Reinhart

August 2014 Employee Benefits Update

Circuit Courts Split on Whether Federal Government May Grant Premium Subsidies in Federal Exchanges

On July 22, 2014, two federal circuit courts issued conflicting decisions regarding whether the federal government may grant premium tax credits in federal Exchanges established under the Affordable Care Act ("ACA"). In a 2-1 decision, the District of Columbia Circuit Court of Appeals in *Halbig v. Burwell* held that the plain meaning of the relevant statute authorizing premium tax credits is based on the cost of coverage obtained "through an Exchange established by the State." Because federal Exchanges are not established by the states, the D.C. Circuit held the federal government may not grant premium tax credits in these Exchanges under the statute. However, in a 3-0 decision, the Fourth Circuit Court of Appeals in *King v. Burwell* held that the same statute, when viewed in light of ACA's policy goals, structure and related provisions, created an ambiguity that the Internal Revenue Service ("IRS") had authority to resolve in favor of granting tax credits in all Exchanges.

The statute in question, Internal Revenue Code ("Code") section 36B(b)(2), provides that the amount of premium tax credits may be calculated based on the cost of monthly premiums for a qualified health plan "enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act." Under Code section 36B(b)(2)'s implementing regulations, the IRS interpreted the statute to make the provision of premium tax credits available to qualifying individuals who purchase health insurance in both state and federal Exchanges.

In both cases, plaintiffs challenged the IRS's interpretation of the statute in its regulation and claimed the IRS had exceeded its rule-making authority. The plaintiffs argued that, if Congress meant to include federal Exchanges, it would not have specifically chosen the word "State" or referenced section 1311 of the ACA. Thus, according to the plaintiffs, the statute explicitly precluded the IRS's interpretation that the tax credits are also available on federal Exchanges.

The IRS responded that the statutory language of Code section 36B and other provisions of the ACA support the interpretation that credits are available to taxpayers who obtain coverage through federal Exchanges, and relevant legislative history did not show that Congress intended to limit the premium tax

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credit to state Exchanges. Therefore, the IRS argued, its interpretation was reasonable and entitled to judicial deference.

The D.C. Circuit disagreed with the IRS and vacated the regulation, concluding that Code section 36B(b)(2) unambiguously restricts tax credits to insurance purchased in Exchanges established by a state. In direct contrast, the Fourth Circuit upheld the IRS regulation as a permissible, reasonable interpretation of the statutory language of Code section 36B(b)(2). The IRS will likely request a full-panel review of the *Halbig* decision. In addition, because of the federal circuit court split, the cases are strong candidates for eventual review by the United States Supreme Court. For now, the IRS regulation remains in effect, and the IRS has announced it will continue to issue tax credits.

SELECT COMPLIANCE DEADLINES AND REMINDERS

Deadline to Provide Second Quarter Benefit Statements and Fee Disclosures

To comply with section 105 of ERISA and the Department of Labor's ("DOL") participant-level disclosure regulations, plan administrators of calendar-year defined contribution plans that permit participant direction of investments must send quarterly benefit statements for the second quarter of the plan year to participants by August 14, 2014 (i.e., within 45 days after the close of the second quarter of the plan year).

Plan administrators must also disclose to participants the dollar amount of plan-related fees and expenses actually charged to or deducted from their individual accounts for the second quarter of the plan year by the same date. This disclosure is generally included in the quarterly benefit statement as well.

Deadline for Annual Fee Disclosure Notice

To comply with the DOL's participant-level disclosure regulations, plan administrators of calendar-year defined contribution plans that permit participant direction of investments must send the annual fee disclosure notice containing certain plan-related and investment-related information to participants by August 30, 2014, unless the plan administrator previously aligned the timing of the notice with other plan disclosures.

New Mental Health Parity Regulations Take Effect for Certain Non-Calendar Year Health Plans

Health plans with plan years beginning on or after July 1, 2014 must now comply

with the final regulations issued under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The MHPAEA generally prohibits health plans that offer mental health and substance use disorder benefits from imposing financial and treatment limits on these benefits that are more restrictive than the plan's medical/surgical benefits.

Final regulations clarifying the MHPAEA's requirements were issued on November 13, 2013. While the final regulations generally left unchanged the requirements outlined in the interim final rules issued in 2010, the final regulations did make certain select changes that could affect some plans. Please refer to Reinhart's December 2013 EB Update for a detailed discussion of these requirements.

Calendar-year plans have until January 1, 2015 to comply with the regulations.

RETIREMENT PLAN DEVELOPMENTS

IRS Issues Final Regulations Allowing Certain Participants to Purchase Longevity Annuity Contracts

The IRS has issued final regulations that permit defined contribution plan sponsors and traditional IRA providers to offer qualified longevity annuity contracts ("QLACs"). Purchased from an insurer, QLACs allow individuals to defer payment of a portion of their retirement income starting at an advanced age—not later than 85—without running afoul of the Code's required minimum distribution ("RMD") requirements. The regulations provide that the value of the QLAC is ignored for purposes of calculating the individual's RMD, resulting in lower RMD payments. The IRS recognized a growing concern that many retirees will outlive their retirement income, and QLACs are intended to provide retirees more flexibility in managing their retirement income for years beyond normal life expectancy.

Employer-sponsored plans are not required to offer QLACs. If a plan offers QLACs as a distribution option, individuals may use up to the lesser of $125,000 or 25% of their individual account balances to purchase QLACs from an insurance company. QLACs cannot be offered under defined benefit plans or Roth IRAs.

PBGC Issues Moratorium on ERISA Section 4062(e) Enforcement

On July 8, 2014, the Pension Benefit Guaranty Corporation ("PBGC") issued a moratorium on the enforcement of ERISA section 4062(e) cases and stated the moratorium will last until the end of 2014. The PBGC has stated that the purpose of the moratorium is to ensure the PBGC can focus its efforts on cases where

pensions are genuinely at risk.

ERISA section 4062(e) requires a plan administrator to report a "section 4062(e) event" to the PBGC. A "section 4062(e) event" occurs if an employer ceases operations at a facility in any location and, because of the cessation, more than 20% of the employer's employees who are participants under a plan maintained by the employer are separated from employment. In such a case, the PBGC may require the employer to financially protect the plan. For example, the PBGC may require the employer to make significant additional contributions to the plan or provide a financial guarantee.

Over the past few years, the PBGC has enforced only those cases it claimed posed significant financial risk. Nonetheless, employers remained uncertain of the potential negative impact section 4062(e) enforcement could have on their business. The moratorium provides employers more certainty with regard to enforcement, at least until the end of 2014.

Despite the temporary moratorium on enforcement, plan sponsors must continue to report new section 4062(e) events during the moratorium, and the PBGC reserves the right to enforce liability for those events after the moratorium expires.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Releases Draft Forms for Reporting Health Coverage under the ACA

The IRS released draft forms for the minimum essential coverage reporting obligation for health plans and the applicable large employer reporting obligation for employers. The draft forms are intended to help filers and other stakeholders prepare for the ACA's reporting provisions, and to invite comments on the forms before they are finalized. Reporting is voluntary in 2015 (for information relating to 2014), but beginning in 2016 (for information relating to 2015), providers of minimum essential coverage and applicable large employers (those with 50 or more full-time employees) must use the forms to comply with the ACA's information reporting requirements.

The IRS has indicated that it will next provide draft instructions for the forms and that both the forms and the instructions will be finalized later this year.

DOL Releases ACA FAQ Clarifying Notice Obligations of Closely Held Corporations that Drop Contraceptive Coverage

In light of the Supreme Court's recent Hobby Lobby decision, the DOL, Department of Health and Human Services and Department of the Treasury have issued a new Frequently Asked Question ("FAQ") addressing the notification obligations of a closely held for-profit corporation that decides to drop coverage for contraceptive services. The FAQ provides that ERISA and longstanding DOL regulations require that the Summary Plan Description ("SPD") must include a description of the extent to which preventative services (including contraceptive services) are covered under the plan. Accordingly, if a plan excludes from coverage all or a subset of contraceptive services, the plan's SPD must describe the extent of the limitation or exclusion of coverage.

Moreover, if a plan reduces or eliminates contraceptive coverage after having provided such coverage, ERISA requires disclosure of any material reduction in contraceptive coverage to participants and beneficiaries generally within 60 days of the adoption of the change through either a revised SPD or a summary of material modification ("SMM").

The FAQ also notes that other disclosure obligations may apply, for example, under state insurance law. In addition, while the FAQ fails to specifically address summaries of benefits and coverage ("SBC"), if a group health plan's SBC contains information regarding contraceptive coverage and that coverage is modified mid-year, an updated SBC must be provided 60 days in advance of the effective date of the change.

Reinhart Comment: Because the Supreme Court's decision in *Hobby Lobby* was limited to a specific set of facts and circumstances, the scope of the decision remains uncertain. Thus, at this early stage of interpretation, it is unclear whether employers should drop or modify contraceptive coverage in reliance on *Hobby Lobby*.

GENERAL DEVELOPMENTS

DC Circuit Holds Exhaustion of Administrative Remedies Requirement Inapplicable to Claims Involving ERISA Statutory Rights

In *Stephens and Mahoney v. PBGC*, the District of Columbia Circuit Court of Appeals ruled that the requirement that a claimant exhaust administrative remedies before filing suit does not apply to claims seeking to enforce rights guaranteed by ERISA. Historically, when claimants have sued to recover benefits under the terms of the plan, courts have required claimants to exhaust the plan's administrative remedies (e.g., a plan's internal claims appeals procedures) as a prerequisite to

filing suit in federal court. In this case, the participants asserted a right granted by ERISA's regulations—the right to receive a timely lump sum payment—rather than a right granted under the terms of the plan. Joining the Third, Fourth, Fifth, Ninth, and Tenth Circuits, the D.C. Circuit held that the exhaustion requirement applied only to claims for benefits, not claims seeking to enforce ERISA statutory rights.