EMPLOYEE BENEFITS DEVELOPMENTS MARCH 2014

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RULINGS, OPINIONS, ETC.

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New Guidance Regarding Preventive Services, Cost Sharing, and Wellness

On January 9, 2014, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Departments") issued additional health care reform guidance in the form of Frequently Asked Questions (FAQs). In this article, we address the FAQ guidance pertaining to preventive services, cost-sharing limitations, and wellness programs. The FAQ guidance also addresses fixed indemnity insurance, expatriate health plans, and mental health parity requirements. The FAQ guidance can be found here.

Coverage of Preventive Services. The Affordable Care Act requires insured and self-insured non-grandfathered group health plans to cover a federally defined set of preventive care services without imposing cost-sharing requirements (e.g., co-pays or deductibles). In accordance with a recommendation issued last year, a new preventive services mandate applies for plan years beginning on or after September 24, 2014 (January 1, 2015, for calendar year plans). The new mandate will require non-grandfathered group health plans to provide women who are at increased risk for breast cancer and at low risk for adverse medication side effects with risk-reducing medications, such as tamoxifen or raloxifene, at no cost.

Limitations on Cost Sharing Under the Affordable Care Act. The Affordable Care Act provides that self-insured and large non-grandfathered group health plans must ensure that any annual out-of-pocket cost-sharing imposed under the plan does not exceed certain dollar limits for a year. For plan years beginning in 2014, the annual limitation on out-of-pocket costs is $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage. These limits do not apply to benefits that are not considered "essential health benefits" under federal law.

For the first plan year beginning on or after January 1, 2014, (and only for that year) there is a special rule that applies to group health plans that utilize more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket costs (e.g., one service provider for major medical coverage and another for pharmacy benefits). Under this special rule, the annual limitation on out-of-pocket costs will be satisfied if:

• The plan complies with the out-of-pocket maximum with respect to its major medical coverage and

• The out-of-pocket maximum on coverage that does not consist solely of major medical coverage (e.g., prescription drug coverage) does not exceed the dollar amounts specified by law.

As noted, this special rule does not apply for plan years beginning on or after January 1, 2015.

The FAQs provide the following guidance:

• To determine which benefits are essential health benefits, the departments will consider self-insured group health plans or large group health plans to have used a permissible definition of essential health benefits if the definition is one that is authorized by the secretary of HHS.

• Plans with multiple service providers may find it easier to divide the annual limit on out-of-pocket costs across multiple categories of benefits rather than reconcile claims across multiple service providers. The FAQ guidance permits plans and issuers to structure a benefit design using separate out-of-pocket limits, provided the combined amount of any separate out-of-pocket limits applicable to all essential health benefits under the plan does not exceed the annual limitation on out-of-pocket maximums for that year.

• A plan may count out-of-pocket spending for *out-of-network* items and services toward the plan's annual maximum out-of-pocket limit, but it is not required to do so.

• A plan may count out-of-pocket spending for *non-covered* services toward the plan's annual maximum out-of-pocket costs, but it is not required to do so.

• The term "cost-sharing" does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. Nothing, however, prohibits a plan or issuer from counting those expenses toward the plan's annual maximum out-of-pocket limit.

Wellness Programs. On June 3, 2013, the Departments issued final regulations regarding nondiscriminatory wellness programs in group health coverage. The final regulations increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20 percent to 30 percent of the cost of coverage, and further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. The final regulations also address the reasonable design of health-contingent wellness programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination.

The new guidance contains the following FAQs, which address a number of issues that have arisen since the publication of the final wellness regulations.

Q8: A group health plan charges participants a tobacco premium surcharge but also provides an opportunity to avoid the surcharge if, at the time of enrollment or annual re-enrollment, the participant agrees to participate in (and subsequently completes within the plan year) a tobacco cessation educational program. A participant who is a tobacco user initially declines the opportunity to participate in the tobacco cessation program, but joins in the middle of the plan year. Is the plan required to provide the opportunity to avoid the surcharge or provide another reward to the individual for that plan year?

No. If a participant is provided a reasonable opportunity to enroll in the tobacco cessation program at the beginning of the plan year and qualify for the reward (i.e., avoiding the tobacco premium surcharge) under the program, the plan is not required (but is permitted) to provide another opportunity to avoid the tobacco premium surcharge until renewal or reenrollment for coverage for the next plan year. Nothing, however, prevents a plan or issuer from allowing rewards (including pro-rated rewards) for mid-year enrollment in a wellness program for that plan year.

Q9: A plan participant's doctor advises that an outcome-based wellness program's standard for obtaining a reward is medically inappropriate for the plan participant. The doctor suggests a weight reduction program (an activity-only program) instead. Does the plan have a say in which one?

Yes. The plan must provide a reward for individuals who qualify by satisfying a reasonable alternative standard. If an individual's personal physician states that the outcome-based wellness program is not medically appropriate for that individual and recommends a weight reduction program (an activity-only program) instead, the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Many different weight reduction programs may be reasonable for this purpose, and a participant should discuss different options with the plan.

PBGC Provides a Single Premium Date for Flat and Variable Rate Premiums for Large Plans and Provides Additional Time for Small Plans to Calculate Variable Rate Premiums

Following on a proposed regulation issued last year, the Pension Benefit Guaranty Corporation (PBGC) finalized one component of the proposed rule dealing with the due date for flat and variable rate premiums for large plans (plans with over 500 participants). Under prior regulations, large plans paid the flat rate premium early within their plan year and paid the variable rate premium later in the year. To simplify the due date and the work required to compute the flat and variable rate premiums, the PBGC finalized regulations providing for a single payment date. Under this new regulation, the PBGC premium due date would be 9 1/2 calendar months after the beginning of the plan year (October 15 for calendar year plans). The regulation became effective on January 3, 2014, and therefore creates a single premium due date for large plans beginning with those plan years commencing January 1, 2014. The PBGC also indicated that it would deal with other aspects of its 2013 proposed regulations in an additional final rule to be issued in the future. Click here for more information.

The PBGC followed through on that promise by issuing a further final regulation for small plans (100 or fewer participants). Small plans will have the same premium filing date as all other plans, 9 1/2 calendar months after the beginning of the plan year. The 2015 premiums for calendar year plans will be due October 15, 2015. The PBGC is also giving small plans time to adjust to the new schedule. For example, a calendar year small plans' 2014 premiums will be due February 15, 2015, instead of October 15, 2014. Small plans generally will base their variable-rate premium on the prior year's data; under prior rules, the data to calculate the premium may not have been available at the time the premium was due. Click here for more information.

PBGC Proposes Changes on Rules for Multiemployer Plans to Provide Efficiencies

The Pension Benefit Guaranty Corporation (PBGC) has proposed amendments to its multiemployer plan regulations which, if enacted, would allow for a more efficient and effective manner to provide information to the PBGC and plan participants. The proposed amendments would reduce the number of actuarial valuations that certain small terminated but not insolvent plans would need to prepare, shorten advance filing requirements for mergers in certain situations, and eliminate certain insolvency notice and update requirements imposed on plans. This is also part of the PBGC's continuing efforts to stream-line and simplify burdens on plans, including multiemployer plans. Click here for more information.

Regulatory Authorities to Make IRA Rollovers an Examination Priority for the Financial Industry in 2014

A rollover, including an individual retirement account (IRA) rollover, is a mechanism by which participants in qualified retirement plans (e.g., 401(k) plans) may defer taxation of plan distributions by moving the distributed amounts into IRAs or other eligible retirement plans. Clearly, the decision in the first instance to receive a distribution of retirement savings from an employer's qualified retirement plan, and the additional decision of whether and where to roll those savings, are important financial decisions affecting an investor's financial security in retirement. And financial industry service providers are frequently consulted in making those decisions.

A U.S. Government Accountability Office (GAO) report published in March 2013 noted that the financial industry generally encourages employees to roll over their assets into IRAs without fully explaining the options that are available to these investors or making a valid determination that a rollover into an IRA is in the investor's best interest. It is also noteworthy that financial industry service providers may have economic incentives for recommending that retirement savings be moved into an IRA or other financial product offered by a particular financial services firm.

It is with this background in mind that the Financial Industry Regulatory Authority (FINRA) and the Securities Exchange Commission (SEC) announced their regulatory and examination priorities, and both regulatory authorities included IRA rollovers among their examination priorities for 2014. The FINRA and SEC announcements, published January 2 and January 9 respectively, reflect a perception on the part of these regulatory authorities that financial industry practices surrounding IRA rollovers are areas of heightened or significant risk that could adversely affect investors.

FINRA specifically indicated that reviewing firm rollover practices will be an examination priority, and firms' marketing materials and supervision in this area will be examined. FINRA will also evaluate securities recommendations made in rollover scenarios to determine whether they comply with FINRA's applicable suitability standards. FINRA is urging financial firms to review FINRA Regulatory Notice 13-45, which was published in late 2013 to remind financial firms of their responsibilities when recommending a rollover or transfer of retirement plan balances to IRAs and when marketing IRAs and associated services.

The SEC indicated, among other things, it will examine the sales practices of investment advisers targeting retirement-age workers to roll over their employer-sponsored 401(k) plan into higher cost investments, including whether advisers are misrepresenting their credentials or the benefits and features of IRA plans or other alternatives. The SEC also will examine broker-dealers and investment advisers for possible improper or misleading marketing and advertising, conflicts, suitability, churning, and other activities. when recommending the movement of assets from a retirement plan to an IRA rollover account.

There is a clear message to the financial industry that the regulatory scrutiny of IRA rollover practices and related marketing materials is going to be dialed up.

CASES

Fifth Circuit Upholds Administrator's Decision Denying SERP Benefits for Violation of Non-Compete Provision

Affirming a lower court decision, the U.S. Court of Appeals for the Fifth Circuit held that a former executive of a pharmaceutical company will not receive benefits under the company's supplemental executive retirement plan (SERP) because a determination by the SERP administrative committee that the executive violated a non-compete provision was not arbitrary and capricious. The executive worked for the company from 1988 until he resigned in 2010 to take a position as vice president of product development with a clinical stage bio-pharma company. On accepting the new job offer in November 2010, the executive notified his employer that he intended to retire from the company and followed up with a written request for his benefits under the SERP.

To determine whether the executive's new employment would violate a non-compete covenant in the SERP, the company asked for additional information about the executive's new employer and the nature of his duties. Under the terms of the SERP, a participant's right to a benefit is conditioned on the participant's compliance with a covenant not to compete. For a period of five years following termination, a SERP participant may not "carry on any business of, or be engaged in, consult or advise . . . or permit his name . . . to be used by any person or entity engaged in or concerned with or interested in any business . . . which competes with the products manufactured or sold" by the company. A participant who violates the non-compete covenant forfeits all SERP benefits. Despite several requests, the executive refused to provide the required information about his new job, eventually responding only that the new company was not a competitor because it was a start-up company. Relying on press releases and the new company's website, the administrative committee determined that the new company was developing products that would compete with the company's products. The committee denied the

executive his SERP benefits for violating the non-compete provision.

The executive sued the company under the Employee Retirement Income Security Act (ERISA), claiming that the committee arbitrarily and capriciously denied him the benefits he was owed. The district court granted summary judgment to the company on the ERISA claim, concluding that the company's decision was not arbitrary and capricious even if other people "might have made a different decision." On appeal, the Fifth Circuit agreed, finding that the committee "sensibly interpreted the non-compete clause as prohibiting a participant from engaging in the development of products that would conflict with [the company's] business when brought to market." Pointing to other "hair-splitting" arguments and failed reasoning by the executive, the court held that it must defer to the ERISA administrator in this case. The court was also swayed by the executive's reluctance to respond to the committee's inquiries about his new employer, and by a provision the executive negotiated in his new employment contract that promised him $50,000 in legal fees should the company dispute whether he had violated the non-compete clause. Finding that the promise likely "reveals at least the reasonableness of the committee's non-compete determination," the court affirmed the lower court decision, concluding that the committee's decision must be upheld and the benefits denied. A related contractual dispute over vesting of restricted stock units was also decided in favor of the Company. (*Wall v. Alcon Labs, Inc.*, 5th Cir., 2014)

Employer Not Penalized for Failing to Provide Timely COBRA Notice

The U.S. District Court for the Northern District of Iowa held that a family, mistakenly receiving almost a year's worth of free employer coverage following a termination of employment, was not entitled to COBRA notice related civil penalties. In 2010, an employee and her family began receiving coverage under her employer's group health plan. Later that year, the employee went on a disability leave of absence and (properly) continued receiving health plan coverage. However, rather than terminating the coverage in June 2011, when the benefits should have ended, the employer mistakenly continued the family's coverage. In April 2012, the employer ultimately discovered its error and terminated the coverage effective May 1, 2012. The employer did not send a COBRA notice to the family, who incurred $1,307 in expenses before enrolling in alternative coverage beginning in June 2012.

Under COBRA, individuals who lose coverage under a group health plan as a result of a qualifying event, such as a termination of employment, may elect to continue coverage at their own expense. An employer must notify the plan administrator within 30 days of the employee's termination, and the plan administrator must, in turn, notify the individuals of their rights to continuation coverage within 14 days. If a plan administrator fails to meet these COBRA notice requirements, the plan administrator "may in the court's discretion be personally liable to such participant or beneficiary in the a mount of up to $110 a day from the date of such failure." The purpose of the penalty is to provide plan administrators with an incentive to comply with the requirements of ERISA and to punish noncompliance. In exercising its discretion to impose statutory damages, a court should primarily consider the prejudice to the plaintiff and the nature of the plan administrator's conduct.

In this case, the court held that the family was not entitled to civil penalties because the employer acted in good faith and the family was not harmed or prejudiced by the tardy COBRA notice. On the issue of prejudice, the court reasoned that the eleven months of free coverage outweighed the $1,307 in medical expenses incurred during the period the family did not have group health plan coverage.

Although no penalties were assessed, this case serves as a reminder of the potential liabilities for failing to provide a timely COBRA notice. Plan administrators should familiarize themselves with their plan documents and leave of absence policies, noting when coverage terminates and the party responsible for communicating the individuals' COBRA rights. (*Cole v. Trinity Health Corp.*, N.D. Iowa, 2014)

Family Trust Not Liable For Withdrawal Liability

Nautical Engineering, Inc. was obligated to contribute to a number of multiemployer pension funds. All the outstanding shares of stock in Nautical were owned by a family trust. Following the death of Nautical's founder, the sole trustee of the family trust was the founder's surviving spouse.

In May 2011, the surviving spouse caused the family trust to loan $500,000 to Nautical. Nautical subsequently sold real property it owned in April 2012, with the surviving spouse and her son executing the corporate resolution authorizing the sale. Sale proceeds in the amount of $370,343.61 were transferred to the family trust to repay the loan. Prior to the sale of real property, Nautical ceased making contributions to the funds and was assessed withdrawal liability. The funds filed suit against Nautical to recover the withdrawal liability in October 2012. The funds' complaint was subsequently amended to add the family trust as a defendant.

The funds alleged the family trust constituted a trade or business under common control with Nautical; ERISA treats all trades or businesses under common control as being a single employer for purposes of withdrawal liability. In essence, the funds alleged the family trust constituted a trade or business because it owned Nautical for ten years, profited from its ownership of Nautical, made the $500,000 loan to the Nautical, and its trustee signed the board resolution authorizing the sale of real property. Finding the family trust's activities to be consistent with that of a mere owner, the court held the family trust was not a trade or business. Accordingly, the family trust was held not to be jointly and severally liable with Nautical for withdrawal liability to the funds.

In the wake of the *Sun Capital* decision (a discussion of the *Sun Capital* case is available here), the case reaffirms the concept that mere ownership of an entity does not convert the owner into a trade or business for purposes of withdrawal liability. (*Pacific Coast Shipyards Pension Fund v. Nautical Engineering, Inc.*, N.D. Ca.).

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