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# May 2014 Employee Benefits Update

## Departments Issue Updated Model COBRA Notices and Additional Guidance on ACA Implementation

On May 2, 2014, the Department of Labor, Health and Human Services and the Treasury (Departments) issued additional Frequently Asked Questions (FAQs) regarding Affordable Care Act (ACA) implementation. The informal guidance addresses issues related to Consolidated Omnibus Budget Reconciliation Act (COBRA) model notices, limitations on cost-sharing, coverage of preventive services, health flexible spending account (FSA) carryover and excepted benefits and summaries of benefits coverage.

**Updated COBRA Model Notices**

Updated versions of the model COBRA general notice, election notice and Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) notice are now available. These updated model notices better explain an individual's health coverage options in the ACA Marketplace. Use of the models (once appropriately completed) is generally considered to constitute compliance with the content requirements of these three notices. The model general notice and election are available on DOL's website as well as the CHIPRA notice. To properly use the model notices, the plan administrator must complete it by filling in the blanks with the appropriate plan information.

In general, a group health plan administrator is required to provide individuals with three different notices explaining certain rights related to available health insurance coverage. The COBRA general notice is provided to covered employees and spouses at the time of commencement of coverage under the plan. The COBRA election notice is provided to qualified beneficiaries (individuals covered by a group health plan on the day before a qualifying event) after a COBRA qualifying event (*e.g.*, termination of employment) has occurred. Certain employers are required to provide a CHIPRA notice to all employees regarding the availability of premium assistance for the purchase of certain insurance coverage.

**Limitations on Cost-Sharing**

The ACA prohibits a non-grandfathered group health plan from imposing any

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annual cost-sharing in excess of certain statutory limitations. For 2015, the maximum out-of-pocket limit that a plan may impose on in-network essential health benefits is $6,600 for self-only coverage and $13,200 for family coverage.

The FAQs also provide specific guidance on the treatment of balance billed charges, mandatory generic drug provisions and reference-based pricing.

- If a plan chooses to count out-of-pocket spending for out-of-network items and services towards the annual out-of-pocket maximum, the plan may use any reasonable method for counting such costs. The FAQs give the example of a plan that covers 75% of the usual, customary and reasonable amount (UCR) charged for out-of-network services and the participant pays the remaining 25% of UCR plus any amounts charged in excess of UCR. This plan may reasonably count the 25% of UCR paid by the participant toward the out-of-pocket maximum without including any amount charged over UCR paid by the participant.
- Self-insured plans and plans with large group market coverage have discretion to define "essential health benefits." Accordingly, if a plan covers only generic drugs, if medically appropriate and available, while providing an option to elect a brand name drug at a higher cost sharing amount, the plan may treat only the generic drug as an essential health benefit counted toward the out-of-pocket maximum. For example, if a participant elects the brand name drug, the plan may provide that all or some of the amount paid by the participant does not count towards satisfaction of the annual out-of-pocket maximum. The FAQs remind plans subject to the Employee Retirement Income Security Act (ERISA) that the Summary Plan Description (SPD) should explain which covered benefits will not count towards an individual's out-of-pocket maximum.
- Large group market plans or self-insured group health plans that use reference-based pricing programs will not be deemed to violate the out-of-pocket maximum requirements because they treat providers that accept the reference amount as the only in-network providers, assuming the plans use a reasonable method to ensure adequate access to quality providers. However, the Departments invite comments on the application of the out-of-pocket limitation to the use of reference-based pricing to ensure that use of reference-based pricing programs are not a subterfuge for imposing otherwise prohibited limitations on coverage.

**Coverage of Preventive Services**

Non-grandfathered group health plans must cover in-network tobacco cessation

intervention without any cost sharing. Previously, it was unclear which services and/or medications would be covered by this requirement. The FAQs now provide an example of what the Departments will consider to be compliance with this requirement:

- Screening for tobacco use; and
- At least two tobacco cessation attempts per year for those who use tobacco. A tobacco cessation attempt includes 4 tobacco cessation counseling sessions of at least 10 minutes each and all Food and Drug Administration-approved tobacco cessation medications (including over-the-counter medications) for a 90-day treatment regimen, when prescribed by a health care provider.

**Reinhart Comment:** It remains unclear whether a plan subject to the Mental Health Parity and Addiction Equity Act (MHPAEA) would be permitted to limit tobacco cessation intervention in this manner. Non-grandfathered plans subject to MHPAEA should carefully review whether covering two tobacco cessation attempts per year would satisfy its obligations under both the ACA and MHPAEA.

**Health FSA Carryover and Excepted Benefits**

The Departments issued guidance in October 2013 modifying the "use or lose" rule for health FSAs to allow up to $500 of unused amounts to be paid for qualified medical expenses incurred during the following plan year, provided that the plan does not incorporate a grace period. The carryover of up to $500 does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under section 125(i) of the Internal Revenue Code (Code).

The FAQs now confirm that unused carry over amounts remaining at the end of a plan year that satisfy the modified "use or lose" rule should not be taken into account when determining if the health FSA satisfies the maximum benefit payable limit prong under the excepted benefits regulations.

**Summary of Benefits and Coverage (SBC)**

The FAQs confirm that plan sponsors may continue to use the updated SBC template issued in April 2013 (available at CMS.gov and DOL.gov) until further guidance is issued. Additionally, the FAQs extend the previously issued enforcement and transition relief until further guidance is issued. Specifically, the transition relief for carve-out arrangements, providing SBCs electronically, penalties for failure to provide an SBC or uniform glossary, use of the coverage

example calculator, expatriate coverage, and Medicare Advantage plans has been extended until further guidance is issued. Plan sponsors may continue to provide information regarding minimum value and minimum essential coverage in a separate cover letter and may delete the annual dollar limit row from the SBC template. Finally, the FAQs confirm that the special rule in the instructions for benefits that cannot reasonably be described in a manner consistent with the SBC template has also been extended until further notice.

## 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 SPD. For calendar year plans that made design changes in 2013, the deadline for providing an SMM is July 29, 2014. Please note that this SMM rule is separate from the rules imposed by ACA for updating a group health plan's SBC.

If a group health plan is modified during the year in a way that is not reflected in the most recently provided SBC, an updated SBC must be provided 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.

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## Retirement Plan Developments

**Social Security Notice of Discontinuation of Letter Forwarding Service**

Since 1945, the Social Security Administration (Administration) has provided a letter forwarding service to the public. The Administration recently announced that it will discontinue this program effective May 19, 2014. The Administration noted the rapid expansion of both free and for-pay locator resources on the internet allowing the public the ability to locate individuals without relying on the Administration's program. Accordingly, as a cost saving measure, the Administration is discontinuing this service. This decision is in line with the IRS's decision to eliminate its letter forwarding service effective August 31, 2012.

**When May a Plan Administrator Reasonably Conclude That a Rollover Contribution Is Valid?**

In Revenue Ruling 2014-9, the IRS provided examples of when a plan administrator may reasonably conclude that a potential rollover contribution is a valid rollover contribution.

The Code and corresponding regulations provide that if a plan accepts an invalid rollover contribution, the contribution will be treated as valid if: (1) when accepting the amount, the plan administrator reasonably concludes that the amount is a valid rollover; and (2) the plan administrator subsequently concludes that the amount is an invalid rollover, the amount is distributed to the employee.

The Revenue Ruling provides two examples of situations where a plan administrator may reasonably conclude that the rollover is a valid rollover.

- An employee requests a distribution of the employee's vested account balance from the employee's prior employer's plan to the employee's current employer's plan. The prior plan provides a check payable to the trustee of the current employer's plan and the employee delivers the check to the current employer's plan with an attached check stub that identifies the prior employer's plan as the source of the funds. The employee also certifies that the distribution from the prior plan does not include after-tax contributions. Under these facts, the plan administrator may reasonably conclude that this is a valid rollover if the plan administrator confirms that the prior plan did not enter code 3C on line 8a of its Form 5500 (indicating that the prior plan is intended to be a qualified plan under Code section 401, 403 or 408). Additionally, if the distribution check is payable to the current plan on behalf of the participant

from the trustee of the prior plan, the plan administrator may reasonably conclude that the plan, which distributed the amount, concluded that the amount is an eligible rollover distribution.

- An employee requests distribution of the account balance in the form of a direct payment from the IRA to the employer's current plan. The trustee for the IRA issues a check payable to the trustee of the plan on behalf of the employee. The check includes a check stub that identifies "IRA of Employee" as the source of the funds. Employee certifies that the distribution does not include after-tax amounts and that the employee will not attain age 70-1/2 by the end of the year in which the check is issued. In this situation, absent any evidence to the contrary, it is reasonable for the plan administrator to conclude that the potential rollover contribution is a valid rollover contribution because the check stub is entitled "IRA of Employee," which suggests that the source of the funds is a traditional, non-inherited IRA, and the employee certified that the distribution included no after-tax amounts and that the employee will not attain age 70-1/2 by the end of the year. If the employee had attained age 70-1/2 by the end of the year in which the check was issued, the plan administrator could not reasonably conclude that the amount was a valid rollover contribution absent additional information that Code sections 408(a)(6) and 408(b)(3) had been satisfied with respect to the IRA for that year.

The IRS further indicated that the above results would be the same even if there had been no check stub identifying the source of the funds, as long as the check itself identified the source of the funds as the employee's prior employer's plan or the employee's IRA. Finally, the IRS noted that a similar conclusion could be drawn if the rollover had been accomplished through a wire transfer or other electronic means, assuming the plan administrator or trustee of the distribution plan or IRA had communicated the same information to the plan administrator of the receiving plan.

## Health and Welfare Plan Developments

**2015 Inflation-Adjusted Amounts for Health Savings Accounts**

In Revenue Procedure 2014-30, the IRS provided the 2015 inflation adjusted amounts for health savings accounts (HSA) and high deductible health plans. For calendar year 2015, a high deductible health plan is a health plan with an annual deductible that is not less than $1,300 for self-only coverage or $2,600 for family coverage, and the annual out-of-pocket expenses do not exceed $6,450 for self-only coverage or $12,900 for family coverage.

The 2015 calendar year HSA contribution limits are as follows:

- $3,350 for an individual with self-only coverage
- $6,650 for an individual with family coverage

**Reinhart Comment:** High deductible health plans must comply with the out-of-pocket limits described above, not the ACA out-of-pocket limits issued by the Departments (discussed in the lead article).

## General Developments

### Supreme Court Holds that Severance Payments are Taxable Wages under FICA

In *US v. Quality Stores, Inc.*, the Supreme Court held that the severance payments at issue are taxable wages for Federal Insurance Contributions Act (FICA) purposes. Quality Stores, Inc. (Quality Stores) made severance payments to some employees who were terminated as part of a bankruptcy based on job seniority and time employed with the company. The payments were not tied to receipt of state unemployment insurance. Quality Stores initially paid the required FICA tax for the severance payments. However, it subsequently determined that the FICA tax should not have been paid and requested a refund from the IRS. The Bankruptcy Court determined that Quality Stores was entitled to a refund and the District Court and the Court of Appeals for the Sixth Circuit affirmed, holding that severance payments are not wages under FICA.

The Supreme Court determined that severance payments generally fit the broad definition of "wages" for purposes of FICA. The Court further held that Code section 3402(o) is not a limitation on the meaning of wages for FICA purposes. The Court expressly noted that the IRS exempts severance payments tied to the receipt of state unemployment benefits from FICA and income tax withholding but determined that exemption was not at issue in this case because the severance payments here were not linked to state unemployment benefits. Because the payments here were not linked to state unemployment benefits, the Court held that they were taxable wages for purposes of FICA.

### Document Retention: Failure to Retain Documents Could Result in Penalties

The District Court for the Northern District of Indiana recently imposed penalties on a retirement plan under ERISA section 502(c)(1) for failing to provide plan documents as required by ERISA section 104. *Hartman v. Dana Holding Corp.*, 2013

BL 290540 (N.D. Ind. 2013). The plaintiff requested a spousal annuity upon the death of her husband. The plan administrator denied her claim after determining that her husband elected a single life annuity in 1979. The plaintiff alleged that she had never signed a spousal waiver. The plaintiff requested her husband's election form, a spousal waiver form and the plan document and SPD in effect in 1979. The plan administrator provided her husband's election form and an SPD from 1986 through 1989 (which required spousal consent for the election of a single life annuity). The plaintiff filed suit after a year and half because she had still not received the 1979 plan document. The plan administrator eventually located the 1979 SPD but was unable to find the plan document. The 1979 SPD did not require spousal consent.

ERISA section 104 requires the plan administrator to furnish "other instruments under which the plan was established or operated." While the court recognized that generally outdated documents are not required to be provided, it cited cases holding that a participant would be entitled to such documents if the documents included information necessary to understand and assert their legal rights under the plan. The court found in this case that the 1979 plan documents were critical to the plaintiff's understanding of her rights and eligibility under the plan and were required to be provided. Because the court concluded that the 1979 documents were required to be produced under ERISA section 104, a penalty should be imposed on the plan. The court imposed a penalty of $4,470 ($10 per day from the date the plaintiff requested the information and the date the plan provided the SPD).

**Reinhart Comment:** This case illustrates the importance of timely responding to document requests from participants and beneficiaries and implementing an effective records retention policy. If you would like assistance creating or reviewing your records retention policy, please contact your Reinhart attorney.