EMPLOYEE BENEFITS DEVELOPMENTS JULY 2014

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More Frequently Asked Questions on the Affordable Care Act

In May 2014, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury issued Frequently Asked Questions (FAQs) Part XIX, addressing, among other subjects, the following:

The newly revised DOL model COBRA notices. These notices have been updated to include information about the individual medical insurance coverage that is available through the Affordable Care Act (ACA) exchanges. The updated notices can be found here.

Whether the following additional costs incurred by health plan enrollees count against the annual limitation on out-of-pocket costs:

- Balance billing for services provided by out-of-network providers • Additional costs for brand name prescription drugs when generics are available and medically appropriate • For plans that employ reference-based pricing strategies, charges incurred by enrollees for providers who charge more than the reference price for a particular item or service

First dollar coverage of tobacco cessation services for enrollees who use tobacco.

Each of these subjects is discussed below.

Updated Department of Labor Model COBRA Notices

Background. A group health plan must provide a covered employee with a written notice of COBRA rights at the time the employee's coverage commences. If the covered employee is married, the plan must provide notice to the employee's spouse as well. This notice is referred to as the General Notice. Among other requirements, the General Notice must contain a general description of the continuation coverage provided under the plan and an explanation of what qualified beneficiaries must do to notify the plan of qualifying events or disabilities.

A group health plan must also provide qualified beneficiaries with a notice that describes their rights to COBRA continuation coverage and how to make an election. This notice, referred to as the Election Notice, must be provided to enrolled employees and dependents who lose coverage as a result of a qualifying event (e.g., termination of employment). Among other things, the election notice is required to include an explanation of the qualified beneficiaries' right to elect COBRA continuation coverage; the date coverage terminates, if COBRA continuation coverage is not elected; how to elect COBRA continuation coverage; and how COBRA continuation coverage might terminate early.

New DOL model notices. The DOL maintains model notices that plans may use to satisfy the General Notice and Election Notice requirements described above. The updated notices are designed to ensure that qualified beneficiaries understand their right to purchase coverage through the exchange and the premium subsidies and cost-sharing assistance that, if available, would likely make exchange coverage more affordable than COBRA. The new model Election Notice outlines the information qualified beneficiaries will need to consider in deciding whether to choose other available coverage over COBRA, such as, for example, cost sharing provisions (e.g., deductibles and out-of-pocket maximums); provider networks; and the availability of severance benefits that may include subsidized group health plan coverage.

Limitations on Cost Sharing Under the Affordable Care Act

Background. The ACA imposes an annual dollar limit on the amount a group health plan can require enrollees to pay through deductibles and co-payment and coinsurance requirements. For plan years beginning in 2014, the annual limit on the amount enrollees can be required to pay is $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage. For 2015, the annual limitation on out-of-pocket costs will be $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage. The FAQs Part XIX address the question of whether the following additional costs count against the annual out-of-pocket maximum.

Balance billings. When an enrollee receives care from an out-of-network health care provider, the provider's charges for the item or service may exceed the amount the plan allows for that item or service. More often than not, the amount a group health plan will pay an out-of-network provider for a service is limited to the "usual, customary, and reasonable amount (UCR)" for that service as defined by the plan. The DOL confirms that the amount billed and paid by the enrollee above the UCR may be, *but is not required to be*, included in the plan's out-of-pocket maximum and states that if a plan does count such spending toward the out-of-pocket maximum, it may use any reasonable method for doing so.

Costs for electing brand name drugs when a generic is available. Large insured group health plans and self-insured group health plans have discretion to define "essential health benefits." For example, a plan may include only generic drugs in its package of essential health benefits while providing a separate brand name drug option that is not part of the plan's essential health benefits at a higher cost sharing amount. If an enrollee chooses a brand name drug when a generic drug is available and medically appropriate, the DOL guidance provides that the amount paid by the enrollee (e.g., the difference between the cost of the brand name drug and the cost of the generic drug) need not be counted toward the annual out-of-pocket maximum.

Reference based pricing. Reference pricing strategies are designed to encourage plans to negotiate cost effective treatments with high-quality providers at reduced costs. Under this method, a large group insurer or self-insured employer would establish a "reference price" for a particular service (e.g., a hip or knee replacement) to set the maximum amount the plan

will pay for the service. An enrollee would be permitted to go to any number of providers for that service, but if the provider chosen by the enrollee charges more than the reference price, the enrollee would be responsible for charges in excess of the reference price. The question that the DOL addressed is whether the additional cost incurred by an enrollee who uses a higher-cost provider must be included in the plan's out-of-pocket maximum. The DOL guidance states that until further guidance is issued, a large group market plan or self-insured group health plan is not required to count this additional cost against the out-of-pocket cost sharing limitation, provided the plan provides adequate access to quality providers.

Preventive Services: Tobacco Cessation Programs and Drugs

The ACA requires non-grandfathered group health plans to cover preventive services that have received an 'A' or 'B' grade recommendation from the U.S. Preventive Services Task Force (USPSTF). These services must be provided with no cost-sharing for the enrollee (i.e., no deductibles, co-pays, or coinsurance).

The USPSTF, an independent, volunteer panel of experts in prevention and evidence-based medicine, has given tobacco cessation interventions for adults an 'A' grade. Thus, clinicians are required to ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.

In the recently issued FAQ guidance, the departments stated that they will consider a group health plan or health insurance issuer to be in compliance with the requirement to cover tobacco use counseling and interventions if, for example, the plan or issuer covers without cost-sharing screening for tobacco use and, for those who use tobacco products, at least two tobacco cessation attempts per year.

A tobacco cessation attempt includes coverage for four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization and all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Action Steps

In light of the new FAQ guidance, employers should:

- Ensure their COBRA notices reflect the exchange-related information outlined in the DOL model COBRA notices
- Determine whether enrollee costs relating to out-of-network balance billings, additional costs for choosing brand name drugs when generics are available, and, if applicable, charges that exceed a reference price count against (or are in addition to) the annual out-of-pocket maximum. If these additional costs do not count against the annual out-of-pocket maximum, a plan that is subject to the Employee Retirement Income Security Act (ERISA) should prominently disclose this fact in its summary plan description
- Ensure the plan's terms and summary plan description include the new guidance on tobacco cessation as a preventive service

PBGC Issues Final Regulation on Phase-In of Guarantee of Plant Shutdown Benefits

The Pension Protection Act of 2006 (PPA) provides for a phase-in period for the Pension Benefit Guaranty Corporation's (PBGC) guarantee of benefits that are contingent upon the occurrence of an unpredictable event, including a plant shutdown. The PBGC guarantee of benefits for an unpredictable contingent event situation within five years of a plan termination or plan sponsor bankruptcy are now generally lower than they were prior to the adoption of the provision in the PPA. The PPA provides that the phase-in period for the guarantee starts no earlier than the date of the plant shutdown or other unpredictable contingent event. The PBGC has adopted final regulations reflecting the PPA change. The PBGC's final regulations provide that the guarantee of an unpredictable contingent event benefit is phased in from the latest to occur of the date the benefit provision is adopted, the date the benefit is effective, or the date the event that makes the benefit payment payable occurs. The regulation provide examples to show how the phase-in will apply in various situations. (Federal Register Vol. 79, No. 87)

PBGC Finalizes Rules Easing Valuation and Reporting Requirements for Some Multiemployer Plans

The Pension Benefit Guaranty Corporation's (PBGC), as part of its continuing regulatory review to promote efficiency, has issued regulations amending the rules applicable to multiemployer pension plans. Under the fianl regulations, the actuarial valuations required for small terminated, but not insolvent plans, may be performed every three years instead of annually. The regulations also shortens the period to provide notice to the PBGC of mergers and transfers of assets in multiemployer plans. Finally, insolvent multiemployer plans are no longer required to provide annual updates of the notice of insolvency to the PBGC and participants and beneficiaries. (Federal Register Vol. 79, No. 102)

IRS Provides Relief For Delinquent Form 5500s

In the case of a failure to timely file a Form 5500, the Internal Revenue Code imposes a penalty of $25 per day for each day the failure continues, up to $15,000 per return. No penalty will be imposed by the IRS if it is demonstrated that the failure to timely file the Form 5500 was due to reasonable cause.

The IRS recently established a one-year pilot program that provides for administrative relief from any penalties associated with a delinquent Form 5500 for non-ERISA plans without requiring that it be demonstrated that the failure to timely file was due to reasonable cause. The program does not require the payment of a user fee or any penalty as a condition of participation in the program.

The program applies solely to non-ERISA plans. In general, a non-ERISA plan includes a plan that covers only the owner of the entire business (or the owner and the owner's spouse) or only one or more partners (or partners and their spouses) in a partnership. The relief provided under the IRS program is not available if the IRS has already assessed a penalty with respect to the delinquent return.

A submission under the IRS program must include a completed IRS transmittal schedule and a complete Form 5500, including all required schedules and attachments, for each plan year for which the applicant is seeking relief. If Form 5500s are delinquent for more than one plan year or there are delinquent returns for more than one plan, the program permits multiple returns to be included as a single submission. However, a separate transmittal schedule must be prepared for each return. Each return filed under the program must be marked in red letters on the top margin of the first page "Delinquent return submitted under Rev. Proc. 2014-32, Eligible for Penalty Relief."

The pilot program runs until June 2, 2015. The IRS announced that it will consider establishing a permanent program to provide for administrative relief from delinquent Form 5500 penalties relating to non-ERISA plans, although the IRS has warned that any permanent program will include a fee or other payment requirement. Taxpayers who are ineligible to participate in the program may still request penalty relief by establishing that reasonable cause exists for the failure to timely file a Form 5500.

The IRS also announced administrative relief from any penalties associated with a delinquent Form 5500 for ERISA plans. To qualify for relief, the person must (i) be eligible for, and satisfy the requirements of, the DOL's Delinquent Filer Voluntary Compliance (DFVC) Program and (ii) file separately with the IRS a Form 8955-SSA (Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits) for the year to which the DFVC filing relates (to the extent that the information was not previously filed with the IRS). Any Form 8955-SSA must be filed with the IRS on paper by the later of 30 calendar days after the filer completes the DFVC filing or December 1, 2014. The requirement to file Form 8955-SSA with the IRS extends to DFVC filings made prior to the issuance of the IRS guidance. As a result, to qualify for administrative relief from IRS penalties, it is generally the case that any DFVC filing made after December 31, 2009, must satisfy the requirement for filing any related Form 8955-SSA.

CASES

Denial of Dependent Coverage to Same-Sex Spouses by Private Health Plan Does Not Violate ERISA

A New York district court recently ruled that an employer's self-funded health plan did not violate ERISA when it denied dependent coverage to the same-sex spouse of an employee. The plaintiffs, identified only as "Jane Roe" and "Jane Doe," were legally married in 2011 under New York State's domestic relations law. During an open enrollment period in late 2011, Jane Roe attempted to add her spouse as a dependent to her medical benefits coverage under her employer's health plan. The plan provides benefits for spouses of employees, but specifically excludes from coverage same-sex spouses and domestic partners. Citing the explicit exclusion, the plan denied coverage to the spouse.

The plaintiffs filed a complaint in 2012 and sought a preliminary injunction in light of the U.S. Supreme Court's decision in *United States v. Windsor* striking down the federal Defense of Marriage Act. They argued that under *Windsor*, in the absence of a federal law regarding the status of same-sex marriage, ERISA must follow New York State's Marriage Equality Act and require nondiscriminatory coverage for same-sex couples. The New York Marriage Equality Act legalizes same-sex marriage and mandates equal treatment for same-sex spouses.

On its part, the health plan filed a motion to dismiss, arguing that the New York law is preempted by ERISA. Putting aside the issue of ERISA preemption of state law, the court focused instead on the question of whether a private health plan violates a provision of ERISA if it excludes same-sex couples from beneficiary status. As the court explained, "the issue is not whether the court should look to New York State Law or ERISA but whether plaintiffs have adequately alleged that defendants violated ERISA."

The court decided that ERISA does not prohibit a private employer from "excluding from the definition of 'spouse' an entire category of people such that the outcome is that same-sex married couples are not entitled to the same benefits under their employer-sponsored plan as other legally married couples." Turning to the legislative history of ERISA, the court

noted that although an anti-discrimination provision was contemplated at the time of enactment, it was ultimately not included in the statute, on the theory that other federal laws already proscribed such discrimination. The court also pointed to a strong policy under ERISA that has long allowed plans the flexibility to provide benefits under such terms as the employer sees fit. Employers may, for example, amend or terminate their welfare plans or simply choose not to provide benefits to spouses at all. Conceding that the practical effect of *Windsor* may be to eventually effect changes in federal regulations with respect to welfare plans, the court nevertheless insisted that it must apply ERISA to the claims made by the plaintiffs as the law currently stands. Noting that there was no adverse employment action against the employee and that ERISA gives employers broad discretion in writing the terms of their plans, the court found no violation of ERISA under current law. The plaintiffs' arguments related to equal protection and violation of fiduciary duties also failed to persuade the court. The court rejected the plaintiffs' request for a preliminary injunction and granted the defendants' motion to dismiss. (*Roe v. Empire Blue Cross Blue Shield*, SDNY, 2014)

Key takeaway. Sponsors of ERISA self-funded plans that do not extend same-sex spouse coverage should be cautious in their reliance on this decision. This court is but one court among many in the federal system; another court might disagree. Furthermore, the court did not rule on whether a same-sex spouse exclusion violated federal antidiscrimination laws. Conservative employers will want to avoid the litigation risks that arise from such an exclusion.

The Supreme Court's Decision on the ACA's Controversial Contraceptive Coverage Mandate

A divided U.S. Supreme Court ruled it is a violation of the Religious Freedom Restoration Act (RFRA) to mandate that certain closely held corporations provide contraceptive coverage under their group health plans. The RFRA prohibits the government from acting in a way that substantially burdens the exercise of religion unless that action is the least restrictive means of serving a compelling government interest. The court determined RFRA protections apply to closely held for-profit corporations and that requiring owners of such corporations to provide contraceptive coverage in opposition to their sincerely held religious beliefs violates RFRA because it is not the least restrictive means of serving this compelling interest. The court observed that the government currently provides an accommodation for certain nonprofit corporations that object to providing contraceptive coverage on the basis of their religious beliefs. Under the existing accommodation, if a nonprofit certifies to its religious opposition to contraceptive coverage and notifies its group health plan participants, the plan is not required to provide the coverage. However, participants in such plans will nonetheless be able to access contraceptive coverage directly from the insurance carrier or third-party administrator (TPA). In response to the ruling, we expect the regulations governing the implementation of the ACA will be amended. Perhaps the accommodation currently available to certain religious, nonprofit corporations will be expanded to closely held, for-profit corporations with sincerely held religious beliefs that oppose contraceptive coverage. In theory, an expansion of the existing accommodation will have little impact on covered employees because they will have alternative access to contraceptives outside the scope of the plan. However, in practice, the existing accommodation has often become a nightmare for employers. Because TPAs have had difficulty receiving reimbursements from the government for contraceptive care provided through the accommodation, some TPAs have threatened to drop their religious nonprofit clients wanting to utilize the accommodation. It is still too early for owners of closely held corporations to know if the accommodation currently available to nonprofit corporations will be expanded to include them. Moreover, even if it eventually becomes an available option, these owners should consult with counsel and their TPAs to confirm that, as a practical matter, the accommodation is a workable solution. (*Burwell v. Hobby Lobby*, U.S. Sup. Ct. 2014)

Stock Drop Case Development: The Supreme Court Rejects the Presumption of Prudence

In most of the federal circuit courts of appeals, fiduciaries of plans that invest in employer stock, including employer stock ownership plans (ESOPs), have been subject to a presumption of prudence with respect to those employer stock investments. The presumption generally requires plaintiffs in stock drop cases to make a showing not ordinarily required in duty-of-prudence cases – for example, that the employer was on the brink of collapse. However, the nature of the presumption has differed from circuit to circuit.

In June, in a case involving the defined contribution retirement savings plan of a large financial services firm, the U.S. Supreme Court unanimously rejected that presumption of prudence. Under the employer's plan, employees could choose to contribute a portion of their compensation to the plan as retirement savings, and the employer would provide matching contributions of up to 4 percent of an employee's compensation. The plan's assets were invested in up to 20 separate funds, including mutual funds and an ESOP that invested primarily in employer stock. Following a substantial drop in the value of the employer stock, the plaintiffs sued. The plaintiffs alleged the plan fiduciaries knew or should have known that the employer's stock was overvalued and excessively risky and that continuing to hold and buy employer stock was imprudent and breached the fiduciaries' duties under ERISA.

At the district court level, the court dismissed the plaintiffs' complaint, holding that when a lawsuit challenges the plan fiduciaries' investment decisions there is a presumption the fiduciaries' decision to remain invested in employer securities was reasonable. The district court also held that the plaintiffs had not made allegations sufficient to overcome that presumption. The plaintiffs appealed and the Court of Appeals for the Sixth Circuit reversed. Although the Sixth Circuit agreed that plan fiduciaries are entitled to a presumption of prudence, the appeals court held that the presumption is evidentiary only and therefore does not apply at the pleading stage. The Sixth Circuit held that the allegations in the complaint were sufficient to state a claim for breach of fiduciary duty.

In light of differences among the courts of appeals as to the nature of the presumption of prudence, the Supreme Court granted the fiduciaries' petition for certiorari. The court's opinion describes the tension created by different congressional directives in ERISA. On the one hand, ERISA subjects pension plan fiduciaries to a duty of prudence. ERISA's duty of prudence provision directs fiduciaries to diversify plan investments so as to minimize the risk of large losses unless under the circumstances it is clearly prudent not to do so. On the other hand, ERISA specifically provides that, in the case of ESOPs and other eligible individual account plans, the diversification requirement and the prudence requirement (only to the extent that it requires diversification) are not violated by acquisition or holding of employer stock. The court noted that several courts of appeals have gone beyond ERISA's express provision that plan fiduciaries need not diversify by giving those fiduciaries a "presumption of prudence" when their decisions to hold or buy employer stock are challenged as imprudent.

The court concluded the law does not reference or create a special presumption favoring ESOP fiduciaries. While ESOP fiduciaries may not be liable for losses that result from a failure to diversify, the same standard of prudence applies to all ERISA fiduciaries, including ESOP fiduciaries. The court also concluded that ERISA does not require plaintiffs to allege particular circumstances, such as the employer being on the brink of collapse.

The elimination of the presumption may be seen as a win for plaintiffs in stock drop cases, but the Supreme Court's decision did not leave plan fiduciaries defenseless in fending off meritless cases. The court decided the presumption of prudence is the wrong mechanism for weeding out meritless lawsuits at the pleading stage, but it also suggests other factors courts should consider when deciding whether to dismiss stock drop cases that still may impose significant burdens on plaintiffs. For example, "where a stock is publicly traded, allegations that a fiduciary should have recognized from publicly available information alone that the market was over- or undervaluing the stock are implausible as a general rule, at least in the absence of special circumstances." The court's opinion did not specify what those special circumstances may be.

Furthermore, to state a claim for breach of the duty of prudence on the basis of nonpublic (i.e., inside) information, "a plaintiff must plausibly allege an alternative action that the defendant could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it." The court offered three points to be considered in deciding whether the complaint states a claim for which relief can be granted. First, ERISA's duty of prudence does not require a fiduciary to break the law (e.g., divesting the employer's stock on the basis of inside information in violation of the securities laws). Second, the courts "should consider the extent to which an ERISA-based obligation either to refrain on the basis of inside information from making a planned trade or to disclose inside information to the public could conflict with the complex insider trading and corporate disclosure requirements imposed by the federal securities laws or with the objectives of those laws." Third, lower courts "should also consider whether the complaint has plausibly alleged that a prudent fiduciary in the defendant's position could not have concluded that stopping purchases—which the market might take as a sign that insider fiduciaries viewed the employer's stock as a bad investment—or publicly disclosing negative information would do more harm than good to the fund by causing a drop in the stock price and a concomitant drop in the value of the stock already held by the fund."

Whether the Supreme Court's decision ultimately will have a chilling effect on retirement plan investments in employer stock remains to be seen. And while it is clear that the ground rules for litigating stock drop cases have changed, it also remains to be seen how the new pleading standards will affect the ability of plaintiffs to bring viable claims for breach of the duty of prudence. (*Fifth Third Bancorp v. Dudenhoeffer*, U.S. Sup. Ct. 2014)