Reinhart

March 2016 Employee Benefits Update

POSTED:

Mar 14, 2016

RELATED PRACTICES:

Employee Benefits

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

RELATED PEOPLE:

Gregory A. Storm

https://www.reinhartlaw.com/people/gregory-storm

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"). Plan sponsors of self-funded health plans and Applicable Large Employers ("ALE") must provide Forms 1095 B and 1095 C 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 ACA reports).

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.

Upcoming Retirement Plan Compliance Deadlines and Reminders

1. Form 1099-R. The deadline to electronically file Form 1099-R to report the prior year's distributions is March 31, 2016.

2. Required Minimum Distributions. Required minimum distributions must begin by April 1, 2016 for participants who reached age 70-1/2 in 2015 and who have terminated employment.

3. 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.

Retirement Plan Developments

IRS Provides Guidance on Mid-Year Changes to Safe Harbor Plans

The IRS issued Notice 2016-16 to provide guidance on mid-year changes to safe

harbor plans under Code sections 401(k) and 401(m). The guidance also applies to Code section 403(b) plans that apply the Code section 401(m) safe harbor rules. A "mid-year change" is a change that becomes effective after the beginning of a plan year or a change that is adopted after the beginning of the plan year but is retroactively effective as of the beginning of the plan year. Under the new guidance, mid-year changes to a safe harbor plan or to a safe harbor notice do not violate the safe harbor rules as long as the plan satisfies the applicable notice and election opportunity conditions, and the mid-year change is not a prohibited mid-year change.

To comply with the new guidance's notice requirements, an updated safe harbor notice that describes the mid-year change and its effective date must be sent to each employee who is required to receive a safe harbor notice within a reasonable period before the effective date of the change. The timing requirement will be deemed to be satisfied if the notice is provided at least 30 days and not more than 90 days before the effective date of the change. For retroactively effective changes, and for changes for which it is not practicable to provide an election opportunity before the effective date, the notice will be considered timely if it is provided as soon as practicable, but no more than 30 days after the adoption of the change. If the information about the mid-year change was previously provided with the annual safe harbor notice, an updated notice is not required.

To comply with the new guidance's election requirements, employees who are required to receive a safe harbor notice must have a reasonable opportunity before the effective date of the mid-year change to modify their cash or deferred elections and any after-tax employee contribution elections. A 30-day election period will be considered reasonable. For retroactively effective changes, and for changes for which it is not practicable to provide an election opportunity before the effective date, an employee will be deemed to have a reasonable opportunity to modify an election if the election opportunity begins as soon as practicable after the updated notice is provided, but no later than 30 days after the date of the adoption of the change.

Unless required by law, the following mid-year changes are prohibited: (1) mid-year change to increase the years of service required for an employee to have a nonforfeitable right to amounts in the employee's account attributable to safe harbor contributions under a qualified automatic contribution arrangement ("QACA"); (2) mid-year change to reduce the number or narrow the group of employees who are eligible to receive safe harbor contributions; (3) mid-year

change that alters the type of safe harbor plan; and (4) mid-year change to (i) modify or add a formula for determining matching contributions (or a change to the definition of compensation for purposes of determining matching contributions) if the change increases matching contribution amounts or (ii) permit discretionary matching contributions. This fourth prohibition does not apply if the change is adopted and updated safe harbor notices and election opportunities are provided at least three months before the end of the plan year and if the change is retroactively effective for the whole plan year.

This guidance is effective for mid-year changes made on or after January 29, 2016. The guidance revokes Announcement 2007-59, which limited permissible changes to changes that implemented a qualified Roth **contribution program or changes to hardship withdrawals.**

Federal District Court Rules that Custodial Agreement Must be Disclosed in ERISA Document Request

A district court judge in the U.S. District Court of the Eastern District of Pennsylvania determined that a custodial agreement between a 401(k) plan and Nationwide Trust Company must be provided when requested under ERISA section 104(b)(4). In *Askew v. R.L. Reppert, Inc.*, the court determined that the custodial agreement was a contract or other instrument "under which the Plan is established or operated." Accordingly, the custodial agreement was required to be disclosed under ERISA section 104(b)(4). In making its decision, the court noted that the custodial agreement contained information regarding the participants' benefits, such as schedules of investment funds in which participants may choose to invest and information regarding the default investment. The court also found that the custodial agreement established details regarding where and how benefits would be invested and who would manage and administer participant accounts. Although this ruling is not precedential, plan sponsors should be aware that some courts may interpret ERISA section 104(b)(4) to require disclosure of custodial agreements upon a participant's request.

Treasury Releases Proposed Regulations to Implement Benefit Suspension Provisions of Multiemployer Pension Reform Act of 2014 ("MPRA")

The United States Department of the Treasury issued proposed regulations regarding the suspension of benefits under MPRA. MPRA allows multiemployer pension plans in "critical and declining status" to suspend accrued benefits under certain circumstances. The proposed regulations provide guidance regarding

plans that cover participants who worked for employers that withdrew from the plan before MPRA went into effect. Specifically, the proposed regulations set forth the limits that apply to suspensions of benefits for multiemployer plans directly attributable to a participant's service with an employer that completely withdrew from the plan, paid its complete withdrawal liability and assumed in a collective bargaining agreement liability to provide benefits in a make-whole plan that are equal to benefits reduced due to the multiemployer plan's financial health ("make-whole agreement"). The regulations provide that, to the maximum extent permissible, a suspension of benefits must first apply to benefits for service with an employer who did not agree to assume liability for benefits under a make-whole agreement ("Subclause 1 Employers"). Thereafter, a suspension may apply to benefits related to service for other employers (*i.e.*, other than Subclause I and III Employers), but only if the suspension with respect to the Subclause I Employers is not reasonably estimated to allow the plan to avoid becoming insolvent. For this second group, the suspension does not need to apply to the maximum extent permitted, but may not be less than reductions that are applied to Subclause III Employers. Finally, the suspension may be applied to benefits for service for a Subclause III Employer.

Federal District Court Determines 401(k) Plan Divestment Decision Was Objectively Prudent

On remand from the Fourth Circuit Court of Appeals, a North Carolina federal district court determined that even though 401(k) plan fiduciaries did not engage in a prudent process in deciding to divest stock, the fiduciaries were not personally liable for resultant losses because a prudent fiduciary would have made the same decision. In *Tatum v. R.J. Reynolds Tobacco Co.*, the Benefits Committee of the R.J. Reynolds 401(k) plan decided to eliminate Nabisco funds from the 401(k) plan after the tobacco portion of the business spun off from Nabisco. In making its decision, the Benefits Committee relied on the recommendation of a company working group and did not meet or discuss the issue. The Benefits Committee did not vote on the issue and also did not create an amendment to document the divestment. Employees filed a class action lawsuit to recover losses caused by the divestment and alleged that the Benefits Committee and the Investment Committee breached their fiduciary duties. The district court found that R.J. Reynolds failed to comply with its duty of prudence but was not liable for any damages because a prudent fiduciary would have made the same decision even if it had exercised the required procedural prudence. Thus, the decision was objectively prudent. The court considered the fiduciaries'

obligations under the plan document, the risk versus the potential return of the investments and the timing of investment decisions. Although this ruling suggests that some courts may allow plan fiduciaries to escape liability if their decisions are objectively prudent, the safer approach is for fiduciaries to ensure that they are engaging in a prudent process and documenting the process before making decisions.

IRS Releases Internal Memorandum Regarding Normal Retirement Ages of 55 and Older

The IRS released an Internal Memorandum on February 23, 2016 to provide guidelines for Employee Plans Determinations and Examinations employees who review multiemployer plans that contain a normal retirement age ("NRA") that is earlier than age 62 but no earlier than age 55. The guidelines provide that if the plan is maintained pursuant to at least one collective bargaining agreement and is a multiemployer plan, an NRA should be considered reasonably representative of the industry's typical retirement age as required by the Internal Revenue Code. The guidance is effective as of February 23, 2016.

IRS Indicates Plan Sponsors Should Skip Certain Questions on Form 5500

Recently, the IRS indicated that plan sponsors should not answer the optional questions on Schedule R (Part VII, lines 20a-c, 21a-b, 22a-d and 23), which relate to compliance with various Internal Revenue Code requirements. Initially, the IRS encouraged plan sponsors to answer those optional questions but has since changed its mind. Plan Sponsors should also skip Lines 4o, 4p, 6a, 6b, 6c and 6d on Schedule H and Schedule I and should not complete the preparer information on the bottom of page 1 of Form 5500. On Form 5500-SF, plan sponsors should not complete the preparer information on the bottom of page 1, Lines 10j, 14a-d and New Part IX (lines 15a-c, 16a-b, 17a-d, 18, 19 and 20). The questions that should be skipped on Schedules H and I and on Form 5500-SF generally relate to Internal Revenue Code requirements and information regarding the trust.

Health and Welfare Plan Developments

Federal Court Declines to Dismiss Case Against Employer for Reducing Work Schedules

A judge in the Southern District of New York has denied a motion to dismiss a class action against Dave & Buster's, Inc. that alleges that Dave & Buster's impermissibly reduced employees' hours to avoid having to provide health

insurance under the Affordable Care Act. The shared responsibility requirements in the ACA require applicable large employers ("ALE") to offer minimum essential health coverage to substantially all full-time employees. If ALEs do not comply with this requirement, employers could be subject to penalties. The plaintiff employees allege that the reduction of hours constitutes a violation of ERISA section 510, which prohibits employers from discriminating against participants or interfering with participant's ability to attain any right to which the participant may become entitled. The employees were working full-time and were eligible for medical coverage until their hours were reduced. The court noted that the complaint alleged sufficient facts to support a finding that Dave & Buster's intentionally impeded the employees' rights to receive benefits, as the complaint referred to e-mails and other evidence that Dave & Buster's was trying to avoid incurring ACA-related expenses. This case is not final, but it demonstrates that judges may be willing to hear challenges related to reductions in employee hours if the reduction is intended to avoid ACA coverage requirements. Future decisions in this case may have greater implications for employers.

Proposed Revisions to Summary of Benefits and Coverage Template Have Been Issued

On February 26, 2016, the Department of Labor ("DOL"), Department of Health and Human Services ("HHS") and Department of the Treasury proposed changes to the Summary of Benefits and Coverage ("SBC") template that incorporates many of the recommendations from the National Association of Insurance Commissioners ("NAIC"). Overall, the revised template is substantially similar to the previous version of the proposed revised template. The most notable changes involve the coverage examples, which will require self-funded plan sponsors to review and compare current SBC provisions to the revised examples. One of the changes requires plans to indicate whether the plan provides minimum essential coverage and whether the plan meets minimum value standards. The revised template also requires plans to provide information regarding abortion services coverage, which information is not required for self-funded plans. In addition to revising the SBC template, the proposed changes include an updated uniform glossary and instructions. Comments on the revised template are due by March 28, 2016.

Improving Health Coverage for Mental Health and Substance Use Disorder Patients Report to Congress

The DOL submitted a report to Congress titled "Improving Health Coverage for

Mental Health and Substance Use Disorder Patients Including Compliance with the Federal Mental Health and Substance Use Disorder Parity Provisions." As part of the report, the DOL distributed questions to stakeholder groups and invited the groups to share their thoughts. Some of the main concerns surrounded transparency, disclosure and what actions are required to comply with the regulations.

Stakeholders representing health plans and behavioral health organizations indicated that they believed that the grant or denial of benefits standing alone does not necessarily indicate compliance, but major discrepancies in denial rates between mental health and medical/surgical benefits is a red flag for noncompliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA"). In response to a question regarding what documents the DOL should request from group health plans to check for MHPAEA compliance, stakeholders suggested that the DOL review medical management documents, among others, to obtain information on the medical necessity criteria. Stakeholders also suggested that it would be helpful if the DOL could provide model language for medical necessity criteria and non-quantitative treatment limitations.

Consumer and provider groups designated the lack of transparency for health plan decision making as a major concern. This lack of transparency appears to stem from health plans' concerns about disclosing proprietary practices. However, the Parity Implementation Coalition ("PIC") noted that MHPAEA and ERISA require disclosure of medical necessity criteria and guidelines. The PIC provided positive comments on the final MHPAEA regulations regarding disclosure, but worried that the disclosure regulations are not being enforced. The report highlights the stakeholders' concerns and may give some indication as to where enforcement efforts may be focused.

Sixth Circuit Determines that Employer May Modify Retiree Medical Benefits

In *Gallo v. Moen*, the Sixth Circuit determined that collective bargaining agreements ("CBA") did not provide vested health care benefits for the life of retirees and their dependents. The court applied an ordinary contract analysis and noted that nothing in the CBAs required the employer to provide unalterable benefits to retirees. The *Moen* case follows a United States Supreme Court decision that rejected the Sixth Circuit's presumption that collectively bargained medical benefits for retirees were vested at retirement unless there was clear evidence demonstrating that the benefits would not vest. The *Moen* case

suggests that the Sixth Circuit will now interpret collective bargaining agreements according to ordinary contract principles and will not presume vesting of collectively bargained retiree medical benefits.

Department of Health and Human Services Office for Civil Rights Issues Guidance Regarding Mobile Application Developer Compliance with HIPAA

The Department of Health and Human Services Office for Civil Rights issued guidance regarding the application of the Health Insurance Portability and Accountability Act ("HIPAA") to mobile applications ("apps"). The guidance suggests that when individuals download a health app and input protected health information ("PHI"), the developer will not generally be a business associate subject to HIPAA unless it creates, receives, maintains and transmits PHI on behalf of a covered entity. For example, if a consumer downloads a blood pressure app and inputs PHI, the developer is not a business associate. In addition, if a health care provider enters an interoperability arrangement that allows information to be exchanged between the provider electronic health record and the app at the consumer's request, the app developer is not a business associate because the interoperability arrangement was put in place at the consumer's request. However, if the provider contracts with the app developer for patient management services, and the data that the patient inputs is incorporated into his or her electronic health record, the app developer would be a business associate.

Department of Health and Human Services Issues Final Notice of Benefit and Payment Parameters for 2017

On March 8, 2016, the HHS issued the final Notice of Benefit and Payment Parameters for 2017 (the "Final Notice"). The Final Notice does not include significant changes from the proposed notice issued in November 2015 but does contain some clarifications.

The premium adjustment percentage for 2017 is 13.2%. Accordingly, for 2017, the maximum in-network out-of-pocket limits for non-grandfathered plans will increase to $7,150/person and $14,300/family. The annual employer shared responsibility penalties will increase to $2,260 for the 4980H(a) penalty and $3,390 for the 4980H(b) penalty.

The Final Notice also provides that for benefit years beginning on or after January 1, 2019, the Exchanges will offer a shorter annual open enrollment period. Annual open enrollment will run from November 1 of the year preceding the

benefit year through December 15 of the same year, starting with the 2019 benefit year. Open enrollment periods for the 2017 and 2018 benefit years will continue to run from November 1 of the year preceding the benefit year through January 31 of the benefit year.

The Final Notice does not make substantial changes to the notices of premium tax credit eligibility described in the proposed Notice of Benefit and Payment Parameters. The current HHS rules require Exchanges to provide a notice to employers if an employee is determined to be eligible for a premium tax credit. The Final Notice provides employers with advance warning of a potential shared responsibility penalty so that the employer can appeal the determination, if necessary. However, as provided in the proposed Notice of Benefit and Payment Parameters, because the shared responsibility penalty is not triggered unless a full-time employee receives a premium tax credit and enrolls in a qualified health plan ("QHP"), HHS has determined that it would be more accurate to send the notice only if the employee is determined eligible for a premium tax credit and the employee enrolls in a QHP on the Exchange. The Final Notice revises the rule accordingly. Additionally, the Exchanges can send a notice to employers each time an employee enrolls in a QHP and receives a premium tax credit or the Exchange could notify employers for groups of employees. The Exchange must send the notices within a "reasonable timeframe" following any month an employee is determined eligible for a premium tax credit and enrolls in a QHP.