Looming Deadline for Another ACA Fee; Treasury Guidance on Employer-Provided Meals; Allocation of After-Tax Amounts to Rollovers; Appeals Decisions We Are Watching

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Health and Welfare: Looming Deadline for Another ACA Fee

Allison Rogers and Fred Oliphant

By November 15, 2014, contributing entities, which generally include all health insurance issuers and self-funded group health plans,[1] must register and report enrollment data on Pay.gov and ultimately pay the transitional reinsurance fee (TRF) by January 15, 2015 (if the contributing entity elects to pay the TRF in one installment) or January 15, 2015 and November 15, 2015 (if the contributing entity elects to pay the TRF in two installments). The TRF is part of the Transitional Reinsurance Fee Program, which is one of three programs, in addition to the Risk Adjustment and Risk Corridors Programs, designed to stabilize premiums and mitigate the potential side effects of adverse selection in the individual and small group markets. While the definition of a contributing entity encompasses the individual, small group and large group markets, HHS will distribute the collected TRF contributions only to certain non-grandfathered plans in the individual market.

Sponsors of self-insured health plans may have had a general awareness of this fee since preparing for the Patient-Centered Outcomes Research Institute (PCORI) fee (*i.e.*, the other *per capita* fee); however, the TRF is substantially greater ($63 per enrollee per year in 2014) and has some unique challenges. The good news is that it only lasts three years (2014-2016) and will decrease each year.

Identified below are some less obvious factors to consider when preparing to remit the fee:

- Sponsors of self-insured health plans may need to report and pay the fee themselves despite having an arrangement with a third-party administrator (TPA) or administrative services only (ASO) contractor;

- To avoid overpayment, contributing entities that cover the same covered life may need to determine who is ultimately responsible for the TRF;

- The method of payment may be administratively complicated and require contributing entities to take certain steps to prepare;

and

- Some technical questions remain and may be clarified in additional forthcoming guidance.

Contributing Entity is Ultimately Responsible for the TRF

A "reporting entity" -- which can be a contributing entity, TPA or ASO contractor -- will carry out the steps for the TRF contribution process. However, the contributing entity, and only the contributing entity, is responsible for reporting and paying the TRF. This means that if the contributing entity does not pay the reinsurance contribution on time, the amount owed will be treated as a determination of debt, subject to the federal debt collection rules and potentially the False Claims Act.

While a contributing entity may delegate its responsibilities to a TPA or ASO contractor, there is nothing in the TRF rules that *requires* a TPA or ASO contractor to agree to accept the responsibility. This is particularly relevant for the 2014 year because many TPAs, uncertain about the specifics of the remittance process, were hesitant to commit to offer this service. However, to the extent a contributing entity delegates its responsibilities, it should recognize that the contract and state law (rather than HHS and federal law) govern the arrangement and therefore negotiate and contract for any necessary protections.

One TRF Payment per Covered Life

HHS does not require contributing entities to pay the TRF more than once with respect to the same covered life. This means that if an employer provides group health coverage to an individual (1) who has individual market coverage for which reinsurance contributions are required, or (2) who has coverage under another group health plan that is primary for which the reinsurance contributions are required, the contributing entity need not make contributions on behalf of that individual. In regard to the situation of two group health plans -- if the terms of the plans do not clarify which plan is primary versus supplemental -- the plan that offers the greater portion of inpatient hospitalization benefits will be considered primary. However, if it is still not clear, HHS will rely on an arrangement between the two plans in accordance with applicable state coordination of benefits laws. Importantly, HHS will not hold a plan sponsor liable for failing to pay reinsurance contributions if it relied in good faith upon a written representation by the other sponsor that the latter's coverage would be primary (and thus responsible for making reinsurance contributions with respect to those covered lives). We recommend maintaining such a representation (in addition to all other relevant TRF documents and records) for at least 10 years to comply with HHS's TRF substantiation requirements and to prepare for a potential audit.

These rules can be illustrated by the following examples:

Example 1: A works for Employer B and is covered under Employer B's major medical plan. A's spouse works for Employer C and A is covered as a dependent under Employer C's self-insured supplemental health plan. The supplemental health plan reimburses a portion of A's out-of-pocket expenses when A visits an out-of-network doctor under A's major medical plan. Employer B's health plan would be primary to Employer C's supplemental health plan and would have to pay the TRF on behalf of A.[2]

Example 2: A is covered under Employer B's major medical plan and as a dependent under Employer C's major medical plan. It is not clear which Employer's plan pays the greater portion of inpatient hospitalization benefits. However, Employer C's health plan specifies that to the extent it covers a dependent and that dependent is covered as an employee under another employer's health plan, it will pay secondary to the other plan. Employer B's health plan does not have a coordination of benefits provision. Employer B and Employer C agree in writing that Employer B's health plan is primary and thus responsible for the TRF for A. Employers B and C should maintain all documentation (for at least 10 years) that demonstrates that Employer B is primary.

Notably, although this provision provides some relief from the TRF, some plan sponsors may find that the necessary information to

determine whether a plan is supplementary or secondary is not readily available to the plan sponsor. Therefore, to the extent this rule would be expensive or impracticable to administer, the plan sponsor may decide to pay the fee on behalf of an individual regardless of whether another contributing entity may *actually* be responsible for making the contribution.

Payment Method

Centers for Medicare & Medicaid Services (CMS) has clarified that TRF contributions may be made *only* on Pay.gov using an Automated Clearing House (ACH) payment. Significantly banks, via an ACH Debit Block security feature, often block automatic debits from a business account. To overcome this feature, a reporting entity would have to contact its bank to add an allowed list of ACH company IDs to enable debits. These company IDs, when working with the U.S. government, are known as the Agency Location Code (or the ALC+2 value). The ALC+2 value for the TRF program is 7505008015. Reporting entities should make these arrangements in advance of the TRF contribution process to avoid any unnecessary errors and delays.

In other words, although some contributing entities may object to providing the government access to their bank account, an ACH transfer through Pay.gov is the *only* method of payment of the TRF. Despite complaints to HHS, the Agency has not yet suggested that it intends to modify the payment method in future years.

Future Guidance Pending

Finally, HHS has released a substantial amount of guidance outside of the rulemaking process that has clarified the TRF program and the steps to remit the TRF. While this guidance has been helpful, some questions have yet to be answered. For example, there may be technical questions regarding the Pay.gov TRF enrollment count and submissions form, which has yet to be released. Additionally, it is not entirely clear how corporate transactions affect the TRF (*e.g.*, who would be the contributing entity if the plan terminates mid-year or the participants under a plan are transferred to another plan). We expect HHS to issue additional guidance at least informally addressing these questions -- however it is important to recognize and appropriately analyze these gray areas to help avoid any incorrect assumptions that could lead to potentially avoidable penalties.

Summary To Do List

We recommend that contributing entities continue to prepare for compliance with the TRF Program because remitting the fee is a multistep process that requires coordination and decision making. Below we identify some of these important considerations:

- Identify which coverage is subject to the TRF and which coverage is excepted from the TRF;
- Choose a covered lives counting method;
- Identify any individuals who may be covered under more than one plan and determine which plan is responsible for the TRF on behalf of those individuals;
- Estimate funds necessary to cover the TRF;
- Deposit sufficient funds in the relevant bank account that will be used to remit the TRF;
- Contact the bank to add the TRF's ALC+2 value to ensure that the bank's ACH Debit Block security feature does not prevent or delay remittance;

- Evaluate whether the contributing entity will pay the TRF in one or two installments;

- Decide who will serve as the reporting entity and contract for any necessary protections;

- Ensure that a system is in place to maintain all documents and records necessary to substantiate the contributing entity's enrollment count for at least 10 years.

Fringe Benefits: Treasury Guidance Plan Indicates Focus on Employer-Provided Meals as Audit Activity Continues

Michael Chittenden and Marianna Dyson

The 2014-2015 Priority Guidance Plan recently released by the Treasury Department indicates that increased scrutiny continues in the area of employer-provided food. The plan indicates that guidance related to employer-provided meals under sections 119 and 132 of the Internal Revenue Code will be issued in the coming fiscal year. Section 119 relates to the older exclusion for meals provided for the convenience of the employer, whereas section 132 refers to the de minimis fringe benefit exclusion for company cafeterias or other subsidized eating facilities added by section 132(e)(2) in 1984. The issue appears to be coming to a head following an increase in IRS audit activity focusing on meals.

Recent events are not the first time that the IRS has focused on the issue. In the 1990s, a flurry of audit activity was directed at the provision of discounted or free food provided at eating facilities on employers' business premises. The decade closed with Boyd Gaming's successful litigation regarding the deductibility of free meals provided to its casino employees and statutory amendments to sections 119 and 132 to incorporate Boyd Gaming's position. See *Boyd Gaming Corp. v. Commissioner*, 106 T.C. 343 (1996) and T.C. Memo. 1997-445, *aff'd*, 177 F.3d 1096 (9th Cir. 1999); sections 119(a)(4) and 132(e)(2)(flush language).

Recent press reports about generous meal benefits being provided to employees in Silicon Valley may have resulted in increased IRS audit activity. Put simply, IRS examiners are extremely skeptical about the motivation of employers to provide free or discounted food, which makes employers who operate company-provided eating facilities vulnerable to examination. Despite the IRS's suspicion regarding the long-standing practice, the Code clearly permits free or discounted meals in various contexts.

Under section 132(e)(2) of the Code, if a company eating facility generates annual revenues that equal or exceed the facility's "direct operating costs" (as defined by the regulations), the value of any discount on the meal qualifies for exclusion as a de minimis fringe benefit. For purposes of this test, employers may exclude the costs and revenues attributable to meals provided for the employer's convenience under section 119 -- a standard that is narrowly interpreted by the IRS. Moreover, a for-profit employer with an eating facility qualifying for exclusion under section 132(e)(2) may deduct the full cost of providing meals, whereas employers providing meals under section 119 may only deduct half of the cost.

In recent years, many employers in the high-tech industry have routinely made meals available to their employees through the use of company-provided cafeterias, which employers have argued are excluded from income under section 119. This is particularly true whenever the employer's business premises are in campus settings and thus local eateries are not readily accessible. Employers have typically asserted that the time required for employees to reach their vehicles, travel to a nearby restaurant, eat, and return is too long for employees' lunch breaks and too great a drain on productivity.

When more than half of the meals provided through an employer-provided dining facility are excluded under section 119, the entire

cost of the facility may be deducted under section 274(n)(2)(B) if the facility otherwise qualifies as an employer-operated eating facility under section 132(e)(2). This is the result of interplay between the two exclusions. Under section 119, if more than half of the meals provided through an employer-provided dining facility are excludable under section 119, all of the meals are considered provided for the convenience of the employer. Under section 132(e)(2), an employee is treated as though he or she paid an amount equal to the cost of providing a meal if it is excludable under section 119. Accordingly, free or discounted meals provided to employees through an employer-operated eating facility are fully excludable from employees' wages under section 132(e)(2) and fully deductible under section 274(n)(2)(B) if at least half of the meals provided are excludable under section 119. The trend toward healthier and more expensive dining options has drawn increasing interest from the IRS as this interplay creates the potential for substantial amounts of -- what the IRS alleges is -- additional compensation that is both deductible by the employer and nontaxable to the employees.

The appearance of an item on Treasury's most recent Priority Guidance Plan clearly signals the IRS's decision to counter employers' position that free and discounted meals do not constitute additional wages for payroll tax purposes. Although some items may remain on the Guidance Plan far beyond the intended date for issuing new regulations, employers with eating facilities should review the related costs and be prepared to respond to continuing IRS audit activity.

Qualified Plans: Allocation of After-Tax Amounts to Rollovers - IRS Changes Its Position

Austen Townsend and Anthony Provenzano

On September 18, 2014, the IRS released Notice 2014-54 (Notice), which permits 401(k) plan [3] participants who elect to directly roll over their entire 401(k) plan account balance, made up of both pre-tax and after-tax amounts, to two or more eligible retirement plans to direct how these amounts are allocated among the plans. The Notice reverses the IRS's prior position, set forth in Notice 2009-68, that required the application of the *pro-rata* rule, set forth in section 72(e)(8) of the Internal Revenue Code (Code), as amended, when pre-tax and after-tax amounts were directly rolled over from a 401(k) plan but split across multiple destination accounts. The new allocation rules officially take effect for distributions made on or after January 1, 2015. However, the IRS has indicated that, prior to the effective date, it would be reasonable for plan administrators to apply the new allocation rules for distributions between the date of the Notice and December 31, 2014, as well as for distributions that have occurred previously, except for pre-September 18th, 2014 distributions from designated Roth accounts, which must follow the separate distribution requirement.

Old Rules -- *Pro-Rata* Allocation

Prior to the Notice, when a participant elected to directly roll over the entirety of his 401(k) plan account to two or more accounts, the plan was required to carve up the after-tax amounts on a *pro-rata* basis among all accounts as illustrated below:

Example: Participant has an account balance of $100,000 in his 401(k) plan, $20,000 of which consists of after-tax funds. He elects to directly roll over $80,000 to a traditional IRA and $20,000 to a Roth IRA. Because 20% of the funds in his 401(k) plan account were after-tax, 20% of each destination account (*i.e.*, the traditional IRA and the Roth IRA) would be after-tax. In other words, the rollover to the traditional IRA would consist of $64,000 of pre-tax and $16,000 of after-tax amounts, and the rollover to the Roth IRA consists of $16,000 of pre-tax and $4,000 of after-tax funds. Thus, although $20,000 of the amount rolled over was contributed to the 401(k) plan on an after-tax basis, the application of this *pro-rata* rule results in $16,000 being treated as reportable income as a Roth conversion.

New Rules -- Participant-Directed Allocation

Under the new allocation rules, a participant may now direct how to allocate his pre-tax and after-tax direct rollover amounts, provided he informs the plan administrator of his desired allocation prior to the time the direct rollovers are made.

Example: Same facts as above. Prior to the time the direct rollover is made, the participant informs the plan administrator that he wishes to roll all of the $80,000 contributed to the 401(k) plan on a pre-tax basis to the traditional IRA and all of the $20,000 contributed to the 401(k) plan on an after-tax basis to the Roth IRA. As a result, none of the amounts will be reportable as income to the participant.

Under the Notice, however, if a participant elects to receive only a partial distribution of his 401(k) plan account balance, the *pro-rata* rules under Code section 72(e)(8) still apply to determine the amount coming out of his account, as illustrated below:

Example: Participant has an account balance of $100,000, including $20,000 of after-tax funds. He requests a $20,000 distribution. In this case, the distribution is treated as $16,000 of pre-tax and $4,000 of after-tax amounts. Under the Notice, the participant is permitted to allocate the $16,000 to a traditional IRA and the $4,000 to a Roth IRA. However, in order to roll over all of his after-tax amounts (*i.e.*, $20,000) to a Roth IRA, he must elect to receive a distribution of his entire $100,000 account balance.

Implications for Employers

Although the elimination of the *pro-rata* allocation rule for direct rollovers of pre-tax and after-tax amounts is technically new, in practice, many employers already effectively administer rollovers in this manner. The IRS's assertion that it is reasonable to apply the new allocation rules retroactively (except in the case of distributions from designated Roth accounts) should give such employers comfort. As a result of the new rules, which make after-tax contributions to a 401(k) plan more appealing as a tax-efficient retirement savings strategy, employers that allow after-tax contributions in their 401(k) plans should anticipate an increase in after-tax contributions. Participants who make after-tax contributions to a 401(k) plan get the benefit of tax-deferred growth on the assets so long as they remain in the plan and, under the Notice, also get the ability to convert those after-tax funds to a Roth IRA to produce tax-free growth in the future.

In addition, employers should review their distribution election forms and rollover notices to ensure that the new rules are adequately described and that participants are given an opportunity to communicate their desired allocation prior to the direct rollover.

ERISA Litigation: Appeals Decisions We Are Watching

Michael Khalil and Anthony Shelley

The odds against having a case heard by the U.S. Supreme Court are high. Nonetheless, the Court loves ERISA cases, and can usually be counted on to take at least one such case for review every year. Here's a round-up of three appeals cases that are on our radar as potential *cert* grants this coming term.

Tibble v. Edison

On August 19, 2014, the Solicitor General's office urged the Supreme Court to grant review of *Tibble v. Edison International*, 729 F.3d 1110 (9th Cir. 2013). *Tibble*, decided by the Ninth Circuit in 2013, is another of the so-called fee cases, involving class action allegations that the defendants breached their fiduciary duties by including as investment options retail mutual funds that charged high fees but participated in revenue-sharing arrangements with the plan sponsor. The plaintiffs' claims were dismissed by the district court, and the dismissal was then upheld by the Ninth Circuit. Both courts held that the participants' claims were time-barred by ERISA's six-year limitations period, in that the complaint had been filed more than six years after the defendants had originally placed plan assets in the higher-fee mutual funds. Both courts also held that the defendant's views as to the meaning of plan terms were entitled to deference. The plaintiffs filed a petition for *certiorari* with the Supreme Court in October 2013, presenting two questions:

(1) Does ERISA's statute of limitations immunize 401(k) plan fiduciaries for retaining imprudent investments that continue to cause the plan losses if the funds were first included in the plan more than six years ago; and (2) whether *Firestone Tire & Rubber Co. v. Bruch* deference applies to fiduciary breach actions under 29 U.S.C. §1132(a)(2), where the fiduciary allegedly violated the terms of the governing plan document in a manner that favors the financial interests of the plan sponsor at the expense of plan participants.

In March 2014, the Court requested that the Solicitor General (SG) file a brief stating the government's position on whether *certiorari* should be granted. In arguing for review, the SG argued that review was warranted on the first question in light of the circuit split on the issue (with the Second and Seventh Circuits in conflict with the Fourth, Ninth, and Eleventh) but argued that the Court should decline to review on the second question. The petition was among many up for consideration at the Court's conference on September 29, 2014, and it is expected that the Court will begin announcing the conference results shortly. The case is docketed as *Glenn Tibble, et al., v. Edison International, et al.* , Case No. 13-550.

Tussey v. ABB

In March of this year, the Eighth Circuit issued a widely anticipated decision in *Tussey v. ABB, Inc*., Case Nos. 12-2056, 12-2060, 12-3794, and 12-3875 (8th Cir. March 19, 2014). The decision was a mixed result for the ERISA defense bar: It affirmed the lower court's $13.4 million judgment against the plan fiduciaries for breaching their fiduciary duties to monitor and control record-keeping fees; it vacated the district court's $21.8 million judgment against ABB on class action claims that challenged the plan's investment options and its so-called "mapping" of plan assets, finding that the district court failed to accord the proper deference to the fiduciaries' interpretation of plan terms; and it reversed the $1.7 million judgment against Fidelity (the plan record keeper) regarding Fidelity's retention of "float" income earned while holding plan contributions and disbursements in overnight accounts, holding that the float interest was not a plan asset.

Both plaintiffs and the ABB defendants sought rehearing, which the Eighth Circuit denied in May. On August 5, 2014, plaintiffs filed a petition for *certiorari* seeking review of the Eighth Circuit's decision. The question presented in the plaintiffs' petition is whether a court should defer to fiduciaries of a retirement plan governed by ERISA when plan participants allege and prove that those fiduciaries breached their statutory duties of loyalty and prudence. Responses to the petition are due on October 6, 2014, meaning that the case will likely be considered in early November. The case is docketed as *Ronald C. Tussey, et al. v. ABB, Inc., et al.* , Case No. 14-130.

Blue Cross Blue Shield of Michigan v. Hi-Lex

In May, the Sixth Circuit issued a ruling in *Hi-Lex v. Blue Cross Blue Shield of Michigan* , Case 13-1773 (6th Cir. May 14, 2014), affirming the district court's judgment against the defendant third-party administrator (TPA) on ERISA breach of fiduciary duty and prohibited transaction claims. The Sixth Circuit found that the TPA in question was an ERISA fiduciary because it exercised control over plan assets. In August, the defendant filed a petition for *certiorari*, presenting two questions: (1) whether a service provider that contracts with an employer to provide services to an ERISA plan exercises "control" over "plan assets" when the service provider contracts with the employer for its compensation and elects to exercise its contractual right to receive that compensation; and (2) whether under ERISA § 408, a provider of services to an ERISA plan can be held to have violated § 406(b) in receiving only "reasonable compensation" for its services.

The Sixth Circuit's ruling has generated significant concern in the ERISA service provider industry, and on September 15, 2014, the Blue Cross Blue Shield Association, America's Health Insurance Plans, and the Pharmaceutical Care Management Association filed an *amicus* brief supporting *certiorari* (note: Miller & Chevalier is counsel for the *amici*). In their brief, the *amici* assert that the Sixth Circuit's fiduciary analysis will subject TPAs and other service providers to tremendous uncertainty as to their fiduciary status, and will threaten to increase exponentially the number of entities deemed to be ERISA fiduciaries. The petition should be distributed for conference in October. The case is docketed as *Blue Cross Blue Shield of Michigan v. Hi-Lex* , Case No. 14-168.

1. For the 2015 and 2016 calendar years only, a contributing entity does not include a self-administered and self-funded plan. *See* 45 C.F.R. § 153.20 (definition of "contributing entity").

2. Additionally, Employer C's self-insured supplemental health plan would not be required to pay the TRF on behalf of its enrollees because it does not provide major medical coverage. Any plan or coverage that is not considered "major medical coverage" is exempt from the TRF requirement. *See* 45 C.F.R. § 153.400(a)(1)(i).

3. The Notice also applies to disbursements from a 403(b) plan or a 457(b) plan maintained by a governmental employer described in Code section 457(e)(1)(A).

For more information, please contact:

Fred Oliphant, foliphant@milchev.com, 202-626-5834

Anthony Provenzano, aprovenzano@milchev.com, 202-626-1463

Anthony Shelley, ashelley@milchev.com, 202-626-5924

Michael Chittenden*

Marianna Dyson*

Michael Khalil*

Allison Rogers*

Austen Townsend*

**Former Miller & Chevalier attorney*