Planning in Response to DOMA Decision; "PCORI Fees" Due July 31; Delay of Employer "Pay-or-Play" and Reporting Requirements; Importance of Clear Plan Terms

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Qualified Plans and Health and Welfare: Planning in Response to DOMA Decision in *Windsor*

Anthony Provenzano and Elizabeth Drake

Last month's Supreme Court decision in *Windsor* (*United States v. Windsor*, No. 12-307, 2013 U.S. LEXIS 4921 (U.S. June 26, 2013)) struck down DOMA's requirement that "marriage" for federal law purposes means only the marriage of a man and a woman and that a "spouse" means a person of the opposite gender. This decision will obviously impact the taxation and administration of employee benefit plans and programs to the extent they are required or permitted to provide spousal benefits.

We understand that the IRS plans to issue preliminary guidance in the coming weeks regarding the impact of the *Windsor* decision. The most important issue we expect the IRS to address is the marital status of same-sex couples who were married in one jurisdiction and now reside in a jurisdiction that does not recognize their marriage. In other words, we anticipate guidance on whether an employer may look to the state in which a marriage was performed in determining whether the employee is currently married for federal tax purposes or whether the employer must look to the state in which the employee is currently domiciled for these purposes. For example, if a same-sex couple was married in New York then moves to Virginia, may the employer look to New York to determine if the employee is married, or must it instead look to Virginia's laws for that determination? The latter interpretation would appear to add a good dose of complexity to an employer's administrative responsibilities. Other tax issues that future IRS guidance might address include the extent to which an employer may or must correct previously filed W-2 forms where benefits were provided to a same-sex spouse on a taxable basis, procedures for correcting employment taxes in those situations, and the spousal consent requirements applicable to 401(k) and pension plans.

Until the IRS issues guidance, employers may want to hold off on implementing changes in response to the *Windsor* decision. An employer who acts earlier may find itself having to implement changes in payroll and benefits administration -- not once but twice -- and perhaps on a retroactive basis where it may not have otherwise been required. In the meantime, employers should review those benefit plans and programs that provide spousal benefits to determine which documents, policies and procedures, employee communications, etc. are impacted by *Windsor*.

Health and Welfare: First Round of Employers' and Insurers' "PCORI Fees" Due July 31

Garrett Fenton and Fred Oliphant

Most employers that sponsor self-funded group health plans, and insurers of fully-insured group health plans, will need to file and pay by **July 31, 2013**, their first round of federal comparative effectiveness research fees imposed under the Patient Protection and Affordable Care Act ("PPACA"). PPACA established the annual fee -- which is known as the "PCORI fee" -- in order to fund comparative clinical effectiveness research to be conducted by the newly-established, non-profit "Patient-Centered Outcomes Research Institute."

The amount of the fee is $1 for each individual covered under the group health plan, for the first plan year ending on or after October 1, 2012 (*i.e.*, 2012, for a calendar-year plan), and must be reported on IRS Form 720 and paid by no later than July 31 of the calendar year following the end of the relevant plan year (*i.e.*, by July 31, 2013, for a calendar-year plan). The amount of the fee will increase to $2 per covered individual for the following plan year, and will be increased further for inflation in subsequent years. The fee is scheduled to expire with the last plan year ending before October 1, 2019, meaning the last fee for a calendar-year plan will need to be filed and paid (for the 2018 plan year) by July 31, 2019. The IRS Office of Chief Counsel recently confirmed that PCORI fees paid by an employer or insurer are tax-deductible, as ordinary and necessary business expenses, under section 162 of the Internal Revenue Code.

The IRS issued final regulations implementing the PCORI fee last December. The regulations include detailed rules regarding the methods by which an employer or insurer may count enrollees under a group health plan for each year, and provide exemptions for certain types of plans and special rules for employers that sponsor multiple plan options. We understand that there has been some confusion among employers regarding the application of the PCORI fee to health flexible spending arrangements ("health FSAs") and health reimbursement arrangements ("HRAs").

As an initial matter, most employer-sponsored health FSAs (but not necessarily HRAs) qualify as "HIPAA-excepted," and are therefore exempt from the PCORI fee. But in some instances -- generally, where the employer makes additional, substantial "non-elective" or "matching" contributions to its employees' health FSAs (or does not offer its employees a primary, major medical plan option in addition to the health FSA) -- the HIPAA-excepted exemption does not apply, meaning the fee will be imposed on the health FSA (perhaps subject to additional, special rules set forth below).

Where an employer offers a *fully-insured* primary group health plan along with an "integrated" HRA (or non-HIPAA-excepted health FSA), two separate PCORI fees will be imposed: the employer/plan sponsor will owe one fee for the HRA or health FSA, and the health insurer will owe a separate fee for the fully-insured primary plan. By contrast, where an employer offers a *self-insured* group health plan along with an integrated HRA (or non-HIPAA-excepted health FSA), a single fee will generally be imposed on the employer, for each employee covered under both the primary plan and the HRA (or health FSA), provided that the primary plan and HRA (or health FSA) have the same plan year.

The IRS recently updated the Form 720 (and related instructions) -- which some employers already file, on a quarterly basis, to report certain federal excise taxes -- to reflect the PCORI fee. Third party service providers, such as third party administrators, will not be allowed to file the Form 720 on behalf of a responsible entity. Therefore, employers sponsoring calendar year, self-funded group health plans (and insurers of calendar-year, fully-insured plans) must be prepared to complete and file the Form 720, and pay their first round of PCORI fees, by July 31.

Health and Welfare: Administration Announces Delay of Employer "Pay-or-Play" and Reporting Requirements

Fred Oliphant, Eva McComas and Garrett Fenton

Last week, Treasury Department and White House officials announced, somewhat informally, that they were delaying by one year any enforcement of the employer shared responsibility (or "pay-or-play") and related employer reporting requirements under the

Patient Protection and Affordable Care Act ("PPACA"). Under PPACA's pay-or-play provisions, certain "large" employers with 50 or more "full-time employees" may be subject to an excise tax penalty for 2014, with respect to the health coverage they offer their employees in certain circumstances.

Separate but related PPACA provisions require employers that offer their employees minimum essential coverage (as well as insurers, in the case of fully-insured plans) to report detailed information about that coverage to both the IRS and all full-time employees and other covered individuals. The reporting requirements were scheduled to begin applying to the 2014 calendar year, with the first reports being issued in early 2015.

The Treasury Department and White House announced on July 2 that the information reporting requirements would be delayed by one year. As the result of the transitional relief for the reporting requirements, it would be impractical to determine which employers owed shared employer responsibility payments for 2014. Accordingly, no pay-or-play excise taxes will apply until 2015.

Treasury promised to publish within the week formal guidance concerning this transition relief. The Treasury Department also indicated that it intends to issue proposed rules implementing the reporting requirements later this summer. Presumably this will be followed at some point by final regulations implementing the pay-or-play provisions.

Health and Welfare: Supreme Court Decision Reinforces the Importance of Clear Plan Terms

Gary Quintiere, Fred Oliphant and Michael Chittenden

Recently, the Supreme Court issued a Solomon-like decision that, from the petitioner's perspective, could be viewed as winning the battle but losing the war. In *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the Court issued two holdings: the first holding (rendered unanimously) declared that where a health plan sues for "appropriate equitable relief" to enforce the terms of the plan, the unambiguous terms of the plan may not be overridden by equitable principles seeking to avoid unjust enrichment[1]. The second holding (decided 5-4) took from the petitioner, US Airways, the bounty provided by the first, stating that because the relevant plan provision was silent as to the "costs of recovery," equitable principles may be used in assisting the court in the proper interpretation of that plan provision.

One the one hand, plan sponsors should be heartened by *McCutchen*, inasmuch as its first holding delivers a clear affirmation of a position advocated by sponsors for years, namely, that the express terms of a plan should be paramount in all cases. On the other hand, sponsors should view the second holding with concern, given that it seems to ignore the clear wording of the relevant provision, the concession by McCutchen as to the unambiguous meaning of the provision, and the traditional deference owed to a plan administrator's interpretation of the terms of its own plan.

Background

James McCutchen, a participant in the US Airways, Inc. Health Benefit Plan (the "Plan"), was badly injured in a car accident, resulting in the Plan paying $66,866 in medical claims. The Plan's recovery provision required the participant to reimburse the Plan for amounts paid for medical claims out of "any monies recovered from [a] third party." McCutchen brought suit against the negligent driver and settled his claims for $110,000. McCutchen's attorney received a 40% contingency fee, leaving McCutchen with a net recovery of $66,000.

US Airways, as Plan Administrator, sought reimbursement from McCutchen for the full $66,866 paid by the plan. When McCutchen refused, US Airways brought suit under section 502(a)(3) of ERISA seeking reimbursement. The district court held that the Plan was entitled to full reimbursement. On appeal, McCutchen argued that the Plan's recovery should be limited by equitable principles regardless of Plan language requiring full reimbursement. The Third Circuit reversed the district court holding that the award of more than the net recovery violated equitable principles and constituted a windfall to the Plan, which elected not

to exercise its subrogation rights nor contribute to McCutchen's cost of recovery (*i.e.*, his attorney fees).

Supreme Court Decision

On appeal from the Third Circuit, US Airways argued that the unambiguous terms of the Plan governed and that the Plan was entitled to full reimbursement. The fact that McCutchen was being asked to pay $66,866 when his net recovery was only $66,000 (thus, requiring him to pay $866 "out of his own pocket") was considered by US Airways to be irrelevant. McCutchen argued that any reimbursement to the Plan should be limited by equitable principles designed to avoid unjust enrichment. He argued that the principle of "double recovery" (that would have restricted the Plan's recovery to that portion of the settlement allocated to "medical expenses") and the "common-fund doctrine" (that would have required the Plan to absorb its share of his attorney fees) should apply regardless of the unambiguous terms of the Plan's recovery provision.

The Court rejected McCutchen's argument that equitable principles could override the explicit terms of an ERISA plan. In this respect, the court found that the Plan's recovery provision was sufficiently clear to abrogate the double-recovery rule. However, in spite of language in the recovery provision permitting the Plan to seek reimbursement from "any monies recovered" from a third party and notwithstanding McCutchen's concession as to the unambiguous meaning of this provision, the Court held that the provision's silence with regard to the specific issue of attorney fees rendered the terms ambiguous such that the Court could use the common-fund doctrine to "inform" its reading of the provision.

The Court seemed to view this result as fair to both parties: McCutchen should not be required to bear the full burden of his attorney fees since to do so would give US Airways "the fruits [of McCutchen's recovery] while contributing nothing to the labor." Furthermore, it doubted that US Airways would want it that way because "[w]hen the next McCutchen comes along, he is not likely to relieve US Airways of the costs of recovery" by bringing his own lawsuit. In this regard, the Court seems to forget that US Airways litigated the case to the highest level for a relatively meager amount solely to make the point that the Plan had the right to reimbursement from "any monies" recovered by a participant, including monies allocated to the participant's attorney's fees.

Plan Sponsor Considerations

This case holds two points of consideration for plan sponsors: one general and one specific.

The general consideration is to make reasonable efforts to eliminate ambiguities from your plans. While the English language is capable of conveying great clarity, there is no way to accomplish this task with perfection. Nonetheless, it is a worthwhile effort because if major issues can be identified and addressed, the plan's interests will be better protected.

The specific consideration is whether the subrogation and recovery provisions in your health, life, and disability plans are written in the manner you intend. Although Justice Kagan's reasoning in *McCutchen* may be viewed as questionable, her point regarding the competing interests of the employer-sponsor and the participant is well taken: if the an employer wishes to encourage its employees to seek recovery for injuries suffered at the hand of another (in lieu of exercising its subrogation rights), the plan provisions should give employees some incentive for doing so. Otherwise, if employees seeking recovery will be exposed to incurring a "net loss" (like McCutchen was), they will no longer be inclined to serve as the "collection agent" for the plan.

[1] In this respect, we note that the unambiguous terms of the "plan" were, in reality, the terms included in the summary plan description. For whatever reason, the plan document did not come to light until the Supreme Court proceeding. In Justice Kagan's view, this was "too late to affect what happens here," thus prompting her to conclude that "[b]ecause everyone in this case has treated the language from the summary description as though it came from the plan, we do so as well."

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