

# Benefits Alert

July 2010

## Plan Administrator Entitled To Deference, Mistake Notwithstanding

Plan administrators are normally entitled to a great deal of deference from the courts when they're interpreting their plan documents. But what happens if they make a mistake? Well, here's some good news for plan administrators — if you make an honest mistake in construing the terms of your plan, you have considerable latitude to correct that mistake. The U.S. Supreme Court has ruled that courts must defer to plan administrators' decisions regarding the interpretation of their plans, even though their initial interpretation may have been mistaken. (*Conkright v. Frommert*, U.S. Sup. Ct., No. 08-810, 2010)

### PHANTOM OF THE RETIREMENT PLAN

Employees who left their company in the 1980s received lump-sum distributions of retirement benefits they had earned up to that point. They were later rehired, and when they retired again, their current retirement benefits had to be adjusted for those previous distributions. To adjust for the time value of money those past distributions represented, the plan administrator initially (and mistakenly) interpreted the plan to allow an adjustment known as the "phantom account method." Under this method, employees' current benefits were reduced by the hypothetical growth that employees'

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past distributions would have experienced if the money had remained in the plan.

Employees sued to prevent the administrator from using the phantom account method, arguing that they had no notice that it would be used. The appeals court ruled that the plan administrator's interpretation of the plan was unreasonable, and sent the case back to the trial court. Because of the plan administrator's mistaken



Robert S. Golden  
M. Dennis Guappone  
Stephen H. Peck

*Expertise*  
*Innovation*  
*Excellence*

181 Wells Avenue  
Newton, MA 02459  
Phone: (617) 969-0100  
[www.ubserv.com](http://www.ubserv.com)

## Plan... (cont.)

interpretation of the plan, the trial court refused to defer to the plan administrator and imposed its own solution. The plan eventually appealed to the U.S. Supreme Court.

### ONE STRIKE AND YOU'RE NOT OUT

The issue for the Supreme Court was whether a single honest mistake in plan interpretation justified stripping the plan administrator of deference for subsequent related interpretations of the plan. The answer, according to the Court, was no. *Court:* People make mistakes. Even administrators of ERISA plans. That should come as no surprise, given that ERISA is an enormously complex and detailed statute. ERISA's interests in efficiency, predictability, and uniformity, and the manner in which they are promoted by deference to reasonable plan construction by administrators, don't suddenly disappear because a plan administrator has made a single honest mistake.

However, the Court didn't hand plan administrators *carte blanche* to misinterpret their plans without court interference. *Court:* Multiple erroneous interpretations of the same plan provision, even if made in good faith, could support a finding that a plan administrator is too incompetent to exercise his/her discretion fairly. Applying a deferential standard of review also doesn't mean that the plan administrator will always prevail in court. It means only that the plan administrator's interpretation won't be disturbed if it's reasonable. ❖

## Health Care Reform Right Now: New Dependent Coverage Rules

Under the Patient Protection and Affordable Care Act, otherwise known as the health care reform law, certain group health plans that offer dependent coverage must extend coverage to employees' adult children until they reach the age of 26. Interim final regulations, which become effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year health plans), explain this provision.

### EXTENDED COVERAGE RULES

These extended coverage rules apply to new group health plans and to existing, *grandfathered* plans, if adult children aren't eligible to be covered under another group plan. Beginning with the 2014 plan year, grandfathered plans must extend coverage without regard to eligibility. Grandfathered plans, however, can voluntarily extend coverage to adult children; plans that extend coverage won't jeopardize their grandfathered status.

Grandfathering rules aside, the interim final regs make these key points, which should be communicated to employees before your next open enrollment period.

- Plans can no longer define dependents in relation to a child's status as a tax dependent. Therefore, adult children don't have to live with their parents, don't have to depend on their parents for more than half of their support, don't have to be students, and can be married to

qualify for extended coverage. However, children's spouses and children (i.e., employees' grandchildren) aren't covered under this provision.

- Adult children can't be whipsawed out of extended coverage. If adult children don't have access to their own health insurance, and their parents' separate plans offer dependent coverage, neither plan can deny extended coverage.

- Adult children who elected COBRA because they aged out of dependent coverage must be allowed to drop COBRA and re-enroll into their parents' group plan.

- Plans must give adult children notice of a 30-day special election period to re-enroll in their parents' plan (providing notice to employees is OK). The notice may be included with other plan materials, as long as it's prominent. This notice requirement and enrollment opportunity must be satisfied by the first day of the first plan year beginning September 23, 2010.

- The 30-day special election period applies regardless of whether the plan offers an open enrollment period, and regardless of when the open enrollment period occurs. *Upshot:* Plans can use their existing open enrollment periods, but if an adult child enrolls, coverage must begin on the first day of the plan year, even if the request for enrollment is made after the plan year begins (i.e., coverage is retroactive to the beginning of the plan year).

## Health Care... (cont.)

- Plans must allow adult children to enroll in any benefit package for which they're qualified, even if they choose an option different from their parents. *Upshot:* Parents will be allowed to switch benefit options, and parents who weren't enrolled in the plan in the first place must be given the opportunity to enroll along with their adult children.

- Adult children cannot be charged more for extended coverage. Surcharges for adult children are allowed only if surcharges apply regardless of the age of the child. Plans that use tiered pricing (e.g., different pricing for self-only, self-plus-one, self-plus-two) may continue to do so.

### TO DO LIST

Between now and September 23, 2010 (or January 1, 2011, if you have a calendar year plan), you should take the following steps.

- Find out if your existing health insurance carrier is voluntarily extending coverage before the deadline.
- Assign responsibility for providing written notice to employees.
- Advertise extended coverage for this coming open enrollment season.
- Track the 30-day special enrollment period.
- Identify employees' dependents who elected COBRA because they aged out of dependent coverage, and provide them with the appropriate notice and election period.
- Review all plan documents, and remove references to tax dependents. ❖

## IRS's Journey Into Health Care Reform Begins With A Postcard

**B**enefits and HR administrators usually don't like to think about taxes. But think about taxes you must, since a major feature of the recently enacted health care reform law is a tax credit for small businesses that provide health benefits to their employees. The tax credit is effective this year. The IRS is mailing postcards regarding the tax credit to potentially eligible employers and has issued guidance regarding the tax credit. As with all things tax-related, however, determining whether you qualify for the credit isn't a snap.

### DETAILS OF THE CREDIT

Overall, the credit is available for six years. For private employers, the maximum credit is 35% through 2013; beginning in 2014, the credit increases to 50%. For employers in the non-profit sector, the credit is 25% through 2013, and 35% beginning in 2014.

Employers with fewer than 25 full-time equivalent employees, or FTEs, who earn not more than \$25,000 qualify for the full credit. *Watch this:* Since employees are counted as FTEs, and not as actual employees, employers with 25 or more employees can qualify for the credit if some employees work part-time. Seasonal employees, sole proprietors, partners, S corp shareholders owning more than 2% of the corporation, more than 5% business owners, and business owners' family members aren't counted as FTEs.

The credit is phased out as employees' average wages increase from \$25,000 to \$50,000, and as the number of FTEs increases from 10 to 25. To qualify for any credit, employers must pay at least 50% of employees' premiums. *Crucial:* Employees' contributions into cafeteria plans don't count as employer payments for this purpose. *Break:* Under transition relief that applies to tax years beginning in 2010, the employer's 50% premium payment is based on self-only coverage, regardless of the actual coverage employees receive. The credit is also available for limited-scope benefits, such as vision or dental care, but plans aren't aggregated when determining whether the employer pays its 50%; each plan is tested separately.

### FIGURING THE CREDIT

Specifically, the credit is the lesser of 35% of employers' contributions toward FTEs' health premiums, or 35% of a so-called small business benchmark premium. The benchmark premium is the average premium for the small group market in a state, or an area within a state. These amounts have been posted on the IRS's website.

To determine the number of FTEs, divide the total hours for which you pay wages (up to 2,080 for any employee) by 2,080 and round down if necessary. The IRS notes two crucial points regarding hours worked.

- Hours worked include each hour for which employees are entitled to be paid, including

## HSA Inflation Adjustments For 2011 Announced

The 2011 inflation-adjusted figures for health savings accounts (HSAs) and high-deductible health plans are unchanged from 2010. *Reminder:* HSA amounts are expressed annually, but figured on a monthly basis.

- **Employees with self-only coverage** under high-deductible health plans can contribute up to \$3,050 into their HSAs. The minimum annual deductible for a high-deductible health plan is \$1,200. The annual maximum amount

of out-of-pocket expenses (i.e., deductibles, co-payments, etc.) is \$5,950.

- **Employees with family coverage** under high-deductible health plans can contribute up to \$6,150 into their HSAs. The minimum annual deductible for a high-deductible health plan is \$2,400. The annual maximum amount out-of-pocket expenses (i.e., deductibles, co-payments, etc.) is \$11,900. ❖

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### IRS's Journey Into Health Care Reform Begins With A Postcard (cont.)

vacations, holidays, illnesses, incapacity, layoffs, jury duty, military duty, or leaves of absence. *Catch:* No more than 160 hours of idle time pay is counted for any single continuous period during which employees don't work.

- You can use employees' actual work hours to determine their hours worked, a days-worked equivalency that credits employees with eight hours of work each day, or a weeks-worked equivalency that credits employees with 40 hours of work each week.

If the number of FTEs exceeds 10, determine the credit reduction by multiplying the credit by a fraction, the numerator of which is the number of FTEs that exceeds 10 and the denominator of which is 15.

Average annual wages are determined by dividing total wages that are subject to Social

Security and Medicare taxes (also known as FICA wages) by the number of FTEs, rounded down to the nearest \$1,000. If average annual wages exceeds \$25,000, the credit reduction is determined by multiplying the credit by a fraction, the numerator of which is the amount by which average annual wages exceeds \$25,000 and the denominator of which is \$25,000.

*Example.* For 2010, Mega's portion of employees' health premiums is \$70,000. It has 12 employees who work 2,080 hours, three employees who work 1,040 hours, and one employee who works 2,300 hours. To figure FTEs:

1. 12 employees working 2,080 hours ( $12 \times 2,080$ ) = 24,960.

2. Three employees working 1,040 hours ( $3 \times 1,040$ ) = 3,120.

3. One employee working 2,300 ( $1 \times 2,080$ ) = 2,080. *Note:* Only the first 2,080 hours are counted.

4. Total hours:  $30,160 \div 2,080 = 14.50$ , or 14 FTEs.

Mega pays \$425,000 in FICA wages. Average annual wages equals \$30,357.14, or \$30,000, rounded down. Mega's tentative credit is \$24,500 (35% of \$70,000). However, since Mega has more than 10 FTEs and average annual wages in excess of \$25,000, it must reduce its credit.

1. Reduction for FTEs exceeding 10:  $\$24,500 \times 4/15 = \$6,533$ .

2. Reduction for average annual wages exceeding \$25,000:  $\$24,500 \times \$5,000/\$25,000 = \$4,900$ .

3. Total reduction: \$11,433.

4. Total 2010 tax credit:  $\$24,500 - \$11,433 = \$13,067$ . ❖