JOHNSON & KROL, LLC

Taft-Hartley Report

OCTOBER 2013 ISSUE

DOMA Invalidated—What's Next? The Implications of the Supreme Court's Decision

On June 26, 2013, the Supreme Court's decision in *United States v. Windsor* deemed Section 3 of the federal Defense of Marriage Act (DOMA) invalid because it did not serve a legitimate purpose to overcome the harm done to a class of people that state marriage laws seek to protect. The full ramifications of the Court's holding for employee benefit plans have yet to be seen, but the impact has already begun.

What is DOMA?

Signed into law by President Clinton in 1996, DOMA which broadly clarified that, for the purposes of federal law, "marriage" did not include a same-sex marriage and "spouse" referred only to an individual of the opposite sex.[1] Therefore, for purposes of the Internal Revenue Code of 1986 (tax code) and the Employee Retirement Income Security Act of 1974 (ERISA), DOMA restricted any reference to "spouse" to mean only opposite-sex spouses. Since 1996, same-sex spouses have been treated as single under ERISA plans, despite the subsequent enactment of several state laws recognizing same-sex marriage.

U.S. v. Windsor

The *Windsor* case is about whether a same sex domestic partner is entitled to the marital estate tax exemption after the death of her partner.[2] Windsor and her partner resided in New York, registered as domestic partners in New York in 1993, and got married in Canada in 2007 because New York did not permit same-sex marriages. Subsequently, in 2008, New York began recognizing same-sex marriages that were performed in other jurisdictions where same-sex marriage was legal. Accordingly, Windsor and her partner were considered married in the state of New York at the time of her partner's death in 2009. Windsor did not qualify for the marital estate tax exemption under the tax code because Section 3 of DOMA restricted the term "spouse" to an individual of the opposite sex for federal tax law purposes.[3] Windsor filed suit in federal court claiming that Section 3 of DOMA violated the Equal Protection Clause of the Fifth Amendment to the U.S. Constitution. The Supreme Court agreed and found Section 3 of DOMA to be unconstitutional.

The Supreme Court affirmed that the regulation of domestic relationships is left to the states. Federal statutes may be enacted to make determinations that bear on marital rights and privileges in order to pursue large goals and policies; however, DOMA's reach was found to be too expansive, hurt the class of people the laws of a state seek to protect, and was motivated by an improper purpose.[4]

The Court did not rule on whether same-sex marriage is a constitutionally-protected right, but the term "spouse" for purposes of ERISA, the tax code and other federal laws is no longer limited to an opposite-sex spouse. Because the Court was silent on the specifics in its ruling, ERISA industry commentators attempted to determine its impact and application and the executive branch, through the Departments, indicated that guidance would be forthcoming. In light of the Court's holding in *U.S. v.* Windsor, the primary questions were: (1) would state of marriage, state of residency or state of administration control the interpretation of "spouse" and (2) would domestic partnerships and civil unions be treated the same as marriage?

Agency Guidance Interpreting *Windsor*

In response to the *Windsor* ruling, the Internal Revenue Service (IRS) issued Revenue Ruling 2013-17 on August 29, 2013. The ruling states that same-sex couples, legally married in jurisdictions that recognize their marriages, will be treated as married for federal tax purposes. This ruling, dubbed a "place of celebration" ruling, applies irrespective of whether or not the couple lives in a domestic or foreign jurisdiction that recognizes same-sex marriage. Simply put, it will not matter if a married same-sex couple lives in a state where such marriages are not legal; all that matters is whether they were married in a state where same-sex marriages are legal.

Under the ruling, same-sex couples will be treated as married for all federal tax purposes, including income, gift and estate taxes.[5,6] The ruling is applicable to all federal tax provisions where marriage is a factor, including employee benefits effective September 16, 2013. For welfare plans where same-sex spouses were treated as dependents of the employee, but such benefits were subject to federal income tax pursuant to the IRC, this means that such benefits are not subject to federal income tax going forward.[7]

FAQ's issued by the IRS on September 19, 2013, specifically state that qualified retirement plans must treat a same-sex spouse as a spouse for purposes of satisfying the federal tax laws relating to qualified retirement plans where the marriage was validly entered into in a jurisdiction whose laws authorize the marriage, even if the married couple lives in a domestic or foreign jurisdiction that does not recognize same-sex marriage. Currently, thirteen states authorize same-sex marriage.[8] Accordingly, qualified retirement plans must recognize same-sex spouses married in one of the thirteen states for the purposes of spousal consent, QDRO administration and survivor benefits. Similarly, the Employee Benefit Security Administration (EBSA) of the Department of Labor (DOL) issued Technical Release No. 2013-04 on September 18, 2013.This Technical Release adopted the "place of celebration rule" stating that where the DOL has the authority to issue regulations, rulings, opinions, and exemptions of Title I of ERISA and the Code of Federal Regulations, the term "spouse" will be read to refer to any individuals who

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are lawfully married under state law, including same-sex marriages.

Unlike the guidance and its application to qualified retirement plans, there is no such clear guidance requiring welfare plans to cover same-sex spouses where spousal coverage is offered. Additionally, ERISA welfare benefit plans are not required to provide spousal coverage of any kind and, while the Affordable Care Act (ACA) requires employers to offer coverage to children up to age 26, there is no requirement for spousal coverage.[9] Accordingly, some commentators think there is no requirement to honor same-sex marriages for the purposes of spousal coverage at this time.

However, all guidance issued refers to the language of *Windsor* and the finding that DOMA is unconstitutional because it violates the principles of equal protection. Moreover, there has been a recent movement by courts to find against private establishments where discrimination and harassment based on sexual orientation is alleged. In most of these cases, local and state ordinances have been the basis for such findings. However, a recent case in the 5th Circuit found in the EEOC's favor on a Title VII claim, specifically finding that it was harassment based on sex where a construction superintendent sexually harassed his subordinate for not acting manly enough.[10] Accordingly, some plans are choosing to cover same-sex spouses consistent with the recent IRS guidance on retirement plans without waiting for similar guidance specific to welfare plans.

Please contact our office with any questions you may have regarding the application of DOMA, *Windsor* and recent guidance, or assistance reviewing plan documents to determine compliance.

[1] 1 U.S.C § 7 (1996).
[2] *U.S. v. Windsor*, 133 S. Ct. 2675 (2013).
[3] Hunter, Katherine Utz. *U.S. v. Windsor and the States' Approaches to Same-Sex Marriage*, Benefits Practice Resource Center, p. 2, (2013).
[4] *U.S. v. Windsor*, 133 S. Ct. 2675 (2013).
[5] IRS News Release, *Treasury and IRS Announce That All Legal Same-Sex Marriages Will be Recognized For Federal Tax Purposes; Ruling Provides Certainty, Benefits and Protections Under Federal Tax Law For Same-Sex Married Couples,* www.irs.gov/newsroom.
[6] The Treasury and the IRS expect to issue restructured procedures for employers who wish to file refund claims for payroll taxes paid on previously-taxed health insurance and fringe benefits provided to same-sex spouses. *Id.* at 2.
[7] Employees may also file amended returns to recoup federal income tax paid on such benefits within a three year period prior to the release of the Revenue Ruling.
[8] CA, CT, DE, IA, ME, MD, MA, MN, NH, NY, RI, VT and WA plus Washington DC.
[9] *Supra* note 6 at 8.
[10] *EEOC v. Boh Bros. Constr. Co.,* 5th Cir., No. 11-30770 (September 27, 2013).

US Airways v. McCutchen: Equitable Doctrines Cannot Override Clear Terms of ERISA Plan

On April 16, 2013, the United States Supreme Court issued its opinion in *U.S. Airways v. McCutchen*. At issue was whether a self-funded benefit plan is entitled to full reimbursement for payments made to a plan participant injured in an accident where the participant sues and recovers damages from a third party.

In *U.S. Airways v. McCutchen*, the beneficiary, James McCutchen, became totally disabled following a serious automobile accident. U.S. Airways, a self-funded health benefit plan, paid $66,866 for his medical expenses. McCutchen settled a lawsuit involving the automobile accident for $110,000, which resulted in a net recovery of $66,000 after attorney's fees and costs.

U.S. Airways demanded that McCutchen reimburse them for the full amount of his medical expenses. Under the terms of the plan, a beneficiary was required to reimburse the plan for any amounts it paid out of any monies recovered from a third party. McCutchen argued that U.S. Airways did not take into account his legal fees, which reduced his recovery amount to less than the amount demanded by the plan. U.S. Airways filed suit in federal court under Section 502(a)(3) of the Employment Retirement Security Income Act (ERISA) seeking "appropriate equitable relief." The district court granted summary judgment to U.S. Airways, holding that the plan's subrogation and reimbursement provision entitled the company to full reimbursement.[1]

Subsequently, the Third Circuit overturned the district court and remanded the case for further consideration.[2] Specifically, the court of appeals held that awarding full reimbursement to U.S. Airways was inequitable under the principle of unjust enrichment because it would leave McCutchen "with less than full payment for emergency medical bills."[3] The court of appeals believed that full reimbursement would amount to "a windfall for U.S. Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining the third-party recovery."[4]

Relying on its earlier decision in *Sereboff v. Mid-Atlantic Medical Services*,[5] the Supreme Court reversed the Third Circuit Court's decision. The Supreme Court held that the plan's lawsuit really sought to enforce an equitable lien by agreement. Such an equitable action "arises from and serves to carry out a contract's provisions."[6] Thus, enforcing the lien means holding the parties to their mutual promises.[7] "Conversely, it means declining to apply rules – even if they would be 'equitable' in a contract's absence – at odds with the parties' expressed commitments."[8] In other words, equitable defenses are not available in Section 502(a)(3) actions based on equitable liens by agreement to the extent those defenses conflict with the terms of the plan.

The Supreme Court also held, however, that even though equitable rules "cannot trump a reimbursement provision, they still might aid in properly construing it."[9] If plan terms are silent or ambiguous on a particular issue, courts must look at the "background of common-sense understandings and legal principles that the parties may not have bothered to incorporate expressly but that operate as default rules to govern in the absence of clear expression of the parties' [contrary] intent."[10]

Here, the Court found that U.S. Airways' plan was silent on the allocation of attorney's fees; thus, the common-fund doctrine provided the applicable default rule.[11] The Court found that if U.S. Airways "wished to depart from the well-established common-fund rule, it had to draft its contract to say so."[12]

U.S. Airways v. McCutchen emphasizes the importance of having clear and concise plan terms. In light of this decision, plan sponsors and administrators should carefully review their plans to ensure that their subrogation and reimbursement provisions are comprehensive and unambiguous to leave no room for a participant's equitable defenses.

[1] *U.S. Airways, Inc. v. McCutchen*, 2010 U.S Dist. LEXIS 89377 (W.D. Pa. Aug. 30, 2010).
[2] *U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3rd Cir. 2011).
[3] *Id.* at 679.
[4] *Id.*
[5] 547 U.S. 356 (2006).
[6] 133 S. Ct. 1537, 1546 (2013).
[7] *Id.*
[8] *Id.*
[9] *Id.* at 1548.
[10] *Id.* at 1549.
[11] *Id.*
[12] *Id.* at 1548.

Taft-Hartley Funds Prevented from Collecting

The Ninth Circuit Court of Appeals in San Francisco recently affirmed a lower court's decision to deny the Alaskan Laborers Funds lawsuit to collect deficiencies revealed by an audit on the basis of *res judicata*. *Res judicata* is a Latin term meaning "a matter already judged." In U.S. Courts, it bars a suit from being brought again on an event which was the subject of a previous legal cause of action that has already been finally decided between the parties.

Prior to bringing the lawsuit at hand, the Alaskan Laborers Funds brought suit against the employer, Alaska Trailblazing, in 2010.[1] In the 2010 lawsuit, the Alaskan Laborers Funds obtained a default judgment for unpaid contributions, liquidated damages, interest and attorney's fees for the period of May 2009 through November 2009 based on reports submitted by the employer. Before obtaining the judgment based on the reports submitted by the employer, the Alaskan Laborers Funds conducted a payroll compliance audit which revealed significant deficiencies during calendar year 2009 in addition to those owed according to the contribution reports submitted by Alaska Trailblazing. However, for unknown reasons, the Alaskan Laborers Funds did not seek to have those deficiencies included in the default judgment.

Thereafter, in early 2011, the Alaskan Laborers Funds filed the lawsuit at issue to collect on the deficiencies revealed by the payroll compliance audit. At that point, the employer raised the defense of *res judicata* and sought to have the lawsuit dismissed. The Court agreed with the employer and dismissed the lawsuit because the Alaskan Laborers Funds were aware of the audit deficiencies when they obtained the first default judgment but did not seek to include them in the judgment.[2] Therefore, the doctrine of *res judicata* prevented the Alaskan Laborers Funds from obtaining a judgment for the audit deficiencies. The Alaskan Laborers Funds appealed the decision to the Ninth Circuit.

On July 24, 2013, the Ninth Circuit affirmed the lower court's decision.[3] The decision relied heavily on the fact that the Alaskan Laborers Funds had been aware of the audit deficiencies when the 2010 lawsuit was pending but failed to act. Therefore, the Alaskan Laborers Funds were prevented from collecting any of the contributions revealed by the payroll compliance audit.

It is important to note that this decision does not prevent Taft-Hartley funds from bringing a second lawsuit when the deficiencies are not revealed until after the first lawsuit is completed. It merely precludes Taft-Hartley funds from sitting on information that is readily available to them. Therefore, collection coordinators should ensure that fund counsel is aware of all deficiencies, including those audit deficiencies which may still be in the review stage or that are being handled internally. Moreover, it is important to act quickly upon receiving an audit so as to avoid any theories that the funds should have acted previously and thus prevent them from asserting any future rights to collection.

[1] *Alaska Laborers Health and Security, Retirement, Training and Legal Services Trust Funds v. Alaska Trailblazing, Inc.,* U.S. Dist. Ct. for the D. of Alaska, Case No. 3:10-cv-003 HRH.
[2] *Alaska Laborers Health and Security, Retirement, Training and Legal Services Trust Funds v. Alaska Trailblazing, Inc.,* U.S. Dist. Ct. for the D. of Alaska, Case No. 3:11-cv-049-RRB, Docket No. 18 (August 8, 2011).
[3] *Alaska Laborers Health and Security, Retirement, Training and Legal Services Trust Funds v. Alaska Trailblazing, Inc.,* No. 11-35845, 2013 U.S. App. LEXIS 15028 (9th Cir. July 24, 2013

Annual Fee Disclosure Date Can Be Reset

Defined contribution retirement plans can now reset the date that the annual fee disclosure notice is sent to participants so that it can be combined with other mailings to participants. Calendar year plans were first required to provide participants with detailed investment-related plan information by August 30, 2012[1] and at least annually thereafter.

Field Assistance Bulletin (FAB) 2013-02 provides that plans can get a onetime reset and provide a follow up notice up to 18 months after the 2013 or 2014 notice is issued. This is an opportunity to establish a distribution date that coincides with other mailings such as the notice related to a qualified default investment alternative (QDIA) or the safe harbor alternative for 401(k) plan nondiscrimination testing which are typically provided in the fourth quarter of the year.

[1] **Non-Calendar Plan Years**. The August 30, 2012 date for the annual fee disclosure notice also applied to non-calendar plan years beginning between November 1, 2011 and July 1, 2012. For plan years beginning after July 1, 2012 and before November 1, 2012, the annual fee disclosure notice was required 60 days following the first day of the 2012 plan year.

We encourage you to contact

JOHNSON & KROL, LLC

if you have any questions regarding the content within this newsletter.

(312) 372-8587

Letter from the Editor: The Fight for Efficiency

We are all familiar with the challenges that our industry face. To name a few:

- Rising health care costs
- Costly and confusing government regulation
- Volatile investment markets
- A young work force that seems to be maturating at later and later ages
- High levels of unemployment
- Challenging collective bargaining
- The blessing and challenge of longer life expectancies.

In this environment where every penny in your contract is precious, don't hesitate to fight for efficiency. The fight for efficiency comes in many forms. It can be something as simple as steering your participants to use more generic drugs or as complicated as installing and testing auto-adjudication software. Whatever the form, I define an efficiency gain as any benefit plan modification, administrative procedure or professional change that has the effect of lowering the plan's costs or increasing the plan's revenues without materially reducing the level of benefits provided to the participants.

These are oftentimes the most difficult decisions Trustees face. Upsetting the status quo can be a difficult thing. The parties who benefit from the status quo will line up to defend it and provide reasons why it cannot be done. The simple fact that change takes energy and effort will oftentimes be the greatest obstacle.

The funds that face these challenges and fight for efficiency will ultimately outperform the funds that don't. Accordingly, I suggest that Trustees consider the following steps to evaluate fund efficiency:

- Make sure your fund's investments program is intelligently designed and efficiently implemented.
- Make sure your welfare plan design aligns the interests of all the participants with the interests of individual participants.
- Make sure your professionals provide timely and effective advice and not a menu of confusing options and memos.
- Make sure your fund office makes full use of technology and manpower.
- Don't allow confusing regulations control your fund. Insist on practical advice from your professionals that that sets forth the available options and then choose the one that best suits your fund.

Minimum Essential Coverage, Minimum Value and Essential Health Benefits

Under the Affordable Care Act (ACA), there are three similar, but different concepts that cause confusion among consumers and plan administrators: minimum essential coverage, minimum value coverage and essential health benefits. These concepts are important to understanding penalties under the ACA and what kind of coverage is required.

Minimum Essential Coverage (MEC)

MEC is the coverage that individuals must have in place to avoid paying the individual mandate penalty beginning in 2014.[1] The following types of coverage constitute minimum essential coverage: (1) coverage under an eligible employer sponsored group health plan (including retiree coverage); (2) coverage under certain government programs; (3) coverage under the exchange; and (4) coverage recognized by HHS. Accordingly, multi-employer plan participants who are enrolled in a self-insured employer sponsored employee group health plan or retiree group health plan provided by their former employer will not be subject to the penalty.[2]

MEC in the insured market requires that non-grandfathered health plans sold in the individual and small group market meet substantially all of the Title I requirements under the ACA including offering essential health benefits. This means that a small group employer plan (less than 50 employees) purchased for employees through the private insurance market must provide all essential benefits and market reforms.[3] However, for the purposes of self-insured employer sponsored health plans and large group health plans, guidance states what is not considered MEC and those are stand-alone vision, dental or limited benefit plans (specific cancer coverage plans).[4] Accordingly, until further guidance is issued, almost anything qualifies for MEC with regards to self-insured plans.

Additionally, beginning in 2015, there is a $2,000 annual *per employee* penalty for certain employers who do not provide MEC to employees where *just one* employee of an employer applies for and receives a cost sharing subsidy or premium tax credit under the marketplace.[5]

Minimum Value Coverage (MV)

MV is the value of coverage offered to an individual and under the ACA it means that the insurance offered by a plan pays for at least 60% of covered health expenses for a typical population. Beginning in 2015, employers may be subject to an annual $3,000 penalty for each employee who enrolls in the marketplace and receives a premium tax credit if: (1) the coverage offered to the employee is not MV; (2) the employee must pay more than 9.5% of their family income to the employer for the employee's coverage; and (3) the employee's family income is less than 400% of the federal poverty level.[6]

Essential Health Benefits (EHB)

After January 1, 2014, all non-grandfathered insured plans must offer coverage that includes EHB. All grandfathered insured and self-insured plans do not have to cover all or any EHB but if they do, they must eliminate annual dollar limits on EHB (but may use cost control mechanisms like utilization review, case management and R&C amounts).

The ACA requires that EHB must include items and services within at least the following 10 categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[7]

Aside from the broad naming of these categories, there is little to no guidance as of yet regarding what specifically constitutes EHB within the categories. In 2010, when EHB were first introduced under the ACA, the requirement was that plans must make a "good faith effort" to define which benefits constitute EHB within those 10 categories. Recently, guidance requires that plans adopt a definition of EHB approved by the Department of Health and Human Services (HHS). Benchmark plans adopted by states administering marketplaces with or without the assistance of the federal government may assist plans in determining what benefits constitute EHB for the purpose of removing annual limits. Currently, a review of publicly available benchmark plans are not definitive regarding EHB because they are 2012 plans which contain limits on services that may be considered EHB. Accordingly, it is recommended that plans and industry professionals review the 2014 benchmark plans once the marketplaces are accessible online and/or the federal employee benefit plans are released for open enrollment.

As explained above, the concepts of MEC, MV and EHB are important to understanding how the ACA will impact health care consumers and sponsors of ERISA employee benefit plans. For more information on any of these concepts or the ACA in general, please contact us at 312-372-8587.

[1] 1% of income above filing threshold for 2014, 2% for 2015, 2.5% for 2016 and beyond. The minimum penalty amount each year is $95 for 2014, $325 for 2015, $695 for 2016 and $695 + inflation adjustment after 2016.
[2] IRC § 5000(A)(f)(2). 45 CFR § 1.5000A-2.
[3] 42 USC 300gg-6(a).
[4] 26 CFR 1.5000A-2.
[5] The employer is required to pay the penalty for all employees (above 30) if the employer employs 50 or more full-time equivalent employees and the employer does not offer MEC to 95% of those employees. However, this employer penalty is only related to the employee, not any dependents that receive a premium tax credit or cost sharing subsidy.
[6] However, this employer penalty is only related to the employee, not any dependents that receive a premium tax credit or cost sharing subsidy.

J&K ATTORNEYS AT LAW
Johnson & Krol, LLC

is pleased to announce that

Catherine J. Rische

and

William P. Callinan

have been named as members to its legal practice

Catherine and William have made a significant contribution to Johnson & Krol, LLC over the last six years and both are a great asset to our law practice as we move forward

Training Funds Must Comply With Disability Law

Federal and state disability laws protect individuals with mental or physical disabilities and medical conditions. The Americans with Disabilities Act (ADA) and applicable regulations define a *Covered Entity* and "an employer, employment agency, labor organization, or joint labor management committee."[1] Therefore, a jointly administered Training Fund is clearly a *Covered Entity* under the ADA.

The definition of disability under the ADA is very broad and can be any physical or mental impairment that substantially limits one or more major life activities. The final regulations provides a non-exhaustive list of major life activities that includes: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others and working.

Disability law prohibits a covered entity, such as a training fund, from discriminating against any *Qualified Individual with a Disability*. A qualified individual with a disability is one that possesses the requisite, skill, experience, education and other job related requirements and is able to perform the *essential functions* of the job with or without reasonable accommodations.[2] Determining whether reasonable accommodations can be made for an individual with a disability must be done on a case-by-case basis.

In order to determine what reasonable accommodations, if any, can be made, the apprenticeship committee must engage in an interactive process with the candidate. The interactive process is a dialogue between the committee and the candidate to identify any limitations and more importantly, whether there is a reasonable accommodation that would enable the individual to perform the essential functions of the job.[3] Following the interactive process, the committee is required to provide a reasonable accommodate to an otherwise qualified candidate, unless the committee demonstrates that to do so would constitute an undue hardship. The failure to engage in the interactive process altogether will result in a per se violation of the ADA and expose the fund to liability.

There are a significant amount of regulatory guidelines and case law that apply to disability law. As a result, this article is merely an overview of the law as it relates to training funds. Training committees should consult with counsel on a case-by-case basis to ensure full compliance.

[1] 29 C.F.R. § 1630.2(b).
[2] 29 C.F.R. § 1630.2(m).
[3] 29 C.F.R. § 1630.2(o)(2)(ii)(3).

What about Retirees under the ACA?

With all of the requirements, mandates and restrictions under the ACA, employers are wondering what the best course of action is for retiree benefits. This article will attempt to explain how retirees are treated under the ACA for the purposes of the individual mandate, premium tax credits, shared employer responsibility penalties and the reinsurance fees.

Retiree-only plans are excluded from many of the market reform requirements.[1] This approach would appear to favor treating retirees different from active employees in all regards. However, as explained below, the Departments have taken very different approaches to the treatment of retirees for the purposes of the individual mandate, premium assistance credit, the employer reporting/shared responsibility requirements and the reinsurance contribution requirements.

The Individual Mandate

For the purposes of the individual mandate and the premium assistance credits, the Departments[2] treat retirees the same as active employees. Generally, beginning in 2014, all individuals will be required to maintain minimum essential coverage each month or pay a tax penalty unless such individual is exempt.[3] The most common ways retirees will avoid the individual mandate penalties are: (1) coverage under Medicare Part A and Medicare Advantage plans; (2) coverage under an employer sponsored health plan; or (3) the required contribution percentage for coverage through the marketplace (after premium assistance credit) or through their former employer if considered unaffordable.

Coverage under Medicare Part A is explicitly considered minimum essential coverage. Accordingly, all Medicare retirees will be considered in compliance with the individual mandate. Additionally, the Departments clarified that for the purposes of the individual mandate, self-insured retiree health coverage offered by an employer or on behalf of an employer (multi-employer plan) will also qualify as eligible employer sponsored coverage where the retiree is enrolled in and entitled to receive benefits under such plan.[4] Stand-alone retiree-only HRA plans where amounts are made available by the employer to reimburse medical expenses, including the purchase of an individual policy are also considered minimum essential coverage for the purpose of the individual mandate.[5] This means that if a retiree is eligible for and enrolls in an employer sponsored coverage (including a stand-alone retiree-only HRA) or Medicare, the retiree will not be assessed an individual penalty. Additionally, there is an exemption from the minimum essential coverage requirement for retirees if coverage available is unaffordable (through marketplace or former employer). Coverage is considered unaffordable with regards to the individual mandate if the premium the retiree is required to pay for self-only coverage exceeds 8.0% of his household income.[6]

Premium Assistance Credit

Generally, in order for an employee to be eligible for a premium assistance credit under the marketplace where he is eligible for coverage through an employer sponsored plan, the coverage offered must be unaffordable and not provide minimum value.[7]

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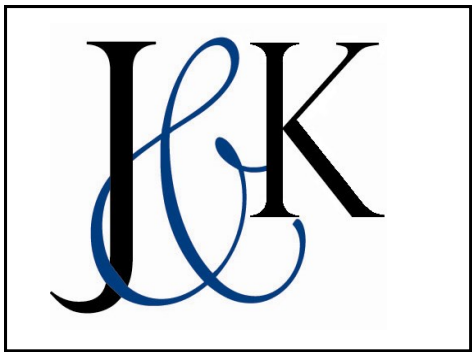

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What about Retirees under the ACA? (*continued from page 7)*

However on May 2, 2013, the IRS issued a proposed rule that stated that a retiree would be eligible for a premium assistance credit if he is eligible to enroll in a retiree health plan but declines enrollment.[8] Accordingly, if finalized as currently written, a retiree who declines coverage will be eligible for a premium assistance credit and the affordability and minimum value standards are not required.[9] This means that the retiree's decision to decline coverage because it is too expensive or does not provide robust enough benefits should not preclude him from receiving a premium assistance credit.

Employer Mandates

The Departments have taken the position that retirees are not the same as active employees with regards to the employer reporting mandates and the play or pay penalties (failure to offer minimum essential coverage that is affordable and provides minimum value). The regulations define employees as full-time or full-time equivalent (more than 30 hours per week on average) workers who are employees of an employer under the common law test.[10] This means that the ACA does not require an employer to offer coverage to retirees and that a retiree's receipt of a premium assistance credit or cost sharing subsidy will not result in play or pay penalties assessed to the employer.

Reinsurance Contribution Requirement

The Departments have adopted a third, bifurcated approach with regards to the reinsurance contribution requirement under section 1341 of the ACA which establishes a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the years 2014 – 2016. For the purposes of determining a plan's reinsurance contribution amount, guidance treats pre-Medicare retirees the same as active employees and excludes post-Medicare retirees when counting covered lives.

Unlike the general retiree-only plan exceptions to market reform requirements, HHS chose to draw the line for including retirees based on whether Medicare is the primary payer (in which case no reinsurance fee is imposed) or the secondary payer (in which case a reinsurance fee is imposed) with regards to the treatment of retirees.[11] Accordingly, all retiree plans, including a stand-alone retiree-only HRA, will be required to submit the reinsurance contribution on behalf of pre-Medicare retirees but not post-Medicare retirees under this approach. This fee is not insignificant, but the breakdown lends itself to the theory that the government expects pre-Medicare retirees to purchase insurance through the marketplace.

Self-insured group health plans are liable for the contributions of $63 per covered life for the 2014 calendar year and will be due in December 2014. The 2015 and 2016 fees are not yet posted but analysts project them to be $42 per covered life for 2015 and $26 per covered life for 2016. They are scheduled to phase out in 2017, unless Congress extends the program before then.

As illustrated above, the Departments have taken three very different approaches to how retirees are treated under the ACA, depending on the issue. For questions about whether your plan is a retiree-only plan, more information about the application of the ACA to retiree benefits, or assistance regarding compliant retiree benefit designs under the ACA, please contact us at 312-372-8587.

[1] 45 CFR §2590 published in the FR, June 28, 2010.
[2] Department of Health and Human Services, Department of Labor and Department of Treasury
[3] IRC §5000A.
[4] However, coverage for other excepted benefits such as stand-alone dental or vision care are not considered minimum essential coverage. http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
[5] Reg. 148500-12, Fed. Reg. at 7318. 45 CFR § 1.5000A published in the FR, August 30, 2013.
[6] As indexed by HHS for subsequent years. 45 CFR § 1.5000A published in the FR, August 30, 2013. Household income is modified adjusted gross income plus that of every other individual in your family for whom the employee can properly claim a personal exemption deduction.
[7] Coverage is considered unaffordable for the purposes of the premium assistance credit if the employee self-only premium exceeds 9.5% of his household family income. Minimum value means that the coverage offered pays 60% of medical expenses (the bronze standard).
[8] Treas. Prop. Regs, §1.36B-2.
[9] It is unclear at this time whether a stand-alone retiree plan would disqualify the retiree from the premium assistance credit. Recent guidance is limited to the effect of an HRA that is integrated with other coverage. FAQ's about Affordable Care Act Implementation Part XI, issued January 23, 2013. DOL Tech. Release No. 2013-03.
[10] Treas. Prop Regs. §54.7980H-1(a)(13).
[11] CMS-9964-F, 78 Fed. Reg. at 15456 (2013).