Benefits Counselor - July/August 2019 Update

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GENERAL EMPLOYEE BENEFITS

DOL Releases Revised Model Summary Annual Reports

The Department of Labor ("DOL") has released revised model summary annual report ("SAR") documents for both pension plans and health and welfare plans. The revised models include minor changes to previous models. Plan sponsors and administrators can download the revised model SARs in Microsoft Word format from the DOL website.

RETIREMENT PLAN DEVELOPMENTS

District Court Denies U.S. Bancorp's Motion to Dismiss Actuarial Equivalence Case

In *Smith v. U.S. Bancorp*, No. 18 3405 (D. Minn. June 26, 2019), the District Court of Minnesota denied U.S. Bancorp's motion to dismiss a proposed class action alleging that the company improperly reduces the pensions of participants who retire early. U.S. Bancorp maintains the U.S. Bank Pension Plan (the "Plan"), which anticipates participants will retire at age 65, but permits early retirement as young as age 55. If a participant elects early retirement, the Plan requires a reduction of the participant's monthly benefit, expressed as a percentage (called an early retirement factor ("ECF")) of the normal retirement benefit the participant would receive if he or she had commenced benefits at age 65. Calculating an ECF requires plans to make actuarial assumptions regarding interest and mortality rates. However, the Plan document does not specify the assumptions U.S. Bancorp uses to calculate the ECFs.

The named plaintiffs, four participants who commenced an early retirement benefit, and whose retirement benefits were reduced by the ECF, make three claims against U.S. Bancorp. First, they allege the ECFs are based on actuarial assumptions which result in benefits not actuarially equivalent to the retirement benefits they would have received had they retired at age 65. The plaintiffs therefore claim that U.S. Bancorp violates the Employee Retirement Income Security Act of 1974 ("ERISA") requirement that an alternate form of benefit be actuarially equivalent to the normal retirement age benefit. Second, the plaintiffs allege that, by using outdated ECFs, U.S. Bancorp violates ERISA's requirement

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that a participant's right to his or her vested retirement benefit be nonforfeitable. Third, the plaintiffs claim U.S. Bancorp breached its fiduciary duty by failing to monitor its Employee Benefits Committee, established to oversee U.S. Bancorp's retirement plans.

The court ruled that, accepting all allegations as true, the plaintiffs' alleged claims are plausible, and rejected U.S. Bancorp's argument that the allegations required reading a "reasonableness" requirement into ERISA, noting that the plaintiffs simply sought what ERISA's plain language requires—actuarial equivalence. However, the court emphasized an analysis of the underlying claims would have to wait until the completion of the discovery process.

This ruling is notable, as it is the first substantive decision in the recent wave of cases targeting pension plan administrators for alleged failures to comply with ERISA's actuarial equivalence requirement. At least eight other cases are currently pending.

Seventh Circuit Holds Doctrine of Substantial Compliance Inapplicable to ERISA's Regulatory Deadlines

In *Fessenden v. Reliance Standard Life Insurance Co*., No. 18 1346 (7th Cir. June 25, 2019), the Seventh Circuit held that plan administrators who issue a benefits decision beyond the ERISA imposed deadline are not entitled to deferential review. Donald Fessenden applied for long term disability benefits through his former employer's benefit plan, administered by Reliance Standard Life Insurance Company ("Reliance"). After Reliance denied the claim, Fessenden timely submitted an appeal with additional evidence. Once Reliance failed to issue a decision on the appeal within the ERISA imposed timeframe, Fessenden sought review in federal court. Eight days after Fessenden filed, Reliance denied Fessenden's appeal. Generally, when a benefit plan grants the plan's administrator discretionary authority to determine a claimant's eligibility for benefits, courts review a denial of said benefits under a deferential standard. The district court applied the deferential standard and granted Reliance's motion for summary judgment.

On appeal, Fessenden argued that, by failing to meet the ERISA imposed deadline for an appeal decision, Reliance forfeited its right to a deferential standard. Instead, Fessenden argued, the court must review Reliance's decision *de novo*. Reliance counter argued that the deferential standard should apply because Reliance's untimely decision could be excused under the doctrine of substantial

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compliance, which posits that courts should still apply a deferential standard where a plan administrator "substantially complies" with a required procedure.

The court rejected Reliance's argument, holding that, while an administrator may "substantially comply" with other procedural requirements, an ERISA imposed deadline creates "a bright line" to which the doctrine of substantial compliance is inapplicable. This case serves as a reminder that plan administrators who wish to take advantage of the deferential standard should remain conscious of—and comply with—ERISA's regulatory deadlines.

IRS Proposes Exception to Unified Plan Rule for Defined Contribution MEPs

In response to Executive Order 13847, "Strengthening Retirement Security in America," which directed the Secretary of the Treasury to consider proposing regulations relating to the unified plan rule, the Internal Revenue Service ("IRS") has issued proposed regulations relating to the tax qualification of multiemployer plans ("MEPs") maintained pursuant to Internal Revenue Code ("Code") section 413(c). Under current regulations, failure by one employer maintaining a MEP to satisfy a qualification requirement results in the MEP's disqualification for all employers maintaining the MEP, which is known as the "unified plan rule." The proposed regulations provide an exception to the unified plan rule for defined contribution MEPs if certain requirements are met, in the event a participating employer fails to meet a qualification requirement or fails to provide information necessary to determine compliance with a qualification requirement.

To be eligible for the exception, a MEP must meet three requirements. First, the plan administrator must have in place practices and procedures reasonably designed to promote compliance with Code requirements. Second, the plan document must include language describing the procedures to be followed to address participating employer failures. Third, the MEP must not be under examination by the IRS.

The proposed regulations would require the plan administrator to provide up to three notices regarding the qualification failure to the unresponsive employer, with the third notice also being provided to participants and the DOL. Once the unresponsive employer has received the third notice, it has 90 days to either take remedial action or instruct the plan administrator to initiate a spin off of plan assets and account balances held on behalf of its employees to a separate, single employer plan. The spinoff must be completed within 180 days of the date

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on which it was initiated. If the employer takes no action by the deadline, the plan administrator must initiate the spinoff, concluding with the termination of the unresponsive employer's plan. The proposed regulations do not provide a strict deadline for completion

of the spinoff termination process, but instead, instruct the plan administrator to take all necessary actions "as soon as reasonably practicable after the deadline for action by the unresponsive employer."

The IRS will accept comments on the proposed regulations until October 1, 2019. The proposed regulations may not be relied upon.

Supreme Court Agrees to Review Claims Against Fiduciaries of Overfunded Pension Plan

The U.S. Supreme Court agreed to review whether participants in an overfunded pension plan have standing to sue for violations of fiduciary duties and prohibited transaction rules under ERISA. In *Thole v. U.S. Bank, N.A.*, retired participants in the U.S. Bank Pension Plan sued the plan's trustees and sponsor after the plan, which was solely invested in equities, incurred approximately $1.1 billion in losses during the Great Recession. The participants claim this investment strategy violated ERISA's fiduciary duties of prudence and loyalty, as well as the prohibited transaction rules. Following the lawsuit's initial filing, U.S. Bank made significant contributions to the plan, eliminating the underfunding. U.S. Bank subsequently moved for dismissal, arguing that participants in an overfunded defined benefit plan do not have the standing to sue under ERISA because no injury occurred. The Eighth Circuit held that ERISA's civil enforcement provisions do not permit participants to sue for fiduciary violations absent proof of actual or imminent injury to the plan or the participants' benefits.

DOL Announces Rule Permitting Association Retirement Plans

On July 31, 2019, the DOL announced a rule easing the restrictions on retirement savings plans offered through association retirement plans ("ARPs"). Under the new rule, an ARP must satisfy these requirements:

- The association must have at least one substantial business purpose other than the provision of benefits;
- The activities of the association must be controlled by its employer members and the participating employers must control the MEP in form and substance;
- The association must have a formal organizational structure;

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- Participation in the plan must be limited to the employees of the association's employer members and certain working owners; and
- The employer members must have some commonality of interest.

The new rule also permits ARPs to be sponsored through professional employer organizations ("PEOs"), provided:

- The PEO performs substantial employment functions;
- The PEO has substantial control over the MEP as the plan sponsor, administrator and named fiduciary;
- All participating employers have at least one nonowner employee; and
- The PEO must ensure participation is limited to only employees of participating employers.

The DOL also requested comment on a variety of questions relating to corporate and open MEPs.

The final rule is effective on September 30, 2019.

DOL Announces MEP Reporting Relief

On July 24, 2019, the DOL released Field Assistance Bulletin 2019 01, which provides guidance and temporary penalty relief relating to certain Form 5500 requirements for MEPs. The Form 5500 instructions require MEP sponsors to include a list of all participating employers, each participating employer's employer identification number ("EIN"), and a good faith estimate of each participating employer's percentage of total contributions to the MEP for the preceding year. Due to a significant number of deficient Forms 5500 filed for the 2016 plan year, the DOL announced it will provide penalty relief for any MEP sponsor failing to properly report its participating employers, provided the sponsor's Form 5500 for the 2018 plan year is properly completed *and* any information missing from prior years' Forms 5500 is also submitted. The DOL granted an automatic Form 5500 filing extension until October 15, 2019, for all MEPs to ensure compliance with the filing requirements.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Final Regulations Expand Availability of HRAs

The IRS, DOL, and Department of Health and Human Services ("HHS") have jointly issued final regulations that expand the availability and permitted uses of health reimbursement arrangements ("HRAs"). The final regulations include

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modifications to 2018's proposed regulations, such as no longer distinguishing between salaried and hourly employees. They are generally applicable to plan years beginning on or after January 1, 2020, and they establish two new types of HRAs, which will be available to employers of any size.

Under the final regulations, employers can offer individual coverage health reimbursement accounts ("ICHRAs") to provide employees with tax preferred funds to pay for costs associated with individual market health insurance or Medicare, if certain conditions are satisfied. First, participants and dependents covered by an ICHRA must be enrolled in an individual market health insurance or Medicare. The ICHRA must implement reasonable procedures to verify that all participants and dependents are enrolled in individual market health insurance or Medicare during the plan year through the documentation by a third party or through an attestation by the participant. Second, an ICHRA must be offered on the same terms and conditions to all employees within a class; however, an employer may increase the maximum amount available to a participant under an ICHRA based on the participant's age or family size. Third, the employer cannot offer an ICHRA to a class of employees if the employer offers a "traditional group health plan" (*i.e.,* one that is neither account based nor limited to excepted benefits). Fourth, ICHRA participants must be given the opportunity to opt-out and waive future reimbursements from the ICHRA, both annually and on termination of employment. Finally, an employer must provide written notice to eligible employees, at least 90 days prior to the beginning of a plan year, that participation in an ICHRA will result in the employee becoming ineligible for a premium tax credit.

The final regulations also create an excepted benefit HRA ("EBHRA"). Employers that offer a traditional group health plan to a class of employees may provide an EBHRA of up to $1,800 per year to that class of employees, even if an employee does not enroll in the traditional group health plan. Employers can use EBHRAs to reimburse employees for certain qualified medical expenses, including premiums for vision, dental, and short term limited-duration insurance.

President Trump Issues Executive Order to Increase Health Care Transparency

On June 24, 2019, President Trump signed an executive order aimed at lowering health care costs by providing patients with greater information on pricing. The order directs several federal agencies to publish proposed regulations, guidance and reports related to health care costs in the coming months, including the

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following:

- **Regulations**. Within 90 days of issuance, the HHS, DOL and IRS must issue an advance notice of proposed rulemaking seeking comments on a proposal to require healthcare providers, health insurance issuers, and self insured group health plans to provide or facilitate access to information about expected out of pocket costs for items or services to patients before they receive care. Similarly, within 60 days of the order, the Secretary of HHS must propose a regulation requiring hospitals to publicly post standard charge information for services, supplies or fees billed by the hospital or provided by employees of the hospital.
- **Guidance**. The order also instructs the IRS to publish guidance on two topics. First, within 120 days, the IRS must publish guidance to expand the ability of patients to select high deductible health plans that can be used alongside a health savings account, and that cover low cost preventive care before the deductible, for medical care that helps maintain health status for individuals with chronic conditions. Second, within 180 days of the order, the IRS must issue guidance to increase the amounts of funds that can carry over without penalty at the end of the year for flexible spending arrangements.
- **Reports**. Within 180 days of the order, HHS, in consultation with the U.S. Attorney General and the Federal Trade Commission, must issue a report describing how the federal government or the private sector is impeding healthcare price and quality transparency for patients, and provide recommendations for how any impediments can be removed to promote competition. Within the same timeframe, HHS must provide the President with a report on steps the Administration can take to implement the principles of surprise medical billing announced in a fact sheet published on May 9, 2019.
- **Claims Data Availability**. Within 180 days of the order, HHS, in consultation with several agencies, must increase access to de identified claims data from taxpayer-funded healthcare programs and group health plans to enable researchers, innovators, providers, and entrepreneurs to locate inefficiencies and opportunities for improvement, in a manner that is consistent with law and ensures patient privacy.

HHS Publishes Fact Sheet on Business Associate Direct Liability

The Department of HHS Office for Civil Rights ("OCR") has issued a new fact sheet listing the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") Privacy, Security, Breach Notification and Enforcement Rules ("HIPAA Rules") for which a business associate can be held directly liable. The fact sheet

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seeks to clarify the OCR's authority to take enforcement action against business associates under the 2013 final rule issued by the OCR and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

The fact sheet states that business associates are directly liable for HIPAA violations as follows:

- Failure to provide the Secretary of HHS with records and compliance reports; failure to cooperate with complaint investigations and compliance reviews; and failure to grant the Secretary access to information, including protected health information ("PHI"), pertinent to determining compliance.
- Taking any retaliatory action against any individual for filing a HIPAA complaint, participating in an investigation or other enforcement processes, or opposing an act or practice that is unlawful under HIPAA.
- Failure to comply with the requirements of the Security Rule.
- Failure to provide breach notification to a covered entity or another business associate.
- Impermissible uses and disclosures of PHI.
- Failure to disclose a copy of electronic PHI to the covered entity, the individual, or the individual's designee (whichever is specified in the business associate agreement) to satisfy a covered entity's obligations regarding the form and format, and the time and manner of access, under 45 C.F.R. §§ 164.524(c)(2)(ii) and 3(ii), respectively.
- Failure to make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
- Failure, in certain circumstances, to provide an accounting of disclosures.
- Failure to enter into business associate agreements with subcontractors that create or receive PHI on their behalf, and failure to comply with the implementation specifications for such agreements.
- Failure to take reasonable steps to address a material breach or violation of the subcontractor's business associate agreement.

OCR also published a fact sheet in April 2019 regarding the use of third party patient apps.

Third Circuit Upholds Injunction Blocking Implementation of Final Rules on Contraceptives

In *Pennsylvania v. President US*, the Third Circuit upheld the district court's preliminary nationwide injunction blocking the Trump Administration's final regulations under the Affordable Care Act's ("ACA") contraceptive mandate. The

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regulations, which were jointly issued by the DOL, HHS and the IRS (collectively, the "Departments"), and finalized in November 2018, expand the existing religious exemption to allow any employer, insurer, entity or individual to object to contraceptive coverage based on a "sincerely held religious belief." The regulations also add a moral conviction exemption for entities and individuals with "sincerely held moral objections" to contraceptive coverage. District courts in California and Pennsylvania have issued preliminary injunctions, finding that the Departments violated administrative procedure by issuing interim regulations, and subsequently final regulations, without advance notice and comment. The Third Circuit affirmed the district court's findings and also concluded that the Departments overstepped their authority in issuing regulations exempting entities from ACA compliance.

IRS Expands Preventative Care Benefits Not Subject to HDHP Deductible

The IRS issued Notice 2019 45, which expands the preventative care benefits provided by a high deductible health plan ("HDHP"). Currently, the health savings account ("HSA") rules provide that preventative care does not include services or benefits intended to treat existing illnesses, injuries or conditions. However, per the Notice, preventative care now includes medical expenses for treatments which, although administered to treat an existing chronic condition, also prevent the development of a secondary condition.

The Notice, which applies only to a specific list of treatments for specific disorders, provides that the intent is to permit coverage of the preventative service if:

- The medical expense is low cost;
- There is medical evidence supporting high cost efficiency of preventing exacerbation of the chronic condition or the development of a secondary condition; and
- There is a strong likelihood, documented by clinical evidence, that the specific service or use of the item will prevent exacerbation of the chronic condition or the development of a secondary condition that requires significantly higher cost treatments.

The IRS cautions that other services may not be considered preventative, even if those services meet the Notice’s criteria. Additionally, services used to treat a previously existing secondary condition are not considered preventative.

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ACA Affordability Percentage Decrease Announced for 2020

On July 22, 2019, the IRS announced that the ACA's affordability percentage for the 2020 calendar year will be reduced from 9.86% to 9.78%. Under the ACA, an applicable large employer is generally required to offer at least one level of health plan coverage that provides affordable, minimum value coverage to its full time employees. "Affordable" coverage means the premium for self only coverage cannot be greater than the designated percentage of the employee's household income. Plan sponsors should review the affordability of their health plan coverage to determine if additional employer contributions are required.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. For plans that obtained an extension for filing their Form 5500, the Form 5500 must be filed by October 15, 2019.

Retirement Plan Compliance Deadlines and Reminders

SAR Deadline for Calendar Year Defined Contribution Plans. Plan administrators must distribute SARs to participants and beneficiaries within nine months of the plan's year end (*e.g.*, for plan years that end December 31, 2018, the SAR is due September 30, 2019). However, if a plan has received an extension for filing its Form 5500 (*i.e.*, due by October 15, 2019), the nine month SAR deadline is extended by two months.

Health Plan Compliance Deadlines and Reminders

PCORI Fee. Sponsors of self funded plans should have paid the annual Patient Centered Outcomes Research Institute ("PCORI") fee by filing IRS Form 720 by July 31, 2019. For calendar year plans, this is the *final* PCORI fee. For non-calendar year plans that end between January 1, 2019, and September 30, 2019, the final PCORI fee must be paid by July 31, 2020.

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