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This newsletter briefly discusses several recent developments in employee benefits and executive compensation that may be of interest. For more details on any item reported herein, please contact any member of Blank Rome's Employee Benefits and Executive Compensation Group.

Recent Developments In Employee Benefits And Executive Compensation

Supreme Court Reinforces Deferential Standard Of Review For Erisa Plan Administrators

Federal courts will continue to defer to the decisions of plan administrators, even after the plan administrator makes a "single honest mistake" in administering or interpreting the plan, according to the Supreme Court's decision in *Conkright v. Frommert* on April 21, 2010.

BACKGROUND

Plaintiffs retired from Xerox Corporation in the 1980's and received lump-sum distributions of benefits from the company's pension plan. Plaintiffs were later rehired by Xerox and upon rehire, the plan administrator was required to calculate the effect of the lump-sum distributions on future benefit accruals, a subject on which the plan document was silent. The plan document did, however, give the administrator broad discretion in making decisions relative to the plan, and in exercising such discretion, the administrator applied the so-called "phantom-account" method to account for previous distributions. Plaintiffs sued, challenging the phantom-account method as unreasonable and for failure by the administrator to provide adequate notice.

In *Firestone v. Bruch* (1989), the Supreme Court held that the reasonable decisions of an ERISA plan administrator must be honored where the plan document gives the administrator discretionary authority to interpret the plan. In other words, if the plan includes the magical words evidencing discretionary authority, a court may not substitute its interpretation of the plan document for the administrator's. Relying on *Firestone,* the District Court deferred to the administrator's interpretation. On appeal, the Second Circuit Court of Appeals ruled that the administrator's interpretation violated ERISA's anti-cutback provision, sending the case back to the District Court, which applied its own interpretation of the plan document, ignoring a new interpretation proffered by the administrator. The Court of Appeals affirmed, creating an exception to *Firestone*. In recognizing this exception, the Court of Appeals ruled that where a plan administrator errs in interpreting the plan provision in one instance the deferential standard is lost with respect to that provision.

SUPREME COURT HOLDING

The Supreme Court rejected the Second Circuit's "one-strike-and-you're-out," holding instead that the District Court should have deferred to the plan administrator's new interpretation of the plan. The Court stated that in the ERISA context, a "single honest mistake" by a plan administrator does not justify a denial of the deferential standard of review in judicial proceedings.

Comment: The key to the Firestone and Conkright decisions was that the plans clearly gave discretionary interpretive authority to the plan administrators. All ERISA plans should be reviewed to make sure that such authority exists and that the plan administrator is clearly identified.

Tri-Agency Guidance Issued On Health Care Reform

The Internal Revenue Service has issued guidance addressing (1) the taxation of health benefits provided by employers for children through the year prior to a child's attaining age 27 and (2) the tax credit available for health care premiums paid by small employers. In addition, the Departments of the Treasury, Labor, and Health and Human Services have collectively published interim final regulations regarding the mandate to provide coverage of "dependent children" up to the age of 26.

DEFINITION OF "DEPENDENT" FOR PURPOSES OF MANDATED COVERAGE

Neither a group health plan nor a group insurance issuer are required to offer coverage of dependents or children of employees. However, the recently enacted Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively

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"Health Care Reform") require that if the plan provides "dependent coverage of children" such coverage must be made available for any "dependent child" up to the age of 26. The interim final regulations define "dependent child" simply as a child of the employee and make clear that coverage must be made available regardless of "dependent" status under the Internal Revenue Code or other traditional markers of dependent status such as student status, financial support, employment or marriage.

Comment: *Since these interim final regulations are applicable to all group health plans and group insurance contracts, including so-called grandfathered plans, each employer must amend its plan to reflect the elimination of the traditional dependency requirements effective January 1, 2011(for calendar year plans) and perhaps sooner for non-calendar year plans. The expansion will also eliminate the need to complete dependent eligibility forms and dependent audits for any employee's child who has not attained age 27.*

The interim final regulations also provide for transition rules with respect to children who have not attained age 27 but who are no longer eligible for coverage because of their age and/or they are not a "dependent." The child must receive notice of the ability to enroll and must be provided with a special enrollment period of not less than thirty (30) days. A notice to the parent of the child regarding this special enrollment opportunity is treated as notice to the child. The enrollment opportunity must be provided not later than the first day of the first plan year that begins on or after September 23, 2010. A child subject to this enrollment period is treated as a "special enrollee" and must therefore be provided the opportunity to elect enrollment in any of the health plan options available under the particular group health plan or insurance policy. In addition, the parent of such child must be given the opportunity to enroll if that parent had not originally elected coverage, but now elects to do so in order to permit the child to enroll. After the initial transition period, children may be required to enroll during the open enrollment period applicable to the group health plan or insurance policy. The interim final regulations also prohibit a group health plan or insurance policy from charging a greater premium for the coverage of a dependent.

Comment: *The interim final regulations confirm that a child did not have to be covered prior to the enactment of Health Care Reform in order to obtain coverage. If a child was never covered or was covered and then offered COBRA, the plan or policy must permit the child to re-enroll.*

Effective for plan years beginning on or after January 1, 2014, grandfathered plans may exclude dependents based upon the availability of other employer coverage. However, if both parents are eligible for employer coverage, such coverage does not constitute "other employer coverage" for purposes of the exclusion.

TAX TREATMENT OF HEALTH CARE BENEFITS PROVIDED TO CHILDREN UP TO THE AGE OF 27

IRS Notice 2010-38 provides guidance regarding the tax-free treatment of employer-provided health benefits. Health Care Reform extended such tax-free treatment to benefits provided by an employer for an employee's child through the end of the year in which the child attained age 26. Notice 2010-38 clarifies that the tax-free treatment applies to section 105 of the Internal Revenue Code (employer reimbursements of medical expenses) as well as section 106 of the Code (employer-provided coverage under a health plan). The IRS also clarified that it does not matter whether the adult child is married, employed or eligible for other employer coverage for purposes of the exclusion from gross income. The individual must be a child of the employee and must not attain age 27 within the year for the exclusion to apply.

In addition, the IRS is retroactively amending the proposed regulations under section 125 of the Code to permit cafeteria plans to treat a health plan as a qualified benefit even if it permits the inclusion of an adult child who has not attained age 27. Notice 2010-38 permits a cafeteria plan (including a flexible spending account) to be amended to permit a change to an employee's election as the result of an adult dependent child's becoming eligible for coverage as a result of the Health Care Reform mandate. Although cafeteria plans generally must be amended in advance of the effective date of any change, Notice 2010-38 permits an employer to operate the cafeteria plan in a manner consistent with the guidance and amend the plan later. Such amendment, however, must be adopted no later than December 31, 2010.

Comment: *Notice 2010-38 serves to clean-up some of the inconsistency and ambiguity created by Health Care Reform as it applies to the mandated for adult children. Although coverage is not mandated until the first plan year beginning on or after September 23, 2010, employers may want to consider earlier inclusion of adult children so that employees can take advantage of the exclusion from taxable income and provide health care for their children, especially in troubling economic times when many recent college graduates are having trouble finding jobs.*

SMALL BUSINESS HEALTH CARE TAX CREDIT

Health Care Reform provides for a tax credit equal to a percentage of the health insurance premium actually paid by an employer on behalf of employees electing to receive health care coverage. The IRS has provided guidance in the form of questions and answers to assist small businesses to determine eligibility for and the amount of the tax credit. Although the tax credit is available to tax-exempt organizations, this initial guidance applies only to taxable entities. The tax credit is only available to small employers, defined as any employer with fewer than 25 full-time equivalent employees averaging less than $50,000 in wages. The tax credit is graduated, beginning with the full credit granted to employers with fewer than 10 FTEs averaging less than $25,000 in wages. For taxable years beginning in 2011 through 2013, the tax credit is equal to 35% of the premiums actually paid by the employer. The tax credit increases to 50% for taxable years beginning in 2014. The IRS guidance clarifies how to calculate the number of FTEs, average wages, eligible expenses and the tax credit. Small businesses should keep in mind the following:

- The calculation of FTEs will include part-time, but not seasonal employees.
- Self-employed individuals, 2% shareholders in S Corporations, and 5% owners of the employer do not count as employees.
- The requirement that the employer pay a uniform percentage of not less than 50% of the premium for health care coverage

applies to employee-only coverage. An employer may charge a different amount for employee plus spouse or family coverage.
- Both the FTE and average wage calculation will reduce the available tax credit to the extent the calculation exceeds 10 FTEs and $25,000 respectively. Therefore a small employer could be ineligible for the tax credit altogether.

Comment: *Small employers that currently offer health care coverage, but do not pay 50% of the employee-only coverage should consider whether increasing the amount of the employer contribution would be offset by the tax credit.*

Cobra Subsidy Extended. . . . Again

On April 15, 2010, the President signed into law the third in a series of extensions to the Federal COBRA subsidy, which was initially enacted as part of the American Recovery and Reinvestment Act of 2009 ("ARRA"). The 15-month, 65%, federal subsidy would have expired on March 31, 2010. As a result of the Continuation Extension Act of 2010 ("CEA"), however, the COBRA subsidy is extended through May 31, 2010 and is retroactively effective to April 1, 2010.

For individuals who experienced a termination of employment on or after April 1, 2010 but before April 16, 2010, the CEA requires plan administrators to notify such individuals by June 15, 2010 of their ARRA rights (including the COBRA subsidy) and to allow them to elect COBRA coverage up to 60 days following receipt of such notice. As clarified by the prior extension, the COBRA subsidy is available both to individuals who experience an involuntary termination resulting in a loss of group health coverage and to those individuals who experience a loss of group health coverage due to a reduction in hours that is followed by an involuntary termination.

Comment: *Administration of COBRA continuation coverage has become increasingly challenging for employers and plan administrators due to the numerous extensions and notice requirements associated with the COBRA subsidy. To avoid the pitfalls of these challenges, employers and plan administrators should review their COBRA notice and practices to make sure they accurately reflect the most up-to-date COBRA subsidy requirements. Additional extensions to the COBRA subsidy are expected. Legislation is currently pending, which, if passed, could extend the COBRA subsidy through December 31, 2010.*

Final Tricare Incentive Prohibition Regulations Issued

On April 9, 2010, the Department of Defense ("DOD") issued final regulations regarding the TRICARE incentive prohibition. TRICARE is the DOD's health care program for military members, their families, or survivors. Under the TRICARE prohibition, employers are prohibited from offering TRICARE beneficiaries financial or other incentives not to enroll in (or to terminate enrollment in) employer-sponsored group health plans, which are primary to TRICARE. The final regulations confirm that the TRICARE incentive prohibition "applies in the same manner" as the prohibition against offering incentives under the Medicare Secondary Payer rules.

According to the final regulations, employers are precluded from offering TRICARE beneficiaries an alternative to the employer's group health plan unless:
- The beneficiary has primary coverage other than TRICARE; or
- The benefit is offered under a cafeteria plan under section 125 of the Internal Revenue Code and is offered to all similarly situated employees, including non-TRICARE-eligible employees; or
- The benefit is offered under section 125 of the Internal Revenue Code and, although offered only to TRICARE-eligible employees, the employer does not provide any payment for the benefit nor receive any direct or indirect consideration or compensation for offering the benefit; the employer's only involvement is providing administrative support for the benefit under the cafeteria plan, and the employee's participation in the plan is completely voluntary.

All employers, except those with less than 20 employees, are subject to the TRICARE incentive prohibition. Employers who violate the TRICARE incentive prohibition could be subject to a penalty of up to $5,000.00

Comment: *Employers subject to the TRICARE incentive prohibition should become familiar with the final regulations, which become effective June 18, 2010. Employers should further consider how the exceptions to the TRICARE incentive prohibition impact on their group health plans and interact with other laws applicable to such plans including ERISA, COBRA and HIPAA.* ■

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