefit, which includes the COLA. The court held that because any annuitant at normal retirement age will receive a set monthly payment that will increase according to a COLA throughout the annuitant's lifetime, the COLA is part of the accrued benefit. In reaching its conclusion, the court rejected the notion that the COLA might be either an ancillary benefit or a retirement-type subsidy. While the court held the plan is liable to the affected participants because it did not provide the lump sum equivalent of the full accrued benefit, the remedies were not established by the court and will be determined in a separate proceeding. *Pikas v. Williams Companies Inc.* (N.D. Okla. 2012)