Reinhart

Employee Benefits Update April 2016

POSTED:

Apr 6, 2016

RELATED PRACTICES:

Employee Benefits

https://www.reinhartlaw.com/practices/employee-benefits

Compliance Deadlines and Reminders

Upcoming Health Plan Compliance Deadlines and Reminders

1. Forms 1095 B and 1095 C. Forms 1095-B and 1095-C must be distributed to participants and filed with the Internal Revenue Service ("IRS"). Self-funded health plan sponsors and Applicable Large Employers ("ALEs") needed to provide Forms 1095 B and 1095 C, respectively, to employees by March 31, 2016. Plan sponsors and ALEs should also file these forms with the IRS by May 31, 2016 (or June 30, 2016, if filing electronically, which is required for entities filing at least 250 information returns).
2. Forms 1094 B and 1094 C. Plan sponsors and ALEs must file the first forms 1094-B and 1094-C with the IRS no later than May 31, 2016 (or June 30, 2016, if filing electronically). These forms serve as transmittal forms for the Forms 1095-B and 1095-C.
3. HSA Contributions. The deadline for employers and employees to make 2015 contributions to a health savings account ("HSA") is April 18, 2016.

Upcoming Retirement Plan Compliance Deadlines and Reminders

1. Annual Funding Notice. Calendar year defined benefit plans with over 100 participants must provide the annual funding notice to required recipients by April 29, 2016 (*e.*, within 120 days of the end of the plan year). Small plans (plans with 100 or fewer participants) generally have until the Form 5500 filing deadline to provide the annual funding notice.
2. Excess Deferrals. Any elective deferrals exceeding the Internal Revenue Code ("Code") section 402(g) limit for 2015 ($18,000), plus allocable income, must be distributed to affected participants by April 15, 2016.

Retirement Plan Developments

Seventh Circuit Finds Retirement Plan Established by Church-Affiliated Organization Fails to Qualify for ERISA's Church Plan Exemption

On March 17, 2016, the U.S. Court of Appeals for the Seventh Circuit in *Stapleton v. Advocate Health Care Network* held that a retirement plan established by a church-affiliated organization was not a church plan exempt from the Employee

Retirement Income Security Act of 1974 ("ERISA"). Noting that the question has divided district courts across the country, the Seventh Circuit joins the Third Circuit as the only other circuit court to rule on the issue.

The retirement plan in this case was a defined benefit plan sponsored by Advocate Health Care Network ("Advocate"), a hospital operator with ties to the Lutheran church. Advocate's predecessors had received private letter rulings from the IRS indicating that the plan qualified for the church plan exemption. Plan participants sued Advocate, claiming that the plan was subject to ERISA and therefore failed to comply with ERISA's funding, vesting and notice requirements. As an initial matter, the Seventh Circuit refused to give deference to the plan's private letter rulings from the IRS, noting that the letter rulings conflicted with the plain reading of the definition of "church plan" in the statute. Next, in reviewing the statutory text under ERISA section 3(33), the Seventh Circuit reasoned that the church plan exemption requires a plan to be both (1) established by a church and (2) maintained by a church or a church-affiliated organization. Even though Advocate was a church-affiliated organization, because neither Advocate nor its predecessors were churches, the court held that the plan was not established by a church and thus failed to qualify for ERISA's church plan exemption.

Plan Sues IRS Over Use of Voluntary Correction Program

In what may be the first lawsuit of its kind, a retirement plan has sued the IRS for refusing to allow the plan to use the IRS's Voluntary Correction Program ("VCP").

VCP, a component of the IRS's Employee Plans Compliance Resolution System, allows plans to voluntarily correct plan mistakes that potentially jeopardize their tax-qualified status. The plan sponsor of a money purchase plan submitted a VCP application to the IRS seeking to correct alleged operational errors. Specifically, the complaint alleged that in administering the plan, a court-appointed independent fiduciary: (1) miscalculated years of service for vesting purposes, (2) used incorrect compensation and birth, hire and termination dates, and (3) maintained an unallocated suspense account for payment of fees. According to the complaint, the IRS refused to consider the VCP submission because, in erroneously assuming that the plan's independent fiduciary was appointed by the Department of Labor, the IRS directed the plan to request relief from the Department of Labor. The plan sponsor argued that all errors were operational and, therefore, were within the scope of the IRS's authority regarding plan qualification.

The district court judge presiding over the case denied the IRS's motion to dismiss, allowing the case to proceed. Depending on the outcome, the case could result in future lawsuits against the IRS and other agencies over use of their voluntary compliance programs.

Court Refuses to Allow Recovery of Overpayments from Retiree

On March 2, 2016, in an unpublished opinion, the U.S. Court of Appeals for the Sixth Circuit affirmed a district court ruling that a pension plan could not recover $17,776 in alleged overpayments made to a retiree because the retiree had provided facts sufficient to support his claim of equitable estoppel. *Paul v. Detroit Edison Co. Pension Plan*, 6th Cir. No. 15-1493 (March 2, 2016).

Upon receipt of a benefit calculation from the plan administrator, a union employee elected an early retirement benefit. Two years after his retirement, the plan administrator informed the retiree that his years of service had been miscalculated and he owed $17,776 in overpayments. The retiree refused to repay and sued the plan. Ruling in the retiree's favor, the Sixth Circuit found that the retiree satisfied the standard for proving equitable estoppel, which includes the following additional elements in the ERISA context: (1) written representation from the plan; (2) plan provisions which, even though unambiguous, fail to allow an individual to calculate his or her benefits (*e.g.*, require complex actuarial assumptions); and (3) "extraordinary circumstances" in which the balance of equities strongly favors the application of estoppel.

The case serves as a reminder that equitable estoppel, which in the court's words is a "rare remedy in the ERISA context," is a potential roadblock when the plan administrator miscalculates benefits and the participant relies on the erroneous calculation to his or her detriment.

Health and Welfare Plan Developments

Supreme Court Rules that ERISA Preempts Vermont's Claims Reporting Law

On March 1, 2016, the U.S. Supreme Court in *Gobeille v. Liberty Mutual Insurance Co.* held that ERISA preempted a Vermont law requiring self-funded health plans to submit health data reports to a state agency.

Vermont is one of at least 20 states that has or is implementing laws requiring collection of claims information and other health data from health plans. The Vermont law required the plaintiff, a self-funded health plan sponsor providing

benefits to over 80,000 individuals in all 50 states, to report eligibility and medical claims information to a state agency on behalf of the plan's participants and beneficiaries who resided in Vermont. Failure to report could result in a fine of up to $2,000 per day. The plaintiff sued, claiming that the Vermont law was preempted under ERISA section 514 because the law was impermissibly connected with an employee benefit plan. The Supreme Court agreed, holding that the law was preempted because it both "intrudes upon a central matter of plan administration" and "interferes with nationally uniform plan administration." In light of *Gobeille*, other states' efforts to collect health data from self-funded health plans may face similar preemption challenges.

Supreme Court Vacates Decision Upholding Michigan's HICA Act

On March 1, 2016, following its ruling in *Gobeille v. Liberty Mutual Insurance Co.*, the U.S. Supreme Court vacated and remanded a Sixth Circuit decision upholding Michigan's Health Insurance Claims Assessment ("HICA") Act. The Sixth Circuit had previously ruled in *Self-Insurance Institute of America v. Snyder* that the HICA Act, which, among other requirements, imposes a 0.75% tax on all health claims paid by self-funded health plans, was not preempted by ERISA. On remand, the Supreme Court has ordered the Sixth Circuit to reconsider the plaintiff's preemption challenge in light of the Supreme Court's decision in *Gobeille v. Liberty Mutual Insurance Co.* (see above).

HHS Launches Phase 2 of its HIPAA Enforcement Audits

On March 18, 2016, the Department of Health and Human Services' ("HHS") Office of Civil Rights ("OCR") announced it had begun its second phase of enforcement audits under the Health Insurance Portability and Accountability Act ("HIPAA"). The audits are designed to ensure compliance with HIPAA's Privacy Rule and Security Rule, uncover potential violations and identify vulnerabilities regarding protected health information. OCR has stated that these audits will primarily be desk audits, although some on-site audits will also be conducted. Unlike Phase 1 audits conducted in 2011 and 2012, the Phase 2 audits include both covered entities (which include group health plans) and business associates. OCR has advised that it will initiate the audit process by e mailing an organization to verify contact information. OCR will next send a preaudit questionnaire to potential auditees, who may or may not be selected for a full audit. OCR has indicated that it will focus on compliance with specific Privacy Rule and Security Rule provisions, including risk assessments, risk management, workforce training and content and timeliness of required notifications. OCR expects all Phase 2 desk audits to be

completed by the end of 2016.

OCR will post updated audit protocols on its website to assist plans and organizations with completing the audit. Health plan administrators and business associates should monitor their e-mails to ensure they timely respond to requests for information from OCR.

CMS Proposes Cuts to Employers Sponsoring Medicare Plans for Retirees

On March 7, 2016, the Centers for Medicare & Medicaid Services ("CMS") released a memorandum confirming that its proposed changes to the payment structure of the Medicare Advantage and Medicare Part D programs for retirees would result in an average funding reduction of 2.5% for employer group waiver plans ("EGWPs"). CMS released the memorandum as a follow-up to the "2017 Medicare Advantage and Part D Advance Notice and Draft Call Letter," which CMS published on February 19, 2016. Each year, CMS releases its proposed changes to the Medicare Advantage and Medicare Part D programs in the advance notice and call letter, and accepts public comments on the proposal. This year, CMS expects to publish the final payment rates and any other changes proposed in the advance notice by April 4, 2016.

General Developments

First Circuit Rules that Plan's Statute of Limitations is Unenforceable if Not Contained in Final Denial Letter

Joining the Third and Sixth Circuits' interpretation of ERISA's claims procedure regulations, the U.S. Court of Appeals for the First Circuit held that a plan-imposed three-year statute of limitations on filing suit was unenforceable if the participant was not informed of the deadline in the claim denial letter.

In *Santana-Diaz v. Metro. Life Insurance Co.*, the First Circuit refused to apply a long-term disability plan's contractual limitations period for filing a civil action in court. The court held that, although both the initial denial of benefits letter and final denial letter informed the participant that he could bring a civil action, neither letter included a time limit for doing so or mentioned that the right to file suit was subject to a limitations period. Therefore, the court held, the plan violated ERISA's claims procedures regulations. Setting aside the plan's three-year limitations period as unenforceable, the court borrowed the forum jurisdiction's most closely analogous statute of limitations for an ERISA claim, which allowed the participant's claim to proceed.

In light of recent holdings from the First, Third and Sixth Circuits, plan sponsors and administrators should consider adding any applicable limitations period to their denial letters to ensure their plan-imposed statutes of limitations remain enforceable.

Supreme Court Refuses to Consider Extension of Plan's Deadline to File an Appeal

The U.S. Supreme Court declined to hear a Ninth Circuit decision that allowed a participant to appeal a disability plan's denial of benefits beyond the plan's 180-day deadline. *Aetna Life Ins. Co. v. LeGras*, U.S., No. 15-439, *cert. denied* (March 21, 2016).

In complying with ERISA's claims procedure regulations, the plan required participants to submit appeals within 180 days after receiving the plan's initial determination. The 180-day period expired on a Saturday, but the participant mailed his appeal the following Monday. The Plan denied the participant's appeal as untimely and the participant sued in federal court. The plan argued that the participant's claim should be dismissed for failing to exhaust the plan's administrative remedies. The Ninth Circuit disagreed, holding that under ERISA federal common law, the regulation's 180-day deadline is automatically extended to the following Monday. With the Supreme Court's refusal to hear the case on appeal, the Ninth Circuit's decision to extend the 180-day deadline to the first weekday following a weekend will stand.