

# October 2015 Employee Benefits Update

## COMPLIANCE DEADLINES AND REMINDERS

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1. Summary Annual Report for Calendar Year Group Health Plans. For calendar year plans that obtained an extension to file their annual report (Form 5500), the Summary Annual Report must be distributed to participants and beneficiaries no later than December 15, 2015 (two months after the close of the extension period).

2. 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, 2015. Applicable group health plans that have not yet provided the notice should send the notice as soon as possible. The Centers for Medicare and Medicaid Services ("CMS") provides a model notice that can be accessed through the CMS website. Plan sponsors should review the model notice to ensure it accurately reflects the plan provisions.

3. Reinsurance Fee for Group Health Plans.

a. Reporting for 2015. 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 health plans' annual enrollment counts by November 16, 2015 using the electronic 2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form. The form will then calculate the contribution amount owed. The contribution rate for the 2015 calendar year is \$44 per reinsurance covered life.

b. Payment for 2014. For contributing entities that chose to pay the 2014 reinsurance fee in two installments, the second payment (\$10.50 per reinsurance covered life) is due by November 15, 2015.

4. Health Plan Open Enrollment Requirements.

a. SBCs. Plan sponsors of group health plans must issue a new summary of benefits and coverage ("SBC") to participants and beneficiaries covered under the



plan with each open enrollment. Group health plans without open enrollment must issue the SBC 30 days in advance of the plan year (December 2, 2015 for calendar year plans).

b. HRA Opt-Out. 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.

5. 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 2, 2015.

6. 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 2, 2015. Plan sponsors can combine the automatic enrollment notice with the QDIA notice.

7. 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 2, 2015. Plan sponsors can combine the safe harbor notice with other required notices, such as the QDIA notice.

## **RETIREMENT PLAN DEVELOPMENTS**

### **IRS Publishes Interim Guidance on Processing Determination Letter Applications**

On September 1, 2015, the Internal Revenue Service ("IRS") published a memorandum providing interim guidance on the revised determination letter application processing procedures originally outlined in Revenue Procedure

2015-6. The memorandum provides the periods for responding to an IRS request for information to make an application complete or request for information relating to technical compliance. The memorandum also clarifies when extensions will be granted and when a case will be closed for a procedurally or technically incomplete application. Questions remain regarding further changes to the determination letter program for individually designed plans, which the IRS may address in future guidance. The memorandum is effective September 1, 2015, and the guidance will be incorporated into Internal Revenue Manual section 7.11.1, Employee Plans Determination Letter Program, by August 31, 2017.

## **IRS Issues Final Regulations on Minimum Required Contributions**

On September 8, 2015, the IRS issued final regulations under Internal Revenue Code ("Code") section 430 for determining the yearly minimum required contribution for single employer defined benefit pension plans. Single employer defined benefit plans must satisfy the Code's "minimum funding standard" under section 412 by making a yearly minimum required contribution calculated under Code section 430 and its corresponding regulations. The amount of the contribution depends on whether the value of a plan's assets is less than or equal to the plan's funding target for the year. The final regulations, while generally similar to the proposed regulations issued in 2008, include additional rules addressing the amount of the required contribution, liquidity requirements and contributions for short plan years. The final regulations also contain provisions addressing the excise tax imposed on plans failing to satisfy the Code's minimum funding standard. The final regulations will apply to plan years beginning on or after January 1, 2016, but plan sponsors may apply or rely on them for earlier years.

## **PBGC Issues Updated Regulations on Reportable Events**

On September 11, 2015, the Pension Benefit Guaranty Corporation ("PBGC") published final regulations on events required to be reported under section 4043 of the Employee Retirement Income Security Act of 1974 ("ERISA"). Section 4043 requires defined benefit plan sponsors to notify the PBGC of certain events that may signal financial problems and put pensions at risk. To reduce the burden on plan sponsors and reduce the number of reports, the final regulations target the



small number of plans and plan sponsors posing the greatest financial risk to the PBGC by increasing waivers and extensions available to financially solvent plans and plans with sufficient funding. Under the relief provided in the final regulations, the PBGC expects that about 94% of plans will be exempt from many of the reporting obligations. The final regulations apply to events occurring after January 1, 2016.

## **IRS Updates Instructions for Forms 8950 and 8951**

On September 23, 2015, the IRS published revised instructions to Form 8950, Application for Voluntary Correction Program (VCP), and Form 8951, Compliance Fee for Application for Voluntary Correction Program (VCP), to reflect recent changes made to the IRS's Employee Plans Compliance Resolution System ("EPCRS"). Changes to EPCRS included new safe harbor corrections for 401(k) and 403(b) plans, expansion of overpayment and underpayment correction methods, and a reduction of VCP compliance fees. The IRS has stated it will continue to accept prior versions of Forms 8950 and 8951 until January 1, 2016.

## **HEALTH AND WELFARE PLAN DEVELOPMENTS**

### **CMS Releases Proposed 2017 Essential Health Benefits Benchmark Plans**

On August 28, 2015, CMS released proposed 2017 essential health benefits benchmark plans for each state. The 2017 benchmark plans are based on plans available in 2014, and many states proposed using the largest small group health plans operating in their state. CMS accepted public comments on the proposed benchmark plans until September 30, 2015, after which CMS expects to publish the final list.

Under the Affordable Care Act ("ACA"), essential health benefits comprise ten broad categories of benefits (e.g., hospitalization, emergency services, maternity care), but no specific services are listed under each category. Instead, HHS regulations define essential health benefits based on state benchmark plans. The ACA does not require employer-sponsored self-insured health plans, insured large group health plans and grandfathered health plans to offer essential health benefits. However, because these plans may not impose annual and lifetime dollar limits on any essential health benefits they do offer, these plans must define their essential health benefits by either selecting a benchmark plan or using a good faith, reasonable definition of essential health benefits. Plan sponsors that decide not to select a benchmark plan may wish to review which

services are essential health benefits in benchmark plans in defining their plans' essential health benefits under the good faith standard.

## **IRS Releases Final Forms and Instructions for Forms 1094-B, 1095-B, 1094-C and 1095-C**

On September 15, 2015, the IRS published final forms and instructions for the B-Series (1094-B and 1095-B) and C-Series (1094-C and 1095-C) ACA Information Returns. All applicable large employers and self-funded plan sponsors must file ACA Information Returns with the IRS by February 29, 2016 (March 31, 2016 if filing electronically) to report coverage offered to fulltime employees and participants during the 2015 calendar year. A copy of the return is due to employees/participants by February 1, 2016.

The final forms are substantially identical to the draft forms. The final instructions retain most of the information in the draft instructions, but the IRS added some changes, including:

- Reporting More Than One Type of Coverage. The final instructions for Forms 1094-B and 1095-B state that a plan providing more than one type of minimum essential coverage to an individual need only report one type of coverage. Thus, if an individual is covered by a self-insured medical plan and an HRA provided by the same employer, the employer need only report the medical coverage or the HRA, but not both. The instructions also state that a plan providing minimum essential coverage generally need not report coverage for which an individual is eligible if the individual is covered by other minimum essential coverage for which reporting is required. Thus, if an individual is covered by an insured group health plan and a self-funded HRA offered by the same plan sponsor, the plan sponsor is not required to report the HRA. The insurer will report the individual's coverage under the group health plan.
- Medicare. The final instructions for Forms 1094-B and 1095-B state that if an individual is covered by Medicare and a Medicare Supplement, the plan sponsor of the Medicare Supplement is not required to report that individual's coverage.
- Reporting COBRA Offers to Former Employees. The final instructions for Forms 1094-C and 1095-C state that an offer of COBRA continuation coverage made to a former employee upon termination should not be reported as an "Offer of Coverage."

## GENERAL DEVELOPMENTS

### **Third Circuit Rules that Plan's Statute of Limitations for Filing Suit Is Unenforceable if Not in Final Denial Letter**

In *Mirza v. Insurance Administrators of America, Inc.*, the Third Circuit Court of Appeals refused to apply a plan's contractual limitations period for filing a civil action in court. The Third Circuit held that, because the limitations period was not disclosed in the final adverse determination letter provided to the claimant, the plan violated ERISA's claims procedures regulations. Setting aside the plan's one-year limitations period, the Third Circuit borrowed New Jersey's six-year statute of limitations used for breach of contract claims.

In 2013, the Supreme Court upheld the enforceability of a plan's self-imposed limitations period for filing suit in *Heimeshoff v. Hartford Life Insurance Co.*, provided the limitations period is reasonable and there is no controlling statute to the contrary. Since *Heimeshoff*, courts have split on whether the claims procedures regulations require plans to notify claimants of any contractual limitations period in the final denial of an appeal. In light of recent court holdings, plan sponsors and administrators should consider adding any applicable contractual limitations period to their denial letters to ensure their plans' internal statutes of limitations remain enforceable.

### **Ninth Circuit Rules that Successor Liability Doctrine May Apply in Withdrawal Liability Context**

Reversing and remanding the lower court's decision, the Ninth Circuit Court of Appeals in *Resilient Floor Covering Pension Trust Fund v. Michael's Floor Covering, Inc.*, ruled that a successor employer, including a building and construction industry employer, could be held liable for its predecessor's withdrawal liability owed to a multiemployer pension plan so long as the successor had notice of the liability. The Ninth Circuit noted that it previously held successor employers liable for their predecessors' delinquent contributions, but now was extending the successor liability doctrine to the withdrawal liability context. In reviewing whether the employer was a successor in the case, the court held that the primary factor was whether substantial continuity in the business operations existed between the predecessor and the successor employer, determined largely by whether the new employer retained the "same body of customers" as the prior employer. The court also provided a list of successorship factors that courts must analyze when imposing withdrawal liability on a successor entity, which include



market share, continuity of workforce and similarity of owners and operators.

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