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Benefits Counselor – June 2019 Update

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RETIREMENT PLAN DEVELOPMENTS

IRS Opens Determination Letter Program for Hybrid and Merged Plans

In Revenue Procedure 2019-20 ("Rev. Proc. 2019-20"), the Internal Revenue Service ("IRS") announced it will accept determination letter applications for individually designed statutory hybrid plans during the 12 month period beginning September 1, 2019. The IRS said it will also accept determination letter applications for certain individually designed merged plans on an ongoing basis.

Since the IRS eliminated the remedial amendment cycle review program in 2017, plan sponsors of individually designed plans could request determination letters only for initial plan qualification, qualification upon plan termination, and certain other circumstances as determined annually by the IRS.

Beginning September 1, 2019, certain merged plans resulting from a merger or acquisition of a previously unrelated entity may apply for a determination letter on an ongoing basis. Merged plans are eligible if: (1) the plan merger was completed by the end of the first plan year after the merger or acquisition and (2) the determination letter application is submitted after the plan merger and before the end of the first plan year beginning after the plan merger effective date.

Pending Retirement Plan Legislation

On May 23, 2019, the U.S. House of Representatives overwhelmingly approved the Setting Every Community Up for Retirement Enhancement Act of 2019 (H.R. 1994) (the "SECURE Act"). The broad legislation is designed to expand access to employer provided retirement plans and increase retirement savings.

Among other changes, the SECURE Act would increase the automatic deferral maximum for safe harbor plans, simplify the 401(k) safe harbor rules, require 401(k) plans to permit participation for certain long term, part time employees, provide for portability of lifetime income options and modify the required minimum distribution rules. The SECURE Act would also allow open multiple employer plans, which permit unrelated employers to join together to form one

retirement plan.

The SECURE Act will now move to the U.S. Senate, which may vote on it or vote on the Senate's previously introduced Retirement Enhancement and Savings Act (H.R. 1007) ("RESA") (the SECURE Act contains many key provisions of RESA).

Release in Severance Agreement Bars Former Employee's Claim Against ESOP Trustee

In *Innis v. Bankers Trust Co. of South Dakota*, the U.S. District Court for the Southern District of Iowa ruled that a former employee was barred from suing the trustee of an Employee Stock Ownership Plan ("ESOP") regarding the ESOP's purchase of stock because the former employee had signed a severance agreement with a general release. The decision details how general releases can prohibit participants from pursuing Employee Retirement Income Security Act of 1974 ("ERISA") claims on behalf of a plan.

Upon terminating employment at Telligen, Inc., the former employee signed a severance agreement with a general release stating "by signing this document you are releasing all known claims." The former employee subsequently filed a lawsuit against the ESOP Trustee on behalf of the plan. The ESOP Trustee argued the former employee had released her claims in the severance agreement. The former employee argued she had not entered into the release knowingly and voluntarily, and that the release did not cover her ERISA claims.

The court examined the totality of the circumstances wherein the release had been signed. Specifically, the court analyzed the former employee's education and business experience, the length of time she had had to review the release before signing (45 days) and then revoke it after signing (7 days), her knowledge of the relevant facts (*i.e.*, the ESOP transaction) and her opportunity to consult an attorney. The court found that, even though the former employee had not consulted an attorney or negotiated the language contained in the release, the release was voluntary. The court also found the general release was broad enough to cover ERISA fiduciary breach claims against the ESOP Trustee. The release included all claims arising under federal law and covered claims against Telligen, Inc., its owners, stockholders, affiliates and all persons acting on behalf of them. The court further found the release encompassed the ESOP Trustee, even though the employer obtained the release, because the ESOP Trustee acted on behalf of owners and stockholders who were plan participants and who owned stock as a result of the ESOP transaction. The court also found that, although not

specifically mentioned therein, the release was broad enough to cover ERISA claims.

While the release prevented the former employee from asserting her claims on behalf of the plan, it did not release the plan's claims. The court noted an employee cannot release a plan's claims without the plan's consent.

PBGC Issues Final Rule for Terminated and Insolvent Multiemployer Plans

On May 2, 2019, the Pension Benefit Guaranty Corporation ("PBGC") issued a final rule on Terminated and Insolvent Multiemployer Plans and Duties of Plan Sponsors. The final rule amends the multiemployer reporting, disclosure and valuation regulations and is generally effective January 1, 2019. Primary changes in the final rule include:

- Notice Requirements. The final rule revises the notice requirements for plans that are, or are expected to be, insolvent. Under the existing regulations, such plans must provide a notice of insolvency, as well as a separate, annual notice of insolvency benefit level to participants and beneficiaries. Under the final rule, these separate notices can be combined into one notice (for the same plan year). Furthermore, the final rule provides that an updated notice is required only when there is a change in the benefit payment amount, which effectively eliminates the annual notice of insolvency benefit level requirement.
- Actuarial Valuation Requirement. Under existing regulations, multiemployer plans terminated by mass withdrawal are generally required to annually perform an actuarial valuation. However, the regulations provide an exception under which certain plans are permitted to complete the valuation less frequently. Under the final rule, insolvent plans that are receiving financial assistance from the PBGC and plans terminated by plan amendment may perform this actuarial valuation once every five years (up from three years) if the value of nonforfeitable benefits is $50 million or less (up from $25 million).
- Withdrawal Liability Information. The final rule requires plans subject to the actuarial valuation requirements to file withdrawal liability information with the PBGC within 180 days after the earlier of the end of the calendar year wherein the plan becomes insolvent or the calendar year wherein the plan terminates, and each plan year thereafter.

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HEALTH AND WELFARE PLAN DEVELOPMENTS

DOL Issues Additional Q&As on AHPs

On May 13, 2019, the Department of Labor ("DOL") released a second set of questions and answers ("Q&As") regarding the district court's decision in *State of New York, et al. v. U.S. Dep't of Labor, et al.* vacating provisions of the DOL final rule expanding the availability of Association Health Plans ("AHPs") (the "Final Rule"). The Q&As are intended to provide further clarification on the DOL's recent statement (discussed in our May 2019 Benefits Counselor), which permits existing AHPs to continue their current benefits through the remainder of the applicable plan year (or contract term, if later) and includes a temporary nonenforcement policy.

The Q&As clarify that AHPs formed under the DOL's pre Final Rule subregulatory guidance, which the DOL refers to as "Pathway 1 AHPs," are unaffected by the district court's decision. Employer groups and associations that satisfy the criteria to be treated as an employer under such subregulatory guidance can continue to act as an "employer" for purposes of sponsoring an AHP. The DOL refers to AHPs established under the Final Rule, but prior to the district court's ruling, as "Pathway 2 AHPs." Pathway 2 AHPs may not market to, or sign up, new employer members.

The DOL's enforcement relief is limited to violations resulting from actions taken before the ruling in good faith reliance on the AHP rule's validity. However, existing employer members can enroll new employees upon special enrollment events and under the plan's eligibility terms under the enforcement relief.

HHS Proposes Changes to the ACA's Section 1557 nonDiscrimination Rules

On May 24, 2019, the U.S. Department of Health and Human Services ("HHS") released a proposed rule that would substantially revise the regulations implementing the Affordable Care Act's ("ACA") Section 1557—the ACA's primary nondiscrimination provision. The proposed rule would reverse certain provisions of the Section 1557 final regulations issued by the HHS in 2016.

Section 1557 directs the HHS to apply existing civil rights law, including Title IX (which prohibits discrimination on the basis of sex), to healthcare. The 2016 regulations defined discrimination "on the basis of sex" as to include termination of pregnancy, and gender identity, defined as an individual's internal

sense of being “male, female, neither, or a combination of male and female.” Following the issuance of the 2016 regulations, the district court in *Franciscan Alliance Inc. v. Burwell,* 227 F. Supp. 3d 660 (N.D. Tex., 2016), issued a preliminary injunction barring the HHS from enforcing the prohibition on discrimination based on termination of pregnancy and gender identity. The proposed rule would repeal the definition of "on the basis of sex" under the 2016 final regulations.

The proposed rule would repeal the provisions in the 2016 regulations requiring notices of nondiscrimination and taglines and the use of language access plans. The proposed rule would also revise the 2016 regulations' interpretation of Section 1557 as applying to all operations of an entity, even if the entity is not principally engaged in healthcare. Under the proposed rule, Section 1557 would apply to the healthcare activities of entities principally engaged in healthcare and entities that receive federal financial assistance from the HHS. And, if an entity that is not principally engaged in healthcare receives financial assistance for certain components but not others, only the particular components for which the entity receives HHS funding would be subject to the final rule.

Divorce Decree Overrides Life Insurance Beneficiary Designation

In *Teenor v. LeBlanc*, Case No. 18 cv 12364 (E.D. Mich. May 10, 2019), the U.S. District Court for the Eastern District of Michigan found that a divorce decree met the requirements of a qualified domestic relations order ("QDRO") under ERISA, and, as such, overrode a decedent's life insurance policy (*i.e.*, the life insurance benefit goes to the decedent's ex spouse, not the beneficiary currently named on the decedent's life insurance policy). Through his employment, the decedent obtained a life insurance policy funded by Metropolitan Life (“MetLife”) which named his then spouse as the beneficiary. When the decedent divorced his spouse, she was still named as the beneficiary. The divorce decree required the decedent to maintain his ex spouse as the "beneficiary on all life insurance policies." Despite this language, the decedent eventually changed the named beneficiary on the life insurance policy to his then current domestic partner. After the decedent's death, both the ex spouse and the domestic partner claimed entitlement to the life insurance benefit. MetLife filed an interpleader action requesting the court to determine the proper beneficiary.

The domestic partner argued she was the rightful beneficiary because ERISA preempts the divorce decree, and ERISA provides life insurance benefits should be distributed per the life insurance policy's named beneficiary. The ex spouse

argued she was the rightful beneficiary because the divorce decree was a QDRO, thereby constituting an exception to ERISA's preemption rules.

The court agreed with the ex spouse. Citing long standing precedent, the court noted ERISA generally preempts state law that relates to employee benefit plans. However, an exception arises where an employee benefit plan is the subject of a QDRO. The court further noted Sixth Circuit precedent provides a QDRO is not preempted by ERISA irrespective of whether the QDRO applies to a pension or a welfare plan. The court then determined the divorce decree contained the necessary specificity to qualify as a QDRO. According to the court, the requirement that a QDRO include the parties' mailing addresses was satisfied because the decedent's address was contained in the plan administrator's records, and the ex spouse's attorney's address was included in the divorce decree. The divorce decree specified the percentage of the life insurance proceeds to be paid to the ex spouse by requiring the ex spouse to be maintained as the principal beneficiary so long as spousal support was payable (which support was payable until the decedent's death). Finally, the divorce decree sufficiently identified the plan to which the order applied because it provided the ex spouse was the beneficiary on "all life insurance policies."

IRS Releases 2020 Limits for HSAs and HDHPs

In Revenue Procedure 2019 25, the IRS announced the 2020 inflation adjusted limits for Health Savings Accounts ("HSAs") and high deductible health plans ("HDHPs"). These limits are as follows:

- HSA Annual Contribution Limits. For 2020, the limit on deductible contributions for individuals with self only coverage under an HDHP has increased from $3,500 (2019) to $3,550, and family coverage has increased from $7,000 (2019) to $7,100. The HSA catch up contribution limit for individuals age 55 or older, which is not subject to cost of living adjustments, remains $1,000 for 2020.
- HDHP Annual Deductible Limit. The 2020 minimum deductible amount for self only HDHP coverage has increased from $1,350 (2019) to $1,400, and family HDHP coverage has increased from $2,700 (2019) to $2,800.
- HDHP Maximum Annual Out of Pocket Expenses. For 2020, out of pocket expenses (including deductibles, co pays and co insurance, but not premiums) cannot exceed $6,900 for self only HDHP coverage (up from $6,750 for 2019) and $13,800 for family HDHP coverage (up from $13,500 for 2019).

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UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Form 5500 for Calendar Year Plans. Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. Thus, for plan years ending December 31, 2018, the Form 5500 filing deadline is July 31, 2019. However, by filing Form 5558 by July 31, 2019, plan administrators can apply for a deadline extension to October 15, 2019.

SMM for Calendar Year Plans. Plan administrators generally have 210 days after the end of a plan year to provide a Summary of Material Modifications ("SMM") of a plan change. Thus, for a plan change adopted in 2018, the filing deadline is July 29, 2019.

Health Plan Compliance Deadlines and Reminders

PCORI Fee. Plan sponsors of self funded plans must report and pay the annual Patient Centered Outcomes Research Institute ("PCORI") fee by filing Form 720 by July 31, 2019.

Retirement Plan Compliance Deadlines and Reminders

Annual Funding Notice. Defined benefit plans with 100 or fewer participants generally must provide the annual funding notice to required recipients by the Form 5500 filing deadline.

Form 8955 SSA. Like the Form 5500, Form 8955 SSA (*Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits*) is due seven months after the end of a plan year (July 31, 2019 for calendar year plans). Also like the Form 5500, by filing Form 5558 by July 31, 2019, plan administrators can obtain an extension. Plan administrators must also provide the individual statements to those separated participants identified on the Form 8955 SSA *prior* to the deadline for filing the Form 8955 SSA.