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Retirement Plan Developments

DOL Releases Guidance on Fiduciary Rule

The Department of Labor ("DOL") released its first series of frequently asked questions ("FAQs") regarding its new fiduciary rule and related prohibited transaction exemptions which govern the provision of fiduciary investment advice to retirement plan sponsors, participants and owners of individual retirement accounts. The FAQs mostly address questions surrounding the scope of, and compliance with, the "Best Interest Contract" Exemption and the "Principal Transactions" Exemption, both of which allow financial advisors to use otherwise prohibited compensation arrangements if certain requirements are met. The FAQs also provide limited transition relief for these Exemptions, with full compliance extended until January 1, 2018. The DOL indicates that it plans to release two more series of FAQs before the fiduciary rule goes into effect on April 10, 2017.

IRS Announces Benefit and Contribution Limits for 2017

In Notice 2016-62, the Internal Revenue Service ("IRS") released the 2017 cost of living adjustments to the Internal Revenue Code's ("Code") benefit and contribution limits for qualified retirement plans. The 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 remains unchanged at $18,000.
- 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 $265,000 to $270,000.
- Annual Additions Limit. The annual additions limit for a defined contribution plan under Code section 415(c)(1)(A) increases from $53,000 to $54,000.
- Annual Benefit Limit. The annual benefit limit from a defined benefit plan under Code section 415(b)(1)(A) increases from $210,000 to $215,000.
- Definition of Highly Compensated Employee. The limit used in the definition of

a highly compensated employee under Code section 414(q)(1)(B) remains unchanged at $120,000.
- 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 $170,000 to $175,000.

Health and Welfare Plan Developments

New FAQs on Affordable Care Act and Mental Health Parity Implementation

The DOL, the Department of Health and Human Services ("HHS") and the Department of the Treasury jointly issued their 34th series of FAQs regarding the implementation of the market reform provisions of the Affordable Care Act ("ACA") and the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Specifically, the FAQs cover tobacco cessation, application of financial requirements and treatment limitations under mental health parity, medication assistance treatment for opioid use disorder, and court-ordered treatment for substance abuse. Notable highlights from the FAQs include the following:

Tobacco Cessation. The agencies requested comments from stakeholders regarding compliance with the United States Preventative Services Task Force's updated tobacco use recommendation.

Quantitative Treatment Limits. Under the MHPAEA, group health plans that offer mental health or substance use disorder ("MH/SUD") benefits may not impose financial requirements (such as a copayment or coinsurance) or quantitative treatment limitations (such as a day or visit limit) more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. Any financial requirement or quantitative treatment limitation must apply to at least two-thirds of medical and surgical benefits in order to be applied to MH/SUD benefits. Plans may use any "reasonable method" for the substantially all and predominant analyses. The FAQs clarify that these analyses must be based on group health plan-level claims data rather than an issuer's or third party administrator's ("TPA") broader book of business because the broader book of business would include unrelated plans with benefit designs that insufficiently resemble the target group health plan. If group health plan-level data is unavailable, the plan should use other reasonable claims data, such as data from other similarly-structured plans with similar demographics. The FAQs also advise plans to document the assumptions used in

choosing a data set and making projections.

Non-Quantitative Treatment Limits ("NQTL"). Under the MHPAEA, group health plans that offer MH/SUD benefits may not impose a NQTL in any "classification" (i.e., in network, out of network, inpatient, outpatient, emergency care and prescription drugs) unless, under the terms of the plan and in operation, any processes, evidentiary standards or other factors applying the NQTL to the MH/SUD benefit are comparable to, and not more stringent than, those factors used in applying the NQTL to medical/surgical benefits in the same classification.

The agencies have been issuing examples of NQTLs that may be impermissible. The FAQs provide the following additional examples of impermissible NQTLs:

- In-person examinations for prior authorization of inpatient admissions to a MH/SUD facility while medical/surgical inpatient admissions may be authorized over the phone;
- Fail-first requirements for inpatient MH/SUD treatment benefits that include a condition that an individual cannot reasonably satisfy or the lack of programs necessary to satisfy the requirement if it is only for MH/SUD benefits (effective for plan years beginning on or after March 1, 2017);
- Prior authorization requirements for opioid use disorder prescription drugs due to safety concerns, if the plan does not impose similar requirements for medical/surgical prescription drugs;
- Deviating from the plan's designated treatment guidelines for setting prior authorization requirements for MH/SUD prescription refills only;
- Nonpharmacological fail-first requirements for MH/SUD prescriptions, if the plan does not impose similar requirement for medical/surgical prescription drugs and;
- Court-ordered treatment exclusions for MH/SUDs, if the plan does not exclude court-ordered treatment for medical/surgical conditions.

Federal Agencies Publish Final Regulations on Short-Term, Limited Duration Benefits, Supplemental Coverage, and Lifetime and Annual Dollar Limits

The DOL, HHS and the Department of the Treasury published final regulations on short-term, limited duration coverage, supplemental coverage and annual and lifetime limits on essential health benefits. The final regulations, mostly unchanged from the proposed regulations, make a few technical clarifications to the definitions for various ACA compliance items, including defining "short-term,

limited duration" insurance for purposes of the exclusion from the definition of individual health insurance coverage and essential health benefits. The final regulations also provide standards for travel insurance and other supplemental coverage to be considered excepted benefits. The final regulations become effective on December 31, 2016 and apply to plan years beginning on or after January 1, 2017, but will likely have little administrative or operational impact on most group health plans.

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

The IRS released final forms and instructions for the B Series (1094 B and 1095 B) and C Series (1094 C and 1095 C) ACA Information Returns. All applicable large employers and self funded plan sponsors must file ACA Information Returns with the IRS by February 28, 2017 (March 31, 2017 if filing electronically) to report coverage offered to full time employees and participants during the 2016 calendar year. A copy of the return is due to employees/participants by January 31, 2017.

Except for minor changes and clarifications, the 2016 forms and instructions are mostly unchanged from the 2015 forms and instructions. Some changes include: clarifying the process for requesting a waiver from electronic filing, posting adjusted penalties for failures to timely file forms and furnish individual statements (increased to $260 per violation with an annual maximum of $3,193,000), updating the remaining transition relief available for 2016, and providing two new "Offer of Coverage" Codes for Form 1095 C.

HHS Releases Guidance on HIPAA and Cloud Computing

HHS recently released guidance on cloud service providers as business associates to health plans and other covered entities under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Health plans and TPAs are increasingly using third party cloud providers to store electronic information offsite on pooled (shared) servers (i.e., in the "cloud"). The HHS guidance provides that a cloud service provider is a business associate to a health plan or the plan's TPA if the cloud provider receives, uses or discloses electronic protected health information ("PHI") on behalf of the plan. The guidance clarifies that a business associate relationship exists even if the cloud provider only stores encrypted PHI and even if the cloud provider cannot decrypt the PHI. The guidance also notes that a cloud provider usually fails to satisfy the "conduit" exception to the definition of

business associate. Therefore, in most instances, a business associate agreement must be in place before any PHI is shared with a cloud provider performing storage services on behalf of a health plan or its TPA.

DOL Issues FAQs and Fact Sheet on Paid Sick Leave Final Rule

As a companion to its final rule mandating paid sick leave for federal contractors, the DOL issued a series of FAQs and a fact sheet summarizing key provisions of the final rule. The guidance summarizes which employees and contracts are covered by the rule, how paid sick leave is accrued and used, how the rule interacts with other laws and paid time off policies, and how the rule will be enforced.

Upcoming Compliance Deadlines and Reminders

1. Reinsurance Fee for Group Health Plans.

Contributing entities (the TPA for self funded plans or the insurer for fully insured plans) must report to HHS their annual enrollment counts by November 15, 2016 using the electronic "2016 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form." The Form calculates the contribution amount owed. The contribution rate for 2016 is $27 per reinsurance covered life. As in 2015, self insured, self administered plans exempt from the reinsurance fee requirement may wish to send an e mail to CMS indicating their self insured, self administered status. This is the last year that the reinsurance fee is payable.

2. Health Plan Open Enrollment Requirements.

a. Plan sponsors of group health plans must issue a new summary of benefits and coverage ("SBC") to participants and beneficiaries covered under the plan in conjunction with open enrollment. Group health plans without open enrollment must issue the SBC no later than 30 days prior to the beginning of the plan year (December 1, 2016 for calendar year plans).

b. Plan sponsors of health reimbursement arrangements ("HRA") must offer participants an annual opportunity to opt out of and waive all future reimbursements from their HRA. This opt out notice can be provided with the open enrollment materials.

3. Defined Contribution Plan Annual Notices.

Plan sponsors of defined contribution plans must provide the following notices, if applicable, at least 30 but not more than 90 days prior to the beginning of the Plan Year. Plan sponsors of calendar year plans must send the notices between October 3 and December 1, 2016.

a. Plan sponsors of defined contribution plans that invest participant contributions in a qualified default investment alternative ("QDIA") due to the participant's failure to make an investment election must provide an annual notice to all participants.

b. Plan sponsors of defined contribution plans with an eligible automatic contribution arrangement or a qualified automatic contribution arrangement must provide an annual notice to all participants on whose behalf contributions may be automatically contributed to the plan. Plan sponsors can combine the automatic enrollment notice with the QDIA notice.

c. Plan sponsors of safe harbor 401(k) plans must provide participants an annual safe harbor notice that describes the safe harbor contribution and other material plan features. Plan sponsors can combine the safe harbor notice with other required notices, such as the QDIA notice.

4. Summary Annual Reports ("SAR").

For calendar year plans that obtained an extension to file their annual report (Form 5500), the SAR must be distributed to participants and beneficiaries no later than two months following the close of the extension period (December 15, 2016).