For Your Benefit

A newsletter on current legal issues impacting employee benefits and executive compensation

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May 2013

New Guidance Issued on the Affordable Care Act's Implementation

By Daniel N. Kuperstein

April was a productive month for the agencies guiding us through the implementation of the Affordable Care Act (ACA). New guidance was issued throughout the month and covered issues pertaining to the Summaries of Benefits and Coverage requirements, health insurance market reforms and the Exchanges. On April 29, in the most recent FAQs to be published on the U.S. Department of Labor (DOL) website, the DOL, Health and Human Services (HHS), and the Treasury (collectively, the "Departments") address annual limit waiver expiration dates, provider non-discrimination, coverage for individuals participating in approved clinical trials and transparency in reporting coverage.

Annual Limit Waiver Expiration Dates

The first issue discussed in the new FAQs is a response to a question regarding the ACA's health plan annual limit waiver expiration dates. The ACA generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits beginning in 2014 (restrictions on such annual limits are permitted before 2014). Certain group health plans and health insurance issuers were granted waivers from the ACA's annual limit prohibition. The FAQ clarifies that if a plan or issuer has such a waiver, the waiver expiration date does not change if the plan or issuer changes its plan or policy year prior to the waiver's expiration. Providing an example, the FAQ explains that if "a waiver approval letter states that a waiver is granted for an April 1, 2013 plan or policy year, the waiver will expire on March 31, 2014, regardless of whether the plan or issuer later amends its plan or policy year."

Provider Non-Discrimination

Another section of the ACA prohibits group health plans and health insurance issuers from discriminating with respect to participation under the plan or coverage against any health care provider who is "acting within the scope of that provider's license or certification under applicable state law" ("the non-discrimination provision"). This section applies to non-grandfathered group health plans and health insurance issuers offering group or individual health coverage for plan or policy years beginning on or after January 1, 2014.

In response to a question asking whether the Departments will be issuing regulations addressing the non-discrimination provision prior to its effective date, the FAQ explains that this section is a "self-implementing" provision, and that the Departments do not expect to issue regulations on this section prior to its effective date. However, the FAQ does provide some clarification by explaining that plans and issuers are expected to implement the requirements of this section using a "good faith, reasonable interpretation of the law," that this provision "does not require plans or issuers to accept all types of providers into a network," and that this provision "also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations."

Clinical Trials

As with the above non-discrimination provision of the ACA, the Departments also deemed a provision of the ACA dealing with clinical trials to be "self-implementing." Specifically, the ACA requires non-grandfathered group health plans and issuers offering group or individual coverage, with respect to a "qualified individual" (as that term is defined in the law), to: (1) not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) not discriminate against the individual on the basis of the individual's participation in the trial.

The FAQ clarifies that the Departments do not expect to issue regulations on this section in the near future, but do provide that until further guidance is issued, plans and issuers are expected to implement the requirements of this section using a good faith, reasonable interpretation of the law, and that the Departments will "work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the law," and with "families and individuals to help them understand the coverage for clinical trials provision and benefit from it as intended."

In This Issue:

One problem that is likely to come from the Departments' decision to refrain from issuing regulations on this section is how to interpret the meaning of the prohibition's application to clinical trials with respect to the treatment of "another life-threatening disease or condition." Although the Departments have determined that this section is self-implementing, this term's meaning is certainly not self-explanatory. A very broad spectrum of diseases and conditions can be "life-threatening" depending on the time frame that is to be considered. Accordingly, additional guidance is likely needed here.

Transparency in Coverage Reporting Requirements

Finally, the FAQ considers the issue of the ACA's requirements pertaining to transparency in coverage reporting. Under the ACA, health insurance issuers seeking certification of a health plan as a qualified health plan ("QHP") are required to make accurate and timely disclosures of certain information to the appropriate Health Insurance Marketplace (also known as the Exchange), HHS and the state insurance commissioner, and to make this information available to the public. The FAQ clarifies that because QHP issuers will not initially have all of the data that will need to be reported (such as QHP enrollment and disenrollment), such issuers need only begin submitting information after they have been certified as QHPs for one benefit year (defined as a calendar year for which a health plan provides coverage for health benefits). In addition, the FAQ notes that the Departments intend to coordinate regulatory guidance on the transparency in coverage standards for coverage offered both inside and outside of the Exchanges.

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Opportunity for In-Plan Roth Conversion Expanded

By Susan Foreman Jordan

Included in the Small Business Jobs and Credit Act of 2010 was a provision which enabled participants in 401(k) plans to convert their pre-tax salary deferral contribution accounts into after-tax Roth accounts through in-plan Roth rollover. Until that option was added, Roth conversion could be accomplished only through direct rollover from the plan to a Roth IRA. At that time, however, in-plan Roth rollover was available only to participants who then were eligible for distribution from the plan. Consequently, unless and until the participant had attained age 59-1/2 and unless the plan permitted in-service distributions, in-plan Roth rollover was not an option.

Under the American Taxpayer Relief Act of 2012, the availability of in-plan Roth conversion is extended, on a permanent basis, effective January 1, 2013, to all participants with pre-tax salary deferral contribution accounts, whether or not otherwise is eligible for distribution. Although the original 2010 legislation allowed taxpayers to split the income tax liability over two years, under current law, the full amount will be included in income the year in which the account is converted, in the same manner as if that amount had been distributed directly to the participant.

Generally speaking, the 10% early distribution excise tax does not apply to an in-plan Roth conversion, regardless of the participant's age. However, there is a recapture rule while will result in imposition of that added tax, if the participant takes a distribution from the Roth account (to which the early distribution penalty would apply) within five years.

Certainly, the benefits of Roth conversion must be weighed against the cost, given the recently increased income tax rates, and in light of the fact that in-plan conversion (unlike Roth IRA rollover) is irrevocable. However, Roth conversion may remain appealing to those individuals who expect that their income tax rates will increase further in the future. Likewise, because the minimum distribution requirements do not apply to Roth accounts, wealthy individuals who desire to preserve and pass on to their heirs more of their retirement savings may want to take advantage of this new opportunity.

Keep in mind that in-plan Roth conversion is not permissible unless the plan expressly provides for that option. A number of issues remain unresolved, including whether distribution restrictions continue to apply to converted amounts, whether plans may impose an all-or-nothing requirement with regard to conversion, what plan language is required, and what impact the conversion option will have on various disclosure materials. As such plan sponsors are advised to delay action to add or implement the expanded in-plan conversion provisions, pending the issuance of further guidance by the IRS.

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Contributing Employers Beware: Has the Tipping Point for Multiemployer Plans Arrived?

By Harvey M. Katz

Earlier this year, an announcement by the PBGC that attracted little notice will have a large and negative impact on employers who contribute to multiemployer plans. The announcement stated that the PBGC multiemployer insurance system is expected to run out of money in approximately 10 years, even before any new obligations are added. This announcement is just further confirmation of what many contributing employers have already realized: the system is unsustainable and cannot - and will not - survive. The announcement also represents a time frame, beginning now, that signals the beginning of the end for the PBGC insurance system, which will have dramatic consequences for any employer still contributing to a multiemployer plan.

To understand why the demise of the multiemployer plan system is inevitable, an understanding of the history of multiemployer plans is necessary. Before 1980, a contributing employer's sole liability was the negotiated rate of contribution to the plan. In 1980, the Multi-Employer Pension Amendments Act (MEPAA) imposed a withdrawal liability on employers who withdrew from any multiemployer plan. While helpful in shoring up the finances of many plans, withdrawal liability was not enough to save the system. The liability imposed on withdrawing employers was, and still is, too easily avoided because many withdrawing employers withdraw because of bankruptcy, insolvency, or they avoided payment through loopholes in the statute. In addition, poor assessment and collection practices by many multiemployer plans in the past allowed many withdrawing employers (and affiliated businesses who are also liable for withdrawal liability) to avoid payment of their share of withdrawal liability. Because of this dynamic, PBGC, the government insurer of pension plans (similar to the manner in which FDIC insures banks) has been called upon to bail out insolvent multiemployer plans with increasing frequency.
The Pension Protection Act (PPA) was enacted in 2006 to try and deal with some of the problems not addressed by MEPPA. PPA imposed additional contribution requirements on contributing employers who contribute to plans in endangered and critical status (euphemistically referred to as "yellow zone" and "red zone plans"). These measures have undoubtedly helped, as the number of plans in the "green zone" (i.e. with assets to cover more than 80% of their liabilities) has increased to 60%, up from 35% in 2009 at the height of the recession. Arguably, this improvement is largely attributable to stock market gains, and is not a true indication of the long-term health of the system.

However, by requiring additional contributions from ***contributing***, as opposed to withdrawing employers, PPA focused employers on the increasing cost of remaining in a troubled plan, in a way MEPPA never did. As a result, those employers began to carefully weigh the cost of continued participation versus the cost of withdrawal liability, with the knowledge that most of their fellow contributing employers are performing the same analysis.

Many knowledgeable observers believe that, like MEPPA, PPA is a stopgap solution at best because the root cause of problem is the shrinking number of employees and employers who contribute to many multiemployer funds, particularly in declining industries. This places the increasing strain on the plans themselves as well as the PBGC insurance system. If fact, many employees who participate in financially troubled plans, now realize that that a large percentage of their employer's contribution is used to pay for benefits due to participants that have already retired. When this fact becomes more widely understood by multiemployer plan participants, more and more of them will support employer efforts to substitute another type of pension arrangement. The difficulties faced by PBGC insurance system will undoubtedly exacerbate this problem.

In the author's view, there is an increasingly narrow set of possible scenarios in light of the large (and snowballing) problem faced by the system. Undoubtedly, Congress will step in and help save the PBGC insurance system. This is not a final solution, however, and any Congressional fix will undoubtedly require employers to pay even more in an effort to minimize the need for an infusion of taxpayer funds. Even before the PBGC announcement, many employers have realized the failing state of the system and began to monitor the status of their plans more carefully, as simple logic suggests that the last few remaining employers in a troubled multiemployer plan will be saddled with very high rehabilitation plan contributions and withdrawal liabilities. However, many employers do not realize that they could be left in that very position quickly. With the collapse of the PBGC multiemployer insurance system a real possibility, many employers could decide to leave the system at once and the tide could turn very quickly.

The bottom line is that the PBGC Insurance system will almost certainly not survive in its current form, despite congressional intervention. Given this reality, despite the cost of withdrawal liability, many employers should be seriously considering negotiating a withdrawal from their multiemployer plans now, as more of their fellow contributors are undoubtedly doing the same thing. The risk of involvement with a rapidly deteriorating fund should be a concern to all multiemployer plan contributors even those who contribute adequately funded plans. The additional pressure imposed upon the insurance system by the PBGC announcement should be a wake up call for a tipping point may come very quickly if employers begin leaving the system in large numbers.

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The New EPCRS... Much Like the Old EPCRS

By Seth I. Corbin

On December 31, 2012, the IRS released Revenue Procedure 2013-12, its latest iteration of the Employee Plans Compliance Resolution System (EPCRS). EPCRS is a collection of IRS approved programs available to correct certain qualified plan errors or defects. The most recent EPCRS guidance had been issued in 2008, and the significant changes to the programs include the availability for corrections to 403(b) plan and revised submission procedures under the Voluntary Correction Program (VCP).

Although the new guidance became available for plan sponsors and practitioners to use beginning January 1, 2013, it became mandatory to follow as of April 1, 2013. So far, in this author's experience, the changes are primarily form over substance. In fact, the issues available for correction under EPCRS remain largely the same and most clients – except those few that have been down the correction road before – will not notice a difference. This is especially true because the fee structure, based on the number of participants in the qualified plan with the failure, has not changed since 2008. Aside from the new submission procedures under VCP, the new guidance accounts for certain changes since 2008, including the fact that the IRS eliminated the IRS Letter Forwarding Program in August 2012. The Letter Forwarding Program had been a useful tool (not to mention, IRS approved) to locate lost participants who were affected by qualified plan failures. Contacting all affected participants is a critical element of EPRCRS and can often be a time consuming and costly process for plan sponsors. The new guidance acknowledges the elimination of the Letter Forwarding Program and provides that reasonable actions must be taken to locate lost participants, including, but not limited to: (i) mailing to the individual's last known address via certified mail; and (ii) using other locator services such as the Social Security letter forwarding program.

If you are aware of operational or document failures related to your qualified retirement plan, it is strongly recommended that you take a proactive approach to correcting such failures by contacting your professional retirement plan advisors. By being proactive, plan sponsors can help preserve the tax qualified status of their plan. That approach will often – but not always – include voluntarily going to the IRS to get its approval through VCP. Nothing in the new guidance, or its application in its first few months, suggests that using EPCRS is any less attractive for plan sponsors as it had recently been.

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Qualified Charitable Distributions – They Keep Going and Going

By Susan Foreman Jordan

Thanks to a provision first introduced by the Pension Protection Act of 2006, an individual who has attained age 70-1/2 may make a tax-free donation of up to $100,000 directly from his or her IRA to a qualified charity. Such a qualified charitable distribution (QCD) can be excluded from the IRA owner's income and, in addition, can be used to satisfy any required minimum distribution for the year. The amount of the QCD which is excluded from gross income is not taken into account in determining any deduction for other charitable contributions. Initially, the QCD option was available only in 2006 and 2007, but it has been extended multiple times, most recently under the American Taxpayer Relief Act of 2012, and it remains available at least through the end of the current year. Under the extension, any donation made through January, 2013, may be treated as a 2012 QCD. However, to the extent that a QCD made in January, 2013, is treated as a 2012 QCD, it may not be used to satisfy any portion of the required minimum distribution for 2013. Further, in determining the required minimum distribution for 2013, the 2012 QCD must be subtracted from the December 31, 2012, IRA account balance.

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