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Benefits Counselor Fall 2018 Update

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General Employee Benefits

IRS and OCR Publish Cybersecurity Tips Applicable to Plan Sponsors

The Internal Revenue Service ("IRS") and the Department of Health and Human Services' ("HHS") Office for Civil Rights ("OCR") have issued newsletters highlighting various items for plan sponsors to consider when securing confidential electronic information. The IRS newsletter focuses on steps plan sponsors can take to limit access to information, such as granting access only to select employees, requiring strong passwords, locking computer screens during periods of inactivity, securing portable devices, and terminating access for employees who no longer need access. The IRS newsletter also emphasizes training employees on basic security principles, reminding employees of written policies, and disciplining employees for violations. The OCR newsletter reiterates many of the points raised in the IRS newsletter, but also cites security standards established under the Health Insurance Portability and Accountability Act ("HIPAA"), suggesting covered entities consider whether they have adequate records to track the location, movement, modifications, repairs and disposition of electronic devices and media throughout their lifecycles. The OCR newsletter also notes that organizations should implement risk analysis and risk management processes to identify and implement appropriate controls under the HIPAA standards, based on the size of the organization. The OCR newsletter also identifies several factors to consider when determining appropriate security measures, such as the organization's size, complexity, technical capabilities, costs of the security measures, and the probability and criticality of risks to unprotected information.

IRS Approves Procedures for Awarding Employer-Related Scholarships

The IRS has approved procedures established by a private foundation to award scholarships to an employer's employees and their children, despite the foundation's inability to guarantee that certain threshold percentage tests will be met. Generally, the Internal Revenue Code (the "Code") treats scholarship programs that favor employees or their family members as taxable expenditures unless it can be shown that such programs satisfy seven conditions, including separate percentage tests for employees and their children established by the

IRS, or, if no applicable percentage test can be met, based on a facts and circumstances test. In this case, the foundation represented that its program would meet all seven conditions, but could not guarantee the percentage tests would be satisfied. Furthermore, given the small number of scholarships granted and each scholarship's small value, the foundation argued that annual testing would be unreasonably expensive. The IRS agreed with the foundation, and, as an alternative to the percentage tests, found that the following representations would be sufficient to prove tax exempt status: scholarship recipients would be selected by an independent committee; scholarships would not be used for recruiting or be terminated upon termination of employment; recipients would be selected based on objective selection standards unrelated to employment; and the scholarships would not limit recipients to a field of study beneficial to the employer.

Third Circuit Adopts "Material Involvement" Standard in Voluntary Plan Ruling

The Third Circuit Court of Appeals has held that an employer's "material involvement" with respect to a supplemental long term disability policy resulted in the policy's removal from ERISA's voluntary plan safe harbor. *McCann v. Unum Provident*, No. 16 2014 (3d Cir. Oct. 5, 2018). Under the safe harbor, certain "voluntary plans" do not become employee benefit plans subject to ERISA if certain conditions are met. One such condition is the absence of the employer's endorsement of the plan. The Third Circuit concluded that an employer crosses the line of neutrality and endorses a plan when the employer exercises some level of "material involvement" in the creation or administration of the plan. In this case, which the court conceded was "close" on the question of endorsement, the court highlighted evidence of the employer's material involvement, which included selecting Provident as the sole provider of the policies rather than offering employees a menu of insurers from which to select, encouraging employees to enroll in coverage, expressing judgment about the policy, determining who was eligible for the policy, and suggesting the policy was part of the employer's standard benefits package. Thus, the Third Circuit held that a dispute regarding coverage under the policy was governed by ERISA.

Retirement Plan Development

IRS Revises Employee Plans Compliance Resolution System

On September 28, the IRS issued Revenue Procedure 2018-52, superseding

Revenue Procedure 2016-51 as the most recent consolidated statement of the correction programs under the Employee Plans Compliance Resolution System ("EPCRS"). Notable changes include:

- From January 1, 2019, through March 31, 2019, plan sponsors may file submissions under the voluntary correction program ("VCP") with the IRS by either paper submissions in accordance with Revenue Procedure 2016-51 or online at pay.gov. However, beginning April 1, 2019, the IRS will no longer accept paper submissions and plan sponsors must file VCP submissions online using www.pay.gov.
- Beginning April 1, 2019, applicants must generally convert documents relating to a VCP submission, including descriptions of failures, Form 14568, Schedules 1 through 9 of Form 14568, and any other applicable items into a single PDF document to be uploaded to pay.gov, subject to a 15-megabyte size limitation. Submissions exceeding 15 megabytes should be faxed separately to the IRS.
- The IRS will no longer send the applicant a letter via the U.S. Mail to acknowledge a VCP submission made via www.pay.gov. Rather, receipt of a VCP submission will be acknowledged through the generation of a unique tracking ID included with the e mailed payment confirmation after a VCP submission is filed and the user fee paid.

IRS Updates Model Eligible Rollover Distribution Notice to Address Plan Loan Offsets and Other Legal Changes

The IRS has updated safe harbor explanations for eligible rollover distributions to reflect recent legal changes and IRS guidance. Internal Revenue Code (the "Code") section 402(f) requires plans to provide recipients of eligible rollover distributions with a written explanation of their rollover options and the tax consequences thereof. Previously, the IRS provided two model safe harbor rollover explanations deemed to satisfy Code section 402(f): one for distributions from a designated Roth account, and another for distributions *not* from a designated Roth account. Under IRS Notice 2018-74, the notices have been updated to incorporate recent updates to the Code which provide an extended deadline for "qualified plan loan offset amounts," which are amounts distributed solely due to a plan's termination or a participant's severance from employment. The revised model notices also incorporate various other statutory changes, including new exceptions to the 10% additional tax under Code section 72(t) and recent IRS guidance regarding self-certification for taxpayers claiming a waiver of the usual rollover deadline for 60-

day rollover distributions. The revised model notices include language regarding special rollover rights that may apply to individuals affected by a federally declared disaster.

PBGC Issues Final Regulations Addressing Multiemployer Plan Mergers and Transfers

On September 13, the Pension Benefit Guaranty Corporation (“PBGC”) issued final regulations regarding mergers and transfers between multiemployer plans under the Employee Retirement Income Security Act of 1974 ("ERISA") (the “Final Regulations”). By way of background, ERISA section 4231 permits one or more multiemployer plans to merge or transfer assets or liabilities, provided the plans provide notice to the PBGC and certain precautions are taken to protect plan participants. The Multiemployer Pension Reform Act of 2014 (“MPRA”) added specific authorization for the PBGC to “facilitate” mergers between multiemployer plans. Upon request, the PBGC may provide financial assistance (including training, technical assistance, mediation, communication with stakeholders, support with requests from government agencies, and financial assistance), provided it determines that the merger is in the interests of the participants of at least one of the plans in the merger and not adverse to the interests of all of the plans in the merger.

In June 2016, the PBGC issued proposed regulations that would implement MPRA’s changes to ERISA section 4231. The Final Regulations adopt many, but not all, of the proposed regulations’ provisions, and modify several others:

- ERISA section 4231(b) prohibits mergers or transfers unless the plan sponsor can demonstrate a plan’s solvency after such merger or transfer. The proposed regulations would have included solvency tests more rigorous than those in the current regulations. The PBGC declined to adopt the proposed changes after receiving comments that they were unduly restrictive and could negatively impact beneficial transfers allowed under the current regulations.

- Under ERISA section 4231(b)(2), a participant's or beneficiary's accrued benefit may not be lower immediately after a plan merger or transfer than it was immediately before the merger or transfer. The PBGC added a new subsection providing that it may waive this requirement if the benefit suspension and merger or transfer happen simultaneously.

- The Final Regulations adopt the procedures and information requirements for a voluntary request for a facilitated merger under MPRA and reorganize and

update existing provisions of PBGC's merger regulation. The Final Regulations also outline the process to be followed for multiemployer mergers, including:

- The process to submit a notice of merger or transfer, and a request for a compliance determination or facilitated merger;
- Information to include in notices and requests to the PBGC, such as:
  - A description of the merger and how the merger satisfies the requirements under MPRA;
  - Actuarial information about the plan's funded status, significant risks, assumptions and methods and long-term projections of benefit disbursements;
  - Financial information from the plan, including annual cash flow projections;
  - Plan and trust documents (including an IRS determination letter);
  - Rehabilitation or funding improvement plans, including any application for suspension of benefits;
  - Additional documentation to submit (*g.*, the plan's most recent Form 5500, list of contributing employers, participant counts, census data, and withdrawal liability schedules).

- The Final Regulations also contain information regarding how the PBGC will provide notice of facilitated merger decisions and explain the PBGC's jurisdiction over a merged plan that has received financial assistance.

The Final Regulations apply to mergers and transfers between multiemployer plans for which a notice, and, if applicable, a request for a facilitated merger, are filed on or after October 15, 2018.

DOL Issues Proposed Regulations on Multiple Employer Retirement Plans

The DOL has issued proposed regulations to expand the types of groups and associations that may sponsor multiple employer retirement plans ("MEPs") (also called "association retirement plans"). The proposed regulations clarify the circumstances under which a group or association of employers, or a professional employer organization ("PEO"), may join together as an "employer" to sponsor a single defined contribution retirement plan under ERISA. The proposed

regulations would allow different businesses and certain working owners to join a MEP, either through a group or an association or a PEO. Specifically, the proposed regulations allow a "*bona fide* group or association" to establish a MEP, provided it meets the following criteria:

1. Purpose. The group or association must have at least one substantial business purpose unrelated to providing MEP coverage or other benefits to its employer members and their employees.

2. Direct Employer. Each employer member must be a person acting directly as the employer of at least one person who is a participant under the MEP.

3. Organization. The group or association must have a formal organizational structure, including a governing body and by laws (or other similar formalities).

4. Employer Control. The employer members must have control, in form and substance, over the functions and activities of the group or association.

5. Commonality of Interest. The employer members must have a commonality of interest; that is, the employer members are either (a) in the same trade, industry, line of business or profession; or (b) in the same principal place of business within the same state, or a common metropolitan area (even if the area straddles state lines).

6. Participation. The group or association may only offer MEP participation to employer members, employees' eligible dependents, and certain eligible former employees.

7. Ineligible Group or Association. The group or association must not be a bank or trust company, insurance issuer, broker dealer, or other similar financial services firm (including a pension record keepers or third party administrator), or be owned or controlled by such an entity or be any subsidiary or affiliate of such an entity, other than to the extent such an entity, subsidiary or affiliate participates in the group or association in its capacity as an employer member thereof.

A PEO is a human resource company that contractually assumes certain employer responsibilities of its client employers. A "*bona fide* PEO" may establish a MEP, provided it meets the following criteria:

1. The PEO performs "substantial employment functions" (as further described in the proposed regulations), on behalf of its client employers, and maintains adequate records relating to such functions.
2. The PEO has substantial control over the functions and activities of the MEP, as the plan sponsor, the plan administrator, and a named fiduciary, as those terms are defined in ERISA.
3. The PEO ensures that each client employer that adopts the MEP acts directly as an employer of at least one employee who is a participant covered under the defined contribution MEP.
4. The PEO ensures that participation in the MEP is available only to employees and former employees of the organization and client employers, and their beneficiaries.

The DOL promulgated similar regulations in June 2018 that expand the types of groups and associations that may sponsor multiple employer health plans (also called "association health plans"). **[Link to July EB Update]**

IRS Announces Benefit and Contribution Limits for 2019

In Notice 2018 83, the IRS released the 2019 cost of living adjustments to the Code's benefit and contribution limits for qualified retirement plans. Highlights are as follows:

- Elective Deferrals. The elective deferral (contribution) limit for employees who participate in 401(k), 403(b), most 457 plans and the federal government's Thrift Savings Plan increases from $18,500 to $19,000.
- Catch Up Contributions. The catch up contribution limit for employees age 50 and over who participate in 401(k), 403(b), most 457 plans and the federal government's Thrift Savings Plan remains unchanged at $6,000.
- Annual Compensation Limit. The annual compensation limit under Code sections 401(a)(17), 404(l), 408(k)(3)(C) and 408(k)(6)(D)(ii) increases from $275,000 to $280,000.
- Annual Additions Limit. The annual additions limit for a defined contribution plan under Code section 415(c)(1)(A) increases from $55,000 to $56,000.
- Annual Benefit Limit. The annual benefit limit from a defined benefit plan under

Code section 415(b)(1)(A) increases from $220,000 to $225,000.

- Definition of Highly Compensated Employee. The limit used in the definition of a highly compensated employee under Code section 414(q)(1)(B) increases from $120,000 to $125,000.

- Definition of Key Employee. The limit used in the definition of a key employee in a top heavy plan under Code section 416(i)(1)(A)(i) increases from $175,000 to $180,000.

PBGC Announces Premium Rates for 2019

The PBGC has issued a notice outlining premium increases for 2019. The per participant flat rate premium for the PBGC's single employer plan termination insurance program increases from $74 to $80. The per participant flat rate premium for multiemployer plans increases from $28 to $29. The variable rate premium per $1,000 of unfunded vested benefits increases from $38 to $43. The variable rate premium cap increases from $523 times the number of participants to $541. (However, plans sponsored by small employers (generally, employers with fewer than 25 employees) may be subject to a lower variable rate premium cap.)

PBGC Guarantee Limit for Single Employer Plans Increases in 2019

The PBGC has announced that its guarantee limit for single employer plans is increasing in 2019. The increase will only apply to plans terminating in 2019 (payments to retirees whose plans terminated before 2019 will not change). Beginning in 2019, the age adjusted annual maximums for a single life annuity are age 55—$30,283; age 60—$43,742; age 65—$67,295; age 70—$111,710. Annual maximums for a joint and 50% survivor annuity are also increasing. The guarantee for multiemployer plans has not changed.

Health and Welfare Plan Developments

DOL Advises FLSA Does Not Require Compensation for Participation in Various Wellness Activities

The Department of Labor's ("DOL") Wage and Hour Division has released DOL Opinion Letter FLSA2018-20, addressing whether the Fair Labor Standards Act ("FLSA") requires employers to compensate employees for time spent participating in an employer's wellness program. Generally, the FLSA requires

employers to compensate employees for any time spent predominantly for the employer's benefit other than "off-duty" time, which is defined as time during which employees are completely relieved from duty for a period long enough to use their time effectively for their own purposes. In the letter, the DOL concluded that the FLSA does not require employers to compensate employees for time spent participating in three different components of the employer's wellness program (benefit fairs, biometric screenings, and certain other "wellness activities," such as participating in health education classes, telephonic or online health coaching sessions, or participating in fitness activities). The employer represented that each component was voluntary, unrelated to the employee's job duties, and of no direct financial benefit to the employer (although certain activities could reduce employees' monthly insurance premiums or deductibles). Also, the letter noted the activities were not compensable because participation primarily benefits employees and time spent on the specified components is primarily "off-duty" time. The letter also noted its conclusions are not dependent on whether the activities are performed onsite or during regular working hours. However, the DOL noted the use of otherwise compensable break time for wellness activities would not make such break time noncompensable.

District Court Allows ACA Section 1557 Gender Identity Discrimination Claim to Proceed

The District Court for the District of Minnesota has denied a motion to dismiss a claim that a health plan's denial of gender transition benefits violated Affordable Care Act ("ACA") section 1557. ACA section 1557 incorporates by reference various federal civil rights laws to prohibit discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age or disability. In the relevant case, a participant and her son claimed that her employer-sponsored plan's categorical exclusion of all services relating to gender reassignment was discriminatory under ACA section 1557. The employer and the plan's third-party administrator ("TPA") moved to dismiss on the basis that ACA section 1557's protections do not extend to gender identity discrimination. The court denied the employer's motion to dismiss, noting that other courts have interpreted civil rights law to conclude that gender identity discrimination is within the scope of prohibited discrimination based on sex under ACA section 1557. The court also denied the TPA's dismissal request, noting that nothing in ACA section 1557 exempts TPAs from the nondiscrimination requirements. Notably, the court also refused to stay the action until after final resolution of the *Franciscan Alliance* case, which imposed a nationwide preliminary injunction on

enforcement of regulations issued under ACA section 1557, noting its conclusion was based on the plain language of ACA section 1557.

District Court Holds Intoxication Exclusion Extends to Snowmobile Accidents

The District Court for the District of Minnesota has approved a plan administrator's decision to deny coverage for death in a snowmobile accident, holding that a snowmobile was a "motor vehicle" and that driving it under the influence could negate coverage. In *Rathman v. Union Security Insurance Company*, a participant submitted a claim for accidental death and dismemberment ("AD&D") coverage after her husband died following a snowmobile accident in which he was intoxicated. The AD&D policy under which the claim was submitted excluded coverage stemming from "intoxication while operating a motor vehicle." The court found that the plan administrator was within its rights to extend the definition of "motor vehicle" to include a snowmobile, noting, among other things, that a goal of the plan was "to reduce moral hazard – [or] to avoid creating an incentive for employees to engage in risky or self-injurious behavior." The court also noted the plan's exclusion of injuries resulting from rioting and suicide supported its conclusion.

Courts Address Medical Providers' Rights under Assignment of Benefits Clauses

Two recent cases have addressed the scope of medical providers' rights to sue plan fiduciaries and seek plan documents and summary plan descriptions ("SPDs") under assignments of benefits from patients. In *Griffin v. Aetna Health Inc.*, a provider under assignments from various patients requested an SPD from an ERISA plan administrator and sued to collect statutory penalties after the plan administrator failed to produce the SPD. After a trial court dismissed the action, noting that patients did not assign their right to sue for statutory penalties, the provider obtained a second assignment from each patient explicitly conferring the right to sue for statutory penalties. On appeal, the Eleventh Circuit noted the provider had no right to request the SPD because the provider was neither a participant nor a beneficiary. Therefore, as no party entitled to the SPD had requested it, no penalty liability arose, regardless of whether the assignment gave the provider the right to sue.

In *University Spine Center v. Cigna Health & Life Insurance Company*, a surgical provider sued a claims administrator for underpayment and breach of fiduciary duty. The provider asserted it had requested but had not received copies of the

plan document and SPD, but the District Court for the District of New Jersey nevertheless dismissed the underpayment claim because the provider had not identified specific plan provisions showing that the services were covered. However, the court allowed the fiduciary breach claim to proceed, as well as the issue of whether an assignment of benefits allows providers (rather than participants or beneficiaries) to sue for fiduciary breach in addition to suing for benefits, noting that prior courts had reached inconsistent conclusions regarding the scope of rights available to providers acting under an assignment clause.

Agencies Propose Expansion of HRAs

The DOL, HHS, and Department of the Treasury have proposed regulations that expand the permissible purposes under which employers may establish health reimbursement arrangements ("HRAs"). The proposed regulations would allow employers to establish HRAs for active employees that reimburse the employees' premiums for major medical insurance purchased on the individual market, provided certain requirements are met. Such requirements include the following:

- the employer can offer major medical coverage to other classes of employees;
- any enrollee must actually have individual coverage;
- the employer must substantiate that coverage upon enrollment and before reimbursing each expense;
- the HRA must be provided on the same terms to all employees within a class;
- the HRA must allow participants to opt out at least annually; and
- the employer must provide a written notice to all participants upon becoming eligible and annually thereafter.

Under the proposed regulations, these "premium reimbursement HRAs" would be integrated with individual health insurance coverage, which is currently prohibited under the ACA, and could potentially qualify as minimum essential coverage and/or minimum value for purposes of determining an employer's compliance with the ACA's employer shared responsibility provisions.

In addition, the proposed regulations expand the circumstances under which employers can establish nonintegrated excepted benefit HRAs. To provide an HRA that qualifies on its own as an excepted benefit, and therefore does not need to be integrated with any other coverage, the following conditions apply:

- the plan sponsor must also make available other traditional group health plan coverage;
- the HRA cannot newly offer more than $1,800 per plan year, indexed for inflation;
- the HRA cannot reimburse premiums for individual coverage, coverage under a group health plan (other than COBRA or other continuation coverage), or Medicare Parts B or D; and
- the HRA must be made available under the same terms to all similarly situated individuals.

Due to their respective requirements, an employer could not offer both an HRA integrated with individual coverage and the above described excepted benefit HRA.

The proposed regulations would be effective for plan years beginning on or after January 1, 2020, and cannot be relied on before that date.

Anthem to Pay $16 Million to Settle HIPAA Breach with OCR

Anthem, Inc. has agreed to pay a record $16 million to HHS' OCR to settle alleged violations of the HIPAA Privacy and Security Rules. The OCR settlement arose from a series of cyber attacks Anthem suffered in 2015. The resulting breach was the then largest health related breach to date, affecting over 79 million individuals and numerous health plan clients. The $16 million settlement is nearly three times higher than the previous record high $5.5 million paid to OCR in 2016. The settlement also requires Anthem to take corrective action to address allegedly deficient security procedures, including conducting a thorough risk analysis of vulnerabilities to electronic protected health information ("ePHI"), updating policies and procedures, and implementing adequate system access controls. This $16 million settlement with OCR is separate from a $115 million settlement Anthem reached in August 2018 in a class action brought by 9.1 million potentially affected individuals.

HHS Announces Annual Adjustments of Civil Monetary Penalties

HHS has announced its annual adjustments of civil monetary penalties for various statutory violations, including HIPAA Administrative Simplification, Summary of Benefits and Coverage, and Medicare Secondary Payer violations. The

adjustments are effective for penalties assessed on or after October 11, 2018, for violations occurring on or after November 2, 2015. Some of the highlights are as follows:

- HIPAA Administration Simplification. The minimums, maximums and yearly caps on penalties for violating the HIPAA Privacy, Security, Breach Notification, and Electronic Data Interchange Rules have all been increased.
- Medicare Secondary Payer. The penalties imposed on plan sponsors for violating applicable provisions of the Medicare Secondary Payer rules (for example, the prohibition on plan sponsors offering incentives to employees to forgo group health plan coverage that would otherwise be primary to Medicare) have all been increased.
- SBC. The maximum penalty for willfully failing to provide the summary of benefits and coverage ("SBC") increases from $1,105 per failure to $1,128 per failure.

EEOC Announces New Delay on Updating Wellness Regulations

The Equal Employment Opportunity Commission ("EEOC") has announced it is delaying issuance of proposed updates to its wellness regulations from January 2019 to June 2019. The proposed updates were in response to the D.C. District Court's decision in *AARP v. EEOC*, in which the court vacated the incentive provisions of the EEOC's final wellness regulations. Under the EEOC's current wellness regulations, which became effective January 1, 2017, plan sponsors may use incentives of up to 30% of the cost of coverage to encourage participation in a wellness program without rendering the program "involuntary" for purposes of the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act. However, in *AARP v. EEOC*, the court determined the EEOC had failed to provide sufficient justification as to why the 30% threshold represented the line between "voluntary" and "involuntary," and, ultimately, ordered that the incentive provisions be vacated effective January 1, 2019.

IRS Releases Final Forms and Instructions for Forms 1094/1095 B and 1094/1095 C

The IRS has released final forms and instructions for the B Series (1094 B and 1095 B) and C Series (1094 C and 1095 C) Information Returns required under the ACA. All applicable large employers and self funded plan sponsors must file such Information Returns with the IRS by February 28, 2019 (or April 1, 2019, if

filing electronically) to report coverage offered to full time employees and participants during the 2018 calendar year. A copy of the Information Return must be provided to employees and participants by January 31, 2019.

The 2018 forms and instructions are mostly unchanged from the 2017 versions. As a reminder, the IRS uses information collected on the Information Returns to administer the ACA's employer shared responsibility payment provisions and the premium tax credit. The IRS sent its first round of payment notices to employers beginning in November 2017.