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# March 2014 Employee Benefits Update

## AGENCIES ISSUE FINAL RULES PROHIBITING WAITING PERIODS IN EXCESS OF 90 DAYS

The Departments of Labor and Health and Human Services and the Internal Revenue Service (collectively, the Agencies) have issued the final rules implementing the Patient Protection and Affordable Care Act (ACA) prohibition on waiting periods in excess of 90 days. Under the 90-day waiting period rule, a group health plan cannot generally require an eligible individual to wait more than 90 days before coverage becomes effective. The final regulations largely incorporate the rules set forth in the proposed regulations, with some clarifications. Additionally, the agencies issued proposed regulations describing a new "bona fide employment-based orientation period" that can be used in conjunction with the 90-day waiting period.

*Waiting Period*. The final regulations reiterate that a waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan becomes effective. Nothing in the final regulations requires a plan sponsor to offer coverage to any particular class of employees, but if a plan sponsor chooses to offer coverage to an eligible class of employees, the plan cannot impose a waiting period in excess of 90 days. The final regulations continue to provide that three months does not equal 90 days and that all days, including weekends and holidays, must be counted in the 90-day calculation.

*Eligibility Conditions*. Being "otherwise eligible to enroll" under the terms of the plan means that an employee has satisfied the plan's substantive "eligibility conditions." Eligibility conditions based solely on the lapse of time are not permissible for more than 90 days. The final regulations permit the same list of the eligibility conditions as previously outlined in the proposed regulations:

- Being in an eligible job classification.
- Attaining a job-related licensure requirement.
- Accumulating a specified number of hours of service, not to exceed 1,200 hours of service.
- Regularly working a specified number of hours per period. The final regulations continue to provide that a plan sponsor may use a look-back measurement period of no more than 12 months to determine whether variable-hour

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employees meet this requirement.

Compliant eligibility conditions will not be considered as designed to avoid compliance with the 90-day waiting period prohibition.

The final regulations also permit a plan sponsor to impose a new eligibility condition: satisfying a reasonable and bona fide employment-based orientation period. The final regulations do not provide much detail on this new permissible eligibility condition, but the new proposed regulations provide that a bona fide employment-based orientation period would be a period not exceeding one month. The orientation period would therefore begin on any day of a calendar month and would be determined by adding one calendar month and subtracting one day. The preamble to the proposed regulations notes that the Agencies envision that the orientation period would be used by the employer and employee to evaluate whether the employment situation was satisfactory and the standard orientation and training processes would begin.

*Rehired Employees*. The final regulations permit a plan sponsor to treat a rehired former employee as a newly eligible employee. Thus, the plan sponsor can require a rehired employee to satisfy any applicable eligibility condition and waiting period again, provided the waiting period is reasonable under the circumstances. The same rule applies to employees who move between eligible and ineligible job classifications.

**REINHART COMMENT**: It is unclear how this rule will interact with the employer shared responsibility rule that prohibits an applicable large employer from treating a rehired employee as a new employee unless the employee had a break in service of 13 weeks or more (26 or more weeks for employers that are educational organizations). It may be that the employer shared responsibility rule would take precedence over the 90-day waiting period rule for employers subject to both rules. If so, applicable large employers will not be able to treat a rehired employee as a newly eligible employee unless the employee had a 13-week (or 26-week) break in service. (As we previously reported the definition of applicable large employer is subject to a transition rule for 2015. For more information see our March 4 Employer Shared Responsibility e-alert)

*Multiemployer Plans*. The proposed regulations did not provide any special rules for multiemployer plans. Subsequent to the publication of the proposed regulations, the Agencies issued a Frequently Asked Question (FAQ), permitting eligibility conditions in a multiemployer plan operating pursuant to a collective bargaining agreement that requires employees to accumulate hours of covered


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employment, which may occur across multiple contributing employers.

The final regulations include an example clarifying this FAQ:

> A multiemployer operating pursuant to a collective bargaining agreement has an eligibility condition that allows employees to become eligible for coverage by working a specified number of hours of covered employment for multiple contributing employers. The multiemployer plan aggregates hours in a calendar quarter and then, if enough hours are earned, coverage begins the first day of the next calendar quarter. Coverage for an employee would then extend for the next full calendar quarter, regardless of whether an employee's employment has terminated.

The Agencies will consider this eligibility condition permissible as an eligibility condition is designed to accommodate a unique operating structure.

**REINHART COMMENT**: This clarification may be welcome news for multiemployer plans that use a calendar quarter eligibility period. We note, however, that the example does not expressly permit any lag month(s) between the measurement period and the effective date of the coverage.

*Effective Date*. The final regulations are effective plan years beginning on or after January 1, 2015. Plan sponsors may continue to rely on the proposed regulations through the end of the 2014 plan year. Alternatively, plan sponsors may choose to comply with the final regulations for the 2014 plan year. Plan sponsors may rely on the new proposed regulations on "bona fide employment-based orientation periods" through at least the end of 2014.

*Additional Guidance*. The final regulations also confirm that the rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the ACA prohibition on preexisting condition exclusion. Accordingly, beginning on and after January 1, 2015, plan sponsors will no longer be required to provide a certificate of creditable coverage upon termination of employment or upon the request of the participant.

## SELECT COMPLIANCE DEADLINES AND REMINDERS

Deadline for 2013 Employer and Employee HSA Contributions is April 15, 2014

The deadline for employers and employees to make 2013 contributions to a


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health savings account (HSA) is April 15, 2014. Although the dollar limit on HSA contributions is determined monthly, HSA contributions for a taxable year may be made in one or more payments as long as the payments are not made before the beginning of the applicable tax year and not later than the original filing deadline (without extensions) for the individual's federal income tax return for that year.

**Annual Funding Notice Deadline is April 30, 2014**

All defined benefit plans must provide an annual funding notice to participants, beneficiaries, the Pension Benefit Guaranty Corporation (PBGC), labor organizations representing participants and beneficiaries, and, for multiemployer plans, contributing employers. The annual funding notice for large plans (plans with more than 100 participants) must be provided within 120 days following the end of the plan year (for example, April 30, 2014, for calendar year plans). Small plans (plans with 100 or fewer participants) generally have until the Form 5500 filing deadline to provide the annual funding notice.

## RETIREMENT PLAN DEVELOPMENTS

**PBGC Partitions Multiemployer Plan to Extend Plan's Solvency**

For only the third time in its history, the PBGC has partitioned a multiemployer plan and will assume the responsibility to pay benefits for only a portion of the multiemployer plan's participants. The Bakery and Sales Drivers Local 33 Industry Pension Fund (Fund) asked the PBGC to pay the benefits for former Hostess employees as the Fund could no longer afford the Hostess employees' retirement benefits. To help the Fund avoid insolvency, the PBGC agreed to partition the Fund. The remaining participants in the Fund will be merged into another multiemployer plan. The PBGC chief of negotiations and restructuring, Sanford Rich, indicated that another multiemployer plan had requested partitioning as a result of the Hostess liquidation and several more requests were expected. However, Mr. Rich also implied that a partition may not be an available option for all troubled multiemployer plans, noting that the PBGC would do this to help preserve other multiemployer plans only if the PBGC had the resources to do so.

**Seventh Circuit Affirms Successor Liability for Unpaid Multiemployer Plan Contributions**

Affirming the holding of the district court, the Seventh Circuit Court of Appeals found sufficient continuity between a father's irrigation company and his son's irrigation company to impose successor liability on the son's company for unpaid


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contributions to the Chicago Journeyman Plumbers Union.

Robert Zeh, owner of Alpine Irrigation Company (Alpine), was $56,000 in arrears in multiemployer plan contributions and subsequently closed his business. Contemporaneously with the closing of Alpine, Robert's son Jeffery opened Running Waters Irrigation, Inc. (Running Waters) and JV Equipment Leasing, LLC. The district court found that Jeffery had actual knowledge of Alpine's unpaid plan contributions and that Running Waters, JV Equipment Leasing, LLC and Alpine had similar leadership, employees, customers, office space, equipment and were therefore substantially the same business. For example, all but one of Running Waters' employees had been Alpine employees, Running Waters used Alpine's former office space and Running Waters' customers were nearly identical to Alpine's. As such, the district court held, and the Seventh Circuit affirmed, that there was substantial continuity between Alpine and Running Waters and, therefore, Running Waters was liable for the unpaid multiemployer plan contributions.

**REINHART COMMENT**: This case serves as an important reminder of the potential impact of Employment Retirement Income Security Act's (ERISA) successor liability doctrine as it relates to unpaid multiemployer plan contributions. In light of the potential risk of successor liability, purchasers of businesses who participate in multiemployer plans should address any potential pension liabilities prior to completing a transaction.

## HEALTH AND WELFARE PLAN DEVELOPMENTS

### IRS Issues New Proposed Regulations on Calculating UBTI for VEBAs

The Internal Revenue Service (IRS) has issued new proposed regulations to replace existing temporary regulations issued in 1986 on how voluntary employees' beneficiary associations (VEBA) calculate unrelated business taxable income (UBTI). The proposed regulations generally have the same effect as the 1986 temporary regulations but reflect statutory changes and clarify how investment income will be counted when calculating UBTI.

Although VEBA is generally exempt from taxes, it is subject to tax on its UBTI. The UBTI equals the VEBA's gross income, less any directly connected expenses and "exempt function income." The amount of exempt function income (other than reserves for postretirement medical benefits) that a VEBA can set aside tax free is limited. The IRS had previously determined that UBTI is calculated based on the extent to which assets of a VEBA at the end of the year exceed the exempt


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function income limitation, regardless of whether income was allocated to payment of benefits during the course of the year. While most courts to consider the issue had agreed with this interpretation, the Sixth Circuit Court of Appeals held that investment income that was earmarked and spent prior to the end of the year on reasonable costs of administration was not subject to the limit on exempt function income.

Rejecting the position of the Sixth Circuit, the proposed regulations would clarify that any investment income earned during the tax year would be subject to UBTI to the extent the VEBA's year-end assets exceed the exempt function income limitation regardless of how the income is used. The proposed regulations would apply to tax years ending on or after the date the final regulations are published.

**Eleventh Circuit Holds LTD Plan Administrator Responsible for Gathering Evidence Not Submitted by Claimant**

In *Melech v. Life Insurance Co. of North America*, the Eleventh Circuit Court of Appeals held that plan administrators have an obligation to consider a claimant's Social Security Administration (SSA) disability file where the long term disability (LTD) plan or policy requires a claimant to file for SSA disability benefits, the plan or policy allows the administrator to offset benefits by the SSA award amount and the plan administrator can insert itself in the SSA process in instances the administrator approves LTD benefits. Disregarding the SSA disability file, even where the file is not provided to the plan, would be procedurally unfair to the claimant.

Ms. Melech filed a claim for LTD with her employer, Hertz. Life Insurance Company of North America (LIMA) issued and administered the LTD policy. The LIMA policy required LTD claimants to file for SSA disability and would offset any LTD benefit by the amount of the SSA award or the amount the claimant would have received from SSA. Ms. Melech's claim for SSA disability was not complete when LIMA denied her claim for LTD benefits. The SSA subsequently approved Ms. Melech's claim for disability and Ms. Melech informed LIMA of the approval. However, Ms. Melech never provided LIMA with the SSA disability file and LIMA never specifically requested the file (though LIMA informed Ms. Melech on each of her appeals that she could provide any additional medical information she had in her possession).

After LIMA denied Ms. Melech's claim on appeal, Ms. Melech sued LIMA and alleged that LIMA violated the LTD policy and ERISA. The district court granted


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summary judgment to LIMA, agreeing that LIMA's denial was correct based on the administrative record in LIMA's possession at the time of the decision. The Eleventh Circuit, however, reversed the district court. The Eleventh Circuit held LIMA had an obligation to consider the SSA disability file, even though it was not part of the administrative record at the time of the claim or appeal. Though the court noted that ERISA does not require a plan administrator to "ferret out evidence" not in its possession and that the burden of providing proof lays with the claimant, LIMA could not ignore the outcome of the SSA determination. Because the court found LIMA acted upon an incomplete administrative record, the Eleventh Circuit remanded the case to the district court with instructions to remand the claim to LIMA for further review.

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