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RETIREMENT PLAN DEVELOPMENTS

IRS Releases Final Regulations Governing Hardship Distributions

The Internal Revenue Service ("IRS") has released final regulations governing events that qualify as hardship distributions, funds available for hardship distributions, and standards determining whether such funds are necessary to relieve hardships. The final regulations are substantially similar to proposed regulations issued in November 2018, but with several clarifications.

- The final regulations confirm that safe harbor relief for expenses and losses incurred as the result of a federally declared disaster only applies to participants whose principal residence or place of employment is within the designated disaster area, and does not extend to losses incurred by relatives and dependents.
- The final regulations confirm that funds available for hardship distributions may include employer contributions, but plan sponsors may limit the availability of these funds in their discretion.
- The final regulations provide that participants must represent that they do not have sufficient cash or other liquid assets "reasonably available" to satisfy the need for a hardship distribution. Such representation may be made by telephone.

The final regulations generally apply to hardship distributions made on or after January 1, 2020, but plans may retroactively apply the final regulations to hardship distributions made in plan years beginning after 2018.

IRS Guidance Establishes Recurring Remedial Amendment Periods for 403(b) Plans

On September 30, 2019, the IRS issued Rev. Proc. 2019 39, which establishes recurring remedial amendment periods and pre approved plan cycles for plans established under Internal Revenue Code (the "Code") section 403(b). Remedial amendment periods for plan defects are generally determined based on the type of defect, whether the plan is a governmental or non-governmental plan, whether the plan is newly established, and whether the plan has terminated. Starting in

2019, the IRS will also include changes in 403(b) plan requirements in the annual required amendments list and operational compliance list.

Rev. Proc. 2019 39 also creates recurring pre approval cycles for 403(b) plans. Each cycle will have a one year submission window, during which time plan sponsors may apply for opinion and advisory letters. The IRS plans to issue subsequent guidance regarding application procedures and the timing of cycles.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Agencies Release Final Mental Health Parity FAQs and Model Disclosure Request Forms

The Department of Labor ("DOL"), Department of Health and Human Services ("HHS") and the IRS (collectively, the "Departments") have released final FAQ guidance regarding disclosure and nonquantitative treatment limits ("NQTLs") under the Mental Health Parity and Addiction Equity Act ("MHPAEA"), including optional model disclosure request forms. The final FAQs and model disclosure request forms generally reflect the proposed FAQs and other guidance issued in 2018, and include the following:

- As required under MHPAEA, group health plans and insurers generally may not impose NQTLs on mental health or substance use disorder benefits unless such limits are comparable to, and are applied no more stringently than, medical/surgical benefits in the same classification. The FAQs provide examples of how to evaluate the factors used to develop and apply certain NQTLs, including investigative or experimental treatment exclusions, dosage limits for prescription medications, step therapy and fail first policies, network provider credentialing and reimbursement rates, and facility type restrictions. The FAQs also emphasize that NQTLs may still violate the mental health parity requirements if they are applied differently in operation, even if the NQTL is neutral on its face.

- The FAQs emphasize plan administrators' obligation to include information specific to mental health and substance use disorder benefits in plan documents, such as summary plan descriptions ("SPDs") and summaries of benefits and coverage ("SBCs"). Also, provider networks and directories must be kept up to date and, in some circumstances, may be provided electronically by means of a hyperlink or URL address in SPDs and SBCs.

- The Departments also note that individuals or their authorized representatives

can use the model disclosure request form to request information regarding their mental health or substance use disorder benefits. However, the FAQs confirm that the use of the form is optional.

DOL Issues Report of 2018 Mental Health Parity Enforcement Activity

The DOL issued a fact sheet summarizing its 2018 mental health parity enforcement activity. Notable highlights include:

- Given the DOL's limited enforcement resources, the DOL noted that it works with insurers and other service providers to make voluntary corrections for violations relating to plan provisions or operations that affect multiple plans.
- The DOL also notes that it uses specialized teams, consisting of medical claims data review specialists, economists, attorneys and outside experts to evaluate compliance.
- The fact sheet outlines the process the DOL uses when initiating a mental health parity investigation. Generally, before opening a formal investigation, the DOL will attempt to work with a plan sponsor to achieve voluntary compliance. If a formal investigation is opened, the DOL will review plan documents for compliance with all aspects of the mental health parity rules, including quantitative and nonquantitative treatment limits. If violations are found, plan sponsors must remove noncompliant provisions, as well as pay for any improperly denied benefits.
- The fact sheet notes that the DOL closed 115 formal investigations in 2018 over 6 general categories: annual dollar limits, aggregate lifetime dollar limits, provision of benefits, cost sharing requirements, and treatment limits (quantitative and nonquantitative).
- Finally, the fact sheet contains 5 examples of 21 mental health parity violations cited in 2018, including cases where plans imposed higher co pays for mental health and substance use disorder outpatient visits and improper preauthorization requirements applicable only to mental health and substance use disorder benefits.

IRS Clarifies Employer Shared Responsibility and Nondiscrimination Rules for Integrated HRA Coverage

The IRS has issued proposed regulations that clarify the employer shared responsibility and nondiscrimination rules applicable to health reimbursement

accounts integrated with individual health insurance coverage ("ICHRAs"), which will be permitted beginning in 2020.

- The proposed regulations identify safe harbors to determine affordability for applicable large employers ("ALEs"). Generally, an ICHRA is considered affordable if an individual's required contribution (typically the excess of the premium for self only coverage under the lowest cost silver exchange plan available to the individual over the premium the ALE offers to its employee) does not exceed a specified percentage of household income. Under the proposed regulations, ALEs may designate a look back month before the plan year to determine the applicable premium rate, and also may use the employee's primary worksite, rather than residence, to determine the silver exchange coverage available.

- The proposed regulations confirm that ALEs offering an ICHRA will be treated as though they were offering an eligible employer sponsored plan providing minimum value when determining whether the employer offered coverage to its full time employees and their dependents for purposes of Code section 4980H.

- The proposed regulations also outline nondiscrimination safe harbors for ICHRAs. The proposed regulations confirm that the maximum benefit amount of an ICHRA may vary within a class of employees based on age or family size, provided the ICHRA is offered on the same terms and any variation in the maximum dollar amount is applied consistently among employee classes.

Eighth Circuit Holds SPD Can Serve as Plan Document

In *MBI Energy Servs. v. Hoch*, the Eighth Circuit has held that an ERISA welfare benefit plan can use a single document as both a formal plan document and an SPD. In *Hoch*, a self insured medical plan administrator that provided benefits to an injured participant sought reimbursement of expenses received from a third party source. Although there was no clearly identified formal plan document, the plan's administrative services agreement ("ASA") stated that the plan's benefits, terms and conditions were set forth in the SPD, which also contained provisions regarding subrogation, reimbursement and assignment. The participant argued that the SPD's reimbursement provision was unenforceable, as the SPD could not constitute the plan document. However, the Eighth Circuit disagreed, holding that, absent a formal plan document, the SPD could itself constitute the plan and, given that the ASA was silent regarding reimbursement and expressly

incorporated the terms and conditions of the SPD, the plan administrator was entitled to reimbursement.

The Eighth Circuit joins the Fifth, Sixth, Ninth and Tenth Circuits in holding that an SPD can serve as the "formal" plan document.

Sixth Circuit Rules Change in Premium Payment Method Does Not Trigger COBRA Loss of Coverage

In *Morehouse v. Steak N Shake*, the Sixth Circuit held that altering a group health plan participant's contribution method does not in itself change the terms and conditions of plan coverage, and therefore does not constitute a loss of coverage under COBRA. In *Morehouse*, following leave for a workplace injury, a group health plan participant's health insurance contributions were deducted from her workers' compensation payments, rather than through payroll deduction. However, when the employee did not return to work and her workers' compensation benefits terminated, the employee was unable to pay her premiums and her group health coverage was canceled. The employee sued her employer, alleging that the employer had failed to notify her of her right to continue coverage under COBRA. A trial court agreed with the participant, finding that a COBRA qualifying event occurred when the employee did not return from work, which led to a loss of coverage when her contribution method changed from payroll reductions to deductions from workers' compensation checks.

The Sixth Circuit reversed the trial court, holding that the change in contribution method did not constitute a change to the plan's terms and conditions, and therefore did not trigger a notice obligation under COBRA. The Sixth Circuit specifically noted that the employee did not identify any other term or condition of coverage under the plan that had changed other than the contribution method.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Retirement Plan 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.

SAR Deadline for Calendar Year Plans. Plan administrators who must distribute Summary Annual Reports ("SARs") must distribute them to participants and beneficiaries within nine months of the plan's year end (*e.g.*, for plan years that

ended December 31, 2018, the SAR was 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 to November 30, 2019.

Retirement Plan QDIA Notice. Plan sponsors of defined contribution plans that, as a result of a participant's failure to make an investment election, invest participant contributions in a qualified default investment alternative ("QDIA") must provide an annual notice to all participants at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019 and December 1, 2019.

Retirement Plan Automatic Enrollment Notice. 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 made to the plan at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019 and December 1, 2019. Plan sponsors may combine the automatic enrollment notice with the QDIA notice.

Safe Harbor 401(k) Plan Notice. Plan sponsors of safe harbor 401(k) plans must provide participants with an annual safe harbor notice that describes the safe harbor contribution and other material plan features at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2019 and December 1, 2019. Plan sponsors may combine the safe harbor notice with other required notices, such as the QDIA notice.

Health Plan Compliance Deadlines and Reminders

Medicare Part D Notice of Creditable Coverage. All group health plans that offer prescription drug coverage to Medicare eligible employees (under either an active plan or a retiree plan) must provide an annual creditable coverage disclosure notice to their Medicare eligible participants and dependents no later than October 15, 2019. The Centers for Medicare and Medicaid Services ("CMS") provides a model notice that can be accessed through the CMS website at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html. Plan sponsors should review the model notice to ensure it accurately reflects the provisions of their plan.

Health Plan Open Enrollment Requirements.

- Plan sponsors of group health plans must issue a new 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, 2019, for calendar year plans).
- 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 notice of opt out can be provided with open enrollment materials.