EMPLOYEE BENEFITS DEVELOPMENTS JULY 2012

Hodgson Russ Newsletter
July 31, 2012

Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Agencies Issue New FAQs Regarding Summary of Benefits and Coverage

The U.S. Departments of Labor, Health and Human Services and the Treasury have issued a set of frequently asked questions (FAQs) regarding the implementation of the Patient Protection and Affordable Care Act. This recent guidance, the ninth in a series of FAQs that the agencies have published, focuses on the summary of benefits and coverage (SBC). The SBC is a new document that group health plans and insurance issuers will be required to provide to plan participants regarding their benefits. Below is a summary of some of the issues addressed by the recent guidance.

New electronic disclosure safe harbor for SBCs. Under previous guidance, the agencies outlined several situations where an SBC may be provided electronically (see our April 2012 newsletter). Under this new guidance, the agencies further stipulated that an SBC may be distributed electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs may also be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request.

The agencies will develop a calculator for assistance with coverage examples. The regulations require SBCs to include certain coverage examples to illustrate the costs associated with common coverage scenarios. The agencies are developing an online calculator that plans can use to complete the coverage examples. Plans will be able to input certain information, which the calculator will use to create a coverage example that can be used in the SBC. Once developed, the calculator will be posted on the resources page of the Center for Consumer Information & Insurance Oversight website.

Group health plans responsible for providing SBC information for carve-out arrangements. To provide a complete SBC, a plan administrator that uses two or more insurance products provided by separate insurers with respect to a single group

health plan must synthesize the information into a single SBC. The plan administrator may contract with one of the insurers or other service providers to perform that function. However, unless it contracts otherwise, an insurer has no obligation to provide coverage information for benefits that it does not insure.

In recognition of the administrative challenge of synthesizing this information, for enforcement purposes, the agencies will allow plans that utilize multiple insurers to provide multiple partial SBCs that together provide all the relevant information to meet the SBC content requirements. In such circumstances, plan administrators should include a cover letter to indicate that the plan provides coverage using different insurers, and that individuals who would like assistance understanding how these products work together may contact the plan administrator for more information.

All of the FAQs on the new health care law can be found by clicking on the "FAQs" tab on the left side of the U.S. Department of Labor Employee Benefit Security Administration website, or may be accessed directly here.

IRS Notice Provides Guidance on the Health FSA Salary Reduction Limit

Internal Revenue Service (IRS) Notice 2012-40 addresses a number of important issues regarding the implementation of the salary reduction limit for cafeteria plan health flexible spending accounts (health FSAs). Under the Patient Protection and Affordable Care Act, beginning in 2013, health FSAs must limit employee salary reductions to no more than $2,500 per year. This notice clarifies that the salary reduction limit will be applicable on a *plan-year* basis and will be effective for plan years beginning on or after January 1, 2013.

Although health FSAs must comply operationally with these limits in 2013, health FSAs have until December 31, 2014 to adopt an amendment reflecting this limit (with a retroactive effective date of the first day of the plan year beginning on or after January 1, 2013).

Some health FSAs provide a grace period (of up to two and a half months) following the end of the plan year in which participants may continue to incur expenses that can be reimbursed from amounts withheld during the prior plan year. This new guidance clarifies that if a health FSA provides a grace period, any unused salary reduction contributions for plan years beginning in 2012 or later that are carried over onto the grace period for that plan year will not count against the $2,500 limit for the subsequent plan year.

This notice also provides limited relief for health FSAs that mistakenly allow participants to make salary reduction contributions exceeding $2,500. Specifically, if the health FSA is amended to comply with this salary reduction limit by the end of 2014, the health FSA will not be disqualified if all of the following requirements are met:

1. The terms of the plan apply uniformly to all participants.

2. The error results from a reasonable mistake by the employer (or employer's agent) and is not due to willful neglect.

3. The salary reduction contributions in excess of $2,500 are paid to the employee and reported as wages for income tax withholding and employment tax purposes on the employee's Form W-2 (or W-2c) for the employee's taxable year in which, or with which, ends the health FSA plan year in which the correction is made.

This notice clarifies a number of issues regarding the implementation of the salary reduction limitation and provides a great deal of relief for plan sponsors trying to comply with the new law. (IRS Notice 2012-40)

2013 Inflation-Adjusted Limits for Health Savings Accounts

New inflation-adjusted limits for contributions, deductibles, and out-of-pocket expenses for health savings accounts (HSAs) have been released by the Internal Revenue Service (IRS). For 2013, the annual limitation on deductions for an individual with self-only coverage under a high-deductible health plan is $3,250. For an individual with family coverage, the limitation is $6,450. A high-deductible health plan is defined under Internal Revenue Code § 223(c)(2)(A) as a health plan with an annual deductible for 2013 that is not less than $1,250 for self-only coverage or $2,500 for family coverage. To qualify as a high-deductible health plan in 2013, annual out-of-pocket expenses for deductibles, co-payments, and other amounts (not including premiums) also must not exceed $6,250 for self-only coverage and $12,500 for family coverage.

Proposed Section 83 Regulations Provide Clarifications

The Internal Revenue Service (IRS) issued proposed regulations under Internal Revenue Code (IRC) § 83, which governs the timing of income inclusion for property that is subject to a substantial risk of forfeiture. The proposed regulations would make three clarifications:

1. A substantial risk of forfeiture arises only through a service condition or a condition related to the purpose of the transfer of property and not as a result of other conditions.

2. With respect to transfer restrictions on securities, such as lock-up provisions, buy-back provisions, or restrictions relating to insider trading, there is no substantial risk of forfeiture. Only when a security is subject to the short-swing profit rules under § 16(b) of the Securities Exchange Act of 1934 is there a substantial risk of forfeiture.

3. The IRS indicates that in determining whether there is a substantial risk of forfeiture, both the likelihood that the forfeiture will occur and be enforced are relevant to making the determination.

This last clarification is highlighted by an example in the preamble to the proposed regulations, where a risk of forfeiture is not viewed as substantial because the condition causing the forfeiture was so unlikely to occur. This example may indicate a potential change in interpretation by the IRS under IRC § 83.

IRS Issues Final Regulations Regarding Affordable Care Act's Premium Tax Credit

On May 18, 2012, the IRS issued final regulations relating to the health insurance premium tax credit enacted as part of the Affordable Care Act. The regulations finalize rules proposed by the IRS in August 2011. The final rules provide guidance to individuals who enroll in qualified health plans through affordable insurance exchanges and claim the premium tax credit, and to exchanges that make qualified health plans available to individuals and employers. Although the final regulations

are designed to provide guidance to individual taxpayers and exchanges, employers will find them instructive because of the relationship between an employee's eligibility for the premium tax credit and employer liability under the employer mandate (the so-called "pay or play" penalty).

Premium Tax Credits. Under Section 36B of the Internal Revenue Code, certain individuals are entitled to a tax credit for health insurance coverage that is purchased through an exchange.

To be eligible for a premium tax credit, an "applicable taxpayer" is allowed a premium tax credit if the applicable taxpayer, or the applicable taxpayer's spouse or dependent, is enrolled in a qualified health plan through an exchange; is not eligible for government-sponsored coverage (e.g., Medicare. Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and VA health care); and is not *enrolled* in employer-sponsored coverage. An employee who is eligible for employer-sponsored coverage does not qualify for a premium tax credit if the employer-sponsored coverage provides minimum value and is affordable. An employee who is *eligible* for employer-sponsored coverage that does not provide minimum value or is unaffordable can still qualify for the premium tax credit.

An "applicable taxpayer" is a taxpayer who:

- has household income that is at least 100 percent but not more than 400 percent of the federal poverty line for the taxpayer's family size for the taxable year,
- is lawfully present in the United States and not incarcerated,
- files a joint tax return, if married, and
- cannot be claimed as a dependent on anyone else's return.

Automatic Enrollment. Under the final regulations, an employee who is automatically enrolled in an employer-sponsored plan retains his or her eligibility for the premium tax credit, provided the individual terminates the coverage before the later of the first day of the second full calendar month of the plan year or other period, or by the last day of a permissible opt-out period provided by the plan or in DOL regulations.

COBRA Coverage. Under the final regulations, an individual is eligible for employer-sponsored COBRA or mini-COBRA only if he or she is actually *enrolled* in such coverage.

What Is "Minimum Value?" Employer-sponsored coverage provides minimum value only if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent. In Notice 2012-31, the IRS outlined three potential approaches that could be used to determine whether an employer-sponsored plan provides minimum value. The final regulations do not address minimum value other than to state that future guidance will be forthcoming.

When Is Employer-Sponsored Coverage "Affordable?" Under the final regulations, an employer-sponsored plan is affordable for the employee (and only the employee) if the portion of the premium the employee must pay for self-only coverage does not exceed 9.5 percent of household income. The final regulations reserve the issue of the affordability of family coverage for later resolution.

With respect to affordability, the final regulations state that employer contributions to an HSA would not affect affordability of employer-sponsored coverage because HSA contributions may not be used to pay for premiums for health insurance coverage. Likewise, amounts available under an HRA that may be used to reimburse medical expenses *other than the employee's required share of the cost of employer-sponsored coverage* would not affect the affordability of employer-sponsored coverage. The final regulations do not address how other HRAs are treated for purposes of determining affordability.

The final regulations do not address the effect on affordability of wellness incentives that increase or decrease an employee's share of premiums. The final regulations, however, authorize the IRS to issue guidance on this issue. The IRS has requested comments on types of wellness incentives that increase or decrease an employee's share of premiums; how these programs affect the affordability of eligible employer-sponsored coverage for employees and related individuals; and how incentives are earned and applied.

The Employer Mandate. The Affordable Care Act does not mandate that an employer offer health coverage; however, effective January 1, 2014, certain employers with 50 or more employees, counting both full-time employees and full-time equivalent employees, will be liable for a penalty if they do not offer coverage to all full-time employees, or if the coverage offered is neither affordable nor valuable.

Under the circumstances described below, an employer would be liable for a penalty if at least one of its full-time employees purchases coverage through an exchange and receives a premium credit.

1. If an employer and each of the employer's controlled group members fail to offer *all* full-time employees and their dependents medical coverage that meets minimum federal standards, the employer will be liable for a penalty if one or more of the employer's employees qualify for a premium tax credit or cost-sharing subsidy for individual coverage that the employee purchases through an exchange. The penalty is $2,000 times the number of full-time employees in excess of 30.

2. If an employer *does* make minimum essential coverage available to all full-time employees, the employer will nevertheless be liable for a penalty if (a) the employer's coverage either is not "affordable" or does not provide "minimum value" and (b) the employer has one or more employees who qualify for a premium tax credit for individual coverage purchased through an exchange. The penalty in this situation is $3,000 for each employee who receives a premium credit through the exchange.

Unlike the definition of affordability for purposes of entitlement to the premium tax credit, which is based on household income, affordability for purposes of the pay-or-play mandate is based on an employee's W-2 income. In Notice 2011-73, the IRS stated that for the purpose of the employer-mandate, employer-sponsored health coverage is deemed affordable if the premium required to be paid by the employee for self-only coverage is equal to or less than 9.5 percent of the employee's W-2 wages. As noted, employer-provided coverage is deemed to provide "minimum value" if the plan pays at least 60 percent of covered medical benefits of a hypothetical or a standard population. Thus, for example, a plan that has no employee cost sharing (e.g., no co-pays, deductibles, and co-insurance amounts) would pay 100 percent of covered medical benefits.

Action Steps. While the final regulations addressing the premium tax credit are not intended to provide guidance to employers for the purposes of the employer mandate, they do provide some useful insight into IRS thinking about affordability and other matters relating to eligibility for the premium tax credit. In light of the recent Supreme Court decision upholding the constitutionality of the Affordable Care Act, we encourage employers to begin a review of the

impact of the employer mandate on plan design.

CASES

Withdrawal Liability Exemption Under Asset Sale More Difficult in Second Circuit.

In 2007, HOP Energy, LLC sold the operating assets of its subsidiary, Madison Oil, to Approved Oil Company. Madison Oil was obligated to contribute to a multiemployer pension plan. Generally, when assets are sold, the employer's obligation to contribute to the multiemployer plan would end and that would trigger withdrawal liability. After the sale of the assets of Madison Oil, the fund assessed HOP Energy and Madison Oil $1.2 million in withdrawal liability.

HOP Energy had intended to avoid this liability by use of the asset sale exception found in the Employee Retirement Income Security Act of 1974 (ERISA) Section 4204(a)(1) and thus challenged the withdrawal liability assessment in arbitration and in district court. Both the arbitrator and district court upheld the assessment.

On appeal, the U.S. Court of Appeals for the Second Circuit also upheld the assessment of the withdrawal liability in a split decision. The Second Circuit found that the terms of the asset purchase agreement obligated Approved Oil to make contributions to the multiemployer plan at the same hourly rate that contributions were made by Madison Oil. However, the asset purchase agreement provided that Approved Oil was not obligated to continue the same level of hours of employment of union employees after the acquisition. The majority opinion for the Second Circuit found that the failure to obligate Approved Oil to contribute for the same number of hours meant that the statutory requirement for the asset sale exemption had not been met. The dissenting justice strongly criticized the majority opinion, stating that the decision could be read to require that a purchaser of assets must not agree to reduce its contributions at any time in the future. The majority said that the parties had not argued in the case whether there was an appropriate timeframe for continuing the same level of contributions; therefore, that matter was not considered. That Approved Oil had actually made contributions for a similar number of hours after the sale was rejected by the Second Circuit because it found that the obligation under the sale agreement was controlling and not what actually occurs after the sale.

This is a rather new holding for a provision that has been in effect for many years. If the decision does require that there be an unending obligation to contribute at the same rate and level of units, this will make utilization of the asset sale exemption very difficult. Employers should watch further developments in this area to see if courts outside the Second Circuit agree with this decision. (*HOP Energy L.L.C. v. Local 553 Pension Fund*, 2nd Cir. 2012)

Employer Has Successor Liability for Retiree Medical Benefits

The Court of Appeals for the Sixth Circuit recently affirmed the decision of a federal trial court that an employer-defendant is liable as a successor under collective bargaining agreements (CBAs) for certain vested retiree health care benefits, even though the employer was never a party to those CBAs. Those benefits included company-paid health insurance and/or Medicare Part B premium reimbursements.

The retirees were bargaining-unit employees at a window manufacturing plant that changed hands multiple times. The Sixth Circuit ruled the trial court did not err in finding that the employer-defendant is the successor in interest to the CBAs, in part because court papers filed by the employer-defendant in other litigation included admissions that the employer-defendant was a successor in interest. Those admissions were confirmed by other documentary evidence, including a "due diligence" memorandum.

The Sixth Circuit also ruled that the employees' rights to retiree health care benefits had vested for certain employees. Among other things, the employer-defendant argued that the CBAs incorporated by reference the reservation-of-rights language in the summary plan descriptions (SPDs), which gave the employer the right to amend the plans under which the retiree health care benefits were provided. Because the CBAs only made an ambiguous reference to a "booklet and policy" and did not include any explicit language of incorporation, the Sixth Circuit ruled that the federal trial court did not err in rejecting the defendants' incorporation-by-reference argument, ultimately ruling that certain employees' rights to retiree health care benefits had vested. (*Bender v. Newell Window Furnishing Inc.*, 6th Cir. 2012)

Employee Benefits Practice Group

Peter K. Bradley
pbradley@hodgsonruss.com

Anita Costello Greer
agreer@hodgsonruss.com

Michael J. Flanagan
mflanagan@hodgsonruss.com

Richard W. Kaiser
rkaiser@hodgsonruss.com

Arthur A. Marrapese, III
art_marrapese@hodgsonruss.com

Ryan M. Murphy
rmurphy@hodgsonruss.com