EMPLOYEE BENEFITS DEVELOPMENTS NOVEMBER 2015

Hodgson Russ Newsletter
November 30, 2015

RULINGS, ETC.

PACE Act Changes the Definition of 'Small Group' for Market Reform Purposes. On October 7, 2015, President Obama signed into law the Protecting Affordable Coverage for Employees Act (PACE Act). The PACE Act changed the definition of small group for the purposes of the ACA's small group market reforms. Under the PACE Act, a small employer is an employer who employed an average of 1 to 50 employees on business days during the preceding calendar year (the default rule). Importantly, however, the PACE Act permits the states to elect to extend the definition to include employers with up to 100 full-time employees. But for the PACE Act, the ACA would have mandated an expanded definition of small employer to include employers with 51 to 100 full-time employees, effective for plan years beginning in 2016.

In accordance with recent guidance issued by the Centers for Medicare and Medicaid Services, states that wished to extend the small employer definition to up to 100 employees for coverage effective January 1, 2016, were required to notify CMS of their election by October 30, 2015. States that elect to extend the small employer definition with another coverage effective date are requested to notify CMS as soon as soon as practicable. The CMS guidance can be found here.

A state that elects to expand the small group definition to employers with between 51 and 100 full-time employees will subject those groups, previously regarded as large groups in most states, to a number of new ACA small group benefit and rating requirements effective for plan years beginning on or after January 1, 2016. Among other things, these employer groups would cease to be experience-rated. Instead, under the ACA's small group rules, policies issued to these groups would need to comply with modified community rating rules that prohibit group rating based on health history and gender, and that limit rating based on age. These plans would also need to cover essential health benefits.

While employers that self-insure are not subject to these requirements, some states (including New York) do not permit stop-loss carriers to issue policies to groups that are required to be community rated (i.e., small groups); therefore, if a group with 51 to 100 employees is self-insured, it may lose its stop loss coverage for the 2016

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renewal year if the state in which the policy is issued elects to expand the definition of small group. Small employers that self-insure should review this issue with counsel.

Agencies Issue FAQs Regarding Preventive Care Services, Wellness Programs, and Mental Health Parity. The Departments of Labor, Health and Human Services, and the Treasury (the agencies) issued another set of frequently asked questions (FAQs) regarding the implementation of the Affordable Care Act (ACA). This recent guidance, the twenty-ninth in a series of FAQs that the agencies have published, focuses on certain preventive care services, wellness programs, and mental health parity. Some of the issues discussed in this guidance are highlighted below.

- Preventive Care Services - Lactation. Under the ACA, non-grandfathered group health plans are required to cover, without the imposition of any cost-sharing requirements, certain preventive care and screening services. Under these recently issued FAQs, the agencies identify a number of breastfeeding and lactation support services that must be provided by plans as preventive care services. For example, plans are required to provide a list of the lactation counseling providers within their network. The FAQs also state that a plan may not impose cost-sharing on out-of-network lactation counseling services if the plan does not offer free in network lactation counseling services. Also, a plan may not limit the free coverage for lactation counseling to those services provided on an in-patient basis.
- Preventive Care Services - Colonoscopy. The agencies state that if a colonoscopy is scheduled and performed as a screening procedure, a plan may not impose cost-sharing for the required specialist consultation prior to the screening procedure if the health care provider determines that the pre-procedure consultation would be medically appropriate for the individual. Such consultations are considered an integral part of the colonoscopy. Also, under the same reasoning, after a colonoscopy has been performed as part of a screening procedure, the plan is required to cover any pathology exam on a polyp biopsy without cost-sharing.
- Wellness Programs. Group health plans are generally prohibited from discriminating against participants when establishing eligibility, benefits, or premiums based on a health factor. An exception to this rule allows financial incentives for certain health promotion and disease prevention arrangements, often referred to as wellness programs. Under final regulations, the maximum permissible reward under a wellness program that is part of a group health plan is 30 percent of the total cost of coverage under the plan (or 50 percent for wellness programs designed to prevent or reduce tobacco use). These FAQs clarify that the wellness program regulations also apply to plans that offer participants rewards in the form of non-financial (or in-kind) incentives (for example, gift cards, thermoses, and sports gear).
- Mental Health Parity. In general, the Mental Health Parity Act requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. The agencies state in these FAQs that if a plan provides treatment for anorexia as a mental health benefit, the plan must disclose the criteria for making medical necessity determinations as well as any processes, strategies, evidentiary standards, or other factors used in developing any underlying non-quantitative treatment limitation, regardless of any assertions as to the proprietary nature or commercial value of the information.

All the FAQs on the ACA may be found by clicking on the FAQs tab on the left side of the Department of Labor's Employee Benefit Security Administration's website at www.dol.gov/ebsa. You may access the release directly here.

DOL Concludes Stop-Loss Policy for Contributory Self-Insured Welfare Plan Is Not a Plan Asset. The U.S. Department of Labor (DOL) has previously considered whether a stop-loss insurance policy purchased by a plan sponsor to manage risk associated with the liabilities under a self-insured medical plan is a plan asset and concluded that the stop-loss policy would not be a plan asset where the plan did *not* allow employee contributions and the employer paid plan benefits exclusively from its general assets (see DOL Adv. Op. 92-02A). In a new advisory opinion, the DOL was asked to consider whether a similar stop-loss insurance policy would be a plan asset where the policy is purchased by the plan sponsor to manage risk associated with the liabilities under the medical benefit portion of a *contributory* self-insured welfare plan. The DOL again concluded that the stop-loss policy in question would not be a plan asset, but based its conclusion a number of key facts, including the fact that the plan sponsor will have put in place an accounting system that ensures that the payment of premiums for the stop-loss policy includes no employee contributions, and the policy will reimburse the plan sponsor only if the plan sponsor pays claims from their own assets so that the plan sponsor will never receive any reimbursement from the insurer for claim amounts paid with participant contributions. *DOL Adv. Op. 2015-02A*

PBGC Maximum Guaranteed Benefit Unchanged for 2016. The Pension Benefit Guaranty Corporation (PBGC) announced that the annual maximum guarantee for retirees receiving benefits in failed single-employer pension plans will not increase for 2016. The PBGC maximum guaranteed benefit is linked to Social Security cost-of-living adjustments (COLA) every year. Because there is no Social Security COLA for 2016, the PBGC annual guaranteed benefit in underfunded plans that terminate in 2016 will remain at $60,136 for a 65-year old retiree with a single life annuity. Because the maximum guarantee for participants in multiemployer plans is not indexed, it does not change from year to year. The current limits, which vary based on a retiree's length of service, have been in place since 2001. You can access the PBGC press release here.

Private Letter Ruling Illustrates Complex Nature of Taxation of Group Term Life Coverage. Internal Revenue Code Section 79 provides the rules of taxation for group term life coverage. Many times the law is stated simply to allow group term coverage of up to $50,000 of tax-free coverage. However, as is usually the case in the Internal Revenue Code, the rules are much more complex. A recent IRS letter ruling highlights some of the complex rules that are applicable. In the letter ruling, an employer, who is also the insurance company issuing the coverage, provided two types of group term life programs. The employer provided basic coverage with no cost to employees. While not explicitly stated, it appears that the basic coverage did not exceed the $50,000 limit and also complied with the discrimination rules under Section 79. The second, optional, coverage allowed employees to purchase additional coverage on an after-tax basis. Section 79 can impute income on this optional coverage unless certain conditions are satisfied. Here, the employer demonstrated that the basic and optional coverage may be treated as separate programs because they were not considered "sold in conjunction" with each other. The employer was also able to demonstrate that all of the premium rates were the same as or less than table 1 rates. If the premium rate for a single employee had exceeded the table 1 rate, there could have been imputed income to employees.

This letter ruling demonstrates that what might be viewed as a very straightforward employee benefit does have some very complicated tax rules to determine the tax treatment to employees. (PLR 2015420030)

CASES

Failure to Challenge Withdrawal Liability Assessment Precludes Defenses. In March 2012, a company informed the union representing its workers that it would not be renewing its collective bargaining agreement. In response to this notice, the related multiemployer pension fund actuary computed the company's withdrawal liability and gave notice of the withdrawal liability assessment in June 2012. In July 2012, the company responded and requested worksheets for the calculation performed by the actuary in determining the amount of withdrawal liability. The fund responded with this information, and the company never took any further action. The company paid the first two installment payments on the withdrawal liability to the fund but failed to make any other payments. The fund sued the company for the withdrawal liability that remained unpaid. The U.S. District Court for the Southern District of Indiana held that the company failed to take advantage of the informal review procedure provided under the Employee Retirement Income Security Act of 1974 (ERISA) and also found that the employer failed to request arbitration of the dispute pursuant to the arbitration provisions of ERISA. As a defense, the company claimed that a withdrawal had not occurred because it met the construction industry exception. The district court ruled that the failure of the company to raise this issue in an informal review and the failure to request arbitration precluded any defense to the withdrawal liability assessment.

Again, this case should serve as a reminder to employers that when a withdrawal liability assessment is issued, the proper procedural steps must be taken in order to preserve all legal rights and defenses the employer may have to the assessment. *Frye v. Youngs Excavating, Inc.*, (S.D. Ind., 2015)

Pension Plan Must Provide Equitable Relief Following Misrepresentations. A group of current and former employees sued for equitable relief in the form of a reformation of their pension plan to conform the plan to the benefits they understood their employer had promised them. The primary claim in the lawsuit is that the employer, in connection with the conversion of a defined benefit pension plan to a cash balance plan, failed to adequately inform the employees that the plan had been amended in a way that effectively implemented a freeze on growth of the employees' pension benefits by not granting additional accruals during a "wear-away" period. The court found clear and convincing evidence that:

- The wear-away was an intended feature of the plan;
- Plan disclosures and other communications to participants failed to disclose the wear-away;
- The lack of disclosure was intentional;
- The wear-away impacted thousands of employees and that many of those employees, including the named plaintiff, terminated employment and were paid benefits while they were still in the wear-away period;
- Participants did not understand that, as a result of the wear-away, additional periods of service after January 1, 1996, would not and did not increase the benefit received; and
- Appropriate disclosure would not have been too confusing and, had it been given, plan participants would have understood the consequences of the wear-away.

Because the employees proved by a preponderance of the evidence that the employer violated ERISA by issuing false, misleading, and incomplete plan descriptions, and because there was clear and convincing evidence that, as a result of those ERISA violations, employees reasonably but mistakenly believed that growth in their cash balance benefit equaled growth

in their pension benefit, the court ruled that the pension plan must be reformed to actually provide the benefit that the misrepresentations inequitably caused the employees to reasonably expect. In reaching its decision, the court concluded that the circumstances were more egregious than those present in the Supreme Court's decision in *Amara v. CIGNA Corp.*, and that the employer's conduct amounted to "equitable fraud." *Osberg v. Foot Locker, Inc.* (S.D.N.Y. 2015)

Court Orders Retirees to Return Overpayment to Pension Plan. In our September 2015 *Employee Benefits Developments*, we wrote about an action brought by an ERISA pension plan to recover overpaid benefits from a plan participant. In that case, the court held that the plan could bring an equitable action for restitution relating to the overpaid benefits. However, the plan's recovery would be limited to specifically identifiable overpaid funds (or the identifiable proceeds thereof) that were still in the participant's possession.

It is not uncommon that plans inadvertently overpay plan participants. Thus, it should come as no surprise that we are reporting on another overpayment of benefits case this month. In *Retirement Committee of DAK Americas LLC v. Smith*, the DAK Americas LLC pension plan was amended to provide for a lump sum window benefit in connection with DAK Americas LLC's shutdown of its Wilmington, North Carolina, facility. Due to an error in the calculation of the lump sum value of participants' accrued benefits, a number of participants who elected lump sum distributions received an overpayment of plan benefits. The Retirement Committee, in its capacity as plan administrator, brought an equitable restitution claim to have the overpayments returned to the plan.

Similar to the case we reported on in September, the *DAK* court granted summary judgment in favor of the Retirement Committee on its equitable restitution claim against the plan participants. Because the overpayments were discovered shortly after the distributions had been made, the Retirement Committee had been able to quickly obtain a preliminary injunction enjoining the participants from spending or transferring the overpayment amounts. As a result, the Retirement Committee was able to identify specific funds within the participants' possession as part of its equitable restitution claim.

There is a split among the appellate courts on whether plans must trace overpayments to funds within a participants's possession. The Supreme Court has agreed to hear a case where the tracing requirement is at issue. In the interim, we reiterate the recommendation from our September 2015 *Employee Benefits Developments* that plan sponsors consider amending their plan documents, if necessary, to require participants to return overpaid amounts to the plan, in order that plan administrators may be better positioned to argue that no "tracing" requirement should exist for recovering overpayments. *Retirement Committee of DAK Americas LLC v. Smith et al*, (S.D.N.C.)