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WEB's ***Benefits Insider*** is a bi-monthly member exclusive publication providing the latest developments from Washington, DC, on matters of interest to employee benefits professionals. The content of this newsletter is being provided through a partnership with the American Benefits Council, a premier benefits advocacy organization, which provides its core content, and is edited by Christopher M. Smith, Employee Benefits attorney and Principal of Flexible Benefits Systems, Inc., csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Rubio Unveils Retirement Security Proposal

Senator (and possible presidential candidate) Marco Rubio (R-FL) released a proposal on May 13 designed, in his words, "to strengthen entitlement programs, make it easier for young Americans to save for retirement, and remove financial penalties on Americans who choose to keep working into their golden years." A fact sheet is also available.

The centerpiece of Rubio's proposal is the expansion of the federal Thrift Savings Plan (TSP), which covers federal workers, to permit coverage of private sector workers without access to an employer plan. "Today there are 75 million Americans working for employers that do not offer a retirement plan. … I propose we give Americans who do not have access to an employer sponsored plan the option of enrolling in the federal Thrift Savings Plan. Opening Congress' retirement plan to the American people will allow us to bring the prospect of a secure, comfortable and independent retirement into reach of millions of people."

The proposal also includes a number of reforms to the Social Security program, including:

- Eliminating the 12.4 percent Social Security payroll tax for all individuals who have reached retirement age;
- Eliminating the Retirement Earnings Test, under which benefits are reduced approximately 50 cents for every dollar a person between the ages of 62 to 65 earns in excess of $15,000 a year;
- Gradually increasing the retirement age for future retirees to account for the rise in life expectancy; and
- Adjusting the calculation of initial benefits to reduce the growth of benefits for upper income seniors.

Rubio's proposal also endorses the Medicare premium support plan adapted from Representative Paul Ryan's (R-WI) Fiscal Year 2015 budget proposal.

These retirement proposals represent the latest element of Rubio's series of policy initiatives, following his prior proposals to address poverty, higher education and economic growth.

RECENT REGULATORY ACTIVITY

DOL Proposes Changes to COBRA Health Care Continuation Coverage Notices; CMS Provides Special Enrollment Period

The U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) issued proposed regulations on May 2, seeking to amend the notice requirements of the health care continuation coverage (COBRA) provisions of ERISA. The changes are intended "to better align the provision of guidance under the COBRA notice requirements with the [Patient Protection and Affordable Care Act (PPACA)] provisions already in effect, as well as any provisions of federal law that will become applicable in the future."

Also today, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight

issued a corresponding guidance document providing a limited special enrollment period for individuals enrolled in or eligible for COBRA coverage.

Under the COBRA continuation coverage provisions (and described in final COBRA regulations issued in 2004), an individual who was covered by a group health plan on the day before a qualifying event occurred may be able to elect COBRA continuation coverage upon a qualifying event (such as termination of employment or reduction in hours that causes loss of coverage under the plan). A group health plan must provide such "qualified beneficiaries" with an election notice, which describes their rights to continuation coverage and how to make an election. On May 8, 2013, DOL issued Technical Release 2013-02 (along with a series of model COBRA notices), noting that some qualified beneficiaries (1) may want to consider and compare health coverage alternatives to COBRA continuation coverage that are available through the PPACA exchanges and (2) may also be eligible for a premium tax credit to help pay for the cost of coverage.

Currently, the COBRA model general notice and model election notice (collectively, the model notices) are provided as appendices to the COBRA regulations themselves. The proposed regulations eliminate the current versions of the model notices and delete them as appendices to the regulations as a procedural matter that will permit DOL to amend the model notices as necessary and provide the most current versions of the model notices on the DOL website. Once available, updated versions of the model notices will be posted at the following links:

- COBRA Model General Notice
- COBRA Model Election Notice

Until rulemaking is finalized and effective, DOL will consider appropriately completed use of the model notices that are available on its website to constitute good faith compliance with the notice content requirements of COBRA. Use of the model notices is not required; the model notices are provided solely for the purpose of facilitating compliance with the applicable notice requirements.

The corresponding guidance issued by HHS is explicitly intended to address the concern that the prior COBRA model election notices did not adequately address the exchange options for persons eligible for COBRA and COBRA beneficiaries. HHS is therefore "providing an additional special enrollment period based on exceptional circumstances so that persons eligible for COBRA and COBRA beneficiaries are able to select [qualified health plans (QHPs)] in the [federally facilitated marketplaces]." Affected individuals have through July 1, 2014, to activate the special enrollment period by contacting the Marketplace call center.

The Obama Administration also released a Frequently Asked Questions (FAQ) document on May 2 (see related story, below) with additional discussion of this topic.
EBSA is soliciting comments on the proposed regulations through July 6 [Note: this is a Sunday].

New FAQ Guidance Addresses Range of PPACA Topics

On May 2, the U.S. departments of Treasury, Labor (DOL) and Health and Human Services (HHS) released Frequently Asked Questions (FAQ) Part XIX regarding implementation of the Patient Protection and Affordable Care Act (PPACA).

FAQ Part XIX addresses COBRA model notices, limitations on cost-sharing under PPACA, coverage of preventive services, the carryover of funds from health flexible spending accounts (FSAs) and excepted benefits, and Summary of Benefits and Coverage (SBC) notice requirements.

Limitations on Cost-Sharing and Out-of-Pocket Limits
Public Health Service Act (PHSA) Section 2707(b) (as added by PPACA) provides that any annual cost-sharing imposed under a non-grandfathered group health plan must not exceed certain limitations on out-of-pocket (OOP) costs. For plan or policy years beginning in 2014, these limits are $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage, with future limits increased by a statutorily-defined percentage. HHS has proposed 2015 limits of $6,600 for self-only coverage and $13,200 for other coverage.

Prior FAQ guidance stated that a plan may (but is not required to) count OOP spending for out-of-network items and services toward the plan's annual out-of-pocket maximum and may use "any reasonable method" for doing so. The new FAQ includes an example of a reasonable method for counting toward the OOP maximum for individual spending for an amount in excess of an allowed amount for out-of-network provider charges (also known as "balance billing").

The new FAQ also provides that:

- If a participant or beneficiary selects a brand-name prescription drug in circumstances in which a generic was available and medically appropriate, depending on the plan design, the plan may provide that all or some of the amount paid by the participant or beneficiary (for example, the difference between the cost of the brand name drug and the cost of the generic drug) is not required to be counted toward the annual out-of-pocket maximum.

- Until new guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements even though it treats providers that accept the reference amount as the only in-network providers, as long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers. DOL is soliciting comments on standards for plans using reference-based pricing structures by August 1, 2014.

Preventive Care
PHSA Section 2713 (as added by PPACA) and interim final regulations issued in July 2010, non-grandfathered plans are required to provide preventive care services (such as mammograms, colonoscopies and immunizations) without cost-sharing, consistent with published recommendations and guidelines from the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control (CDC) and the Prevention Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration.

The FAQ affirms that plans may use "reasonable medical management techniques" to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service. The FAQ states that the departments will consider a group health plan or insurer 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. For this purpose, covering a 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.

Health FSA Carryovers and Excepted Benefits

Excepted benefits provided under a group health plan or health insurance coverage generally are exempt from the Health Insurance Portability and Accountability Act (HIPAA) and PPACA market reform requirements. Under previously issued regulations, health FSAs generally constitute excepted benefits if (1) The employer also makes available group health plan coverage that is not limited to excepted benefits for the year to the class of participants by reason of their employment; and (2) the arrangement is structured so that the maximum benefit payable to any employee participant in the class cannot exceed certain limits.

In October 2013, Treasury and the Internal Revenue Service issued guidance modifying the "use-or-lose" rule for health FSAs to allow up to $500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate a grace period. The guidance provided that 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 ($2,500 adjusted for inflation after 2012).

The FAQ states that unused carry-over amounts remaining at the end of a plan year in a health FSA 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 Under PPACA, any group health plan or health insurance issuer offering group or individual health insurance coverage must provide a Summary of Benefits and Coverage (SBC) that "accurately describes the benefits and coverage under the applicable plan or coverage."

The FAQ notes that an updated SBC template (and sample completed SBC) have been made available at http://cciio.cms.gov and http://www.dol.gov/ebsa/healthreform and will continue to be authorized until further guidance is issued. The FAQ also confirms that previously-issued enforcement and transition relief guidance, including certain specific safe harbors, continues to apply until further guidance is provided. The departments also reiterated that their "approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."

PBGC Finalizes Rule on Unpredictable Contingent Events

On March 10, the Pension Benefit Guaranty Corporation (PBGC) issued final regulations interpreting the section of the Pension Protection Act of 2006 (PPA) that changed the phase-in period for the guarantee of benefits contingent upon the occurrence of an "unpredictable contingent event (UCE)" (such as a plant shutdown). Previously, the five-year phase-in (20 percent per year) began when the amendment providing UCE benefits (UCEBs) was adopted or effective (whichever is later), but PPA added a third factor that the phase-in period starts no earlier than the date of the shutdown or other unpredictable event. The statutory change applies to benefits that become payable as a result of a UCE that occurs after July 26, 2005.

The final rule generally follows the proposed regulations issued in March 2011, which stated:

- PPA did not alter the rule that UCEBs are not guaranteed at all unless the triggering event occurred prior to the plan termination date;
- The reference to "plant shutdown" in the statutory definition of UCEB includes a full or partial shutdown;
- When the UCEB is payable only upon the occurrence of more than one UCE, the guarantee is phased in from the latest date when all such UCEs have occurred;
- Based on plan provisions and other facts and circumstances, the PBGC would solely determine (a) which plan benefits are subject to the UCEB phase in and (b) the date(s) for which each such UCEB would be subject to the phase in;
- The proposed regulations includes eight examples that show how the UCEB phase-in rules would apply in the following situations:
- Shutdown that occurs later than the announced shutdown date;
- Sequential permanent layoffs;
- Skeleton shutdown crews;
- Permanent layoff benefits for which the participant qualifies shortly before the sponsor enters bankruptcy;
- Employer declaration during a layoff that return to work is unlikely;
- Shutdown benefit with age requirement that can be met after the shutdown;
- Retroactive UCEB; and
- Removal of Internal Revenue Code (Code) Section 436 restrictions (see discussion below).
- If a UCE occurs after a bankruptcy filing date, UCEBs arising from the UCE are not guaranteed at all because the benefits are not nonforfeitable as of the bankruptcy filing date; and
- If a UCE occurs before the bankruptcy filing date, the five-year phase-in period is measured from the date of the UCE to the bankruptcy filing date, rather than the plan termination date.

PPA also added a rule that prohibits UCEB payments with respect to a UCE if the plan is less than 60 percent funded for the plan year in which the UCE occurs (or would be less than 60 percent funded taking the UCEB into account). This Code Section 436 restriction is permanent unless additional contributions are made to the plan, or an actual certification meeting certain requirements is made, during the same plan year as the UCE. If a UCEB becomes payable because the funding restriction has been removed, the effective date of the UCEB for phase-in purposes is determined without regard to the restriction.

In response to a comment received from a collection of organized labor groups, PBGC made a single change to the proposed regulations. Noting that "determinations made by a plan,

arbitrator, or court regarding the date when participants became entitled to the UCEB may be relevant," the final rule "specifically includes determinations and statements by such parties as factors that will be considered, to the extent relevant, in establishing the UCE date. PBGC will not, however, treat any such determinations or statements as controlling."

IRS Guidance Clarifies Treatment of Mid-Year Plan Amendments Under Windsor

The Internal Revenue Service (IRS) issued **Notice 2014-37** on May 15, providing additional guidance for retirement plan administration under the U.S. Supreme Court's decision in *U.S. vs. Windsor.* Specifically, the notice amplifies Notice 2014-19 (issued April 4) to provide guidance on mid-year amendments to safe harbor 401(k) plans.

In light of the *Windsor* ruling, which struck down key sections of the Defense of Marriage Act, retirement plans must recognize same-sex marriages for purposes of issuing survivor benefits, obtaining spousal consent, eligibility for joint and survivor annuities and other administrative functions. In some cases, a plan amendment must be made to comply with the with the "state of celebration" standard established by the IRS under Revenue Ruling 2013-17.

Question No. 8 of Notice 2014-19 established that "the deadline to adopt a plan amendment is the later of (i) the otherwise applicable deadline under section 5.05 of Revenue Procedure 2007-44 [which established the staggered remedial amendment period,] or its successor, or (ii) December 31, 2014. Moreover, in the case of a governmental plan, any amendment made pursuant to this notice need not be adopted before the close of the first regular legislative session of the legislative body with the authority to amend the plan that ends after December 31, 2014."

Under prevailing regulations, a 401(k) safe harbor plan must be adopted before the beginning of the plan year and be maintained throughout a full 12-month plan year, except as otherwise provided under sections 1.401(k)-3(g) of the tax code (relating to the reduction or suspension of safe harbor contributions) or other general guidance.

Notice 2014-37 clarifies that a 401(k) or (m) safe harbor plan can adopt a mid-year amendment pursuant to Notice 2014-19. "A plan will not fail to satisfy the requirements to be a […] 401(k) or (m) safe harbor plan merely because the plan sponsor adopts a mid-year amendment pursuant to Q&A-8 of Notice 2014-19." This guidance is being provided to help non-calendar year plans, which would have had difficulty meeting the deadline without a mid-year amendment.

IRS Issues Final Regulations Regarding Tax Treatment of Payments by Qualified Plans for Medical or Accident Insurance

The Internal Revenue Service (IRS) released final regulations on May 9 clarifying the rules regarding the tax treatment of payments by qualified retirement plans for accident or health insurance. These regulations affect administrators, participants and beneficiaries of qualified retirement plans and generally apply for taxable years that begin on or after January 1, 2015. Taxpayers are permitted to elect to apply the regulations to earlier taxable years.

The final regulations adopt, with some modifications, the provisions of the proposed regulations issued in August 2007. Consistent with the proposed regulations, the final regulations clarify that a payment from a qualified plan for an accident or health insurance premium generally constitutes a distribution under section 402(a) that is taxable to the distributee in the taxable

year in which the premium is paid. The taxable amount generally equals the amount of the premium charged against the participant's benefits under the plan.

Most notably, the final regulations provide a special rule for disability insurance coverage under which the payment of disability insurance premiums from a qualified plan is excepted "if the insurance contract provides for payment of benefits to be made to the trust in the event of an employee's inability to continue employment with the employer due to disability, provided that the payment of benefits with respect to an employee's account does not exceed the reasonable expectation of the annual contributions that would have been made to the plan on the employee's behalf during the period of disability, reduced by any other contributions made on the employee's behalf for the period of disability within the year." The final regulations further state that "The Treasury Department and the IRS agree that the purchase of this type of disability coverage by a qualified plan is distinguishable from the purchase of medical insurance by a plan because the functional purpose of the disability insurance coverage is to replace retirement contributions to the plan, instead of providing medical benefits outside of the plan."

The final regulations also make technical and conforming changes based on various laws enacted since the issuance of the proposed regulations.

IRS Offers Relief from Certain Late Filing Penalties

The Internal Revenue Service (IRS) issued Notice 2014-35 on May 9, providing administrative relief from penalties under the Internal Revenue Code for a failure to comply in a timely fashion with regard to certain annual reporting requirements. The relief is intended for late filers participating in the Delinquent Filer Voluntary Compliance (DFVC) Program administered by the U.S. Department of Labor Employee Benefits Security Administration (EBSA).

Administrators of employee benefit plans subject to Title I of ERISA who fail to file annual reports on a timely basis can be subject to civil penalties. The DFVC Program, adopted in 1995 and most recently updated in 2002, is intended to encourage delinquent plan administrators to comply with their annual reporting obligations under ERISA by reducing these penalties. EBSA updated the DFVC in January 2013, incorporating the mandatory electronic filing of annual reports through the ERISA Filing Acceptance System (EFAST2).

According to Notice 2014-35, IRS will not impose penalties (related to the filing of Form 5500, Form 5500-SF, and Form 8955-SSA) "with respect to a year for which filing of such a form is required on a person who (1) is eligible for and satisfies the requirements of the DFVC Program with respect to a delinquent Form 5500 series return for such year and (2) files separately with the [IRS], in the form and within the time prescribed by this notice, a Form 8955-SSA with any information required to be filed under § 6057 for the year to which the DFVC filing relates (to the extent that the information has not previously been provided to the [IRS]). Relief is provided under the notice only if a Form 8955-SSA is filed on paper with the IRS.

IRS Provides Transition Period for Withholding Agents Complying with FATCA
In Notice 2014-33, issued May 2, the Internal Revenue Service (IRS) announced that "calendar years 2014 and 2015 will be regarded as a transition period" for purposes of enforcement and administration of the Foreign Account Tax Compliance Act (FATCA). The guidance does not directly apply to retirement plans but rather "to withholding agents, foreign financial institutions (FFIs), and other entities" that have withholding responsibilities.

This notice also announces the intention of the U.S. Treasury Department and the IRS to further amend the regulations that a withholding agent or foreign financial institution (FFI) may treat an obligation (which includes an account) held by an entity that is opened, executed, or issued on or after July 1, 2014, and before January 1, 2015, as a "preexisting obligation," subject to certain modifications. Prior to the issuance of such amendments, taxpayers may rely on the provisions of this notice regarding these proposed amendments to the regulations.

IRS, PBGC Issue Filing Relief for Federal Disaster Victims

On May 8, the Internal Revenue Service (IRS) and Pension Benefit Guaranty Corporation (PBGC) announced that they will waive certain penalties and extend certain deadlines in response to the severe storms and flooding that began on April 28, 2014, in the southeastern United States.

The IRS is postponing certain deadlines for taxpayers who reside or have a business in federal disaster areas in Florida, Alabama, Arkansas and Mississippi. For instance, certain deadlines falling on or after April 28, and on or before October 15, have been postponed to October 15, 2014. This includes the deadline for filing extensions for Form 5500 series returns as well as the deadline for many tax-exempt organizations to file their annual Form 990. It also includes the June 16 and September 15 deadlines for making quarterly estimated tax payments. A variety of business tax deadlines are also affected, including the April 30 and July 31 deadlines for quarterly payroll and excise tax returns.

The PBGC relief similarly applies to any "designated person" responsible for meeting a PBGC deadline (e.g., a plan administrator or contributing sponsor) who is located in Florida, Alabama, Arkansas and Mississippi and "cannot reasonably obtain information or other assistance needed to meet the deadline from a service provider, bank, or other person whose operations are directly affected by the severe weather." The PBGC announcement discusses requests for case-by-case relief, how to claim relief, assessment of premium payments, treatment of single-employer plan terminations, reportable event notices, requests for reconsideration and appeals, and multiemployer plan deadlines.

The IRS and PBGC disaster relief pages are frequently updated to add new states or counties in affected states.

IRS Guidance Affects Certain Foreign Retirement Plans

The Internal Revenue Service (IRS) recently issued Notice 2014-35, providing administrative relief from penalties under the Internal Revenue Code for a failure to comply in a timely fashion with regard to certain annual reporting requirements under ERISA. The relief is intended for late filers participating in the Delinquent Filer Voluntary Compliance (DFVC) Program administered by the U.S. Department of Labor Employee Benefits Security Administration (EBSA).

At the same time, the IRS also issued Revenue Procedure 2014-32, providing guidance on late annual reporting for non-Title I retirement plans. The revenue procedure establishes a temporary one-year pilot program providing administrative relief to plan administrators and plan sponsors of "one-participant plans" and/or certain foreign plans from applicable penalties under the tax code for a failure to timely comply with some annual reporting requirements. This revenue procedure also requests comments as to whether a permanent relief program should be established and, if so, how fees should be determined.

ERISA Advisory Council Announces 2014 Discussion Topics

The ERISA Advisory Council (EAC), a group of benefits experts established by Congress and appointed by the U.S. Department of Labor (DOL) to identify emerging benefits issues and advise the Secretary of Labor on health and retirement policy, has released its working group topics for 2014. These topics are:

- Pharmacy Benefit Manager (PBM) Compensation and Fee Disclosure
- Outsourcing Employee Benefit Plan Services
- Issues and Considerations around Facilitating Lifetime Plan Participation

The chair of the EAC for the 2014 term will be Neal S. Schelberg, senior partner at Proskauer Rose LLP, representing employers on the panel.

Final reports from prior years are available on the EAC website.

RECENT JUDICIAL ACTIVITY

Supreme Court to Hear Retiree Health Benefits Case

The U.S. Supreme Court has announced that it will consider M&G Polymers USA, LLC v. Tackett, a case involving retiree health benefits. The decision is expected to resolve a split among federal appeals courts regarding how to interpret collectively bargained agreements with respect to the duration of retiree health benefits.

In 2013, the U.S. Sixth Circuit Court of Appeals upheld a permanent injunction ordering that retirees be reinstated M&G Polymers health plan. The Sixth Circuit affirmed that the "retirees had [the] vested right to no-cost health care" under the prevailing collective bargaining agreement (CBA) and "certain side agreements between union and various employers that purported to limit retiree health care coverage did not apply to [the] plant that employed retirees." In this and similar cases, the Sixth Circuit has applied a presumption, known as the "Yard-man inference," that union retiree benefits are intended to be vested in the absence of specific plan or bargaining agreement language to the contrary. Other appeals courts, including the Second, Third and Seventh Circuits, have ruled that retiree health benefits are not vested without specific durational language.

M&G Polymers petitioned the Supreme Court for review of the appellate court decision. The court granted review with respect to "Whether, when construing collective bargain agreements in Labor Management Relations Act cases, courts should presume that silence concerning the duration of retiree health benefits means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds, or should require a clear statement that health care benefits are intended to survive the termination of the [CBA], as the Third Circuit holds, or should require at least some language in the agreement that can reasonably support an interpretation that health care benefits should continue indefinitely, as Second and Seventh Circuits hold."