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RECENT DEVELOPMENTS IN EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

[Note that this outline is merely a summary of some recent developments and should not be relied upon as legal advice for any particular situation.]

I. The New Annual Reporting Requirements Under the ACA

The IRS has now released "drafts" of the forms (and instructions) employers, insurance carriers and exchanges will use for reporting Affordable Care Act tax information to individuals and the IRS for 2014 (when filing is voluntary) and for 2015.

The first set of forms is used by employers to report to the IRS whether they make offers of "Minimum Essential Coverage" to their employees. These are Forms 1094-B and 1095-B. However, large (i.e., 50 or more FTEs) self-funded employers can bypass the Form 1094-B/1095-B requirement by completing all of 1095-C discussed below. Small (i.e., fewer than 50 FTEs) self-funded employers have to complete Form 1095-B and its 1094-B transmittal form in all cases. Fully insured employers of any size need not perform this MEC reporting because it is required of their insurance carriers.

The second set of forms, Forms 1094-C and 1095-C, will be used by employers with more than 50 FTEs to determine whether the employer is responsible for penalties under the ACA's employer mandate rules, and whether employees have received an affordable and 60% MAV offer of coverage, rendering them ineligible for premium tax credits on the exchanges.

Each full-time employee of an employer who must file the 1095-Cs must receive a Form 1095-C, and all of the employer's Form 1095-Cs must be filed with the IRS (using transmittal form 1095-B).

The instructions for the employer reporting forms provide for a simplified reporting approach for employers who make a "qualifying offer," defined as an offer to each 30 hour employee of 60% MAV, affordable (using the federal poverty level test) coverage (with spouse and dependent children offered coverage as well). An employer that makes a qualifying offer to an employee for all 12 months of the reporting year may provide each employee who received the qualifying offer with a statement (instead of the more complex Form 1095-C) that the employee (and his or her spouse and dependents, if any) received a qualifying offer for all 12 months and thus is ineligible for a premium tax credit for any month for coverage purchased on an exchange.

For 2015 only, an employer that makes a qualifying offer to at least 95 percent of its full-time employees has an option to provide statements (in lieu of Form 1095-C) to employees who received a qualifying offer. If the employee received a qualifying offer for some months but not

all 12 months, the statement informs employees that they may be eligible for premium tax credits in one or more months. For employees who received a qualifying offer for all 12 months of the reporting year, the statement informs the employee that he or she (and his or her spouse and dependents, if any) received a qualifying offer for all 12 months and thus is ineligible for a premium tax credit for coverage purchased on an exchange.

In lieu of indicating that it has made qualifying offers to its employees, an employer may provide its employees with the formal Form 1095-C. In the case of employees that do not receive qualifying offers, the employer must indicate on the Form 1095-C the dollar amount that employees are required to contribute for the lowest-cost plan offered by the employer providing 60% MAV (to enable the IRS to determine if the coverage meets the ACA affordability requirement).

Finally, the guidance contains a "98% offer" rule that provides that an employer is not required to insert the number of full-time employees employed each month on Form 1094-C and which allows the employer to file Form 1095-C on behalf of all of its employees (rather than just to those who are full-time). The draft instructions on this rather arcane special rule read as follows: "To be eligible to use the 98% Offer Method, an employer must certify that it offered, for all months of the calendar year, affordable health coverage providing minimum value to at least 98% of its employees and their dependents for whom it is filing a Form 1095-C employee statement. The employer is not required to identify which of the employees for whom it is filing were full-time employees, but the employer is still required to file Forms 1095-C on behalf of all of its full-time employees. (For this purpose, the health coverage is affordable if the employer meets one of the section 4980H affordability safe harbors.) Note: If an employer uses this method, it is not required to complete the "Full-Time Employee Count" in Part III, column (b)."

Naturally, employers should begin to study these rules in advance of 2015 and to prepare appropriate compliance procedures.

II. Submission Form for Transitional Reinsurance Program Annual Enrollment Count

On October 20, 2014, the Center for Consumer Information and Insurance Oversight (CCIIO) announced that the form for submitting the Transitional Reinsurance Program (TRP) annual enrollment count is available on Pay.gov.

The transitional reinsurance program is important for group health plans because it is funded by fees assessed against insurers and self-insured plans that provide "major medical coverage" for 2014, 2015, and 2016. The fees are assessed on a per-covered-life basis (which includes enrolled employees and dependents). The fees are $63 per covered life for 2014; $44 per covered life for 2015; and TBD for 2016. Under the current guidance, sponsors of self-funded plans are required to give HHS notice of the number of covered lives by November 15, 2014, 2015, and 2016, respectively. In turn, HHS will invoice the plan for the program fees and plan sponsors must remit the fees within 30 days of the invoice's date.

Contributing entities have the option to pay: 1) the entire 2014 benefit year contribution in one payment no later than January 15, 2015, reflecting $63.00 per covered life or 2) in two separate payments for the 2014 benefit year, with the first remittance due by January 15, 2015 reflecting $52.50 per covered life, and the second remittance due by November 15, 2015, reflecting $10.50

per covered life.

Self-administered (i.e., plans that do not use a TPA for "core administrative functions" such as claims processing/adjudication or plan enrollment services), self-funded plans are exempt from the fee for 2015 and 2016 (but not for 2014). Limited third party activities will preserve the availability of the exemption (e.g., a third party may be used for pharmacy benefits or excepted benefits, a third party may be used to obtain a provider network, etc.)

Using Pay.gov, filers will be able to complete all of the informational requirements: registration, submission of the Annual Enrollment Count, and remittance of contributions.

III. "Skinny Plans" Do Not Provide Minimum Value

On November 4, the regulators issued Notice 2014-69, stating that so-called "skinny health plan" designs not providing hospitalization and/or physician coverage do not meet the 60% Minimum Actuarial Value test of the Affordable Care Act (even if running those designs through the HHS calculator results in a score higher than 60%). Therefore, employers considering adopting such a plan to satisfy this particular ACA requirement should not do so.

IV. Excepted Benefits Regulations Finalized

In October, the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department finalized some of the previously proposed amendments to the excepted benefit regulations.

Excepted benefits are health or accident plans that are exempt from complying with the HIPAA portability requirements (e.g., special enrollment rights and the former preexisting condition exclusion limits). More importantly, most Affordable Care Act mandates also do not apply to plans that qualify as excepted benefits. Common types of excepted benefits include limited-scope dental or vision plans, most typical health FSAs and fixed dollar or hospital indemnity coverage or coverage only for a specified disease (e.g., a cancer-only policy). (Note that some of these benefits are excepted benefits only if certain additional requirements are met, as provided in regulations.)

The final regulations clarify that limited-scope vision or dental benefits do not have to be offered in connection with a separate offer of major medical or "primary" group health coverage under the plan, in order to meet the statutory criterion that such benefits are "otherwise not an integral part of the plan." To meet this criterion, limited-scope vision or dental benefits can be provided without connection to a primary plan, or the limited-scope vision or dental benefits can be offered separately from the major medical or "primary" coverage under the plan (as described in the final regulations). Under the 2013 proposed regulations, in order to satisfy the statutory excepted benefits criterion that such benefits cannot otherwise be "an integral part of the plan," participants must be able to decline coverage. The final regulations provide that this criterion is satisfied if participants may decline coverage or the claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

While coverage for long-term care benefits was not the focus of the rule, the preamble to the final regulations notes that the revisions applicable to limited-scope vision or dental benefits also

apply to coverage of long-term care benefits.

As with the 2013 proposed regulations, the final regulations provide that, for an EAP to constitute excepted benefits, the EAP must satisfy four requirements.

1. The EAP does not provide significant benefits in the nature of medical care.

2. The EAP's benefits are not coordinated with the benefits under another group health plan. This requirement has two elements: (1) participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan; and (2) participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.

3. No employee premiums or contributions may be required as a condition of participation in the EAP.

4. The EAP may not impose any cost-sharing requirements.

The regulations apply to group health plans and group health insurance issuers for plan years beginning on or after 1/1/2015. They do not apply to health insurance issuers offering individual health insurance coverage. Until the applicability date of the final regulations, the IRS will consider dental and vision benefits and EAP benefits meeting conditions of the 2013 proposed regulations or the final regulations to qualify as excepted benefits.

V. New COBRA Qualifying Events

IRS Notice 2014-55 expands the application of the permitted change rules for health coverage under a section 125 cafeteria plan (cafeteria plan). In particular, this notice addresses two specific situations in which a cafeteria plan participant may wish to revoke, during a period of coverage (commonly a plan year), the employee's election for employer-sponsored health coverage under the cafeteria plan in order to purchase a Qualified Health Plan through a competitive marketplace established under section 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace (Marketplace).

The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer's group health plan. (This may occur, for example, under certain employer plan designs intended to avoid any potential assessable payment under section 4980H of the Internal Revenue Code.) The second situation involves an employee participating in an employer's group health plan who would like to cease coverage under the group health plan and purchase coverage through a Marketplace without that resulting either in a period of duplicate coverage under the employer's group health plan and the coverage purchased through a Marketplace or in a period of no coverage. Provided certain specified conditions described in the Notice are met, a cafeteria plan may allow an employee to revoke his or her election under the cafeteria plan for coverage under the employer's group health plan (other than a flexible spending arrangement (FSA)) during a period of coverage in each of those situations. The Treasury Department and the IRS intend to modify the

regulations under section 125 consistent with the provisions of this notice, but taxpayers may rely on the notice immediately.

VI. Taxation of Reimbursement of Exchange Premiums

IRS Notice 2013-54 generally precludes an employer from using pre-tax amounts to fund the purchase of health insurance coverage in the individual market (including inside and outside the exchange) for employees. (Note that this rule does not apply to certain reimbursement arrangements that are "integrated" with an employer sponsored group health plan, retiree-only HRAs, employer-funded payment for excepted benefit coverage (e.g., hospital indemnity, cancer coverage), etc..) The arrangements addressed under Notice 2013-54 include (among other things):

1. Health reimbursement arrangements (HRAs); and

2. Plans under which an employer reimburses an employee on a pre-tax basis for some or all of the premium expenses incurred for an individual health insurance policy or arrangements under which the employer pays directly the premium on a pre-tax basis for an individual health insurance policy covering the employee (collectively referred to as an "employer payment plan" in the Notice).

The Notice expressly states that such arrangements would have to comply with the market reforms of the ACA, but cannot (e.g., an employer payment plan would not be able to comply with the preventive care rules, or with the annual dollar limits under the ACA and cannot be integrated with the individual market coverage to meet the rules).

VII. Employer Stock in Retirement Plans - Fifth Third Bancorp v. Dudenhoeffer, 6/25/14, U.S. Supreme Court

The Supreme Court considered the "presumption of prudence" enjoyed (under Circuit Court case law) by ERISA fiduciaries of Employee Stock Ownership Plans (and, by implication, of other retirement plans that invest in employer stock).

Under this Circuit Court presumption -- developed over time in a series of "stock drop" cases -- plaintiffs had to prove that the employer faced "dire economic circumstances" or "was on the brink of collapse" to overcome a presumption that a continuing Plan investment in employer stock was prudent.

The Supreme Court ruled that no such presumption exists under the law, and therefore, in order to prevail, plaintiffs need only prove that the fiduciaries of a plan acted imprudently (without the need to first prove dire economic circumstances/brink of collapse).

Although the plaintiffs prevailed, the Supreme Court made statements that are helpful to plan fiduciaries. First, the Court held that fiduciaries may assume – absent "special circumstances" that suggest otherwise – that the stock market price of publicly traded employer stock provides a reasonable estimate of the stock's actual value.

Second, the Court held that in the many cases in which ERISA fiduciaries also are securities law

insiders of the employer, the plaintiff must show what action those fiduciaries could have taken with respect to the employer stock in the plan that was "consistent with the applicable securities laws" and that would not have "caused more harm than good" to the value of the plan's holdings in employer stock.

Bottom Line: Because most fiduciaries of ERISA Plans with employer stock investments historically have maintained and followed procedures based on the basic prudence standard -- utilizing the Circuit Court presumption only when faced with litigation -- the Supreme Court's decision arguably is actually beneficial to most fiduciaries because of the Court's statements affirming the ability to rely on stock market prices, affirming fiduciaries' obligations to comply with federal insider trading rules, and introducing the "causing more harm than good" issue.

Naturally, employers should continue to monitor the prudence of investment of ERISA Plan assets in employer stock, and should retain an independent fiduciary to make determinations in cases in which a prudent person would conclude that continued investment in employers stock might not be appropriate and the inside fiduciaries have a conflict of interest, or there is an appearance of a conflict of interest, that impacts their ability to make an independent fiduciary decision on this question.

VIII. Could Have v. Would Have Standard - Tatum v. RJR Pension Investment Committee, 8/4/14, Fourth Circuit

This was a "reverse stock drop" case in which the plaintiff challenged an ERISA Plan fiduciary's decision to remove employer stock from the Plan's investment line-up. (Naturally, the stock price surged soon after the removal.)

This case dealt with the question of whether a court should ask whether an ERISA Plan fiduciary's challenged decision "could reasonably be made" by a prudent fiduciary, or whether a court should ask whether the challenged decision "more likely than not would have been made" by a prudent fiduciary.

Unfortunately, a three-judge panel of our Circuit Court adopted the "would have" standard instead of the much lower "could have" standard, requiring fiduciaries in the Fourth Circuit to document even more carefully the records of their decision-making to ensure that the record reflects that they considered all of the relevant facts and circumstances and all of the courses of action available to them, and to ensure that the record contains a detailed rationale for selecting the course decided upon.

It also would be useful for that record to include a statement that the fiduciary made a determination, after a review of all the relevant facts and circumstances and potential courses of action, that the course selected would be selected by the majority of fiduciaries confronted with the particular question.

Fortunately, the Court expressly acknowledged that this "would have" standard is applied based on the facts known at the time of the decision rather than with the benefit of hindsight, and essentially is a "procedural prudence" requirement.

However, the new higher standard leaves fiduciaries open to allegations that they did not act the

way in which a majority of prudent fiduciaries would have acted (and leaves fiduciaries in a particular predicament in cases in which no clear "majority view" of fiduciaries can be established).

(The defendants purportedly are considering an appeal for an en banc rehearing by the entire Fourth Circuit.)

Bottom Line: When faced with any potentially controversial fiduciary question – and not just whether to retain employer stock as an investment in an ERISA-governed retirement plans – ERISA plan fiduciaries should ensure that the records of their thoughtful decision-making process include a statement that the fiduciary reached its decision only after a careful review of all the relevant facts and circumstances and potential courses of action, and that the fiduciary determined that the course selected would be selected by the majority of fiduciaries confronted with the particular question.

IX. Estoppel Claims - Spiewacki v. Ford Motor Co., 5/1/14, U.S. District Court Northern District of Ohio

In 2011, the Supreme Court decided CIGNA v. Amara, an ERISA fiduciary case that confirmed an ERISA Plan participant's ability to receive more than a Plan's promised benefits in certain limited situations in which the participant reasonably relies on fiduciary statements to the participant's detriment (a so-called "estoppel" recovery).

Relying on Amara, the plaintiff here claimed more than the benefits provided under the formula in the Ford pension plan, because of erroneous information about his benefit amount that he received from Ford.

When contemplating retirement, the plaintiff made a written request for his early retirement benefit amount under the plan. Ford responded with a letter providing him with "benefit amounts that are estimates only and that are based on the information you provided. They represent an estimate of the amounts that may be payable at your Benefit Commencement Date."

After the plaintiff elected early retirement – expecting to receive the amount noted in the Ford letter – Ford noticed that its TPA had credited the plaintiff with more service than he actually had, and adjusted his benefit downward from $2420.53 per month to $1243.47 per month. The plaintiff then brought his estoppel suit seeking the $2420.53 monthly amount.

The Court held that five separate elements must be satisfied by the plaintiff in order to prevail on an estoppel claim:

1. There must be conduct or language amounting to a representation of a material fact;

2. The party to be estopped must be aware of the true facts;

3. The party to be estopped must intend that the representation be relied upon;

4. The complaining party must be unaware of the true facts; and

5. The complaining party must rely on the facts to that party's detriment.

The Court added that, in order to satisfy item 2, a plaintiff must prove that the defendant's actions contained an element of fraud or were grossly negligent, and this requirement was not met.

The Court also held that the plaintiff did not prove element 3, having submitted no evidence that Ford wanted him to retire.

Finally, and most importantly, the Court held that it was unreasonable for the plaintiff to rely on the Ford letter because it was carefully characterized as an "estimate" that provided information on benefit amounts that "may" be payable in the future "based on information the plaintiff provided."

Bottom Line: Employers should not only ensure that all benefit estimates they provide to Plan participants are as accurate as possible, but should note on those estimates that they are estimates only and do not necessarily reflect the amount that ultimately will be received from the Plan.

X. Expanded Definition of "Fiduciary" under ERISA

In October 2010, the DOL proposed a change to the definition of fiduciary under ERISA that would have expanded the scope of those who become fiduciaries, which would capture more of the current services of 401(k) and IRA providers. After significant objections were raised, the DOL announced it would withdraw and re-propose the definition of fiduciary regulation while also conducting further economic analysis. Some commentators are speculating that the re-proposed rule will be issued in early 2015. [There is an entire EBSA website dedicated to this issue: http://www.dol.gov/ebsa/regs/cmt-1210-AB32.html]

XI. Annuities as Permissible Investment Alternatives in Defined Contribution Plans

Through IRS Notice 2014-66 and DOL Information Letter dated 10/23/14, the DOL and the Internal Revenue Service issued guidance stating that qualified defined contribution retirement plans may offer target date funds that include deferred annuities among their assets (even if they are offered only to older participants), and that target date funds serving as default investment alternatives may include annuities among their fixed income investments, so long as certain specified safe harbor requirements are met.

XII. Electronic "Top Hat" Filing Statements

Top Hat Plans may now file their "top hat" registration statement electronically through the DOL's website.

XIII. Upcoming Compliance Deadlines

A. Reminders for calendar year retirement plans –

1. Distribute Safe Harbor, QDIA, Automatic Enrollment Notices generally by November 30.

2. Make 2014 RMD's, adopt discretionary amendments, review/use forfeiture account, and

review terminated participants accounts and possibly make cash-out distributions (depending on plan terms) by December 31.

B. Reminders for calendar year health plans –

1. Report transitional reinsurance fee to HHS on number of covered lives by November 15 (this particular deadline applies regardless of Plan Year).

2. Correct DCAP discrimination test failures, adopt amendments providing for a Health FSA carryover for 2013 and/or for reducing health FSA salary reduction max to $2,500 by December 31.

3. HPIDs - Originally, under rules related to the HIPAA electronic transaction regulations, employer-sponsored health plans, whether insured or self-funded, were required to acquire from the CMS so-called "Health Plan Identification Numbers" (or "HPIDs") by November 5, 2014 (November 5, 2015 for small plans). For insured plans, the insurance carrier was to obtain the HPID. For self-funded plans, the plan sponsor was to obtain the HPID.

On October 31, the regulators announced that the HPID requirement will be delayed indefinitely. Of course, this was after most plans with $5,000,000 or more in annual claims had already acquired their HPIDs in order to meet the previously applicable November 5, 2014 deadline for those plans. (Before the indefinite delay announcement, smaller plans were required to acquire their HPIDs by November 5, 2015.) The regulators' cryptic explanation for this eleventh hour indefinite delay was as follows: "On September 23, 2014, the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, recommended that HHS rectify in rulemaking that all covered entities (health plans, healthcare providers and clearinghouses, and their business associates) not use the HPID in the HIPAA transactions. This [indefinite delay] will allow HHS to review the NCVHS's recommendation and consider any appropriate next steps."

XIV. DOMA/Same-Gender Marriages

XV. Resources

1. http://www.irs.gov/Retirement-Plans/Plan-Sponsor/Fixing-Common-Plan-Mistakes

2. http://www.dol.gov/ebsa/compliance_assistance.html