Reinhart

May 2013 Employee Benefits Update

SELECT COMPLIANCE DEADLINES AND REMINDERS

Summary of Description of Material Modifications for Calendar Year Plans

Plan administrators of employee pension and welfare benefit plans must provide to each participant covered under the plan and each beneficiary receiving benefits under the plan a summary description of any material modifications (SMM) to the plan and changes to the summary plan description. Administrators must provide this summary no later than 210 days after the close of the plan year in which the modification or change was adopted, unless otherwise described in a timely summary plan description. For calendar year plans that made design changes in 2012, the deadline for providing an SMM is July 29, 2013. Please note that group health plan sponsors that make midyear material modifications to plan terms or coverage that are not reflected in the most recently provided summary of benefits and coverage (SBC) must provide notice 60 days in advance of the effective date of the change. No advance notice is required for changes to the SBC that are effective in conjunction with benefit renewal. Plan sponsors that timely comply with the SBC 60-day advance notice requirement do not have to also send an SMM summarizing the changes disclosed in the 60-day advance notice.

FBAR Filing for Certain Foreign Investments

U.S. persons who have a financial interest in, or signature or other authority over, foreign financial accounts are generally required to report on the Treasury Department Form TD F 90 22.1 (the FBAR) by June 30 of each year. While foreign hedge funds and private equity funds are not required to be reported on the FBAR, many other accounts in foreign jurisdictions might. Plan sponsors should consult with tax and legal counsel to determine if any FBAR filing is required.

RETIREMENT PLAN DEVELOPMENTS

PBGC Issues Proposed Regulations on Reportable Events and Other Notification Requirements

The Pension Benefit Guaranty Corp (PBGC) recently issued revised proposed regulations pursuant to the reportable event rules that exempt the majority of companies and plans from many reporting obligations. The proposed rules aim to

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target the small number of companies and plans at risk for default.

Section 4043 of ERISA requires defined benefit plans to file a report upon the occurrence of an event that affects the plan's funding status. Depending on the event, the notice must either be filed 30 days in advance of the event or within 30 days after the plan sponsor knows (or should know) that the event has occurred. Current PBGC regulations provide automatic waivers and extensions for certain reportable events if certain funding requirements are satisfied. In 2009, the PBGC issued proposed regulations that would effectively increase reporting requirements by eliminating the majority of waivers. Numerous objections were received to the proposed regulations, prompting the PBGC to issue the recent revised set of proposed regulations.

Under the revised proposed regulations, reporting would be waived for most events and the existing waivers for small plans would be expanded. A new waiver structure would replace automatic waivers with a simpler system of waivers that feature five safe harbors (for active participant reduction, distribution to a substantial owner, controlled group change, extraordinary dividend and transfer of benefit liabilities) based on a plan sponsor's financial soundness and level of plan funding. The safe harbor for plan sponsors would be based on the ability of the sponsor to meet its financial commitments. To satisfy the requirements, a plan sponsor would have to demonstrate financial soundness through, among other things, a credit score. The standard of financial soundness for a plan would be a plan's funding status.

Additionally, the PBGC proposes to retain a modified version of the small-plan waivers for active participant reductions and make the waiver applicable to more events. The proposals would also make electronic filing of reportable events notices mandatory.

The PBGC is proposing to make these changes applicable to post-event reports for reportable events occurring on or after January 1, 2014, and to advance reports due on or after that date. The PBGC is also considering making the waiver and safe harbor provisions in the final regulation available (in addition to the waivers in the current regulation) during the period from the effective date of the final rule (30 days after publication in the Federal Register) to January 1, 2014.

IRS Provides Relief from the Anti-Cutback Requirements for Certain ESOP Amendments

On April 19, 2013, the IRS issued Notice 2013-17, which generally provides relief

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from the anti-cutback rules of Internal Revenue Code (Code) section 411(d)(6) for certain ESOP amendments. Specifically, a plan sponsor can now eliminate certain distribution options from an ESOP that becomes subject to the diversification requirements of Code section 401(a)(35) as a result of the qualifying employer securities becoming publically traded. The relief provided by this notice allows the plan sponsor to amend the ESOP to eliminate all in-service distribution options previously used to satisfy the diversification requirements of § 401(a)(28)(B)(i).

Notice 2013-17 applies to amendments that are adopted and effective by the last day of the first plan year beginning on or after January 1, 2013, or, if later, by the time the plan must be amended to satisfy Code section 401(a)(35). Additionally, if an amendment has been adopted to satisfy Code section 401(a)(35) and the remedial amendment period expires before the end date of Code section 411(d)(6) relief, Notice 2013-17 extends the remedial amendment period to the last day of the first plan year beginning on or after January 1, 2013, to allow the plan to amend the ESOP to eliminate an applicable distribution option.

HEALTH AND WELFARE PLAN DEVELOPMENTS

FAQs on SBC Requirements and Updated SBC Template for 2014

The Department of Labor (DOL), the Department of Health and Human Services (HHS) and the IRS (collectively, the Departments) have issued a new set of Frequently Asked Questions (FAQ XIV) that address SBC requirements for the 2014 plan year. Additionally, the Departments have issued a revised SBC template that plans must use for coverage beginning on or after January 1, 2014 but before January 1, 2015. Accordingly, plans with plan years beginning prior to January 1, 2014 may continue to use the previously issued template. The following is a brief summary of the FAQ and template highlights.

SBC Template

- The only change to the SBC template is the addition of statements regarding whether the plan provides minimum essential coverage and minimum value.
- The Departments did not remove the question about whether the plan has an annual dollar limit even though annual dollar limits are prohibited for plan years beginning on and after January 1, 2014. The FAQs note that plans can either simply answer "No" or can remove the entire line from that chart.
- No change has been made to the uniform glossary or instructions; the previously issued instructions and uniform glossary may continue to be used.

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Enforcement Relief

The Departments have extended the following enforcement relief through the end of the plan year beginning on or after January 1, 2014:

- The Departments will continue to work with employers and plan sponsors who are working diligently and in good faith to comply with the law. No penalties will be imposed on plan sponsors who are working diligently and in good faith to comply with the SBC rules.
- Plan sponsors may continue to provide SBCs electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan and to participants and beneficiaries who request an SBC online.
- Plan sponsors may continue to rely on the coverage example calculator developed by the Departments.
- The Departments will not take enforcement action against group health plans for failing to provide an SBC for expatriate coverage.
- Additionally, the Departments have extended use of the "special rule" found in the instructions, which permits plans to modify the SBC template in a manner consistent with the instructions and template if necessary to accurately describe the terms of the plan, and the exemption for Medicare Advantage plans.

Departments Issue ACA FAQ XV Highlighting 2014 Implementation

The Departments recently issued another set of Frequently Asked Questions (FAQ XV) to address the implementation of some upcoming Affordable Care Act (ACA) compliance items and annual limit waiver expiration dates. A brief summary of the highlights follows:

- A group health plan that has a waiver for the restricted annual limits cannot extend the expiration date of the waiver by changing the plan year. Accordingly, the waiver will expire at the end of the plan year in effect when the plan sponsor applied for the waiver, even if the plan sponsor subsequently changed its plan year.
- For plan years beginning on and after January 1, 2014, non-grandfathered group health plans should implement the provider non-discrimination rules using a good faith, reasonable interpretation of the requirement. The Departments will not be issuing regulations in the near future. Generally, the provider non-discrimination rule prohibits non-grandfathered group health plans from discriminating against a provider acting within the scope of the

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provider's license or certification with respect to participation in the plan. The Departments note that this rule does not require plan sponsors to accept all types of providers into a network nor does the rule govern provider reimbursement rates.

- For plan years beginning on and after January 1, 2014, non-grandfathered group health plans should implement the clinical trial coverage rules using a good faith, reasonable interpretation of the requirement. The Departments will not be issuing regulations in the near future. Generally, the clinical trial coverage rule mandates that group health plans (1) cover participation in approved clinical trials for treatment of cancer or other life-threatening diseases or conditions; (2) cover, and not limit or impose additional conditions on, routine patient costs for items and services furnished in connection with the trial; and (3) not discriminate against the individual on the basis of the individual's participation in the trial.
- Group health plans are not required to comply with the "transparency in coverage" reporting requirements until qualified health plan (QHP) issuers are required to comply, which will be after the QHPs have been certified as QHPs for one year. Under the transparency in coverage reporting requirement, QHP issuers must disclose certain specified information to the appropriate exchange, HHS, the state insurance commissioner and make the information available to the public. ACA extends this obligation to non-grandfathered group health plans, but group health plans are not required to report to exchanges.

IRS Proposes Regulations on Determining Minimum Value

On April 30, 2013, the IRS issued proposed regulations offering guidance on determining whether health coverage under an employer-sponsored plan provides minimum value (MV). Additionally, the proposed regulations provide guidance with regard to HRAs, HSAs and wellness program incentives. The proposed regulations would apply for tax years ending after December 31, 2013.

Determining Minimum Value

ACA provides a premium tax credit to individuals who are not eligible for affordable coverage through an eligible employer-sponsored plan that provides MV to purchase coverage under a qualified health plan through an exchange.

Plans must notify participants whether the coverage provides MV and whether the coverage is affordable. A plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan (MV Percentage) is at least 60% of the costs. A plan is affordable if the employee's required contribution does not

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exceed 9.5% of his or her household income for the tax year.

As indicated in previous guidance, plan sponsors can use the MV calculator created by HHS and the IRS (MV Calculator) or a safe harbor to determine whether a plan provides MV. Plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all benefits included in the MV Calculator. While the IRS did not specifically state that the safe harbors can be relied upon, they are an indication of where the guidance is headed.

- $3,500 integrated medical and drug deductible, 80% plan cost-sharing and $6,000 maximum out-of-pocket limit;
- $4,500 integrated medical and drug deductible, 70% plan cost-sharing, $6,400 maximum out-of-pocket limit and a $500 employer contribution to an HSA; and
- $3,500 integrated medical deductible, $0 drug deductible, 60% plan medical expense cost-sharing, 75% plan drug cost-sharing, $6,400 maximum out-of-pocket limit and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75% coinsurance for specialty drugs.

Plans with nonstandard features that cannot determine MV using the MV Calculator or the safe harbor must use the actuarial certification method performed by an enrolled actuary.

The proposed regulations reiterate that self-insured and insured large group plans do not need to cover every essential health benefit category. The proposed regulations also provide that, for purposes of calculating MV, all amounts contributed by an employer for the current year to an HSA are taken into account to determine the plan's MV Percentage. Additionally, the proposed regulations allow amounts that are newly made available under an HRA that is integrated with an eligible employer-sponsored plan to be taken into account in calculating MV if the amounts can be used only for cost-sharing and not insurance premiums.

For nondiscriminatory wellness programs, the proposed regulations provide that a plan's MV Percentage is determined without regard to reduced cost-sharing (e.g., deductibles or copayments). For nondiscriminatory wellness programs that are designed to prevent or reduce tobacco use, however, the MV Percentage can be calculated by assuming that every eligible individual will satisfy the program's rules regarding prevention or reduction of tobacco use.

Establishing Affordability

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The proposed regulations also provide guidance regarding how HRAs and wellness program incentives are used to determine the affordability of employer-sponsored coverage.

- HRAs. Amounts that are newly available under an HRA that is included with an employer-sponsored plan are taken into account in determining affordability if: (1) the employee can use the amounts to pay only premiums; or (2) the employee can choose to use the amounts to pay for premiums or cost-sharing.
- Wellness Programs. Affordability is determined by assuming that all employees failed to satisfy the wellness program's requirements, except for a nondiscriminatory wellness program related to tobacco use. Accordingly, for a plan that charges a higher initial premium for tobacco users, affordability is calculated based on the premium charged to either non-tobacco users or tobacco users who complete the wellness program.

Transitional Relief

The proposed regulations include transitional relief for certain plans with plan years beginning before January 1, 2015. Pursuant to the proposed regulations, employers are not subject to an employer shared responsibility penalty for employees who received a premium tax credit because their employer's coverage was unaffordable or did not provide minimum value if the coverage would have been affordable or satisfied MV based on the cost-sharing and premium that would have applied if the employee satisfied the requirements of any wellness program (including those unrelated to tobacco use) under the terms of a wellness program in effect on May 3, 2013.

CMS Guidance

In April, the Centers for Medicare & Medicaid Services (CMS) issued guidance on multiple topics, including Exchanges, the Early Retiree Reinsurance Program (ERRP) and health insurance applications. The following is a brief summary of the relevant guidance for plan sponsors.

- *Notice Regarding Termination of ERRP Processes*. CMS issued a notice setting forth termination dates for several processes under the ERRP in preparation for the January 1, 2014 sunset. The notice provides the following deadlines:
    1. Reimbursement requests must be submitted by July 31, 2013.
    2. Corrections to inaccurate data must be made by July 31, 2013.
    3. Information contained in a paper application or on the ERRP website must be updated by December 31, 2013.

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4. Any ERRP re-opening requests must be made by December 31, 2013.

- *Proposed Regulations on Exchange Functions: Standards for Navigators and Non-Navigators Assistance Personnel*. The proposed regulations issued by CMS clarify the roles of Navigators and Non-Navigators assistance personnel in Federally facilitated Exchanges and Non-Navigators in State-based Exchanges that are funded through Federal Exchange Establishment grants. The proposed regulations create conflict-of-interest, training and certification and access standards to ensure that personnel will be properly trained.
- CMS Announces Simpler and Shorter Application for Health Insurance. CMS announced that it simplified and considerably shorted the application for health insurance through an exchange. Consumers will be able to fill out one application and obtain a range of insurance options.

GENERAL DEVELOPMENTS

Supreme Court Issues Decision in US Airways, Inc. v. McCutchen

"The plan, in short, is at the center of ERISA (and this statutory scheme) is built around the reliance on the face of written plan documents." Citing this core principle, the United States Supreme Court issued its decision in *US Airways, Inc. v. McCutchen* (No. 11-1285) on April 16, 2013. The Court held that the unambiguous terms of an ERISA plan govern a subrogation and reimbursement action brought pursuant to ERISA section 502(a)(3) and the equitable defenses of unjust enrichment, double-recovery or common-fund doctrine do not trump clear plan language. To that end, the Court further held that if a plan fails to disavow the common-fund doctrine, the sharing of attorneys' fees and costs provides the best indication of the parties' intent and will fill in such a gap in the plan.

James McCutchen was a participant in a self-funded ERISA health plan sponsored by his employer, US Airways, Inc. (US Airways). Pursuant to the terms of its plan, US Airways will advance medical expenses incurred by participants or beneficiaries due to a third party's actions. In return, US Airways is then entitled to reimbursement if the injured participant or beneficiary later recovers money from a third-party.

In January 2007, Mr. McCutchen suffered injuries when another driver lost control of her vehicle and collided with Mr. McCutchen. Two passengers in Mr. McCutchen's car were critically injured as well. The plan paid $66,866 in medical expenses on behalf of Mr. McCutchen. Mr. McCutchen retained an attorney and recovered $110,000; the sum of $10,000 came from the negligent driver's

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insurance coverage and the balance from his own underinsured motorist provision. After paying $44,000 in attorneys' fees, Mr. McCutchen recovered $66,000. US Airways asserted its plan rights and demanded reimbursement of the $66,866 it paid in medical expenses. Mr. McCutchen denied that US Airways was entitled to any amount, and

US Airways filed suit in U.S. District Court in Pennsylvania pursuant to ERISA section 502(a)(3) seeking "appropriate equitable relief." Mr. McCutchen first argued that in equity, US Airways could not recover any more than his "double recovery"—the amount he received from the third party to compensate him for the same loss paid for by US Airways. Under this theory, US Airways' recovery would be limited to the share of Mr. McCutchen's recovery for medical expenses only (as opposed to recovery for loss of earnings or pain and suffering). Second, Mr. McCutchen contended that the common-fund doctrine should reduce any award to US Airways by its share of the attorneys' fees charged by his legal counsel to recover the award.

The District Court rejected both of Mr. McCutchen's arguments and granted summary judgment to US Airways. Finding himself in a position in which he had actually lost money, Mr. McCutchen appealed. The United States Court of Appeals for the Third Circuit vacated the District Court's decision, reasoning that unjust enrichment limits the effectiveness of the plan's reimbursement provisions. The Third Circuit found that full reimbursement would leave Mr. McCutchen with less than full payment for his medical bills and provide a windfall to US Airways. Because this decision furthered a split on this issue amongst a number of Circuit Courts of Appeal across the country, the United States Supreme Court granted certiorari to resolve the issue of whether certain equitable defenses trump ERISA unambiguous plan language.

In holding for US Airways, the country's highest court unanimously leaned on the core findings set forth in its most recent ERISA subrogation and reimbursement decision, *Sereboff v. Mid Atlantic Medical Services*, 547 U.S. 356 (2006). In *Sereboff*, the Court found that the plan's "nature of the recovery" was equitable because it claimed "specifically identifiable" funds (i.e., a portion of the settlement received by injured participant). However, the Sereboff decision left open the issue of what role, if any, equitable defenses alleging unjust enrichment play in an action for equitable relief under section 502(a)(3).

Justice Kagen, writing for the Court, confirmed that US Airways was looking to enforce an "equitable lien by agreement." This kind of lien arises out of a

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contract's provisions and "means holding the parties (in this case the ERISA plan and its eligible participant) to their mutual promises." This agreement itself acts as the measure of the parties' equities and therefore the plan is not unjustly enriched because of the benefit of the bargain. Using this logic, the Court held that even in equity, when enforcing a lien by agreement the provisions of the plan control. The Court opined that neither general unjust enrichment principles nor specific doctrines reflecting such principles can trump the contract between the parties, in this case the subrogation and reimbursement provision, which stated that US Airways has first claim on "any monies recovered from the third party."

However, the Court also concluded that such equitable rules can be used to properly construe contract terms when particular plan language is missing. Relying on general contract interpretation principles, five members of the Court (the remaining four dissented on this point) held that where the terms of the plan are silent, courts may properly look outside of the agreement to doctrines that traditionally have provided guidance on a specific topic. In *McCutchen*, because the plan was specifically silent with regard to allocation of the costs of recovery, the Court looked to the common-fund doctrine to provide an indication of the parties' intent. Under this doctrine, the vast majority of state courts have traditionally held that an individual who recovers a "common fund" that benefits another individual or entity is entitled to receive reasonable attorneys' fees from the "common fund" as a whole. Thus, Mr. McCutchen was allowed to at least salvage some personal monetary gain from the personal injury settlement.

REINHART COMMENTS

1. The Supreme Court clearly decided in *McCutchen* that plan language is sacrosanct. Therefore, plan sponsors should immediately review their subrogation and reimbursement provisions to ensure they not only include language required to establish the necessary lien, but also exclude any equitable doctrines that might be used to interpret the provisions against the plan's interests. This short-term solution will result in reduction of litigation costs and further encourage companies to maintain or enhance benefit plans in the long term.
2. Unambiguous plan language provides a self-funded ERISA health fund with a marked legal advantage in subrogation and reimbursement matters and allows the plan administrator and/or legal counsel the flexibility to negotiate an outcome in each case that is in the best interests of the plan.
3. Although not an explicit holding in the *McCutchen* case, the Supreme Court hinted in a footnote that any ambiguity between plan documents and SPD

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provisions will be scrutinized closely and may tilt such a case in favor of the participant. Therefore, if your plan issues an SPD to complement its plan document, both subrogation and reimbursement provisions should be uniform. Otherwise, such different language will invite participants to dodge their contractual obligations.

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