HEALTH & WELFARE PLAN LUNCH GROUP

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ALSTON & BIRD LLP

One Atlantic Center
1201 W. Peachtree Street
Atlanta, GA 30309-3424
(404) 881-7885
E-mail: john.hickman@alston.com

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Employee Benefits & Executive Compensation ADVISORY ■

JANUARY 30, 2015

Notices of Employee Eligibility for Exchange Subsidies – What They Are and What You Should Do About Them

The Affordable Care Act[1] requires the ACA Exchanges (both state and federal) to send notices ("Exchange Notices") to employers regarding employees who purchase coverage through the Exchange and qualified for a subsidy.[2] To clarify from the outset, the Exchange Notices are not directly related to employer excise taxes under Section 4980H of the Internal Revenue Code. More specifically, the Exchange Notices, although they may make mention of such taxes, are not by themselves notification that the employer will be assessed excise taxes or other penalties of any kind.[3] Instead, the Exchange Notices are a part of the Exchanges' verification process regarding eligibility for subsidies. (For example, even small employers, to which excise taxes under Code Section 4980H do not apply, will receive these notices if they have employees who qualify for an Exchange subsidy.)

Who Will Receive Exchange Notices?

While the Department of Health and Human Services (HHS) has not provided specific guidance as to where the Exchange Notices will be sent (e.g., which employer location), it appears that the Exchange Notices will be sent to the employers at the addresses provided by employees during the Exchange coverage application process. Acknowledging that employees may provide incorrect contact information, the HHS has indicated that it will work with Exchanges and employers to develop a solution to ensure that Exchange Notices reach the correct employer.[4] The specific method by which the correct employer address is verified by the Exchanges (if at all) is yet unknown.

The HHS has also noted that for efficiency reasons, Exchanges can either send the Exchange Notices on an employee-by-employee basis as subsidy eligibility determinations are made or send it to employers for groups of employees.[5]

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1 Section 1411(e)(4)(B)(iii) of the Affordable Care Act; 45 C.F.R. 155.310(h).

2 That is, either an advance payment of premium tax credit or a cost-sharing reduction.

3 The "Section 1411 Certification" referenced in the regulations regarding Code Section 4980H excise taxes is a separate notice, to come from the IRS pursuant to 45 C.F.R. 155.310(i). See 26 C.F.R. 54.4980H-4(a) and -5(a); 26 C.F.R. 54.4980H-1(a)(40).

4 77 Fed. Reg. 18356 (March 27, 2012).

5 78 Fed. Reg. 54113 (August 30, 2013).

Content of Exchange Notices

Each Exchange Notice will:

- **Identify the employee;**
- **Indicate that the employee has been determined eligible for an Exchange subsidy (e.g., advance payment of the premium tax credit);[6]**
- **Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the excise tax assessed under Code Section 4980H; and**
- **Notify the employer of the right to appeal the determination[7]**

Should Employers Request an Appeal?

If an employee is determined eligible for Exchange subsidies, the employer appeal is the opportunity for an employer to correct information about employer-sponsored coverage offered to the employee (e.g., that an employee should not be entitled to an Exchange subsidy because he or she was offered the opportunity to enroll in minimum essential coverage that is affordable and provides minimum value) and for the Exchange to use such information to confirm (or refute) that the employee's eligibility determination for Exchange subsidies is correct.

The potential benefits of filing an appeal are two-fold: it can minimize the employee's potential liability to repay Exchange subsidies that he or she was not eligible to receive[8] and can help protect the employer from being incorrectly assessed an excise tax under Code Section 4980H.

Employer Appeal Process

Each State Exchange may create its own appeal process or choose not to establish an appeal process and have the HHS conduct the appeal in accordance with the Federal Exchange appeal process. In either case, the relevant Exchange must:

- **Allow employers 90 days (from the date of the Exchange Notice) to request an appeal;**
- **Accept appeal requests by telephone, by mail, via the Internet or in person (if the Exchange is capable of receiving in-person appeal requests) and provide assistance in making the appeal request if such assistance is requested;**
- **Allow employers to submit relevant evidence to support the appeal; and**
- **Not limit or interfere with the right to make an appeal request[9]**

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6 The regulation specifically requires Exchange Notices to state that the employee "has been determined eligible for advance payments of the premium tax credit," without mention of the cost-sharing reductions. We believe this is likely a drafting error, as the first sentence of 45 C.F.R. 155.310(h) clearly requires that Exchanges notify employers that an employee "has been determined eligible for advance payments of the premium tax credit *or cost-sharing reductions...*" [emphasis ours].

7 45 C.F.R. 155.310(h).

8 The HHS indicated that employers can develop policies to allow an employee to enroll in employer-sponsored coverage outside an open enrollment period when the employee is redetermined as ineligible for Exchange subsidies as a result of an employer appeal decision.

9 45 C.F.R. 155.555(c).

Upon receipt of a timely appeal request, the Exchange conducting the appeal (the "appeals entity") is required to timely acknowledge the receipt of the request and provide an explanation of the appeals process and to inform the employee of the appeal and provide the employee with instructions for submitting any additional evidence for consideration by the appeals entity.[10] In addition, the appeals entity must provide the employer the opportunity to review information regarding whether the employee's income is above or below the threshold by which "affordability" is measured, as well as certain other data used to make the determination that the employee qualifies for an Exchange subsidy.[11] The appeals entity's decision is required to be provided to both the employer and employee generally within 90 days of the date the appeal request is received.[12]

Importantly for the employer, HHS regulations clarify that an appeal decision (e.g., that the employee is in fact entitled to Exchange subsidies) does not foreclose any appeal rights the employer may have under the Code for excise tax liabilities under Code Section 4980H.[13] Thus, while an appeal may be beneficial, employers are not necessarily required to appeal an award determination to preserve their rights against the assessment of excise tax.

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10 45 C.F.R. 155.555(d).

11 45 C.F.R. 155.555(g).

12 45 C.F.R. 155.555(k).

13 See 45 C.F.R. 155.555(k)(1)(ii).

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If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.239.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Stacy C. Clark
404.881.7897
stacy.clark@alston.com

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Emily C. Hootkins
404.881.4601
emily.hootkins@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Johann Lee
202.239.3574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.239.3374
emily.mao@alston.com

Steven Mindy
202.239.3816
steven.mindy@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

Thomas G. Schendt
202.239.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Richard S. Siegel
202.239.3696
richard.siegel@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Jahnisa P. Tate
202.239.3670
jahnisa.tate@alston.com

Daniel G. Taylor
404.881.7567
dan.taylor@alston.com

Elizabeth Vaughan
404.881.4965
beth.vaughan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON&BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 1950 University Avenue ■ 5th Floor ■ East Palo Alto, California, USA, 94303-2282 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333

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FEBRUARY 3, 2015

M&G Polymers v. Tackett: New Standards for Vesting of Retiree Medical Benefits in Collective Bargaining Agreements

On January 26, 2015, the U.S. Supreme Court changed the landscape for vesting of collectively bargained retiree medical benefits with its 9-0 decision in *M&G Polymers v. Tackett*.[1] Overturning the Sixth Circuit's *Yard-Man* presumption, that such benefits should vest for life, the Court held that collective bargaining agreements (CBAs) should be interpreted using "ordinary contract principles" without putting a "thumb on the scale" in favor of retiree vesting. However, the instructions that "courts should not construe ambiguous writings to create lifetime promises," and "an employer's commitment to vest such benefits is not to be inferred lightly," may tilt the scale in the other direction.

Background

The Employee Retirement Income Security Act (ERISA) provides vesting requirements for pension benefits, but not for health and welfare (H&W) benefits. ERISA leaves any H&W vesting to the discretion of employers. Where benefits are collectively bargained, the vesting of H&W benefits is determined by the collective bargaining process. Retiree medical benefits, an interesting hybrid of retirement and H&W, have generated tremendous controversy and litigation.

Most CBAs expire at a certain date and the benefits thereof likewise expire. For pension benefits, which are required to be vested, retirees will continue to collect the benefits they have earned for life, even after the expiration of the CBA.

A CBA can specify that retiree medical benefits "vest" (that is, last for life) or that they do not vest, and may expire or be curtailed when the CBA expires, or sooner. However, most CBAs have no specific language as to whether retiree medical benefits vest. Perhaps this is because the employers and unions believed the standard durational language, that any portion of the agreement may be modified by the parties after the expiration date, controlled retiree medical benefits as well as all other benefits.

Typically, such modification would be the result of collective bargaining. So, when retirees claim their benefits are "vested," they not only challenge the employer's right to curtail the benefits, but also the union's right to bargain for wages, job security or other benefits in exchange for modifications to the retiree medical benefits. Under federal law, however, unions generally do not have a legal obligation to represent the retirees, and some courts have been skeptical of subsequent agreements that curtail retiree benefits.

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[1] 2015 WL 303218 (U.S. 2015).

This issue has only become more important over time; with skyrocketing medical costs resulting in liabilities that may far exceed what employers and unions had planned, often the parties are contracting to decrease or terminate retiree medical benefits entirely.

Prior to *M&G Polymers*, there was a federal circuit split over how to interpret collective bargaining agreements to determine whether retiree medical benefits are vested after the expiration of the CBA. *International Union, United Auto, Aerospace, & Agricultural Implement Workers of Am. v. Yard-Man, Inc.*[2] *(Yard-Man)* controlled in the Sixth Circuit. *Yard-Man* and its progeny created a presumption in favor of vesting retiree medical benefits. The Sixth Circuit reasoned that such benefits would be partly illusory if they could be taken away and inferred that parties to the agreement would want the benefits to be vested.

Yard-Man was the most pro-vesting standard imposed in any of the federal circuits. For instance, the Third Circuit generally requires a clear statement that health care benefits are intended to survive the termination of the CBA in order to find that such benefits are vested. The Second and Seventh Circuits require at least some language in the CBA that can reasonably support an interpretation that health care benefits should continue indefinitely.

M&G Polymers v. Tackett

M&G Polymers entered into a CBA and Pension, Insurance, and Service Award Agreement with the union,[3] which provided for retiree medical coverage with a full employer contribution to be provided "for the duration" of the agreement (with future renegotiations). After these agreements expired, M&G decided to require retirees to contribute to the cost of their health coverage. Several retirees sued, arguing that they had a vested right to retiree medical benefits with no contribution requirement. The district court initially dismissed the case, but the Sixth Circuit, on appeal, applied *Yard-Man* and reversed. On remand, both the district court and the Sixth Circuit ruled in favor of the retirees. In *M&G Polymers*, the Court disagreed, holding the Sixth Circuit's use of *Yard-Man* was "incompatible with ordinary principles of contract law."

Critique of *Yard-Man*

The main focus of the Court's opinion was its critique of the *Yard-Man* inferences, which favor vesting. The Court began by noting that collective bargaining agreements must be interpreted according to ordinary principles of contract law, when not inconsistent with federal labor policy. The Sixth Circuit analysis distorts the attempt to ascertain the intention of the parties by placing a thumb on the scale in favor of vesting. The Sixth Circuit's "assessment of likely behavior in collective bargaining is too speculative and too far removed from the context of any particular contract to be useful in discerning the parties' intention." The Sixth Circuit relied on its own suppositions about the intentions of the parties and improperly applied those theories indiscriminately.

The Supreme Court found fault with the Sixth Circuit's refusal to apply general durational clauses to retiree benefits (on the theory that various inferences outweigh routine duration clauses); the Court found that this distorted the text and conflicted with the principle that a written contract is presumed to encompass the parties' entire agreement.

Traditional Contract Principles

The Supreme Court disagreed with the Sixth Circuit's analysis that unvested benefits create a partially illusory promise because they benefit some, but not all, retirees. Illusory promises have no substance and therefore cannot provide

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2 716 F.2d 1476 (6th Cir. 1983).

3 United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC.

consideration for a contract. However, under the Supreme Court's guidance, a *partly* illusory promise is not illusory at all. If it is only *partly* illusory, then it has *some* substance. If a promise benefits some retirees, then it is sufficient to provide consideration. This is particularly common in the CBA context, where agreements are negotiated on behalf of broad categories of individuals and may not benefit every member.

The Court laid out a number of principles of contract construction applicable to the vesting analysis. For example, courts should not construe ambiguous writings to create lifetime promises. Also, contracts that are silent on duration will not ordinarily be treated as "operative in perpetuity" but rather as "operative for a reasonable period of time." The Court also instructed that contractual obligations will generally cease upon the termination of the bargaining agreement. Such agreements may provide for lifetime benefits, in specific terms, but courts cannot infer this when a contract is silent. And, "when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life."

Taken together, these principles of construction provide a framework under which the typical CBA will not result in vesting. The vast majority of CBAs contain general limits on duration, but very few directly address vesting of retiree medical benefits.[4] If vesting is not to be inferred lightly, and if ambiguous writings should not create lifetime promises, then it would seem that most CBAs should not result in vesting.

The Supreme Court vacated the lower court decision and remanded the case for the Sixth Circuit to review under "ordinary principles of contract law."

Concurrence

The concurring opinion of Justice Ginsburg (joined by Justices Breyer, Sotomayor and Kagan) encouraged the lower courts to look at the entire agreement to discern the intent of the parties. Justice Ginsburg stated that when a contract is ambiguous, a court may consider extrinsic evidence to determine the intent of the parties. According to Justice Ginsburg, a determination of vesting can be made from a CBA's explicit *and* implied terms. However, Justice Ginsburg agreed that the analysis must be done "without *Yard-Man's* 'thumb on the scale in favor of vested retiree benefits.'"

What Does *M&G Polymers* Mean?

The *Yard-Man* standard is dead. However, the Court did not reach a conclusion as to whether the benefits in this case were vested. The many various ways that durational limits are expressed in CBAs, and the many various statements suggestive of vesting in such CBAs, ensures that courts will be fleshing out the implications of *M&G Polymers* for years to come.

Potential Implications for Employers

For employers and unions currently negotiating CBAs, the clear message is to be explicit about whether they intend to assume liability for unalterable lifetime retiree medical benefits. For existing CBAs, *M&G Polymers* will likely generate much litigation as to the application of "ordinary contract principles" to the many variations of specific contractual language.

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[4] An interesting amicus brief filed by Goldstein & Russell, P.C. "in support of neither party" provided statistics on clauses in a nonscientific sample of CBAs. According to the amicus, only 6% of private sector CBAs state outright that retiree medical benefits vest. In contrast, 14% were completely silent on the question of vesting, while 70% contain one or more statements that may be recognized to preclude vesting and 30% contain statements suggesting that benefits do vest. These percentages add to more than 100% because many CBAs have statements suggestive of both positions—vesting and not vesting.

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Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.239.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Stacy C. Clark
404.881.7897
stacy.clark@alston.com

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Emily C. Hootkins
404.881.4601
emily.hootkins@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Johann Lee
202.239.3574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.239.3374
emily.mao@alston.com

Steven Mindy
202.239.3816
steven.mindy@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

Thomas G. Schendt
202.239.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Richard S. Siegel
202.239.3696
richard.siegel@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Daniel G. Taylor
404.881.7567
dan.taylor@alston.com

Elizabeth Vaughan
404.881.4965
beth.vaughan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON&BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 1950 University Avenue ■ 5th Floor ■ East Palo Alto, California, USA, 94303-2282 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333

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Employee Benefits & Executive Compensation ADVISORY ■

FEBRUARY 4, 2015

Agencies Issue New Proposed Rules for the Summary of Benefits and Coverage

On December 30, 2014, the Departments of the U.S. Treasury (Treasury), Labor (DOL) and Health and Human Services (HHS) (the "agencies") jointly published proposed rules (the "Proposed Rules") that update and clarify the final regulations regarding the Summary of Benefits and Coverage (SBC) published in 2012.

Practice pointer: The new regulations are only proposed regulations, so some aspects could change before they are finalized. If finalized, however, the new SBC rules, template and glossary should be used for all SBCs issued on or after September 1, 2015.

The Proposed Rules incorporate previous subregulatory guidance issued in the form of Frequently Asked Questions (FAQs), as well as make some new changes. The proposed template and the proposed glossary can be found on the DOL's website.[1]

Changes to the SBC Template and Glossary

A template and glossary for the SBC were issued in connection with the 2012 final regulations. The Proposed Rules make a number of additions and deletions to these form documents and the glossary. First, the Proposed Rules would require the SBC to state whether the coverage offers minimum essential coverage and minimum value. This would end the current safe harbor that allows this information to be delivered through a separate letter.[2] The Proposed Rules would also require the SBC to add a third coverage example, an emergency room visit for a simple foot fracture, to the two previously required examples involving a routine delivery and the management of type 2 diabetes.

Despite these new additions, the Proposed Rules actually shorten the completed SBC template to two and a half pages from the original four pages. This is accomplished by removing some information that is not required by statute. For example, references to annual limits for essential health benefits and pre-existing condition exclusions would be removed. Conversely, the glossary is expanded from four to six pages. The Proposed Rules will add definitions for several new terms, including "claim," "cost sharing" and "individual responsibility requirement." Several existing

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1 The proposed template can be found at http://www.dol.gov/ebsa/pdf/sbctemplateproposed.pdf. The proposed glossary is at http://www.dol.gov/ebsa/pdf/sbcuniformglossaryproposed.pdf.

2 As found in FAQ XIV, Q2. http://www.dol.gov/ebsa/faqs/faq-aca14.html.

definitions are also changed slightly. Furthermore, changes are proposed to the SBC instruction sheet and the "Why This Matters" language.

In addition, the continuation of coverage, minimum essential coverage and minimum value disclosures are revised in an effort to provide more useful information.

Changes to the SBC Delivery Requirement

Plan and/or insurer's requirement to provide SBCs to participants

The Proposed Rules make several clarifications regarding the provision of the SBC to participants, all of which are discussed in previous FAQs issued by the agencies. For instance, the Proposed Rules state that an SBC must be provided to participants upon automatic re-issuance or re-enrollment.[3] They also codify the safe harbor providing for electronic delivery of SBCs in connections with online enrollment, renewal or online request from a participant or beneficiary.[4]

The Proposed Rules also extend previous safe harbors in an attempt to streamline the SBC delivery process to participants and reduce duplication issues that may arise when SBCs are delivered by a third party.[5] A plan or issuer that contracts with a third party to provide an SBC will be considered to satisfy the requirement to provide an SBC if the plan or issuer monitors the performance of the contract, corrects noncompliance with the contract "as soon as practicable" and communicates with participants and beneficiaries affected by the noncompliance and takes "significant steps as soon as possible to avoid future violations."

Furthermore, if a group health plan contracts with more than one issuer to provide benefits for a single plan, the Proposed Rules require the plan administrator to provide a consolidated SBC for the plan.[6] An issuer has no obligation to provide an SBC containing information for benefits that it does not insure, but a plan administrator may contract with an issuer to do so. In addition, the safe harbor allowing plan administrators to either synthesize information into a single SBC or provide multiple SBCs is left in place.[7]

The antiduplication rules cover individual student health insurance plans as well.[8] The Proposed Rules state that a higher education institution's requirement to provide an SBC to an individual will be considered satisfied if another party, such as a health insurance issuer, provides a timely and complete SBC.

Insurer's requirement to provide SBCs to a plan

The Proposed Rules make several clarifications regarding the provision of the SBC to plans by insurers, all of which were discussed in previous FAQs. First, insurers will not be required to provide updated SBCs during coverage negotiations.[9] If a plan sponsor is still negotiating coverage terms following the application for coverage, the issuer is

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3 Codified from FAQ VIII, Q9. http://www.dol.gov/ebsa/faqs/faq-aca8.html.

4 Codified from FAQ VIII, Q10. http://www.dol.gov/ebsa/faqs/faq-aca8.html and FAQ IX, Q1. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

5 Codified from FAQ VIII, Q5. http://www.dol.gov/ebsa/faqs/faq-aca8.html.

6 Codified from FAQ IX. Q10. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

7 Codified FAQ IX, Q10. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

8 Codified from FAQ XIV, Q7. http://www.dol.gov/ebsa/faqs/faq-aca14.html.

9 Codified from FAQ IX, Q2. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

not required to provide an updated SBC to the plan until the first day of coverage. However, a plan sponsor's request for an updated SBC must otherwise be honored at any time.

In addition, the rules reaffirm that insurers will not be required to provide new SBCs upon application if they were provided prior to application.[10] If a plan or issuer provides an SBC prior to an application for coverage, such as part of its pre-enrollment materials, the plan or issuer is not required to provide another SBC upon application if there is no change to the information.

Summary for Plan Administrators

The Proposed Rules codify many existing SBC practices that plan administrators are probably already taking to deliver the SBC to participants. No new proposed rules would change existing delivery practices. The biggest change for plan administrators will be the use of the new template and glossary, which should be used exclusively after September 1, 2015.

Practice pointer: Many of the delivery practices discussed in the Proposed Rules simply codify delivery practices provided in previous agency FAQs. The FAQs can be found here. The Proposed Rules would make the FAQ guidance permanent.

Penalties for Noncompliance

The 2012 regulations provided that a willful failure to provide an SBC can result in a fine of $1,000 for each such failure, which can be enforced by the DOL, HHS or IRS. The Proposed Rules provide some clarity about DOL and IRS enforcement. For instance, in assessing fines against plans, the Proposed Rules clarify that the DOL will use the same process and procedures it currently uses to enforce the Form 5500 filing rules. The Proposed Rules further clarify that the DOL is not authorized to assess this fine against a health insurance issuer, per ERISA § 502(b)(3). Furthermore, the Proposed Rules state that the IRS will enforce the SBC rules using a process consistent with Internal Revenue Code Section 4980D for failure to meet the Code's group health plan requirements.

The agencies are accepting comments through March 2, 2015, including through www.regulations.gov.

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[10] Codified from FAQ IX, Q3. http://www.dol.gov/ebsa/faqs/faq-aca9.html.

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If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.239.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Stacy C. Clark
404.881.7897
stacy.clark@alston.com

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Emily C. Hootkins
404.881.4601
emily.hootkins@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Johann Lee
202.239.3574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.239.3374
emily.mao@alston.com

Steven Mindy
202.239.3816
steven.mindy@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

Thomas G. Schendt
202.239.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Richard S. Siegel
202.239.3696
richard.siegel@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Jahnisa P. Tate
202.239.3670
jahnisa.tate@alston.com

Daniel G. Taylor
404.881.7567
dan.taylor@alston.com

Elizabeth Vaughan
404.881.4965
beth.vaughan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON&BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 1950 University Avenue ■ 5th Floor ■ East Palo Alto, California, USA, 94303-2282 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333