Proskauer

ERISA Newsletter

Third Quarter 2019

Editor's Overview

In this edition of our Newsletter, we take a look at a pair of cases that, while unrelated, together remind us of the importance of having clear plan rules in place that reflect the plan sponsor's intention. The first article takes a look at a Ninth Circuit decision addressing the interplay between, on the one hand, ERISA and the right to reimbursement for medical bills paid on behalf of a plan participant and, on the other hand, state laws prohibiting such reimbursements in insured plans. The second article reviews a plan's suspension of benefit rules and, more specifically, one plan's efforts to adjust to a change in the law about how such rules should be applied.

As always, the Newsletter provides highlights from our blog over the past quarter, including cases and guidance on arbitration, California state laws, standing, mental health parity, statute of limitations, withdrawal liability, benefit claims, the fiduciary exception, 401(k) plans, 403(b) plans, and the Affordable Care Act.

Ninth Circuit Enforces Hawaii Anti-Reimbursement Statutes Against Insured Plan

By: Russell L. Hirschhorn and Kyle Hansen

ERISA health care plans typically include reimbursement and subrogation clauses, which give plans a right to reimbursement of medical expenses paid on behalf of a beneficiary where the injury is caused by a third party. While such provisions are common in ERISA health care plans, they sometimes conflict with state laws that prohibit plans and insurers from seeking reimbursement. A recent decision from the Ninth Circuit illustrates the interplay between ERISA and state laws prohibiting an insurer's right to reimbursement for medical bills paid on behalf of a participant. *See Rudel v. Haw. Mgmt. Alliance Ass'n*, No. 17-17395, 2019 WL 4283633 (9th Cir. Sept. 11, 2019). As discussed below, the decision also serves as a good reminder to plan sponsors to ensure that their plans' reimbursement and subrogation provisions are updated to achieve the desired outcome.

In this case, Randy Rudel, a plan participant, was hit by a car while riding his motorcycle and, as a result, he sustained numerous and severe injuries. Rudel had health insurance from the Hawaii Medical Alliance Association (HMAA) pursuant to an ERISA plan. HMAA paid $400,779.70 in medical bills on behalf of Rudel. Rudel also received $1.5 million in a tort settlement for "general damages" related to the injury. The damages included medical expenses and damages for emotional distress, but did not include special damages that would "duplicate medical payments, no-fault payments, wage loss, [or] temporary disability benefits."

HMAA subsequently sought reimbursement of the medical bills it paid based on a plan provision that gave HMAA the "right to be reimbursed for any benefits [it] provide[s], from any recovery received from . . . any third party or other source of recovery including general damages from third-party settlements." Rudel refused to reimburse the plan and sued in state court based on two Hawaii statutes that prohibited reimbursement for general damages from third-party settlements.

HMAA removed the case to federal court in Hawaii, arguing that ERISA preempted the Hawaii anti-reimbursement statutes. Subject to certain exceptions, ERISA § 514 provides that ERISA supersedes all state laws insofar as they "relate to" any employee benefit plan. An exception applies for state laws that regulate insurance, banking, or securities—commonly referred to as the "savings clause." Rudel sought to move the case back to state court, arguing that his claim was not preempted because the Hawaii statutes were protected by the savings clause.

The Ninth Circuit held that the Hawaii statutes were saved from ERISA preemption and that HMAA had no right to reimbursement based on the statutes. In so holding, the Court first determined that Rudel's state law claims were completely preempted for purposes of jurisdiction under ERISA § 502(a) because his claim was one to clarify his rights to benefits under the plan. This meant that the case could stay in federal court rather than being remanded to state court. Next, the Court ruled that the Hawaii statutes were saved from preemption because they were directed toward entities engaged in insurance and substantially affected the risk pooling arrangement between the insurer and the insured. In other words, the Hawaii statutes regulate the extent to which insurers may limit coverage and recover certain types of reimbursement and thus impact the eventual net value of any payment made to a plan member and create more risk for insurers.

Proskauer's Perspective

While the Ninth Circuit's decision reminds us that fully-insured plans have to comply with state insurance laws, including anti-reimbursement statutes, it should not be forgotten that state insurance laws apply only to fully-insured plans. ERISA's broad preemption provision continues to apply for self-insured plans. On the topic of plan reimbursement and subrogation provisions, plan sponsors should consider periodically reviewing their plans' reimbursement and subrogation provisions to ensure that they reflect the sponsor's intention in terms of the types of payments subject to recoupment, the type of legal interest created, and the type of funds subject to reimbursement. Because such provisions affect injured beneficiaries' recoveries, they are hotly contested. Accordingly, plan sponsors will want to ensure that their plan provisions are up to date.

Ninth Circuit Enforces Pension Fund's New Interpretation of Plan In-Service Distribution Rules

By: Anthony S. Cacace and Nanci R. Hamilton

A recent Ninth Circuit decision addressing retirement and in-service distribution rules provides an important reminder to plan fiduciaries of defined benefit pension to apply such rules in compliance with both the plan's terms and applicable law. *See Meakin v. California Field Ironworkers Pension Trust*, No. 18-15216, 2019 WL 2375194 (9th Cir. June 5, 2019) (unpublished).

The defined benefit plan at issue in this case (the “Plan”), like many such plans, provided that a participant must have retired to be eligible for a pension benefit. Under the Plan, a pensioner was considered “retired” only if he “withdr[ew] completely and refrain[ed] from any employment or activity in the building and construction industry.” However, the Plan also provided for a limited exemption, which allowed a pensioner to continue employment in certain job positions while commencing receipt of a pension benefit. To receive the exemption, a pensioner was required to submit a retiree work application to the Plan Trustees for approval.

Plaintiff Robert Meakin stopped working in his then current position with his employer in 2008, but continued working for the same employer in a different position. Meakin applied for a retirement benefit, and the Trustees determined that the Plan’s exemption, as referenced above, applied. Meakin thus began receiving his pension benefit while continuing to work for his employer, albeit in his new position.

Several years later, the Trustees commenced a review of the Plan’s retirement and suspension of benefits rules in light of IRS guidelines that had been issued prohibiting in-service distributions. Those guidelines provided that a pension plan can provide for payment of benefits only *after* retirement, and thus that a pension plan could not pay benefits to an individual who did not retire. The Trustees then used the IRS’s voluntary compliance program to adopt administrative procedures that stopped distributions to participants who never actually retired.

The Trustees subsequently sent Meakin a notice informing him that he would stop receiving his pension beginning in April 2014 based on the Plan’s interpretation of its rule regarding retirement. After exhausting the Plan’s administrative appeals process, Meakin filed suit in district court claiming that the Trustees’ discontinuation of his benefits, pursuant to their new interpretations of the Plan’s in-service distribution rules, was unlawful because (1) it constituted an impermissible cutback of an accrued benefit under *Central Laborers’ Pension Fund v. Heinz*, 541 U.S. 739 (2004); and (2) equitable estoppel should bar the Trustees from applying the new interpretation to him.

The district court granted the Fund’s motion for summary judgment because it concluded that the Trustees did not abuse their discretion by “reinterpreting” the Plan to require participants to experience an actual separation from employment in order to be eligible for an early retirement pension.

On appeal, the Ninth Circuit held that the Trustees' new interpretation based on the IRS guidelines was not unreasonable or an abuse of discretion because the Trustees were granted discretion in interpreting plan provisions and thus were not bound to their original interpretation. In so holding, the Court rejected Meakin's reliance on *Central Laborers' Pension Fund v. Heinz*. In *Heinz*, the Supreme Court held that ERISA prohibits a plan amendment from expanding the categories of post-retirement employment that trigger suspension of the payment of already accrued early retirement benefits. According to the Court, unlike in Heinz, the Plan here was not imposing an additional condition for receipt of post-retirement benefits, but rather was reinterpreting an existing provision addressing the requirements for retirement, as defined by the Plan.

The Court also rejected Meakin's equitable estoppel theory because he did not establish the "extraordinary circumstances" necessary for such relief. Additionally, the Court determined that any relief requiring the Trustees to continue paying Meakin's pension would impermissibly contradict the written terms of the Plan.

Proskauer's Perspective

Trustees and administrators of defined benefit pension plans should carefully review any rules and practices that may permit payment of benefits to participants who have not retired under the written terms of the plan in order to ensure that they are in compliance with in-service distribution rules under the Internal Revenue Code. Additionally, if claims for benefits are brought by participants, trustees and fiduciaries are well-advised to administratively adjudicate participants' claims according to the plan document and record the reasoning of their decisions, so that they may be afforded deference should a litigation arise.

Highlights from the Employee Benefits & Executive Compensation Blog

Arbitration

Ninth Circuit Overturns Precedent and Sends ERISA Claims to Individual Arbitration

By: Howard Shapiro, Myron Rumeld, Stacey Cerrone, John E. Roberts, Tulio Chirinos and Lindsey Chopin

In a case of first impression, the Ninth Circuit overturned 35 years of precedent and ruled that ERISA class action claims brought on behalf of an ERISA plan are subject to individual arbitration. The Court also enforced the arbitration agreement's class action waiver and sent plaintiff's putative ERISA class action to individual arbitration with relief limited to plaintiff's individual plan losses. Plaintiff—a former Charles Schwab employee and participant in the Charles Schwab 401(k) sponsored plan—brought a putative ERISA class action lawsuit against the fiduciaries of the Charles Schwab 401(k) plan. Despite the plan's arbitration provision and class action waiver and several other similar employment-related arbitration agreements, plaintiff brought his lawsuit on behalf of the entire 401(k) plan and a putative class of more than 25,000 participants. Plaintiff alleged that the company included proprietary Charles Schwab investment funds in the plan for self-gain in violation of ERISA's prohibited transaction rules and breached its fiduciary duties of prudence and loyalty by allowing participants to invest in proprietary investment options that were more expensive and underperformed comparable non-proprietary options available in the market.

Proskauer moved to compel individual arbitration of plaintiff's claims arguing that claims under ERISA, like any other federal statute, are subject to individual arbitration (class action waiver) under the Federal Arbitration Act. The district court denied Charles Schwab's motion to compel arbitration for multiple reasons, including that the arbitration provision was inserted into the plan document after plaintiff ceased being a plan participant and because plaintiff's claims were brought on behalf of the plan and the plan had not consented to arbitration. The district court also stated that even if the plan did consent to arbitration, the consent would not be valid under ERISA because it would inappropriately limit the plan fiduciaries' liability. Arguing for Charles Schwab before the Ninth Circuit, Howard Shapiro contended that the district court's order was incorrect both factually and legally on each point.

The Ninth Circuit reversed, adopting all of Defendants' arguments and becoming the first federal court of appeal to hold that class action ERISA claims brought on behalf of an entire ERISA plan are subject to individual arbitration with relief limited to the individual plaintiff's claims. First, in light of intervening Supreme Court case law, the Court overruled its longstanding precedent set forth in Amaro v. Continental Can Co., 724 F.2d 747 (9th Cir. 1984), which held that ERISA claims were not arbitrable. Second, the Court ruled that the district court incorrectly found that plaintiff was not bound by the plan's arbitration provision as he was a participant in the plan for nearly a year after the provision was inserted. The Court noted that by participating in the plan plaintiff "agree[d] to be bound by" the arbitration provision. Third, the Court found that the plan had consented to individual arbitration by including the arbitration provision in the plan document. Fourth, the Court rejected the district court's conclusion that the arbitration provision/class action waiver limited the fiduciaries' liability as the arbitration provision merely provided for a different forum that "offered quicker, more informal, and [] cheaper resolutions for everyone involved." Lastly, the Court held that nothing in ERISA precludes limiting plaintiff's relief to his individual losses as the Supreme Court has recognized that claims brought on behalf of a plan "are inherently individualized when brought in the context of a defined contribution plan like that at issue." Therefore, the Court reversed and remanded with instructions for the district court to order arbitration of individual claims limited to seeking relief for the impaired value of the plan assets in the individual's own account.

The decision resulted in two separate opinions: Dorman v. Charles Schwab Corp., No. 18-15281, 2019 WL 3926990, __F.3d__ (9th Cir. Aug. 20, 2019); Dorman v. Charles Schwab Corp., No. 18-15281, 2019 WL 3939644, __F. App'x__ (9th Cir. Aug. 20, 2019). The Proskauer team representing Charles Schwab includes partners Howard Shapiro, Myron Rumeld, and Stacey Cerrone, senior counsel John Roberts, associates Tulio D. Chirinos and Lindsey Chopin, and senior paralegal Blair Jones.

California Laws

Landmark Bill Passes: California Codifies "ABC" Test for Worker Classification

By: Kate Napalkova and Katrine Magas

On Thursday, September 12th, the California State Assembly passed Assembly Bill 5 ("AB 5"), the controversial new law that codifies the three-factor "ABC" test introduced by the California Supreme Court in its 2018 Dynamex decision. The passage of AB 5 marks a sea change in the way that companies doing business in California will be required to classify their workers. AB 5 now goes to Governor Gavin Newsom's desk for his signature, and Governor Newsom has previously committed to sign the bill into effect.

Effective January 1, 2020, AB 5 adopts Dynamex's rigorous three-factor test for determining how a company may classify its workers. Under the so-called "ABC" test, which will be codified in Section 2750.3 of the California Labor Code, a worker will be considered an employee unless the company hiring the worker establishes all of the following three prongs:

(A) the worker is **free from the control and direction of the company** in connection with the performance of the work, both under the contract for the performance of such work and in fact;

(B) the worker performs work that is **outside of the "usual course" of the company's business**; and

(C) the worker is **customarily engaged in an independently established trade, occupation, or business** that is of the same nature as the type of work performed for the company.

Unlike *Dynamex*, which applied only to California Wage Orders (i.e., generally, minimum wage, overtime and meal and rest break liability), AB 5 is far more sweeping, and applies to California's Wage Orders as well as the Labor Code and Unemployment Insurance Code. This means that, in the wake of AB 5, companies that are found to misclassify workers could face broader liability than they would have under Dynamex (including for unemployment insurance, various benefits, paid sick days, and state family leave).

Notably, while AB 5 specifically exempts certain industries, in its current form AB 5 does not include an specific exemption for "gig" economy companies.

To learn more about the California Supreme Court's decision in *Dynamex*, listen to our podcast on The Proskauer Benefits Brief: Legal Insight on Employee Benefits & Executive Compensation.

Please contact any member of the Proskauer Employee Benefits & Executive Compensation Group or the Proskauer Labor & Employment Group with any questions about this post.

Standing

401(k) Plan Participant Cannot Pursue Claims On Behalf Of Plans In Which She Did Not Participate

By: Tulio Chirinos

A federal district court in Ohio concluded that a 401(k) plan participant could assert fiduciary breach and prohibited transaction claims only on behalf of the plan in which she participated, and not on behalf of other plans. In this case, the plaintiff was a participant in Andrus Wagstaff, PC's 401(k) plan, and she alleged that the plan's recordkeeper charged the plan excessive recordkeeping fees. The plaintiff sought to certify two classes: (1) a plaintiff class, represented by plaintiff, consisting of all participants in 401(k) plans that had similar recordkeeping agreements with Nationwide; and (2) a defendant class, represented by Andrus Wagstaff, PC, of all plan sponsors of 401(k) plans that had similar agreements with Nationwide. Before considering whether plaintiff's putative classes satisfied Rule 23, the district court addressed the threshold issue of whether plaintiff had standing to represent and/or sue the putative classes. The court found that plaintiff lacked standing to sue each of the allegedly thousands of similarly situated 401(k) plan sponsors because each plan had different agreements with Nationwide and therefore her alleged injury, i.e., excessive fees, was not traceable to one shared contract. The court then concluded that plaintiff could only assert class claims on behalf of the Andrus Wagstaff, PC's 401(k) plan in which she participated. The case is Brown v. Nationwide Life Insurance, No. 2:17-cv-558, 2019 WL 4543538 (S.D. Ohio Sept. 19, 2019).

SDNY Rejects Class Standing and Fiduciary Breach Claims In Connection With Alleged Double-Charging Scheme

By: Neil V. Shah

A New York federal district court concluded that a defined benefit plan participant lacked standing to seek relief on behalf of plans other than the one in which he was a participant. In this case, plaintiff claimed that defendants breached ERISA fiduciary duties and engaged in prohibited transactions by charging undisclosed markups for securities trades. The court concluded that plaintiff could pursue his claim only with respect to the plan in which he participated because the defendants' alleged improper charges for that plan would not resolve whether, when, and in what amount defendants charged undisclosed markups to other plans.

The court also dismissed the plaintiff's fiduciary breach claims, finding that he failed to plausibly allege that the defendants had discretion over the disposition of plan assets such that they could be deemed functional fiduciaries. In so ruling, the court rejected plaintiff's argument that the defendants became fiduciaries with respect to the markups by virtue of the discretion they exercised over their own compensation. The court concluded that the markups depended on a number of factors outside the defendants' control, such as the type of customer, time of day, the time and amount of securities being traded, and the market price. The case is Fletcher v. Convergex Group LLC, No. 13-cv-9150, 2019 WL 3242586 (S.D.N.Y. July 2, 2019).

Mental Health Parity

Tenth Circuit Upholds Denial of Residential Mental Health Treatment

By: Neil V. Shah

The Tenth Circuit upheld a claims administrator's decision denying a claim for residential mental health treatment as not medically necessary. In so holding, the Court rejected plaintiff's argument that the claims administrator's refusal to produce data on its historical denial rates for mental health treatment warranted a de novo review because that information was not relevant to whether the benefit denial was made in accordance with the plan document. The case is Mary D. v. Anthem Blue Cross Blue Shield, No. 16-cv-00124, 2019 WL 3072468 (10th Cir. July 15, 2019).

District Court Denies Motion to Dismiss Mental Health Parity Act Putative Class Action

By: Jennifer Rigterink

In the latest volley between participants and group health plans over mental health services coverage, a federal district court in California denied United Healthcare's motion to dismiss a putative class action challenging the reimbursement rates for out-of-network mental health services. In this case, the plaintiffs alleged that UHC reduced reimbursement rates for out-of-network services by 25% for services provided by a psychologist and by 35% for services provided by a masters level counselor in violation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act").

The Parity Act, which we have blogged about previously, requires that, if a group health plan or health insurance issuer provides medical/surgical benefits and mental health and substance use disorder (MH/SUD) benefits, the financial requirements and treatment limitations applicable to MH/SUD benefits cannot be more restrictive than those that apply to medical/surgical benefits.

The court ruled that plaintiffs stated a plausible claim under the Parity Act. In so ruling, the court first concluded, over UHC's objections, that plaintiffs could pursue multiple theories as to how the reimbursement adjustment violated the Parity Act—including alleging that the restriction was an impermissible financial requirement, quantitative treatment limitation and nonquantitative treatment limitation. Next, the court rejected UHC's argument that plaintiffs failed to state a claim because the complaint did not identify a medical/surgical benefit comparable to the MH/SUD benefits at issue and did not allege that the reimbursement policy was applied more stringently to the MH/SUD benefits than the comparable medical/surgical benefit. The court explained that it was sufficient for the complaint to allege that the defendant had singled out MH/SUD services for disparate treatment by applying the reimbursement adjustment to MH/SUD services only. According to the court, plaintiffs did not need to identify a medical/surgical analogue that was not subject to a comparable reimbursement adjustment.

The case is Smith v. United Healthcare Insurance Co., No. 18-cv-06336-HSG (N.D. Cal. July 18, 2019).

Statute of Limitations

Prominently Displayed, Fundamental Discrepancy In Benefits Triggered Contractual Limitations Period

By: Neil V. Shah

The Fifth Circuit concluded that a plan's three-year contractual limitations period began to accrue when a beneficiary received a letter in 2008 that prominently displayed on the first page the monthly earnings used to calculate his long term disability benefits. The Court held that the claim was time-barred because the beneficiary failed to bring his miscalculation claim until 2017. In so holding, the Court explained that the alleged discrepancy in monthly earnings of almost $3,000 was so large and fundamental that its effect on the beneficiary's plan benefits was apparent, and the discrepancy was not of a type that required him "to decipher complex formulae or piece together inferences from incomplete information." The case is Faciane v. Sun Life Assurance Co. of Canada, No. 18-30918, 2019 WL 3334654 (5th Cir. July 25, 2019).

Withdrawal Liability

Seventh Circuit Holds Withdrawal Liability Cannot Be "Decelerated"

By: Neil V. Shah

The Seventh Circuit held that a multiemployer pension fund's withdrawal liability claim was barred by the six-year statute of limitations applicable to claims under the Multiemployer Pension Plan Amendments Act (MPPAA). After the employer failed to make several quarterly withdrawal liability payments, the fund declared the employer to be in default, accelerated its withdrawal liability, and filed suit in 2008 to collect the accelerated amount. Shortly thereafter, the parties entered into a settlement pursuant to which the employer cured the default and agreed to resume making quarterly payments. The employer defaulted on its obligation multiple times over the course of several years and in each case entered into a settlement to resume making quarterly payments. The last time the employer defaulted, the fund sued seeking the withdrawal liability owed based on the most recent settlement agreement. The employer argued that the claim was time-barred because it began to accrue in 2008 when the fund first accelerated the employer's withdrawal liability, and not when the employer breached the subsequent settlement agreements. The district court agreed and the Seventh Circuit affirmed. In so holding, the Seventh Circuit rejected the fund's argument that it could "decelerate" an employer's withdrawal liability as there was no basis under the MPPAA for doing so. The Court also commented that its ruling did not affect the fund's right to file a state law claim for breach of the settlement agreements.

The case is Bauwens v Revcon Technology Group, Inc., No. 18-3306,2019 WL 3797983 (7th Cir. 2019).

Benefit Claims

Ninth Circuit Concludes Domestic Partner Entitled To Benefits

By: Kaitlin Hulbert

The Ninth Circuit concluded that a plan fiduciary abused its discretion in denying survival benefits to a pension plan participant's domestic partner. In so ruling, the Court explained that the plan's choice of law provisions provided that the plan would be governed by California law in a manner consistent with the requirements of the Code and ERISA and, at the time the participant retired, California law afforded domestic partners the same rights and benefits as those granted to spouses. Accordingly, the Court reversed the district court's decision that domestic partners were not included within the definition of spouse under the plan and remanded with instructions to determine the benefits due to the domestic partner-beneficiary. The case is Reed v. KRON/IBEW Local 45 Pension Plan, No. 4:16-cv-04471-JSW (9th Cir. May 16, 2019).

Quick Tips for ERISA Plan Administrators When Something Goes Wrong

By: Paul M. Hamburger

In 2010, after nearly two centuries of legal jurisprudence, the U.S. Supreme Court (in Conkright v. Frommert), concluded that "People make mistakes." The Court even acknowledged that administrators of ERISA plans make mistakes!

So what do you do if you find that someone made a mistake in plan administration? When we work with clients to help fix problems, here are the seven (really six because number 7 is a repeat) basic correction steps we use.

VIDEO: 7 Key Steps for ERISA Plan Administrators When Something Goes Wrong

For more on this topic, you can visit our previous blog post here.

Foreign Nationals Don't Have ERISA Claims

By: Kyle Hansen

A federal district court in Pennsylvania held that it did not have subject matter jurisdiction to hear a claim for disability benefits under an ERISA plan brought by foreign nationals working in the Republic of Kosovo. The court explained that absent an "affirmative intention" of Congress that is "clearly expressed" to give a statute extraterritorial reach—which there was not under ERISA—it must presume that ERISA is primarily concerned with "domestic conditions." Accordingly, the court determined that it was precluded from hearing plaintiffs' claims for lack of subject matter jurisdiction. The case is In re Reliance Standard Life Ins. Co., No. 19-331 (E.D. Pa. June 24, 2019).

Attorney-Client Privilege

Life Insurer Compelled to Produce Attorney-Client Communications

By: Lindsey Chopin

A federal district court in Ohio concluded that internal communications between a plan administrator and in-house counsel about a beneficiary's first-level benefit claim remained protected by the attorney-client privilege, and that ERISA's fiduciary exception to the attorney client privilege did not apply. In so ruling, the court explained that once the beneficiary's counsel submitted a "strongly worded, evidence-based letter along with [a doctor's] opinion letter, [defendant] faced more than a mere possibility of future litigation if it continued to deny benefits," and thus the relationship was clearly adversarial and litigation was a near-certainty. The court did, however, compel the production of communications between the plan administrator and in-house counsel before and after the initial claim denial, but only up to the point when the beneficiary's counsel submitted the "strongly worded, evidence-based letter." The case is Charlie Duncan, Ex'r of the Estate Of Paul W. McVay, et al. v. Minnesota Life Ins. Co., No. 17-cv-25, 2019 WL 3000692 (S.D. Ohio July 10, 2019).

403(b) Plans

The Deadline for 403(b) Sponsors to Review Plan Documents for Compliance is Approaching

By: Steven Weinstein

Section 403(b) plans must be maintained pursuant to a written plan document that meets detailed requirements set forth in IRS regulations. If a plan contains a defect as to form (e.g., a provision does not comply with the regulations or a required provision is missing), the plan can be at risk for losing its qualification for favorable tax treatment. The IRS allows a "remedial amendment period" to correct form defects in individually designed plans that were timely adopted, but the remedial amendment period ends ***March 31, 2020*** (subject to a short extension for recently incurred plan defects).

It is not uncommon for the IRS to identify possible defects in well-drafted plan documents that were adopted in good faith. The "remedial amendment period" offers employers an opportunity to review existing language in light of developments over the last several years and to clean up or improve the language retroactively without penalty.

After March 31, 2020, retroactive correction will no longer be permitted outside of the IRS Employee Plans Compliance Resolution System (EPCRS). Because the March 31, 2020 deadline is not likely to be extended by the IRS, sponsors of individually designed section 403(b) plans are encouraged to review their 403(b) plan documents and consult with their advisers to determine if there are any provisions that should be cleaned up by March 31, 2020.

Affordable Care Act

Executive Order Seeks to Improve Consumer-Driven Healthcare

By: Damian Myers and Annie (Chenxiaoyang) Zhang

On June 24, 2019, the President issued his Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. The Executive Order directs regulators to take action to improve healthcare price transparency and to enhance consumer-driven healthcare. The success of consumer-driven healthcare is dependent on patients being able to act as a consumer would – namely, comparing prices and quality before making a decision to purchase. However, patients typically have very limited access to pricing and quality information in the healthcare sector. The Executive Order outlines a number of directives that would improve access to pricing and quality information. The following directives are likely to affect group health plan design and administration:

- **Price and Quality Transparency.** The Executive Order directs regulators to propose regulations that would require hospitals to publicly disclose the standard charge for common items and services. The disclosure would need to be written in a consumer-friendly manner that would enable patients to compare the cost of receiving the item or service at various sites of care. The regulators are also directed to require health plans (both individual and group) to take steps to improve enrollee access to pricing and quality information. Many large insurance carriers and administrative services companies have already developed price transparency tools that have quality ranking features. There is no indication at this point whether these tools would need to be modified to comply with the future regulations.

- **Expanded Use of Consumer-Driven Health Plans.** The Executive Order also directs regulators to adopt rules to make it easier for individuals to use high-deductible health plans tied to health savings accounts (HSAs). This directive includes a mandate to expand the scope of preventive care that can be covered by a high-deductible health plan before the statutory minimum deductible is reached to include maintenance-related care for chronic conditions. The Executive Order further requests that regulators increase the amount of money that can be carried over to future years under a healthcare flexible spending arrangement, from the current limit of $500.

- **Surprise Billing.** The Administration also continues to target surprise billing, which refers to bills that patients unexpectedly receive after they visit in-network healthcare providers. This often occurs when a patient visits an in-network facility and ancillary services are provided by out-of-network providers. For example, a patient could visit an in-network hospital but the anesthesiologist might be out-of-network. In that case, the anesthesiologist might send the patient a bill for the cost of care that is not covered under the health plan. This also occurs in the context of emergency care received at an out-of-network hospital. Although the Affordable Care Act (ACA) requires that point-of-sale cost-sharing be the same for in-network and out-of-network emergency care, the ACA does not prohibit the hospital from later billing the patient for medical costs that exceed the health plan’s reimbursement to the hospital (i.e., balance billing). The Executive Order directs regulators to issue an advance notice of proposed rulemaking that solicits comments on a proposal to address this issue; and the Executive Order directs the Secretary of HHS to submit a report on additional steps the Administration may take to address the issue. The issue of surprise billing has also recently received legislative attention. Ultimately, the solution for surprise billing might necessitate changes to plans’ out-of-network provider reimbursement practices.

The Executive Order itself does not mandate changes, but employers and plan sponsors should anticipate having to make changes in the relatively near future.

IRS

Back to Basics: IRS Issues Ruling About Failure to Cash a Distribution Check from a Qualified Retirement Plan

By: Jennifer Rigterink

In Revenue Ruling 2019-19, the IRS answered three basic questions about the consequences of an individual's failure to cash a distribution check from a qualified retirement plan. Uncashed checks arise in a number of contexts and questions on the taxation of uncashed checks should be carefully considered.

In the hypothetical posed by the IRS, Individual A received a fully taxable distribution check from a qualified retirement plan in 2019. Individual A took no action with respect to the distribution check (and did not make a rollover contribution with respect to any portion of the distribution check). The IRS confirmed the following consequences:

- **Gross income inclusion:** As expected, the IRS confirmed that the amount of the distribution is includible in Individual A's gross income in 2019, explaining that Individual A's failure to cash the distribution check does not permit her to exclude the amount from gross income. The IRS noted that, for purposes of the revenue ruling, it is irrelevant what actually happens to the check (e.g., whether Individual A keeps the check, sends it back, destroys it, or cashes it in a subsequent year). This conclusion makes it clear that recipients are not allowed to manipulate the year of income inclusion by simply holding distribution checks until a later tax year.
- **Withholding and reporting obligations**: The IRS confirmed that the plan administrator's obligation to withhold tax under IRC § 3405(d)(2) from Individual A's distribution is not altered by Individual A's failure to cash the distribution check. Likewise, the plan administrator is required to report the distribution to Individual A on a Form 1099-R for 2019. Because the plan administrator is usually unaware of precisely when a distribution check is cashed, altering the plan administrator's withholding and reporting obligations to align with the time the check is cashed, rather than when the check is issued, would prove very burdensome for plan administrators.

Perhaps the most interesting part of this ruling is the final sentence, in which the IRS alludes to continuing to analyze issues arising in other situations involving uncashed checks – "including situations involving missing individuals with benefits under those plans." So stay tuned for (potential) further guidance from the IRS regarding missing participants.

401(k) Plans and 403(b) Plans

Final Hardship Distribution Regulations, Part One: Key Changes and Deadlines for Plan Sponsors

By: Paul M. Hamburger and Jennifer Rigterink

Last week, the Department of Treasury and the IRS issued final regulations regarding hardship distributions from 401(k) and 403(b) plans. The final regulations respond to comments based on earlier proposed regulations and make a number of significant changes to the existing IRS rules that apply to hardship distributions.

Given the detailed material in the regulatory preamble as well as the final regulations themselves, we intend to release a series of blog entries analyzing the new rules for hardship distributions. Below is a summary of the issues raised in the final regulations that we will address in more detail in upcoming blog entries:

- **Plan Amendments/Plan Action Required**: Individually-designed 401(k) plans that currently permit hardship distributions will likely need to be amended to reflect the final regulations by December 31, 2021 – but operational changes will be needed to comply with the new regulations by *January 1, 2020*. (Individually-designed 403(b) plans and pre-approved 401(k) and/or 403(b) plans might have an earlier amendment deadline.) Plan sponsors that previously took action in response to the proposed regulations should review prior plan amendments and administrative changes to confirm operational and plan document compliance with the final regulations.
- **Elimination of Six-Month Suspension of Contributions:** Effective for hardship distributions on or after January 1, 2020, 401(k) and 403(b) plans cannot impose a six-month suspension of contributions following a hardship distribution.
- **Changes to Safe Harbor Events:** The final regulations modify the list of distributions deemed to be made on account of an immediate and heavy financial need by revising the casualty loss definition and adding a new FEMA disaster category, as well as incorporating prior IRS guidance on hardship distributions for

primary beneficiaries. The revised list may be applied to hardship distributions as early as January 1, 2018.

- **Elimination of Requirement to Take Plan Loans:** Effective January 1, 2019, employees are not required to take plan loans before receiving a hardship distribution.
- **Elimination of "Facts and Circumstances" Analysis:** The facts and circumstances analysis for determining whether a hardship distribution is necessary to satisfy a financial need is eliminated in favor of a general standard that relies on three objective prongs (comparable to what was in the proposed regulations).
- **Expanded Hardship Distribution Sources for 401(k) Plans:** Sources available for hardship distributions now include earnings on elective deferrals, QNECs, QMACs, and earnings on QNECs and QMACs, regardless of when contributed or earned.
- **Expanded Hardship Distribution Sources for 403(b) Plans:** Earnings on pre-tax deferrals made to a 403(b) plan continue to be ineligible for hardship distributions. However, QNECs and QMACs would be eligible for hardship distributions in a 403(b) plan that are not held in a custodial account. QNECs and QMACs in a 403(b) plan that are held in a custodial account continue to be ineligible for hardship distributions.

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As explained above, future blog entries will provide more detailed analyses of these topics and the final regulations and will include best practices for implementing the operational changes affecting plan sponsors and plan administrators.

Final Hardship Distribution Regulations, Part Two: Implementation Considerations

By: Paul M. Hamburger and Jennifer Rigterink

As discussed in our prior blog entry, the IRS recently released final regulations making a number of significant changes to the rules applicable to hardship distributions from 401(k) and 403(b) plans. As part of our continuing series on these final regulations, this blog entry will focus on two specific issues: (1) the elimination of the six-month suspension of contributions following a hardship distribution; and (2) the revised standard used to determine whether a hardship distribution is necessary to meet the financial need.

Elimination of Six-Month Suspension: Under the prior safe harbor hardship distribution standard, employees who took hardship distributions were prohibited from making contributions for at least six months. The final regulations eliminate this prohibition, meaning that plans cannot apply this contribution suspension for hardship distributions from 401(k) and 403(b) plans made on or after **January 1, 2020.**

- **Applicability dates**. Although plans cannot apply the six-month suspension on or after January 1, 2020, plan sponsors may opt to remove the six-month suspension earlier than the required date. Plan sponsors should coordinate with their record-keeper and/or third-party administrator to confirm that their desired applicability date is consistent with operational capacities and will not incur additional service charges.
- **Nonqualified plans**. In response to the proposed regulations, many practitioners had questioned whether nonqualified plans could continue to impose suspensions of contributions following an employee's hardship distribution from a 401(k) or 403(b) plan. The regulatory preamble confirms that the prohibition on suspension of contributions applies only to a qualified plan, 403(b) plan, and most 457(b) plans. Plans subject to section 409A may retain existing suspension provisions or, to the extent consistent with section 409A, may be amended to remove suspension provisions.
- **Safe harbor 401(k) plans**. Safe harbor 401(k) plans are required to issue certain initial and annual notices. These notices must include a description of the withdrawal provisions applicable to plan contributions. If a plan's existing safe harbor notices describe the prior rules that applied to hardship distributions (such as the six-month suspension of contributions), the notices should be updated to reflect the new rules. Employees should then be provided with an updated safe harbor notice and be given a reasonable opportunity to change existing contribution elections.

Revised Standard for Determining Necessity of Hardship Distribution: Under the prior regulations, a hardship distribution was only treated as satisfying an immediate and heavy financial need if there were no alternative means of satisfying the need, as determined under the facts and circumstances. The final regulations eliminate the facts and circumstances analysis in favor of a general standard providing that the distribution is not deemed necessary to satisfy the financial need unless all of the following requirements are satisfied:

- The employee has obtained all other currently available, non-hardship distributions under plans maintained by the employer (including both qualified and nonqualified plans).
- The employee represents to the plan administrator in writing that the employee has insufficient cash or other liquid assets that are "reasonably available" to satisfy the financial need. (The regulatory preamble confirms that this representation may be made by telephone, provided it is recorded.)
- The plan administrator does not have "actual" knowledge that is contrary to the employee's representation. (The plan administrator is not required to inquire into the employee's financial condition for purposes of this rule.)

The regulatory preamble confirms that ESOP dividends that have been paid to the plan and that are available for the employee to elect to receive in cash are generally considered "available" plan distributions that must be taken prior to a hardship distribution. Extending its prior guidance in IRS Notice 2002-2, the IRS confirmed that if an employee has made an irrevocable election to reinvest ESOP dividends and then requests a hardship distribution after that dividend reinvestment election has become effective, any ESOP dividends paid while the irrevocable election is in place are not considered "available" distributions. Further guidance about the extent to which non-irrevocable ESOP dividend reinvestment elections should be overridden before making a hardship distribution would be helpful. In the meantime, plan administrators will need to consider how to determine whether ESOP dividends should be taken into account when a hardship distribution is being approved.

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Stay tuned for our next blog entry, which will focus on the new FEMA disaster hardship event (including its potential impact on future IRS individualized disaster relief) and modified casualty loss definition, as well as the new contribution sources available for hardship distributions.

Final Hardship Distribution Regulations, Part Three: New Disaster Relief and Expanded Sources Available for Hardship Distributions

By: Paul M. Hamburger and Jennifer Rigterink

The IRS recently released final regulations making a number of changes to the rules applicable to hardship distributions from 401(k) and 403(b) plans. Concluding our three-part series on the final regulations, this blog entry will focus on the following changes to the hardship distribution rules: (1) modifications to the list of safe harbor expenses that qualify for hardship distributions, and (2) additional contribution sources that are now available for hardship distributions.

Modifications to Safe Harbor Expenses: Distributions made for certain "safe harbor" hardship expenses are deemed to be made on account of an immediate and heavy financial need. The final regulations modify this list of safe harbor expenses as follows:

- **Casualty loss**: Employees may receive hardship distributions for expenses to repair damage to a principal residence if the expenses qualify for any type of casualty loss deduction under Code Section 165. As a result of the 2018 Tax Cuts and Jobs Act (TCJA), through 2025, the Section 165 casualty loss deduction by its terms is not available unless the loss is due to a federally-declared disaster. To avoid this unintended limitation on available hardship distributions, the final regulations modify the casualty loss safe harbor so that it covers casualty loss expenses regardless of whether the damage resulted from a federally-declared disaster.

  The revised casualty loss definition may be applied on or after January 1, 2018. So, if a plan made casualty loss hardship distributions in 2018 *without* regard to the TCJA changes discussed above, the plan may be amended to apply the revised casualty loss definition effective January 1, 2018. That way, the plan provisions will conform to the plan's operations.

- **FEMA-designated disaster**: The final regulations add a new "FEMA-designated disaster" safe harbor expense category. Under this new category, hardship distributions may be made for expenses and losses incurred by an employee on account of a FEMA-designated disaster, provided that the employee's principal residence or principal place of employment at the time of disaster is in the FEMA-designated disaster zone.

  Note that prior disaster relief issued by the IRS extended the relief to expenses incurred by an employee's dependents or qualifying relatives. The new regulatory safe harbor is narrower in that it only applies to expenses incurred by the *employee* . In the regulatory preamble, the IRS indicated that it does not anticipate issuing disaster relief by individualized notice in the future. As a result, plan sponsors cannot necessarily rely on extended deadlines to adopt disaster relief provisions.

Pending further guidance from the IRS, plan sponsors that wish to incorporate the FEMA-designated disaster safe harbor category into a plan's hardship distribution provisions would need to do so by the end of the plan year in which the amendment is first effective. Like the revised casualty loss definition, the new FEMA-designated disaster category may be applied on or after January 1, 2018.

- **Primary beneficiary**: Incorporating prior guidance issued by the IRS in Notice 2007-7, the final regulations clarify that hardship distributions for qualifying medical, educational, and funeral expenses may be made for expenses incurred by a participant's "primary beneficiary" (someone named as a beneficiary and who has an unconditional right, upon the employee's death, to all or part of the employee's plan account).

Expanded Sources for Hardship Distributions: Expanding the current contribution sources that may be distributed on account of hardship, the final regulations provide that sources available for hardship distributions from 401(k) plans include earnings on elective deferrals, qualified non-elective contributions (QNECs), qualified matching contributions (QMACs), and earnings on QNECs and QMACs, regardless of when contributed or earned. Plan sponsors are not required to expand the available sources and may continue to limit the amounts available for hardship distributions consistent with the prior rules.

- **Special note for 403(b) plans:** Earnings on pre-tax deferrals made to a 403(b) plan continue to be ineligible for hardship distributions. However, QNECs and QMACs in a 403(b) plan that are not held in a custodial account would be eligible for hardship distributions. QNECs and QMACs in a 403(b) plan that are held in a custodial account continue to be ineligible for hardship distributions.

Reminder – Plan Amendment/Operational Changes Required: As summarized in our prior blog entry, individually-designed 401(k) plans that currently permit hardship distributions will likely need to be amended to reflect the final regulations by December 31, 2021. The amendment deadline for pre-approved 401(k) plans is more complicated and depends on several factors; however, generally, the deadline to make changes for the final regulations would likely be the employer's tax filing deadline (plus extensions) for 2020. The amendment deadline for 403(b) plans is similarly complicated. Although the general remedial amendment deadline for 403(b) plans is March 31, 2020, as a result of recently-released Rev. Proc. 2019-39, both individually-designed and pre-approved 403(b) plans will likely have additional time to adopt plan amendments relating to the final regulations.

In addition to monitoring the plan amendment deadlines summarized above, plan sponsors should also be aware that if a plan currently imposes a six-month suspension of contributions following a hardship distribution, the suspension must be eliminated for hardship distributions on or after January 1, 2020.

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You can read more about the final hardship distribution regulations in our prior blog posts in this series, including a summary of the key changes to the hardship distribution rules, as well as important implementation considerations for plan sponsors.

HRAs

Digging into the New HRA Regulations, Part 2 – ERISA Implications

By: Damian Myers and Jennifer Rigterink

New regulations issued by the Departments of Labor, Treasury, and Health and Human Services have expanded the use of health reimbursement accounts ("HRAs") by allowing reimbursements for individual market insurance premiums. As noted in the final regulations, Individual Coverage HRAs and Excepted Benefit HRAs are group health plans subject to ERISA. However, individual health insurance coverage purchased through an Individual Coverage HRA will not be deemed to be an ERISA-covered group health plan or part of a group health plan, provided that the safe harbor described below is satisfied. If the safe harbor is not satisfied, the individual policies could become subject to ERISA's regulatory framework, which includes coverage continuation requirements under COBRA, fiduciary responsibility, and various reporting and disclosure requirements.

Accordingly, to clarify these issues, the final regulations include a safe harbor that excludes individual insurance coverage that is reimbursed by an HRA from being deemed to be part of an ERISA-covered group health plan. The safe harbor generally tracks criteria recognized under similar safe harbor rules for voluntary employee benefit plans (i.e., common employee-paid voluntary insurance for things such as critical illness or accidents). In order to qualify for the safe harbor for individual insurance coverage, all of the following conditions must be satisfied:

1. **The purchase of any individual health insurance coverage is completely voluntary for employees**. An employee participating in an Individual Coverage HRA must be enrolled in individual insurance coverage. However, the fact that a plan sponsor requires an employee to purchase insurance coverage as a condition of participating in the Individual Coverage HRA does not make the purchase "involuntary" for the purpose of the safe harbor.
2. **The employer, employee organization, or other plan sponsor does not select or endorse any particular issuer or insurance coverage**. Plan sponsors may provide general assistance to employees in shopping for health insurance coverage, but the assistance must be unbiased and cannot steer employees towards a particular health insurer or type of coverage. Although plan sponsors may accommodate requests from insurance brokers to speak with employees or distribute informational materials at worksites, plan sponsors must accommodate such requests on a uniform basis and without preference for brokers that represent particular firms or have relationships with certain health insurance carriers. Maintaining an online platform that displays information about all coverage options in a state is permitted—but in order to be eligible for the safe harbor, the platform must present the coverage options in a way that is "entirely neutral" and plan sponsors could not recommend or "star" insurance coverage

options on the platform.

3. **Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage**. In order to comply with the safe harbor, only premiums for individual health insurance coverage as defined in DOL Reg. §2590.701-2 may be reimbursed; individual health insurance coverage that consists solely of excepted benefits does not satisfy the safe harbor. That said, the HRA may reimburse Medicare premiums for Medicare beneficiaries, as permitted under DOL Reg. § 2590.702-2, without falling outside the safe harbor. Reimbursement is defined broadly to include employee-initiated payments made through financial instruments such as pre-paid debit cards, as well as direct payments (individual or in the aggregate) made by the plan sponsor directly to the health insurance issuer. Employers cannot apply reimbursement procedures in a way that limits or endorses one insurer over another (for example, by making direct payments to certain health insurers and refusing to make direct payments to others). This would run afoul of the "endorsement" requirement discussed above.

4. **The employer, employee organization, or other plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage**. The preamble to the final regulations emphasizes that plan sponsors may not receive consideration or "kick-backs" from any insurance issuer or affiliated person in connection with any employee's purchase or renewal of individual insurance coverage that is reimbursed by the HRA. Accordingly, compensation from third parties (such as individual insurers) to cover the cost of operating the HRA would be prohibited payments and not permissible under the safe harbor. This requirement does not affect the rules that apply to determining whether ERISA-covered plans (including HRAs) may reimburse plan sponsors for certain expenses associated with plan administration—so, to the extent that plan assets are used to reimburse a plan sponsor for administration expenses, such reimbursements would need to be permissible under ERISA section 408(b)(2) and DOL Reg. § 2550.408b-2(e).

5. **Each plan participant is notified annually that the individual health insurance coverage is not subject to ERISA**. For Individual Coverage HRAs, the annual notice must meet the notice requirements set forth in the Individual Coverage HRA integration rules at DOL Reg. § 2590.702-2(c)(6). For qualified small business health reimbursement arrangements or HRAs that are not subject to those notice requirements, the regulations provide sample notice language that may be used to satisfy the safe harbor.

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The safe harbor in the final regulations provides some, but not complete, relief for plan sponsors. For those plan sponsors that allow employees to purchase any individual market coverage, the safe harbor should be easy to satisfy. However, some plan sponsors may wish to establish a private individual health coverage exchange through which employees can purchase selected health insurance policies. In that case, plan sponsors will need to be cognizant of the "no endorsement" requirement when designing the scope of the private exchange.

Digging into the New HRA Regulations, Part 3 – Premium Tax Credit and Employer Mandate Impact on Individual Coverage HRAs

By: Damian Myers, Kaitlin Hulbert and Malerie Bulot

As part of our ongoing series on the final regulations expanding the availability of health reimbursement accounts ("HRAs"), we discussed the newly-created Individual Coverage HRAs, which generally allow for employers to reimburse employees' premiums for health coverage purchased on the individual market. As noted in the final regulations, the new Individual Coverage HRA is a group health plan subject to ERISA and the Affordable Care Act ("ACA"). Therefore, Individual Coverage HRAs can impact employees' access to premium tax credits ("PTCs") available on the ACA Marketplace and play a role in an employer's compliance with the ACA's employer shared responsibility mandate. These issues are described more fully below.

ACA Marketplace Impact

In general, the ACA Marketplace provides access to individual market health insurance coverage, and depending on household income, an individual could get an advance PTC to reduce the cost of coverage. In addition to meeting income requirements, to be eligible for the PTC, an individual generally cannot have access to employer-sponsored minimum essential coverage that is affordable (i.e., the self-only cost is less than 9.86% (in 2019) of household income) and has minimum value (i.e., the plan pays at least 60% of covered services under the plan). If an individual actually enrolls in his or her employer's group health plan, even if it is not affordable or does not have minimum value, he or she will not be eligible for a PTC on the ACA Marketplace.

Individual Coverage HRAs are group health plans. They are also considered minimum essential coverage under the ACA. Therefore, if an employee enrolls in an Individual Coverage HRA, he or she will be ineligible for a PTC on the ACA Marketplace. If the employee opts out of the Individual Coverage HRA and seeks coverage on the ACA Marketplace, eligibility for a PTC depends on whether or not the Individual Coverage HRA is affordable.

Under the regulations, an Individual Coverage HRA is affordable for purposes of the PTC if the "employee's required HRA contribution" for the month does not exceed 1/12 (a) the employee's household income for the taxable year multiplied by (b) the "required contribution percentage." An employee's required HRA contribution amount is determined by subtracting the monthly HRA contribution for self-only coverage by the lowest cost silver-level plan available on the ACA Marketplace. The required contribution percentage is adjusted annually and is set at 9.86% for plan years beginning in 2019. As a technical matter, affordability of an Individual Coverage HRA, and thus an employee's eligibility to claim the PTC, is determined on a monthly basis. However, the regulations state that if, at the time the employee enrolled in a qualified health plan, the ACA Marketplace determines the Individual Coverage HRA is not affordable, the HRA will be considered not affordable for the entire year.

The final regulations require that employers and plan sponsors provide written notice when an Individual Coverage HRA is made available to employees. That notice must contain information regarding the availability of the PTC, an explanation of the right to opt out of the HRA and potentially receive a PTC for any month the HRA is considered "unaffordable," and a statement that opting out of an affordable HRA would make the participant ineligible for a PTC. The Department of Labor's model notice for Individual Coverage HRAs issued concurrently with the final regulations contains the required language. The use of the model notice will generally be considered to be good faith compliance with the notice requirement.

The final regulations also establish a new ACA Marketplace special enrollment event for Individual Coverage HRA eligibility. Open enrollment in the ACA Marketplace currently spans November and December. Outside of that period, individuals need a special enrollment event (i.e., loss of other coverage, birth of a child, etc.) to enroll in Marketplace coverage. Recognizing that Individual Coverage HRAs will first become available on January 1, 2020, and most likely each January 1st thereafter as employers and plan sponsors adopt these HRAs, individuals will have an ACA Marketplace special enrollment event when they obtain access to an Individual Coverage HRA.

ACA Employer Mandate Impact

Under the ACA, applicable large employers, or "ALEs" (generally those that have 50 or more full-time employees and equivalents on a controlled-group basis) must offer an eligible employer-sponsored health coverage (i.e., "minimum essential coverage") to at least 95% of its full-time employees and their dependent children or pay a significant penalty. Even if an ALE meets the 95% requirement, if the coverage that is offered is not affordable or does not have minimum value, the ALE could face a smaller penalty. In order for either penalty to be triggered, at least one employee would need to opt out of available employer-sponsored coverage and receive a PTC.

The final HRA regulations contain very little substantive guidance regarding the impact that Individual Coverage HRAs will have on employer mandate compliance. Instead, the regulations point to IRS Notice 2018-88 as setting the groundwork for future proposed regulations. Notice 2018-88 provides that Individual Coverage HRAs are minimum essential coverage, and therefore, as long as these HRAs or other forms of minimum essential coverage are made available to 95% or more of the full-time workforce, the massive ACA penalty (under Section 4980H(a) of the Internal Revenue Code (the "Code")) should be avoided.

However, the smaller, individualized penalty (under Section 4980H(b) of the Code) can still be triggered if the Individual Coverage HRA is not affordable (minimum value is assumed if the HRA is affordable). Although Notice 2018-88 explains that the same affordability methodology applied for purposes of the PTC can be used for purposes of the employer shared responsibility mandate, that methodology can be problematic for employers. For one thing, the "required HRA contribution" is based on a formula that includes household income, which is information that employers are unlikely to have. Further, the lowest-cost silver plan available to employees on the ACA Marketplace varies on an employee-by-employee basis, depending on age and place of residence. Given these challenges, Notice 2018-88 requested comments on various affordability safe harbors, including the ability to use the existing employer mandate affordability safe harbors (i.e., W-2, rate of pay, and federal poverty line) when determining Individual Coverage HRA affordability. The Treasury Department is expected to issue proposed regulations on these safe harbors in the coming months.

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Individual Coverage HRAs are a welcome addition to the health insurance space. With this addition comes the potential for missteps, however. For example, the final regulations provide that an offer of an Individual Coverage HRA will qualify as an offer of minimum essential coverage under the ACA's employer shared responsibility mandate. However, employer mandate penalties are still possible if the Individual Coverage HRA is not affordable. Although determining affordability for PTC purposes is generally straightforward, applying the same affordability methodology to the employer shared responsibility mandate can be problematic. The IRS has indicated that future proposed regulations may (1) propose allowing the use of existing affordability safe harbors to Individual Coverage HRAs and (2) propose new affordability safe harbors for Individual Coverage HRAs.

Digging into the New HRA Regulations Part 4: Excepted Benefit HRAs

By: Damian Myers and Jennifer Rigterink

New regulations issued by the Departments of Labor, Treasury, and Health and Human Services (the “Departments”) have expanded the use of health reimbursement arrangements (“HRAs”), including permitting the use of HRAs to reimburse premiums for individual health insurance coverage. As part of this expansion, and recognizing that some employers might want the flexibility to offer a limited scope HRA alongside traditional group health plan coverage, the Departments established a new type of excepted benefit – an “Excepted Benefit HRA.”

Prior to the new regulations, HRAs could be designed to excepted benefits (such as limited scope vision and dental coverage) only. Unlike those HRAs, Excepted Benefit HRAs can be used to reimburse expenses that are not necessarily related to excepted benefits (e.g., cost sharing, deductibles, and other non-covered medical expenses). However, Excepted Benefit HRAs must satisfy the following requirements in order to reimburse these medical expenses:

- **Otherwise Not an Integral Part of the Plan:** To satisfy this condition, the employer must offer traditional group health plan coverage (i.e., coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan) to the participants offered the Excepted Benefit HRA. However, unlike Individual Coverage HRAs discussed in prior blogs, there is no requirement that the participant be enrolled in the traditional group health coverage in order to participate in an Excepted Benefit HRA.
- **Limited in Amount:** The amount made newly available in an Excepted Benefit HRA for a plan year cannot exceed $1,800 (indexed for inflation for plan years beginning after December 31, 2020). Recognizing that plan sponsors need time to prepare and implement changes relating to the annual limit, the IRS and the Department of Treasury committed to publishing the adjusted amount for plan years no later than June 1 of the preceding calendar year.
- **Limitations on Reimbursement for Certain Types of Coverage:** An Excepted Benefit HRA cannot reimburse premiums for Medicare Parts A, B, C and D, individual health insurance coverage, or coverage under a group health plan (other than COBRA), although it can reimburse premiums for excepted benefits (such as dental and vision coverage). The agencies recognized concerns from commenters that reimbursing short-term limited duration insurance (STLDI) premiums could destabilize the ACA Marketplace, but the final regulations nevertheless allow reimbursement of STLDI premiums. However, if evidence later shows that the insurance marketplace has been adversely impacted, the agencies could issue guidance prohibiting STLDI premium reimbursement.

- **Uniform Availability:** The employer must make an Excepted Benefit HRA available under the same terms to all similarly situated individuals, without consideration of health status. For purposes of this rule, “similarly situated individuals” is defined by reference to the definition of “similarly situated individuals” in the HIPAA nondiscrimination rules. Generally, this means that the terms of Excepted Benefit HRAs can vary among distinct groups of participants, provided that the distinction is based on a bona fide employment-based classification consistent with the employer’s usual business practice (e.g., full-time versus part-time status).
- **Cannot be Offered with an Individual Coverage HRA.** Employers may only offer Excepted Benefit HRAs to employees if traditional group health coverage is also offered to the employees who are eligible to participate in the Excepted Benefit HRA. In contrast, employers cannot offer Individual Coverage HRAs to employees who are also eligible for traditional group health coverage sponsored by their employers. Therefore, employers cannot offer both Individual Coverage HRAs and Excepted Benefit HRAs to the same employees.

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Addition of the Excepted Benefit HRA gives employers the ability to offer a flexible, limited-scope HRA to employees. Although the amount available for each plan year is limited, amounts in an Excepted Benefit HRA may be rolled over and accumulated from year-to-year (unlike health care flexible spending accounts, which are “use it or lose it” accounts, subject to limited designed-based carryovers or grace periods). Further, employees covered by Excepted Benefit HRAs are eligible to make contributions to health savings accounts, assuming the individual does not otherwise have disqualifying coverage.

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