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Employee Benefits Update September 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 the SAR 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.

3. 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 retiree plan) must provide an annual creditable coverage disclosure notice to Medicare-eligible participants and dependents no later than October 15, 2016. The Centers for Medicare and Medicaid Services ("CMS") provides a model notice that can be accessed through the CMS website, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html. Plan sponsors should review the model notice to ensure that it accurately reflects the plan provisions.

4. **Reinsurance Fee for Group Health Plans.** Contributing entities (the third party administrator for self-funded plans or the insurer for fully insured plans) must report to the Department of Health and Human Services ("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 will then calculate 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.

5. **Health Plan Open Enrollment Requirements.**

6. 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 in advance of the plan year (December 1, 2016 for calendar year plans).

7. 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 the open enrollment materials.

8. **Retirement Plan QDIA Notice.** Plan sponsors of defined contribution plans that invest participant contributions in a qualified default investment alternative ("QDIA") because the participant failed to make an investment election must provide an annual notice to all participants at least 30 days but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 3 and December 1, 2016.

9. **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 contributed to the plan at least 30 days, but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 3 and December 1, 2016. Plan sponsors can combine the automatic enrollment notice with the QDIA notice.

10. **Safe Harbor 401(k) Plan Notice.** 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 at least 30 days, but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 3 and December 1, 2016. Plan sponsors can combine the safe harbor notice with other required notices, such as the QDIA notice.

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General Benefit Plan Developments

IRS Issues Final Regulations Consolidating Previously Published Same-Sex Marriage Guidance

The Internal Revenue Service ("IRS") finalized its regulations reflecting the recent U.S. Supreme Court decisions in *Obergefell v. Hodges* and *Windsor v. U.S.* and previous IRS guidance in Revenue Ruling 2013-17 on the treatment of same-sex marriage for federal tax purposes. The final regulations are essentially unchanged from proposed regulations issued in 2015.

The purpose of these regulations is to formally update existing IRS regulations to provide that the terms "spouse," "husband," and "wife" mean an individual lawfully married to another individual, and the term "husband and wife" means two individuals lawfully married to each other. The final regulations also clarify that foreign marriages will be recognized for federal tax purposes if *any* state, possession, or territory of the United States would recognize the relationship.

Retirement Plan Developments

Revenue Procedure 2016-47 Establishes Procedure for Self-Certifying that Rollover Qualifies for Waiver of 60-Day Requirement

On August 24, 2016, the IRS issued Revenue Procedure 2016-47, which allows plan administrators to accept late 60-day rollovers from individuals who inadvertently fail to complete the rollover of a distribution from an individual retirement account ("IRA") or qualified employer retirement through a self-certification procedure. Under the new guidance, individuals who fail to meet the 60-day rollover deadline may complete a written self-certification to receive a waiver. The self-certification must include certain specific elements, and the IRS published a model for this purpose.

Plan administrators or IRA custodians may rely upon the self-certification to accept a late rollover contribution from a participant, unless the plan administrator or custodian "has actual knowledge that is contrary to the self-certification."

IRS Issues Updated Model Form 14568 Series for VCP Submissions

The IRS has updated its Form 14568 series used in connection with its Voluntary Correction Program ("VCP") component of the Employee Plans Compliance

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Resolution System ("EPCRS"). Most of the updates reflect the elimination of Schedule C in the 2015 modifications to EPCRS, changes announced to the remedial amendment periods for individually designed plans and modification of the determination letter program. The forms are available on the IRS's Retirement Plans Forms and Publications website [LINK to https://www.irs.gov/retirement-plans/retirement-plan-forms-and-publications], and must be used for any new VCP filing.

Health and Welfare Plan Developments

HHS Releases 2018 Proposed Notice of Benefit and Payment Parameters

HHS has released proposed regulations that include benefit and payment parameters for 2018. Key proposals include:

- *Increased Annual Cost-Sharing Limits*: HHS has proposed to increase the maximum annual cost-sharing limitations for 2018 to $7,350 for individual coverage and $14,700 for family coverage (compared to $7,150 and $14,300 respectively, in 2017).
- *Increased Penalties*: The annual employer shared responsibility penalties would increase to $2,323 for a 4980H(a) penalty and $3,485 for a 4980H(b) penalty.
- *New Bronze-Level High-Deductible Health Plan ("HDHP") Coverage*: HHS has proposed an Exchange standardized plan option at the bronze level of coverage that qualifies as an HSA-eligible HDHP.
- *Revised SHOP Enrollment Rules*: HHS has proposed that SHOPs would be required to provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period that begins on the date the qualified employer notifies the SHOP of the newly qualified employee. Qualified employers would need to notify the SHOP of the newly qualified employee on or before the 30th day after the day the employee becomes eligible for coverage.

HHS has also requested comment on several issues for future guidance, including the possibility of eliminating the requirement tying an insurer's participation in the federal SHOP to its participation in the federal Exchange, and eliminating online enrollment in the federal SHOP.

Sixth Circuit Again Holds Michigan's Tax on Health Claim Payments

Enforceable

The Sixth Circuit again ruled that ERISA does not preempt Michigan's tax on health claims paid in the state for self-insured plans in *Self-Insurance Institute of America, Inc. v. Snyder*. Michigan state law currently imposes a tax on medical claims paid for services rendered in-state to Michigan residents, including claims paid by ERISA plans and their administrators. In reconsidering whether the Michigan law is enforceable under new Supreme Court precedent, the Sixth Circuit focused on the difference between a state law that regulates integral aspects of ERISA plan administration and one that only touches on those aspects peripherally. The Sixth Circuit again upheld the Michigan law, concluding it fell into the second category.

Ninth Circuit Concludes Penalties Do Not Apply to Requests for Claims-Related Documents

The Ninth Circuit recently joined several other circuits (the First, Second, Third, Sixth, Seventh, Eighth, and Tenth) in ruling that plaintiffs may not recover penalties under ERISA section 502(c)(1) for a plan administrator's failure to timely provide requested benefit claims documents. In *Lee v. ING Groep, N.V.*, a former employee whose long-term disability benefits were terminated sued for penalties, claiming the plan administrator had failed to timely provide him with all relevant documents requested, including the plan document and claims-related e-mails. The Ninth Circuit held that ERISA section 502(c)(1) statutory penalties of $110 per day do not apply for a plan administrator's failure to follow its claims procedure rules and timely produce requested claims documents.

Plan administrators should note that the court's holding was narrowly tailored to ERISA § 502(c)(1) statutory penalties; plan administrators would likely still be subject to other penalties under ERISA section 104(b)(4) for failing to provide requested documentation.

U.S. District Courts Continue to Address Scope of Mental Health Coverage

Two recent U.S. district court decisions have addressed the scope of prohibited nonquantitative treatment limits under the Mental Health Parity and Addiction Equity Act. As indicated below, these cases likely would have turned out differently under existing guidance.

In *Stephanie C. v. Blue Cross Blue Shield of Mass.*, the District Court of Massachusetts upheld a health plan's exclusion of mental health services

provided in an educational setting. The plan expressly excluded benefits for "services that are performed in educational, vocational, or recreational settings," and denied coverage of mental health services provided at a mental health residential treatment facility. The participant argued that, despite the school setting, the mental health services should be covered because they included therapeutic elements and clinical staff services. The court concluded that the participant failed to show that the treatment provided at the facility fell outside the plan's exclusion and that the participant had failed to demonstrate that she had met the plan's medical necessity requirement, since she did not show a record of unsuccessful treatment within a year before admission to the program. Commenters note that this case would likely have a different outcome under the final mental health regulations applicable to group health plans for plan years beginning on or after July 1, 2014. The "fail-first" provision of the plan at issue in this case, which required an unsuccessful treatment before residential admission, would also likely be questioned under a recent DOL checklist of plan provisions that might violate MHPAEA requirements.

In *Danny P. v. Catholic Health Initiatives*, the District Court of the Western District of Washington declined to adopt the position that a self-insured health plan's coverage for residential mental health treatment must be "on par" with coverage it provides for medical or surgical treatment at an analogous level of care. The employee claimed that mental health residential treatment, which was not covered by the plan, was analogous to skilled nursing, which was covered by the plan. The court held that there was no violation of the interim mental health parity regulations, but that the final regulations likely would have required such coverage. However, the court concluded that, since the final regulations are not retroactive and do not inform the application of the earlier rules, coverage of residential treatment was not required. Commenters also note that this case would likely have a different outcome under the final mental health regulations, which clarify group health plans may not impose disparate treatment limits on "intermediate services" for mental health, such as residential treatment, if such treatment limits do not also apply to medical/surgical benefits.

U.S. District Court Allows COBRA Claim Filed Four Years after Employee's Termination

In *Pankey v. Mississippi State University*, the District Court of the Northern District of Mississippi denied an employer's motion to dismiss, holding that an employee could sue her employer four years after her termination for failing to provide a COBRA election notice. In this case, an employee claimed she first learned of the

COBRA notice failure during proceedings for a related wrongful termination lawsuit, and that she would not have incurred out-of-pocket expenses for multiple medical visits if she had known she could continue her group health coverage. The court held the applicable limitations period did not begin running until the employee discovered she was entitled to a COBRA election notice, and therefore the claim was not barred by the three-year limitations period under applicable state law.

This case does not involve a decision on the merits. Regarding the merits of the case, the court acknowledged the employer's detailed notice procedures, and found that a material issue existed as to whether the employee's notice had been mailed.

CMS Releases Interactive Tool to Help Determine HIPAA Covered Entity Status

The Centers for Medicare and Medicaid Services ("CMS") has released an updated interactive tool to determine whether an individual or organization is a covered entity for purposes of HIPAA's administrative simplification rules. Covered entities must comply with the administrative simplification requirements, such as HIPAA's privacy, security, breach notification, and electronic data interchange rules. Under the HITECH Act, several administrative simplification requirements also apply directly to business associates.

The tool allows an individual or organization to answer a series of questions to determine whether it may be a covered entity and is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/Downloads/CoveredEntitiesChart20160617.pdf.