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Employee Benefits Update August 2016

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Select Compliance Deadlines and Reminders

1. **Summary Annual Report ("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. For plan years that end December 31, the SAR is due September 30, 2016. If the plan received an extension for filing Form 5500, the deadline for providing SARs is extended by two months.
2. **Form 5500 Filing Deadline for Calendar Year Plans with Extensions.** For plans that obtained an extension for filing Form 5500, the Form 5500 must be filed by October 15, 2016.

General Benefit Plan Developments

The DOL Proposes to Modernize the Form 5500

The Department of Labor ("DOL") proposed revisions to modernize and improve the Form 5500 Annual Report to keep pace with changing conditions in the employee benefit plan and financial market sectors. The DOL also hopes to remedy the Form's current gaps in collecting data from ERISA group health plans. The proposed revisions intend to:

- Modernize the financial statements and investment information about employee benefit plans;
- Update the reporting requirements for service provider fee and expense information;
- Enhance accessibility and usability of data on the forms;
- Require reporting by all group health plans covered by Title I of ERISA through a new Schedule J; and
- Improve compliance under ERISA and the Internal Revenue Code through new questions regarding plan operations, service provider relationships and financial management of the plan.

The proposed revisions would apply to the 2019 Plan Year reports, which would not be due until 2020. Many critics of the revisions claim that the new forms will be more tedious and labor intensive, and will significantly increase the burden of

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reporting on plan sponsors. The DOL has requested comments on the proposed revisions, and the deadline to provide comments is October 4, 2016.

Retirement Plan Developments

IRS Issues Clarifications to Instructions for Reporting Failures to Pay Required Minimum Distributions

Line 4l of Schedules H and I of Form 5500 asks "Has the plan failed to provide any benefit due under the plan?" The instructions for the 2015 plan year were amended to explain that reportable failures include failure to pay required minimum distributions ("RMDs"). On July 29, 2016, the IRS released guidance providing that Form 5500 filers do not need to report any unpaid RMDs for participants who have retired or separated from service, or their beneficiaries, but cannot be located after expending reasonable efforts. In addition, a Form 5500 filer that is in the process of expending such reasonable efforts to locate missing participants also does not need to report those unpaid RMDs. This new guidance highlights the importance of plans maintaining appropriate procedures for locating missing participants.

Department of Commerce Issues Final Rule Regarding the Limited Access Death Master File ("DMF")

The U.S. Commerce Department's National Technical Information Service issued the final rule on accessing the DMF. Effective November 28, 2016, any "person" that desires access to the DMF must certify that the person will not disclose a deceased individual's DMF, and further has:

- a legitimate fraud prevention interest or a legitimate business purpose pursuant to the law, governmental rule, regulation or fiduciary duty;
- systems, facilities and procedures in place to safeguard the accessed information; and
- experience in maintaining the confidentiality, security and appropriate use of accessed information.

For purposes of the rule, "person" is defined as any individual, corporation, company, private organization, and state and local government departments and agencies. The current certification fee is $200, and is expected to increase prior to the rule's effective date.

First Circuit Finds Fidelity May Keep Float Income

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On July 13, 2016, the First Circuit issued its decision in In re Fidelity ERISA Float Litigation (formerly Kelley v. Fidelity), upholding Fidelity's practice of retaining "float" income earned from 401(k) accounts. The practice allows Fidelity to keep any interest earned when a 401(k) participant requests a distribution of his or her benefits and the distribution amount is held temporarily in a redemption account. In its decision, the court also focused on whether or not the participants had suffered any injury, noting that participants were not "short so much as a penny." The court held that, because the interest earned by Fidelity was never intended to go to the plan, it did not qualify as a plan asset under ERISA. The court did not address whether the float income was consistent with ERISA's reasonable compensation rules.

Ninth Circuit Finds Church Plan Must Be Sponsored By Church

The Ninth Circuit joined the Third and Seventh Circuits in Rollins v. Dignity Health, holding that a benefit plan of a religiously affiliated hospital does not constitute an ERISA exempt church plan. In its decision, the court found that only benefit plans created by churches qualify for the church plan exemption. In these circuits, the church with which a hospital is associated must create the plan that the hospital administers to qualify for the exemption.

U.S. District Court Finds Plan Can Require Binding Arbitration

In a recent and unusual case, Luciano v. Teachers Ins. & Annuity Assoc. of America/College Retirement Equities Fund, a U.S. District Court in New Jersey upheld a provision in the Education Testing Service's retirement plan requiring that appeals for claims regarding plan benefits be submitted to a binding arbitration process wherein the claimant and the plan "equally share" in the arbitration costs. The court determined that a "full and fair review" is only required of a plan fiduciary, as opposed to an outside body, such as a court.

Health and Welfare Plan Developments

IRS Issues Proposed Rules Regarding Premium Tax Credits

The IRS issued proposed rules addressing how employer payments to employees who decline the employer's health plan coverage ("Opt Out Payments") are treated for purposes of the ACA's shared responsibility penalty provisions. Applicable Large Employers ("ALEs") which offer minimum essential coverage may be liable for penalties if any full time employee receives a premium tax credit for coverage purchased on an Exchange.

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If an employer offers Opt Out Payments regardless of whether the employee enrolls in coverage with another source, the additional compensation is considered an unconditional Opt Out Payment. Under the proposed rules, unconditional Opt Out Payments would be treated as required employee contributions for purposes of determining affordability of employer coverage and eligibility for participant premium tax credits ("PTEs").

In contrast, an Opt Out Payment is considered "conditional" if (1) the employee declining enrollment in employer sponsored coverage, and (2) the employer annually providing reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption have minimum essential coverage for the taxable year other than in the individual market. Conditional Opt Out Payments are considered eligible and the compensation would not be considered a required employee contribution. As a result, employees would likely be ineligible for PTEs.

The IRS cautions employers against making Opt Out Payments because such payments increase the probability that employer sponsored coverage may not be affordable.

Court Finds Mailing of COBRA Notice Defeats Former Employee Claim of Non Receipt

In a recent employment discrimination lawsuit, Perkins v. Rock Tenn Services a former employee claimed her previous employer failed to provide her a COBRA election notice upon her resignation. The employer produced an electronic notice, along with computer records showing the dates on which the notice was created and mailed, and an affidavit from the employee responsible for mailing the COBRA notices. The Western District of Michigan ruled that the employer met its obligation to mail the COBRA notice to the former employee. The court found that the terminated employee's claim of nonreceipt of the notice did not mean the employer failed to comply with COBRA.

HIPAA Updates

Recent Resolution Agreements for Stolen Electronic Devices

The Office for Civil Rights ("OCR") announced an agreement with a HIPAA business associate after a smartphone containing PHI of hundreds of individuals was stolen. The phone was not encrypted or password protected, and the business associate had no policies addressing the removal of mobile devices containing

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PHI. The agreement requires a $650,000 payment from the business associate and a two year corrective action plan.

OCR also recently released a resolution agreement with a large public academic health center and research institute. In this case, two laptops and a thumb drive were stolen, affecting thousands of people. The investigation uncovered widespread vulnerability, including the storage of electronic PHI on a cloud based server without a business agreement. The resolution agreement required a $2.7 million payment from the health center and a three year corrective action plan.

Finally, Advocate Health Care agreed to a $5.5 million settlement—the largest ever against a single entity—with OCR and a two year corrective action plan. The settlement is the largest settlement against a single entity and is the result of a series of three breaches, one of which included an unencrypted laptop stolen from an unlocked car. OCR's investigation also revealed that Advocate Health Care failed to conduct an accurate and thorough assessment of potential risks and vulnerabilities, implement policies and procedures to limit physical access to electronic information systems housed in offsite storage, or execute a written business associate agreement that adequately protected PHI in the business associate's possession. The combined breaches affected the PHI of approximately 4 million individuals.

It is important that all covered entities and business associates give careful consideration to all aspects of their risk management plan. All HIPAA policies and procedures should contain clear protocols for when portable electronic devices are lost or stolen, and these protocols should be followed in the event of a potential breach.

HIPAA Releases Guidance Regarding Ransomware

OCR released guidance on July 11, 2016 regarding ransomware and HIPAA. Ransomware is a type of malware that essentially steals and encrypts data, thereby denying access to its rightful owners. After the attack occurs, the hacker demands a ransom from the rightful owner in exchange for the decryption key. The U.S. government reports that there are, on average, 4,000 ransomware attacks every day.

The guidance reiterated that covered entities and business associates must protect themselves against ransomware and all malware attacks pursuant to HIPAA. Therefore, covered entities and business associates should receive training to detect and report malware incidents. Under the HIPAA Security Rule,

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the presence of ransomware or malware on a covered entity's or business associate's computer is considered a security incident. Once the malware is detected, a security incident response must be initiated. Also, unless the covered entity or business associate can prove that there is a low probability that PHI has been compromised, the presence of malware is considered a breach and must be reported.

Sixth Circuit Finds Tax on ERISA Plans is Not Pre Empted by ERISA

In Self Insurance Institute (SIIA) v. Snyder, the Sixth Circuit held that a 1% tax on all claims paid in Michigan or for Michigan residents imposed on all carriers and third party administrators is not preempted by ERISA. SIIA brought the case against Michigan's governor on behalf of the sponsors and administrators of self funded ERISA benefit plans administered in Michigan. The court found that the law imposing the 1% tax does not directly regulate any integral aspects of ERISA and, at its core, is designed to generate revenue necessary to fund Michigan's obligations under Medicaid. The decision draws a distinction from the Gobeille decision by holding that state laws with an indirect effect on ERISA plans are not pre empted under ERISA. The court also found that the law imposing the 1% tax does not impermissibly alter the relationship between the plan and third party administrators, nor does it impermissibly "refer to" ERISA plans.

IRS Issues Proposed Guidance Regarding Reporting Under Code Section 6055

The IRS issued proposed regulations regarding coverage providers' information reporting of minimum essential coverage ("MEC") under Code section 6055.

- Reporting of Coverage by Multiple MECs. The proposed regulations incorporate the reporting exceptions in the 2015 Instructions for the 1094 B and 1095 B for individuals covered by more than one MEC. Specifically, the proposed regulations provide:
  - If an individual is covered by more than one MEC made available by the same reporting entity, reporting is required for only one of the plans or programs.
  - Reporting is not required for an individual's MEC if the individual's eligibility is conditioned upon coverage by another MEC (sponsored by the same employer) for which section 6055 reporting is necessary.

In these instances, only the program that provides primary coverage is required to report. The two rules generally apply on a month to month basis. Therefore, in situations where an employee is covered by both an employer sponsored, self insured group health plan and an HRA, the employer need only report the group

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health plan coverage for the employee.

- Soliciting Social Security Numbers. As part of Form 1095 reporting, employers must report the Social Security Number (SSN) of each covered person. An employer can be assessed penalties if it fails to fully complete the Form 1095. In previous guidance, the IRS provided that if an employer takes "reasonable efforts" to obtain the covered individual's SSN, such penalties can be waived for any reporting failures. Notice 2015 68 provided that an employer may avoid penalties for missing SSNs if it makes an initial solicitation and first and second annual solicitations for a SSN. The proposed regulations further clarify the steps necessary to demonstrate "reasonable efforts" by requiring that:
  - An account is opened on the date on which the employer receives an application for new coverage or an application to add an individual to existing coverage. The initial solicitation can be requested as part of the enrollment process.
  - The first annual solicitation be made within 75 days of opening the account. If the coverage is retroactive, the first annual solicitation must be made within 75 days after the determination of coverage was made.
  - The deadline for the second annual solicitation is December 31of the year after the year the account is opened.
  - For current enrollees, the account is considered open and an initial solicitation made if the employer requested the SSN at the time of enrollment or any time prior to July 29, 2016. Employers who have not made an initial solicitation prior to July 29, 2016 should do so as soon as possible.

IRS Releases Draft Forms 1094/1095 and Instructions

The IRS issued draft Forms 1094/1095 for the 2016 tax year. The draft forms do not include any significant changes from the 2015 tax year.

The draft instructions for the 1094 C and 1095 C were also released. The instructions are generally the same; however, there are a few clarifications, including:

- Aggregated ALE Groups. Each individual ALE must file its own Form 1094 C (and associated 1095 Cs) under its own individual EIN number. Additionally, if a full time employee works for more than one ALE of an aggregated ALE group, only the ALE for which the employee works the most should report the employee.
- Multiemployer Plan Relief. Multiemployer plan relief has been extended for another year. Employers qualifying for relief do not need to obtain eligibility or other information from their multiemployer plans for the 2016 plan year.

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- Codes for Coverage of Conditional Offers of Spousal Coverage. The draft instructions contain two new codes to reflect conditional offers of spousal coverage made to an employee.
- COBRA and Post Employment Coverage. There are a few clarifications regarding COBRA coverage, including how to report the month in which an employee terminates employment with an ALE. Additionally, if an ALE offers post employment coverage to a former employee, that should not be reported as an offer of coverage.

Instructions for the B series forms are expected later this month.

Multi Department Request for Comment Regarding Accommodation for Religious Objections to Contraceptive Coverage

On May 16, 2016, the Supreme Court remanded Zubik v. Burwell to the lower courts in an attempt to find a compromise regarding nonprofit organizations' religious objections to covering contraceptives as mandated under the ACA. This decision also vacated and remanded seven appellate court decisions that upheld the regulatory accommodation offered by HHS, which was that HHS would provide contraceptive coverage to nonprofit organizations' employees or students. The Court held that the lower courts are in a better position to evaluate the facts and circumstances, and possible alternatives.

On July 21, 2016, the Departments of Health and Human Services, Labor and the Treasury released a request for information seeking further input from interested parties on possible alternatives to the current HHS accommodation. The Departments also requested "stakeholders" who are not parties to the litigation, such as insurers, third party administrators and women who need contraceptives, how any possible accommodations would affect them.

Employer Appeals of Marketplace Notices

Employers have begun receiving Marketplace Notices from the Health Insurance Marketplace Exchange notifying them that one or more of their employees is eligible for the premium tax credit in the Marketplace. The notice also describes an appeal process should the employer choose to dispute any inaccurate information in the notice. Employers may want to consider appealing to correct any misinformation contained in the notices, which could help employees avoid having to repay governmental subsidies to the IRS. Receipt of a Marketplace Notice does not automatically mean the IRS has or will assess a penalty on the employer. Also, failure to appeal the notice does not preclude the employer from

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later appealing an assessment of a penalty by the IRS.

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