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# Managing Health & Welfare Plans During Restructuring

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Employers across the country are restructuring business operations to mitigate the continuing impact of the Covid-19 pandemic. Restructuring business operations—whether by complete shutdown, sale, or bankruptcy—implicates several employer-sponsored health and welfare plan issues. This article provides a high-level overview of common health and welfare plan scenarios that plan sponsors may encounter during a restructuring.

## Termination of Health and Welfare Plans

Often, if there is a complete termination of operations, plan sponsors will terminate their health and welfare plans. This section considers the legal requirements associated with plan termination, with a focus on the rules for group health plans.

***Required Communications to Employees***

Employers should notify employees in a timely manner of any pending health and welfare plan termination. There are a number of notice requirements that plan sponsors should consider.

- Plan fiduciaries owe duties of disclosure to plan participants under the fiduciary rules of the Employee Retirement Income Security Act of 1974, as amended. A key reason for these duties is to provide participants with sufficient information so they can find alternative benefit coverage after a plan is terminated. There is no specific legal rule dictating how much advance notice has to be provided by a prudent plan fiduciary, but consideration of participant needs and available alternatives will help inform the decision.

- Plan administrators and insurers must also provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect in the middle of a plan year and affects the content of the plan's summary of benefits and coverage. There is a penalty of $1,176 for each failure to provide the SBC (which could be quite significant for a large group health plan). PHSA §2715(f). It is not clear whether a full plan termination necessarily implicates this rule, whereas a material reduction in benefits likely would. Nevertheless, plan administrators and insurers will want to consider carefully whether the rule applies.

- Plan administrators must notify plan participants of any material modifications to an ERISA-covered plan within 210 days after the end of the plan year in which the change is adopted. ERISA §104(b)(1). Group health plan administrators are required to inform plan participants of a material reduction in covered services or benefits within 60 days of adopting the change. ERISA §104(b)(1); 29 C.F.R. §2520.104b-3.

- If the group health or welfare plan is fully insured, there may be additional state laws that require the employer to provide advance notice to employees by a specific deadline.

These notice requirements are important; however, plan sponsors should be aware that the ERISA fiduciary responsibility rules described in (1) may require more timely notification to affected participants than the above notice rules.

***Run-Out Period for Claims***

If the group health plan is self-insured, the plan sponsor should review the applicable run-out period for submitting claims and ensure this deadline is communicated to participants. Self-insured group health plan sponsors should coordinate the cancellation or modification of any stop loss insurance coverage with the run-out period.

If the plan is fully-insured, the run-out period for claims is set by the certificate of coverage or insurance policy. Plan sponsors should ensure that the run-out period for fully insured plans is accurately communicated to plan participants. If the run-out period deadline is not accurately communicated, the plan sponsor runs the risk of accidentally creating a "self-insured" plan for any portion of the run-out period not covered by the insurance policy.

> **Practice Tip:** On May 4, 2020, the Internal Revenue Service, Department of Labor, and the Department of Health and Human Services issued a final rule temporarily extending certain deadlines under group health plans during the Covid-19 national emergency. In coordinating the termination of the group health

 

plan and the claims run-out period, plan sponsors should be mindful of the extension's impact and limitation on their ability to "close out" plan claims.

***ACA Implications***

The Affordable Care Act requires applicable large employers, generally those employing more than 50 full-time employees, to offer affordable minimum value group health coverage to 95% or more of their full-time employees and their dependent children. If an ALE fails to offer qualifying coverage, the ALE could face significant tax penalties. These rules do not prevent an employer from terminating its group health coverage in connection with a complete business shutdown. The penalties could apply, though, if there are related businesses still in existence.

Separately, IRS reporting requirements continue to apply to periods during which coverage was provided. Certain ALEs are required to report whether they offered health coverage to their employees and if so, information about the coverage offered. This information also must be provided to employees. An employer fully shutting down its business should consider how these reporting requirements will be fulfilled after the shutdown.

***COBRA Obligation in Complete Business Shutdown***

Employers of 20 or more employees are subject to COBRA continuation coverage rules. In general, these rules require that coverage must be provided for up to 18 months following a termination of employment that causes a loss of coverage (the "qualifying event"). A business shutdown whereby employees are terminated from employment can certainly trigger COBRA continuation coverage rules. However, as long as all group health plans in the employer's controlled group are terminated simultaneously with the business shutdown, the employer is not obligated to offer COBRA coverage to terminated employees or their spouses and dependents, and coverage can end for any qualified beneficiaries already enrolled in the group health plan. I.R.C. §4980B(f)(2)(B)(ii); ERISA §602(2)(B); 26 C.F.R. §54.4980B-7, Q&A-1(a)(3).

If any member of the employer's controlled group continues to offer group health coverage following the termination, however, COBRA coverage must continue to be offered to terminated employees and current COBRA beneficiaries. Other rules could apply if there is a "successor" employer in the picture. The ramifications of this rule are explained in more detail immediately below.

In addition, plan sponsors of fully-insured plans should be mindful of state law "mini-COBRA" requirements to offer continuation coverage, which could also apply to smaller employers. Under some of these state law continuation coverage rules, there could be continuation coverage requirements imposed on insurers themselves. Plan sponsors should consider these rules, which vary from state to state, when reviewing any notice obligations.

***COBRA Obligation in Partial Business Shutdown***

COBRA coverage must be offered to employees who incur a qualifying event—such as loss of group health coverage due to termination or reduction of hours of employment—as long as any member of the employer's controlled group sponsors a group health plan. This is the case even if the specific employer's group health plan is terminated and other employers in the controlled group offer completely separate and different group health plans. Complying with this requirement poses a number of practical implementation issues.

For example, if one of the other controlled group members is located in a separate region of the country with a region-specific plan, does that employer have to open up that plan to the terminated employees of the shut-down business? The COBRA regulations do not answer this question. On the one hand, the regulations state that qualified beneficiaries only have to be given an opportunity to continue the coverage they had immediately before the qualifying event, even if it ceases to be of value. 26 C.F.R. §54.4980B-5, Q&A-4. Nevertheless, these rules provide that if a qualified beneficiary moves out of a region-specific coverage area, the employer has to provide some alternative coverage if available to other non-COBRA beneficiaries. It is not clear how to apply these rules in every scenario.

At least one court has held that an employer had to create coverage for qualified beneficiaries where their only recourse was to a region-specific benefit plan for which they were not eligible (they did not live in the region). The court decided that the employer had better bargaining power to purchase coverage than the affected qualified beneficiaries. This is only one case, but it does identify the practical difficulties that employers face when complying with this requirement. *Coble v. Bonita House, Inc.*, 789 F. Supp. 320 (N.D. Cal. 1992).

The bottom line here is that if an employer is part of a controlled group of employers that will continue to offer group health coverage after the employer's business shutdown, the terminating plan sponsor should consider how the COBRA controlled group rule will apply.

***COBRA 'Successor' Liability***

In addition to the COBRA controlled group rules discussed above, the COBRA regulations impose fairly broad "successor employer" concepts. These rules mean that if an employer shuts down operations and then decides to reopen under some other name, the successor employer rules may prevent the employer from avoiding COBRA liability for events that occurred on and before the earlier business shutdown.

It is not clear how "successor" is defined for this purpose and how far the rule can go, so employers should be mindful of this rule when reviewing potential restructuring strategies and be sure to consult with counsel as to any possibility of successor liability. See, e.g., 26 C.F.R. §§54.4980B-2, Q&A-2; 54.4980B-7, Q&A-1(a)(3); 54.4980B-9, Q&A-8(c).

Be aware that these successor principles are separate from a situation where there can be formal successorship such as through a bankruptcy or business acquisition. The rules that apply in those contexts are clearer, as described below.

***ERISA Filing Compliance***

Plan sponsors are generally required to file annual reports (Forms 5500) for health and welfare benefit plans subject to ERISA. In the plan termination/business shutdown context, plan sponsors should make provisions for filing the final Form 5500 for any impacted plans.

***Distribution of Plan Assets Following Termination***

Typically, group health plans will not have any assets to distribute following termination and payment of all claims submitted during the applicable run-out period. If there are any participant contributions remitted for coverage that applies to a period after the date of plan termination, those contributions should be returned to participants and pro-rated, if applicable, to reflect the period of coverage available.

If the group health plan is funded through a tax-exempt voluntary employees' beneficiary association, however, there may be assets remaining in the VEBA trust following plan termination. In general, assets remaining in a VEBA following termination may not revert to the plan sponsor and any prohibited reversion may cause the employer to incur a 100% excise tax under I.R.C. §4976. Because of this restriction, employers may need to consider distributing assets remaining in the VEBA to covered participants or purchasing a paid-up insurance policy for participants. 26 C.F.R. §1.501(c)(9)-4(d).

Other possible solutions may apply and there are IRS private letter rulings illustrating these opportunities. See, e.g., PLR 200223067 (trust's transfer of excess assets to tax-exempt charitable organization is not a disqualified benefit; no I.R.C. §4976 tax).

***Impact of State Continuation and Conversion Laws on Terminated Plans***

Plan sponsors with fully-insured plans should review the impact of any state conversion and continuation coverage laws on plan terminations. These laws may impact non-health insured welfare plans, such as life insurance and disability insurance. Most states require that employees receive notice of their continuation and conversion privileges.

Employers should be mindful to provide clear, consistent answers to participants about the availability of continuation and conversion coverage after plan termination. Providing materially misleading information, whether by statement or omission, that might prevent an employee from availing themselves of continuation or conversion of their welfare plan benefits may constitute a breach of fiduciary duty under ERISA.

***Terminating Health FSA Plans and Participant Forfeitures***

Some employers sponsor health flexible spending accounts to permit employees to pay for qualifying health expenses on a pre-tax basis. If the health FSA is terminated mid-year, participants might incur forfeitures under the "use it or lose it" rule that applies to health FSAs. Participants who have made large elections in anticipation of expenses to be incurred later in the year may be irritated to find out that they will lose these amounts once the plan is terminated.

To mitigate this issue, and to the extent not already provided by the plan, the employer may amend the plan in advance of termination to adopt a grace period. Adopting a grace period would permit participants to incur expenses for up to two months and 15 days after the health FSA's plan year ends. In considering whether to adopt a grace period, employers should consider the impact of the grace period on employees' ability to contribute to health savings accounts.

> **Practice Tip:** In response to the Covid-19 pandemic, the IRS provided temporary flexibility for participants to change their health FSA elections for the rest of 2020. IRS Notice 2020-29. To address the employee relations issue described above, and depending on timing, some plan sponsors may wish to adopt this relief to give participants the ability to reduce their health FSA elections in advance of the plan termination.

***Distributing Health FSA Plan Assets Upon Termination***

Employees may want to receive any unspent contributions in their health FSA accounts upon plan termination. The IRS rules on health FSAs prohibit the employer from allocating "experience gains" to employees based on their individual claims experience. Prop. Treas. Reg. §1.125-5(o)(2). This means that, upon termination of the health FSA, the plan sponsor may distribute unspent amounts pro rata to participants, subject to income and employment tax withholding, but is not permitted to distribute amounts based on each participant's claims for the year.

## Sale of Business Operations and Health and Welfare Plan Obligations

Rather than shutting down operations, employers may decide to restructure by selling certain business locations, divisions, or affiliates. In addition to the health and welfare plan considerations summarized above, there are some specific group health plan obligations triggered in the transaction context that employers should carefully review.

***COBRA Obligation in Business Transactions: In General***

Buyers and sellers are allowed to allocate COBRA responsibilities in ways that make sense under the circumstances. However, if there is no agreement or if the party to whom responsibilities have been delegated fails to perform, the regulations specify how COBRA responsibilities are to be allocated, as explained in more detail below.

**COBRA Obligation in Stock Sale.** A stock sale, on its own, is not a COBRA qualifying event. Employees who lose coverage under the seller's group health plan as the result of a stock sale are not entitled to COBRA coverage, provided that the employee continues employment with the acquired employer. 26 C.F.R. §54.4980B-9, Q&A-5. If the employee's employment is terminated in connection with the stock sale, though, the employee may be a qualified beneficiary with respect to the stock sale because of the termination of employment. 26 C.F.R. §54.4980B-9, Q&A-4(b).

If the selling employer and every member of its controlled group cease to provide group health coverage after the sale, the buying group is required to provide COBRA continuation coverage to any qualified beneficiaries with respect to the stock sale. 26 C.F.R. §54.4980B-9, Q&A-8(b)(1). Otherwise, the selling group is required to provide COBRA continuation coverage to qualified beneficiaries with respect to the sale. 26 C.F.R. §54.4980B-9, Q&A-8(d), Ex. 3.

**COBRA Obligation in Asset Sale.** Unlike a stock sale, an asset sale will constitute a COBRA qualifying event with respect to covered employees who lose coverage under the seller's group health plan and are transferred to the buyer (as well as to other employees terminated from employment in connection with the sale). 26 C.F.R. §54.4980B-9, Q&A-6. As long as the selling company maintains a group health plan after the sale, it is required to offer COBRA coverage to the qualified beneficiaries with respect to the asset sale. 26 C.F.R. §54.4980B-9, Q&A-8(d), Ex. 5.

There are two exceptions whereby the COBRA liability for the transaction will transfer to the buyer/buying group: when the buyer is a "successor" (meaning generally a continuation of the business enterprise) and the seller is out of business entirely, or the qualified beneficiaries do not lose coverage under the seller's plan due to the sale. Both exceptions are fairly rare. 26 C.F.R. §54.4980B-9, Q&A-8(c)(1); 26 C.F.R. §54.4980B-9, Q&A-8(d), Ex. 6.

***COBRA in Business Transactions: A Practical Approach***

In considering COBRA obligations in a business transaction context, it is often easiest to deal with the issues by considering the various groups of qualified beneficiaries and potential qualified beneficiaries and then address the issues in the transaction documents. The various groups include:

**Active employees and covered spouses and dependent children.** Is the sale a qualifying event for them such that they have to be offered COBRA continuation coverage? Generally not in a stock sale and generally yes in an asset sale.

**Existing qualified beneficiaries with coverage as of the date of the transaction (particularly those associated with the business being sold).** Where are they getting COBRA coverage before the transaction? Will that change? If so, how? Which party is responsible for providing their coverage?

**Existing qualified beneficiaries who do not yet have coverage but who are in the middle of a COBRA election period as of the date of the sale**. Technically, these individuals are not impacted by the sale as such, but their COBRA election period might be open during the transaction. Which business will pick up their COBRA continuation coverage if they elect COBRA? Who will notify them of their rights?

> **Practice Tip:** The DOL, IRS, and HHS published a final regulation temporarily extending the period for individuals to elect COBRA and make COBRA payments during the Covid-19 national emergency. This extension increases the impact of adverse selection on the employer's potential COBRA obligation and may significantly impact transactions occurring during the national emergency.

**Qualified beneficiaries impacted by seller's past COBRA violations.** This group is often addressed by leaving all pre-transaction COBRA violation liabilities with the seller. Of course, if the seller goes out of business and the buyer is a continuation of the seller, this might come back to the buyer. This is why it is important for a buyer to conduct due diligence and assess the seller's ability to address past violations.

### *Transferring Health FSA Coverage in Asset Sale*

Terminating a health FSA mid-year may create friction with participants due to the application of the "use it or lose it" rule. In the business acquisition context, the IRS has issued a ruling providing flexibility whereby the employees who continue with the buyer may be treated the same as if they were in one health FSA for the entire year—i.e., they do not have to forfeit their accounts under the seller's health FSA.

As a practical matter, employers involved in transactions may provide a "true-up" mechanism in the deal documents to minimize the impact on either the buyer or seller for having to assume claims in excess of employee contributions made to either party for only part of a year. For more, see IRS Rev. Rul. 2002-32.

## Bankruptcy and Health and Welfare Plan Obligations

Many employers facing bankruptcy need to consolidate, terminate, or reduce health and welfare benefits. Below are some common issues that may arise during bankruptcy, with a special focus on the retiree COBRA rights that may be triggered by bankruptcy proceedings.

### *General COBRA Obligation in Bankruptcy Context*

Group health plans continue to be subject to COBRA continuation coverage during the bankruptcy process. Bankruptcy, on its own, is not a COBRA qualifying event. This means that an employee who loses coverage as a result of the employer's bankruptcy, for example, because the employer discontinues group health coverage, is generally not entitled to elect COBRA coverage unless the employee also experiences a COBRA qualifying event that triggers the loss of coverage, such as a termination or reduction of hours of employment. (There is a notable exception to this rule for retirees, as explained below.)

One issue to watch out for is a loss of coverage in anticipation of a qualifying event. For example, if an employer terminates coverage for a group of employees and then lays them off in a subsequent bankruptcy, that subsequent termination of employment could be a qualifying event under the COBRA "in anticipation" rule. 26 C.F.R. §54.4980B-4, Q&A-1(c). Of course, this will not have any practical impact if the employer and its entire controlled group cease to provide group health plan coverage. However, it could apply if there are other controlled group members with coverage or if there is a successorship in bankruptcy that sets up a group health plan, subject to applicable bankruptcy rules.

***Retiree Health Coverage in Bankruptcy***

Retirees with group health coverage have special rights if an employer undergoes Chapter 11 bankruptcy. Unlike the general rule summarized above, bankruptcy is a COBRA qualifying event for covered retirees and dependents if it causes a loss of coverage. 26 C.F.R. § 54.4980B-4(c).

So long as any member of the employer's controlled group continues to offer group health coverage, the covered retirees and their dependents have the right to elect COBRA continuation coverage. Of course, if the employer and all members of its controlled group terminate all group health plan coverage (subject to any required court approval), covered retirees and dependents will not have any COBRA rights. To the extent applicable, employers and practitioners should be mindful of some key points in connection with COBRA rights for covered retirees.

**One-Year Triggering Event.** To trigger the special COBRA retiree rule, the loss of coverage due to bankruptcy includes a substantial elimination of coverage under the plan within 12 months before or after the commencement of the bankruptcy proceeding. 26 C.F.R. §54.4980B-4(c). On its face, this suggests that only changes to coverage within one year before or after the bankruptcy filing will trigger the special COBRA retiree obligation. However, this interpretation has not been explicitly confirmed in any guidance.

**Extended Duration of Coverage.** If a loss of coverage arises in connection with a Chapter 11 bankruptcy proceeding, qualified beneficiaries (covered retirees and their dependents) are eligible to elect COBRA. Unlike the usual statutory COBRA period of 18 months, a covered retiree may elect COBRA for life. The maximum period for a covered dependent is the period ending on the earlier of the dependent's death, or 36 months after the covered retiree's death. Code §4980B(f)(2)(B)(i)(III); ERISA §602(2)(A)(iii); 26 C.F.R. §54.4980B-7, Q&A-4(e).

**No Termination of COBRA Coverage in Connection with Medicare Entitlement.** If the covered retiree becomes a qualified beneficiary as a result of the bankruptcy proceeding, COBRA coverage cannot be terminated if the beneficiary becomes entitled to Medicare after electing COBRA. I.R.C. §4980B(f)(2)(B)(iv)(II); ERISA §602(2)(D)(ii).

***Special Chapter 11 Bankruptcy Protection for Retiree Health Coverage***

In the Chapter 11 bankruptcy context, employers cannot reduce or eliminate retiree medical coverage without the bankruptcy court's permission, or, until after the reorganization is completed. 11 U.S.C. §1114. In general, the court must determine that reducing or terminating retiree health benefits is necessary to implement the reorganization and equitable when compared to the impact on other parties in the proceeding. 11 U.S.C. §1114(f)(1)(A). If the employees are unionized, the debtor may also need to seek permission under 11 U.S.C. §1113 to modify the collective bargaining agreement to reduce or eliminate retiree health benefits.

## Conclusion

The above summary highlights health and welfare plan issues that employers may face during common restructuring scenarios. Given the scope of issues—as well as the potential for costly errors—employers should carefully develop a plan of attack for managing health and welfare plan issues as part of their overall restructuring strategy.