Proskauer

The ERISA Litigation Newsletter

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Editor's Overview

This month’s newsletter features an article on the DOL’s recently published interim final rule that increases penalties for notice and disclosure violations, which generally became effective on August 1, 2016. The article explores the application of each penalty and emphasizes the need for plan administrators and sponsors to remain vigilant with respect to these notice and disclosure requirements.

Be sure to review the Rulings, Filings and Settlements of Interest where we provide additional updates on the litigation involving the DOL’s new fiduciary rule, as well as guidance on ACA Reporting.

View From Proskauer: U.S. Department of Labor Raises Penalties for Notice and Disclosure Violations [1]

By Lindsey Chopin

ERISA subjects employers, plan sponsors, plan administrators and insurers to a variety of reporting and disclosure requirements, and the failure to comply with those requirements may result in monetary penalties. In an effort to increase the deterrent impact of these penalties, the Employee Benefits Security Administration of the U.S. Department of Labor (DOL) recently published an interim final rule that increases, and in some cases doubles, these penalties. The new penalties became effective on August 1, 2016 and apply to any assessments after August 1, 2016 where the associated violation occurred after November 2, 2015.

Below, the penalties have been categorized based on their application to the type of plan: (i) penalties applicable to all types of employee benefit plans, (ii) penalties applicable to group health plans, (iii) penalties applicable to multiemployer welfare arrangements, (iv) penalties applicable to multiemployer pension plans, and (v) penalties applicable to retirement plans.

I. Penalties Applicable to All Types of Employee Benefit Plans

Employee Records and Benefit Statements

Employers generally must maintain records that are sufficient to allow a determination of benefits due. When a plan participant requests a benefit statement, terminates his or her service with the employer, or has a one-year break in service with the employer, the plan administrator is supposed to produce a report to the participant of benefits that are due or will be due. Failure to maintain these records and/or furnish such reports is punishable by a fine of up to $28 per employee. The penalty had been up to $11 per employee.

Annual Reports

Plan administrators are required to file with the DOL annual reports (Form 5500) containing certain actuarial and financial information about the plan, as well as terminal and supplementary reports when a benefit plan is winding down. Failure to timely file such reports is subject to a penalty of up to $2,063 per day past the filing deadline. Notably, if the DOL rejects a filing as insufficient, it is considered to have not been submitted so as to trigger these penalties. The penalty had been up to $1,100 per day. Notably, plan administrators can limit the amount of this penalty by filing delinquent reports through the DOL's Delinquent Filer Voluntary Correction Program. This program allows unlimited correction of missed filings for a flat fee (usually $4,000)—a significant savings relative to the cost of non-compliance if the DOL discovers a delinquency.

Plan Documents Requested by the DOL

Upon request by the DOL, a plan administrator must provide any document relating to an employee benefit plan. This includes plan and trust documents, summary plan descriptions, and collective bargaining agreements. Failure to comply is punishable by fines up to $147 per day, not to exceed $1,472 per request. The prior penalty was up to $110 per day with a maximum of $1,100 per request.

II. Penalties Applicable to Group Health Plans

Summary of Benefits and Coverage

A group health plan's insurance issuer and plan administrator are required to provide to plan sponsors and participants/beneficiaries, respectively, a written summary of benefits and coverage, in four situations: (i) upon application to the issuer or administrator for coverage, (ii) by the first day of coverage under the plan if any changes are made after application, (iii) during open enrollment periods or upon reissuance of coverage in certain cases, and (iv) upon request. Failure to provide an SBC as required can result in penalties of up to $1,087 per failure, up from up to $1,000 per failure.

CHIP Coverage

An employer that maintains a group health plan must provide notice to its employees of potential Children's Health Insurance Program, or CHIP, coverage. CHIP programs are state-run health insurance programs that provide low-cost health care for uninsured children who are not eligible for Medicaid. Additionally, a plan administrator of such a plan must provide the State in which the plan is maintained information about the benefits offered under the plan, to allow the State to determine the cost-effectiveness of premium assistance and supplemental CHIP benefits. Failure to provide proper notice and information can now be fined at a rate of up to $110 per day per employee, up $10 from the former penalty.

Genetic Testing and Information

The Genetic Information Nondiscrimination Act of 2008 amended ERISA to generally prohibit discrimination based on genetic information. As such, a group health plan sponsor or insurer may not seek, purchase, or require testing of participants' genetic information. Moreover, a plan sponsor and/or insurer may not determine eligibility for coverage or raise premiums based on genetic information. Sponsors and insurers who fail to comply may be fined up to $110 per day during any non-compliance period. Repeated and/or uncorrected failures to comply result in higher penalties: a minimum of $2,745 per violation per day for de minimis failures to meet these requirements that are not corrected prior to notice by the Secretary of Labor and a minimum of $16,473 per violation per day for failures that are not de minimis and that are not corrected prior to notice by the Secretary of Labor. Additionally, the maximum penalty for unintentional failures was raised from $500,000 to $549,095.

III. Penalties Applicable to Multiemployer Welfare Arrangements

Multiemployer welfare arrangements that provide medical benefits, but that are not group health plans (welfare plans that provide health benefits directly or through insurance, reimbursement, or otherwise), are required to register and timely file reports not less frequently than annually concerning compliance with regulations governing such plans. Failure to timely file the required reports is now fined at a rate of up to $1,502 per day, up from $1,100 per day.

IV. Penalties Applicable to Multiemployer Pension Plans

Endangered or Critical Status of Multiemployer Plans

Each year, a multiemployer plan's actuary must certify to the Secretary of the Treasury and the plan sponsor whether or not the plan is in endangered or critical status with respect to funding and provide certain actuarial data supportive of the certification. If the plan already has been so designated and is subject to a funding rehabilitation or improvement plan, the actuary must certify whether or not the plan is making funding progress as provided in the plan. Plan administrators may be penalized up to $2,063 per day that the certification is late, up from $1,100 per day.

Plan Document Requests

Contributing employers, participants, beneficiaries and employee representatives of a multiemployer defined benefit pension plan may request certain documents, including: the current plan and trust document, financial statement, summary plan description, and annual report. Upon a written request for such documents, the plan administrator must generally comply within thirty days. Failure to timely and properly provide any of the following is now subject to a fine of up to $1,632 per day of violation, rather than the prior penalty of up to $1,000 per day. Notably, this requirement is different than ERISA Section 104(b)(4)'s requirement that plan administrators for all types of employee benefit plans supply similar documents upon request, and only applies to multiemployer plan administrators, as described in ERISA Section 101(k). This distinction is important because a violation of Section 104(b)(4) permits a participant or beneficiary to hold the plan administrator liable for monetary penalties, whereas a violation of Section 101(k) only allows the DOL to fine the plan administrator.

Withdrawal Liability Calculations

Contributing employers to a multiemployer plan may request, and the plan sponsor or administrator must provide, a notice of the estimated amount of an employer's withdrawal liability and an explanation of how such liability was determined. Failure to timely and properly provide any of the following is now subject to a fine of up to $1,632 per day of violation, up from the prior penalty of up to $1,000 per day.

Failure to Adopt Funding Improvement/Rehabilitation Plans

Multiemployer plans in endangered or critical status must adopt funding improvement and rehabilitation plans, respectively. A plan sponsor who fails to timely adopt the required plan may be fined up to $1,296 per day, up from up to $1,100 per day.

V. Penalties Applicable to Retirement Plans

Single Employer Defined Benefit Plans with Liquidity Shortfalls and/or Funding Limitations

The plan administrator of a single-employer defined benefit plan must provide notice to participants and beneficiaries if the plan becomes subject to a funding-based limitation on benefits, e.g., when a plan is barred from making accelerated benefit distributions because the plan is less than 60% funded. Failure to provide notice is now penalized at a rate of up to $1,632 per day of violation, rather than the former $1,000 per day penalty.

Additionally, if such a plan sponsor is required to make accelerated contributions due to a funding shortfall and fails to do so, the plan's fiduciary may be penalized if it authorizes certain distributions, including certain amounts in excess of monthly single life annuity payments to participants and beneficiaries and payments for purchases of an irrevocable commitment from an insurer to pay benefits. Any distribution made in violation of these provisions shall be penalized at a rate of up to $15,909 per distribution, up from $10,000 per distribution. Significantly, while the other penalties discussed herein are discretionary, ERISA requires the DOL to assess a penalty for such improper distributions.

Automatic Contribution Arrangements

When a plan contains an automatic contribution arrangement, meaning that plan participants automatically defer or contribute part of their compensation to the plan unless they opt out, the plan administrator must provide a notice of certain rights and obligations under the arrangement. Failure to timely and properly provide any of the foregoing is now subject to a fine of up to $1,632 per day of violation, rather than the former penalty of up to $1,000 per day.

Notice of Blackout Periods

The plan administrator of an individual account plan must give participants and beneficiaries notice of any blackout period. The penalty for such failures increased from up to $100 to up to $131 per participant or beneficiary per day.

Divestment of Employer Securities

Plan administrators must give participants and beneficiaries notice of their right to direct proceeds coming from the divestment of employer securities. The penalty for such failures increased from up to $100 to up to $131 per day.

Cooperative and Small Employer Charity Act Plans

CSEC plans are benefit plans maintained by groups of cooperatives and/or charities. The failure of a CSEC plan sponsor to establish or update a funding restoration plan is penalized at a rate of up to $110 per day (up from $100).

Proskauer's Perspective

The penalties imposed by the Interim Final Rule are paid to the DOL in all cases, meaning a participant or beneficiary does not have a right to sue to enforce such penalties. Given the increased exposure due to noncompliance, plan administrators and plan sponsors are well-advised to ensure that they provide all required notices. While the penalties in some cases may be waived or reduced, the potential for substantial penalties for noncompliance exists, particularly where penalties are assessed per participant or beneficiary. Notably, in some cases, noncompliance can also give rise to excise taxes levied under the Tax Code, or even loss of a plan's qualified status. It is therefore essential that plan administrators and sponsors remain vigilant with respect to these notice and disclosure requirements.

The full text of EBSA's Interim Final Rule can be viewed here.

Rulings, Filings, and Settlements of Interest

Update on Lawsuits Challenging the U.S. Department of Labor's Fiduciary Rule

By Russell Hirschhorn and Benjamin Saper

As we previously reported, there are five pending lawsuits challenging the U.S. Department of Labor's new fiduciary rule.

Our client alert on the new rule outlines the significance of the rule and the implications of the expanded definition of "fiduciary" for investment advisors and other related service providers.

First, with respect to the litigation pending in the U.S. District Court for the District of Columbia, captioned *The National Association for Fixed Annuities v. Thomas E. Perez et al.,* Case No. 16-cv-1035, briefing is now complete on the NAFA's motion for a preliminary injunction and for summary judgment, as well as the DOL's cross-motion for summary judgment. We published a summary of the parties' arguments. Oral argument on the motions is currently scheduled for August 25, 2016. AARP, the Public Investors Arbitration Bar Association, Better Markets, Inc., Consumer Federation of America, and Americans for Financial Reform have filed *amicus curie* briefs in support of the DOL and the new rule.

Second, the three lawsuits filed in the U.S. District Court for the Northern District of Texas were consolidated under the caption *Chamber of Commerce of the U.S., et al., v. Perez, et al.*, Case No. 16-cv-1476-M. The Chamber of Commerce and its co-plaintiffs filed their motion for summary judgment on July 18, 2016, arguing that the new rule unlawfully creates a private right of action, that the rule violates the First Amendment as applied to truthful commercial speech, and that the DOL exceeded its statutory authority and acted arbitrarily and capriciously in imposing fiduciary obligations on non-fiduciary speech and disfavoring annuities. They also argued that the rulemaking process was inadequate. It is anticipated that the DOL will file a combined opposition and cross-motion for summary judgment on August 19, 2016. Briefing on the motions is currently scheduled to conclude by October 7, 2016, and oral argument on the motions is currently scheduled for November 17, 2016.

Third, in the lawsuit filed by Market Synergy in the U.S. District Court for the District of Kansas, captioned *Market Synergy Group, Inc., v. U.S. Dept. of Labor, et al.*, Case No. 16-cv-4083, Market Synergy filed a motion for a preliminary injunction postponing implementation of the new rule, arguing that that the DOL failed to adequately consider the impact of its rule on the sale of fixed indexed annuities, and did not provide adequate notice of its decision to allow the sellers of fixed indexed annuities to comply with the rule's best interest contract exemption. The DOL opposed the motion on the ground that Market Synergy failed to show a likelihood of success on the merits given that the administrative process was proper and thorough, and the DOL acted well within its statutory authority. A hearing on the motion for preliminary injunction is scheduled for September 21, 2016. AARP, the Public Investors Arbitration Bar Association, Better Markets, Inc., Consumer Federation of America, and Americans for Financial Reform have sought leave to file *amicus curie* briefs in supports of the DOL. Market Synergy filed an opposition to the motions for leave to file amicus briefs and the court has not yet ruled on the issue.

Challenge to Pension Fund Investment Decision Time Barred

By Steven A. Sutro

A federal district court in California held that a complaint filed by members of the International Union of Operating Engineers that challenged pension plan trustees' decision to make certain investments was filed five days too late and thus barred by ERISA's six-year statute of limitations. In so holding, the court ruled that the limitations period commenced at the time the fund entered into the investment management agreement, not the time when the plan assets were actually invested. The court explained that the action of making the payments into the investment were ministerial acts, as the fund had already been legally obligated to make them. The case is *Slack v. Burns*, 13-CV-5001, 2016 BL 233292 (N.D. Cal. July 20, 2016).

ACA Reporting Update – 2016 Draft Forms & Instructions Released

By Damian A. Myers

Since our last ACA Reporting Update, the extended deadlines to distribute Forms 1095-B and 1095-C to covered individuals and employees and to file the forms with the IRS have passed. The IRS has stated, however, that late forms can still be submitted via electronic filing and the forms that received an error message should be corrected. By many accounts, the first ACA reporting season presented numerous challenges. From collecting large amounts of data to compiling the forms, to working with service providers that faced their own unique challenges, to facing form rejections and error notifications from an inadequate IRS electronic filing system, employers and coverage providers faced obstacles nearly every step of the way. Nevertheless, most employers and coverage providers were able to get the forms filed and put the 2015 ACA reporting season behind them.

But, alas, there is no rest for the weary. In late-July, the IRS released new draft 2016 Forms 1094-B and 1095-B (the "B-Series" Forms) and Forms 1094-C and 1095-C (the "C-Series" Forms). Additionally, on August 1, the IRS released draft instructions to the C-Series Forms (as of the date of this blog, draft instructions for the B-Series Forms have not been released). For the most part, the 2016 ACA reporting requirements are similar to the 2015 requirements, subject to various revisions described below.

- Various changes have been made to the forms and instructions to reflect that certain forms of transition relief are no longer applicable. For example, the non-calendar year transition relief (for plan years starting in 2014) that applied in 2015 does not apply in 2016. Similarly, changes have been made to reflect that the "Section 4980H Transition Relief" is still relevant only for non-calendar year plans though the end of the plan year ending in 2016. The Section 4980H Transition Relief exempts applicable large employers ("ALEs") with 50-99 full-time employees from penalties under Section 4980H of the Internal Revenue Code (the "Code") and reduces the 95% threshold to 70% for other ALEs. The relief also exempts ALEs from having to offer coverage to dependents if certain requirements are met. For calendar year plans, the threshold is at 95% throughout 2016 and dependent coverage must be offered during each month of the year.

The draft instructions to the C-Series Forms provide more detail and examples on how ALEs should prepare the forms. Instead of referring to "employers" throughout the instructions, the IRS has replaced that term in most cases with "ALE Member." The reason for this change is to highlight the fact that each separate ALE Member must file its own forms. Examples related to completing the authoritative Form 1094-C highlight that each separate entity (determined based on employer identification number) is required to file its own authoritative Form 1094-C.

- As promised by the IRS last year, there are two new indicator codes for Line 14 of Form 1095-C. These new codes ask employers to indicate whether a conditional offer was made to a spouse. An offer of coverage to a spouse is conditional if it is subject to one or more reasonable, objective conditions. For example, if a spouse must certify that he or she is not eligible for group health coverage through his or her employer, or is not eligible for Medicare, in order to receive an offer of coverage, the offer is considered conditional.
- The draft instructions to the C-Series Forms reflect that the good faith compliance standard applicable to 2015 forms (under which filers could avoid reporting penalties upon a showing of good faith) no longer applies for 2016 ACA reporting. Going forward, reporting penalties may be waived only upon the standard showing of reasonable cause.
- The draft instructions to the C-Series Forms include new information related to coding for COBRA continuation coverage. There has been some uncertainty regarding how to treat offers of COBRA continuation coverage since the IRS removed relevant guidance from its Frequently Asked Questions website in February 2016. Similar to the 2015 instructions, the draft 2016 instructions provide that offers of COBRA coverage after termination from employment should be coded with 1H (Line 14) and 2A (Line 16) whether or not the COBRA coverage is elected. The new instructions now state that this coding sequence also applies for other, non-COBRA post-employment coverage, such as retiree coverage, when the former employee was a full-time employee for at least one month of the year.

In the case of an offer of COBRA coverage following a reduction in hours, the basic coding requirement is the same as in 2015 – the offer of COBRA coverage is treated as an offer of coverage on Line 14 of the Form 1095-C. The draft instructions expand on this basic requirement to explain how to code Lines 14 and 16 when the offer of COBRA coverage is not made to a spouse or dependent. In general, for purposes of Code Section 4980H, an offer of coverage made once per year to an employee and his or her spouse and dependents is treated as an offer for each month of the year even if the coverage is declined for the employee, spouse, and/or dependents. Under general COBRA rules, only those individuals enrolled in coverage immediately prior to the qualifying event receive an offer of COBRA coverage.

So how does this play out when an employee with a spouse and dependents elects self-only coverage during open enrollment and later loses that coverage due to a reduction in hours? The draft instructions treat the initial offer of coverage at open enrollment and the offer of COBRA coverage as two separate offers of coverage. To determine the proper coding, the employer must look at who had the opportunity to enroll at each offer. During open enrollment, the employee, spouse and dependent had the opportunity to enroll. Thus, until the reduction in hours and loss of coverage, the coding should be 1E (offer to employee, spouse and dependent) in Line 14 and 2C (enrolled in coverage) in Line 15.

In contrast, the offer of COBRA coverage was only available to the employee and, therefore, after the reduction in hours, the coding should be 1B (offer to employee only) in Line 14. If the employee does not elect the COBRA coverage, code 2B (part-time employee) could be inserted in Line 16. If, however, the employee does elect COBRA coverage, it appears that code 2C (enrolled in coverage) should still be inserted in Line 16. Although this latter coding sequence is likely intended to protect the spouse and dependents from being "firewalled" from a premium credit, there appears to be nothing to indicate that the employer should not be assessed a penalty for failing to make an offer to the employee's dependents.

The draft instructions for the C-Series Forms provide additional insight into how to calculate the number of full-time employees for purposes of column (b) in Part III of the Form 1094-C. The draft instructions clarify that the determination of full-time employee status is based on rules under Code Section 4980H and related regulations and not on other criteria established by an employer. Note that, currently, the draft instructions state that the monthly measurement period must be used for this purpose, but it appears that this is a mistake and that it should reference both the monthly measurement and look-back measurement methods. The IRS may clarify this in the final instructions.

- One important non-change in the draft instructions is that the specialized coding for employees subject to the multiemployer plan interim guidance remains in effect for 2016 reporting. The interim guidance provides that an employee is treated as having received an offer of coverage if his or her employer is obligated pursuant to a collective bargaining agreement to contribute to a multiemployer plan on the employee's behalf, provided that the multiemployer plan coverage is affordable and has minimum value and the plan offers dependent coverage to the eligible employee. The coding for such as employee is 1H (no offer of coverage) for Line 14 and 2E (multiemployer plan interim guidance) for Line 16.

There will undoubtedly be tweaks to the draft instructions to the C-Series forms, but significant changes appear unlikely. Given that only five months remain in 2016, employers should start planning now for 2016 ACA reporting based on the draft instructions and make alterations as necessary when final instructions and other guidance is released.

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