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Winter 2016 Client Newsletter

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This newsletter provides clients and friends of Utz & Lattan, LLC, with brief updates on legal and regulatory developments affecting employee benefits and executive compensation. If you would like to discuss any of these items in more detail, please contact one of our attorneys.

## Safe Harbor Plan Guidance

The Internal Revenue Service (the "IRS") issued welcome guidance for safe harbor plans in the form of Notice 2016-16 on January 29, 2016. The Notice liberalizes the rules governing mid-year changes for safe harbor plans. Prior to issuing this Notice, the IRS had taken a very restrictive view on the type of permissible mid-year amendments to safe harbor plans.

The new Notice provides that a safe harbor plan may make a mid-year change if: (1) for changes affecting the safe harbor notice provided annually to employees, employees receive an updated safe harbor notice describing the mid-year change and its effective date within a "reasonable time" (30-90 days) before the effective date of the change, (2) each employee required to receive the updated safe harbor notice is given a reasonable opportunity to change the employee's cash or deferred election, before the effective date of the change, and (3) the mid-year change is not a "prohibited change."

The Notice lists the following four prohibited mid-year changes: (1) a change to increase the number of completed years of service required for an employee to have a vested right to the employee's account balance attributable to safe harbor contributions, (2) a change to reduce the number (or otherwise narrow the group) of employees eligible for safe harbor contributions, (3) a change to the type of safe harbor plan (for example, a change from a traditional 401(k) safe harbor plan to a

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QACA 401(k) safe harbor plan), and (4) a change to modify (or add) a formula used to determine matching contributions (if the change increases the amount of matching contributions) or to permit discretionary matching contributions.

Plan sponsors who previously were uncertain as to their ability to make needed mid-year changes to safe harbor plans (e.g., in connection with mergers or acquisitions) now can rely on Notice 2016-16 to make permissible changes as needed.

## Update on Department of Labor's New Fiduciary Conflict of Interest Rule

The Department of Labor's (DOL) proposed new definition of an ERISA fiduciary is currently under review at the Office of Management and Budget (OMB). The rule, which was proposed in April 2015, has been the subject of much controversy and comment within the retirement and financial industries. As proposed, the rule would expand the definition of an ERISA fiduciary and would subject such fiduciaries to new conflict-of-interest standards intended to ensure that fiduciaries work in the best interest of their ERISA and IRA clients. The DOL has indicated that it has made changes to the initial proposed rule in response to industry comments, but the final rule provisions are not yet known. Sending the regulation to OMB is the last step toward finalization, and the final rule is expected to be released in March or April of this year. Once finalized, an implementation period of eight months or more is likely.

Congress and industry advocates have continued to express concern about the proposed rule. Some have argued that the rule will be too costly to implement, will disrupt current investment advice relationships, and may cause some financial service providers to discontinue providing advice and guidance to small retirement and IRA account holders. Others have argued that the rule provides necessary protections for investors. Most recently, at least two bills have been introduced by members of Congress attempting to stop implementation of the new regulation. Other members have indicated they are reserving judgment until the final rule is released.

## Supreme Court Subrogation Case

On January 20, 2016, the Supreme Court decided a key case involving health plan subrogation rights under ERISA in *Montanile v. Board of Trustees*. In that case, the Court ruled that an ERISA fiduciary does not have a right under ERISA to reimbursement for benefits paid to a plan participant if the participant completely disperses a third-party settlement on items that are *not traceable*. Specifically, an ERISA fiduciary may not bring a claim under Section 502(a)(3) of ERISA for "appropriate equitable relief" if the plan participant spends settlement funds on items that are not traceable (such as food).

In *Montanile*, an ERISA health plan paid $121,000 in claims for a plan participant's medical expenses related to a drunk driving car accident. The plan document included a standard (and rather comprehensive) subrogation and reimbursement provision. Specifically, the plan document provided that amounts recovered by a plan participant from a third party by award, judgment, or settlement should be promptly paid to the plan first, without reduction for any attorney's fees or other costs and expenses. The plan document also required that participants notify the plan and obtain its consent before settling claims. The plan was aware of the participant's settlement for $500,000 from the drunk driver and sought reimbursement of the $121,000 it had paid for the participant's medical expenses relating to the car accident. The participant's attorney refused the plan's request for reimbursement. Negotiations between the plan and the participant's attorney ultimately broke down, at which time the attorney notified the plan that monies would be transferred from a client trust account to the participant unless the plan objected within 14 days. The plan did not object (at least within the 14 day timeframe), and six months later the plan filed a claim under ERISA Section 502(a)(3) against the participant for $121,000. The plan attempted to recover the $121,000 from any unspent settlement proceeds or any property in the participant's actual or "constructive" possession. The Supreme Court reversed the lower courts' decisions and ruled against the plan, holding that an ERISA fiduciary cannot, under ERISA Section 502(a)(3), recover amounts from a settlement if the participant dissipates the whole settlement on "nontraceable items." This is because, according to the Court, obtaining recovery from the participant's general assets is not "equitable relief," which is a requirement for a lawsuit brought under ERISA Section 502(a)(3).

***Why this case is important:*** The *Montanile* case should serve as a warning for plan fiduciaries to quickly pursue reimbursement from a plan participant for recovery against a third party. Plans may want to implement mechanisms to track participants' settlement cases against third parties so that plans can act swiftly when participants do recover from third parties. Plans may want to periodically contact participants who have received plan benefits to ask whether the participant is pursuing recovery from a third party. If a plan uses a third party to pursue subrogation and reimbursement cases, the plan should contact the third party to ensure that timely action will be taken to recover amounts owed to the plan. Finally, plan sponsors may wish to bolster subrogation and reimbursement language in plan documents in an effort to address some of the issues illuminated by the *Montanile* case.

## Year-End Guidance on Health and Welfare Plans

The government issued a fair amount of health and welfare guidance at the end of 2015.

Below we have highlighted the guidance that is most relevant to our clients:

ACA Information Reporting Delay. The IRS issued Notice 2016-4 at the end of December delaying the deadline for certain "information reporting" requirements under the Affordable Care Act (ACA). Specifically, the Notice delayed the deadline for furnishing to individuals the 2015 Form 1095-C (and Form 1095-B for small employers) to **March 31, 2016**, and for filing with the IRS a copy of these forms as well as the 2015 Form 1094-C transmittal (and Form 1094-B transmittal for small employers) **to May 31, 2016** (or **June 30, 2016**, if filing electronically). Employers that do not comply with these extended deadlines will be subject to penalties for failure to timely furnish and file the Forms (see our Summer 2015 newsletter for more information on the penalty amounts); *extensions will not be granted*.

Employees may have questions about how to file their 2015 tax returns without first receiving the Form 1095-C (or Form 1095-B). While plan sponsors should always direct employees to tax advisors for tax advice, employers may want to briefly communicate to employees that they may file 2015 tax returns in reliance on other information received from the employer concerning eligibility for the premium tax credit or liability for a penalty for failure to maintain minimum essential coverage.

Final ACA Regulations. The government issued final regulations concerning certain rules under ACA. The final regulations apply to group health plans as well as health insurance issuers beginning in 2017 and include some clarifications regarding certain ACA rules. Three clarifications are worth mentioning:

***Prohibition on HMO Service Area Requirement for Dependents Under Age 26***. It is a violation of the ACA for a health plan to require that participants live, work, or reside in a specific service area to be eligible for coverage, *to the extent the requirement is applicable to dependent children up to age 26.* Plans that utilize an HMO design should work with their third party administrator - or the health insurance issuer - to remove this requirement beginning with the 2017 plan year.

***Information to be Provided Automatically in Connection with Appeal***. The final regulations clarify that certain information must be provided *automatically* in connection with a health plan appeal. Specifically, health plans must provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan in connection with the claim, as well as any new or additional rationale. This information must be provided as soon as possible and *before* the notice of the final adverse benefit determination is provided. Plan sponsors should review their plan documents and consult with TPAs to ensure that this requirement is satisfied beginning in 2017.

***Patient Protections Clarifications***. The final regulations include a few clarifications regarding "patient protections." First, if a plan requires the designation of a

participating primary care provider for a child, the plan must allow a participant to designate any physician who specializes in pediatrics, including pediatric sub-specialties (for example, pediatric oncology). Second, all women - *regardless of age* - may receive obstetrical and gynecological care without prior authorization (or plan or physician referral). Third, a plan cannot require a time limit within which a participant must seek emergency services for those services to be covered by the plan.

FAQs Concerning the ACA. The government issued FAQs (IRS Notice 2015-87) in December pertaining to various provisions under the ACA that apply to employer-provided health coverage. Below is a summary of some of the highlights:

***Health Reimbursement Accounts (HRAs)***. The guidance includes clarifications on various HRA issues, including (but not limited to): (1) a confirmation that retiree-only HRAs may be used to purchase individual market coverage; and (2) a clarification that an HRA may be integrated with an employer's other group health plan only as to the individuals who are enrolled in both the HRA and other group health plan.

If your company sponsors an HRA, please carefully review your plan documents to ensure the plan's terms comply with the recent guidance. Feel free to contact our law firm for more information on the guidance and its application to your company's HRA.

***Miscellaneous Employer Mandate Issues***. The guidance includes information related to the employer mandate, including (but not limited to) a clarification that for purposes of determining an employee's full-time status under the employer mandate, "hours of service" does not include payments made solely to comply with state disability insurance laws or worker's compensation laws.

The rules pertaining to the employer mandate are complex. Please contact our law firm if you have questions regarding the application of the employer mandate rules to your health plan.

***FSA Guidance.*** The guidance includes information related to health FSAs. For example, the Notice clarifies that health plans that permit participants to carry over up to $500 in unused FSA dollars must factor in any carried over amount when determining whether a participant has overspent or underspent his or her FSA for purposes of COBRA. Additionally, the Notice provides: (1) that the applicable COBRA premium for health FSA coverage may not factor in any carried over amounts; and (2) that a health FSA that allows carryovers for "similarly situated nonCOBRA beneficiaries" must allow a carryover of unused amounts to a COBRA beneficiary even if this causes an extension of the COBRA coverage beyond the plan year.

Health plan documents that permit health FSA carryovers may need to be revised in light of the new guidance. Plan sponsors should review plan documents to determine if modifications to FSA carryover and COBRA rules are necessary.

## Cadillac Tax Delayed

As you may have heard by now, President Obama signed a bill into law in December that, among other things, delays the effective date of the "Cadillac Tax" under the Affordable Care Act. The effective date is now **2020** and not 2018. The fate of the Cadillac Tax (an excise tax on high-cost employer-sponsored health plans) is unknown given the political climate at this time. Many are predicting that the Cadillac Tax is effectively dead and that it is doubtful a similar measure will be enacted to replace the tax. For now, conservative employers may wish to continue to assess their health plans and to anticipate the tax becoming effective in 2020, while delaying any actual benefit design changes until the ultimate fate of the Cadillac Tax is more discernible.

## Compliance Calendar: Key Upcoming 2016 Deadlines and Due Dates*

- **February 29, 2016:** File Notice of Creditable/Non-Creditable Coverage with CMS (for calendar year plans)
- **March 31, 2016:** Provide Form 1095-C to employees (applicable large employers)
- **May 31, 2016:** File Forms 1094-C and 1905-C with IRS (paper filings)
- **June 30, 2016:** File Forms 1094-C and 1095-c with IRS (electronic filings)
- **July 28, 2016:** Summary of Material Modifications (SMM) or updated Summary Plan Description (SPD) generally must be distributed by July 28th (210 days after end of plan year) for plan amendments adopted during prior year
- **July 31, 2016:** Deadline to file Form 5500 (for calendar year plans) without extension
- **July 31, 2016:** Patient Centered Outcomes Research Institute (PCORI) fee due for 2015

*This calendar does not include *every* compliance date that may be applicable to a retirement, health or welfare benefit plan. It simply highlights certain key dates of note. Dates generally apply to calendar year plans.