WINSTON & STRAWN LLP

CLIENT ALERT

We are Making a List and Checking it Twice—End of the Year and Upcoming Employee Benefit Plan Requirements

DECEMBER 11, 2017

CHECKLIST FOR PLAN SPONSORS

As the end of 2017 quickly approaches, employers should actively turn their attention to several compliance obligations for their health and welfare benefit plans and qualified retirement plans. Below is a to-do list of upcoming compliance steps, possible plan amendments, upcoming fees, the filing of required forms, and distribution of relevant notices.

HEALTH AND WELFARE PLANS

Open Enrollment – Deadline to Provide Summary of Benefits and Coverage (SBC)

Group health plans must distribute an SBC that accurately describes benefits and coverage under the plan to all plan participants and beneficiaries beginning on the first day of the first open enrollment period. For those participants and beneficiaries who do not enroll in coverage through an open enrollment period, including individuals who are newly eligible for coverage or who are eligible for special enrollment under the Internal Revenue Code (IRC), the SBC must be distributed upon eligibility for plan coverage. If a group health plan makes any material modification to the terms of the plan or coverage and the modification is not reflected in the most recently provided SBC, the plan must provide notice of the modification not later than 60 days prior to the date the modification becomes effective.

Prepare for the Employer Shared Responsibility Requirements

Employers should prepare for the employer shared responsibility requirements under IRC Section 4980H by completing the following tasks (it is recommended that these tasks be completed during the end of 2017 to ensure compliance by January 2018):

- Identify full-time employees (those working 30 or more hours per week)
- Apply an hours-counting methodology for variable, part-time, part-time temporary, and seasonal employees
- Apply your monthly measurement or look-back measurement method
- Comply with your plan's eligibility rules
- Test plans for 2018 affordability and minimum value
- Examine the design of any health reimbursement account/health flexible spending account plans to ensure compliance with the Affordable Care Act, including agency guidance addressing stand-alone and integrated arrangements and how to count health reimbursement accounts for purposes of affordability requirements under IRC Section 4980H
- Respond to any IRC Section 226J Letters

For IRC Section 6056 reporting, plan sponsors must provide the Internal Revenue Service (IRS) and Full Time Employees (FTEs) with information about the plan's compliance with the employer mandate, minimum value, and affordability. The plan sponsor must report for any employee who was full-time for at least one month in the year. All FTEs must be provided one IRS Form 1095-C, while the IRS receives one Form 1094-C (transmittal) and one Form 1095-C for each FTE. Additional IRC Section 6055 reporting is also required for self-insured medical plans.

December 15 – Deadline to Provide Summary Annual Report (SAR) (if Form 5500 Extension Granted)

For plans that complete the Form 5500 annual report, the SAR is provided automatically to plan participants and includes a summary of the Form 5500 and statement of the right to receive the annual report.

SARs should be distributed to plan participants two months after the due date for filing the Form 5500 (as long as an extension has been obtained). Calendar year health and welfare plans that were granted an extension to file the Form 5500 have until December 15 to furnish the related SAR to plan participants.

December 31 – Deadline to Execute the Health Flexible Spending Account Amendment

The maximum health flexible spending account contribution for 2018 is $2,650. If a plan sponsor wants to increase its maximum contribution for 2018, it must amend the plan before the beginning of the 2018 plan year, by December 31, 2017 for a calendar year plan.

In addition, while not required, a health flexible spending account can be amended to provide for a carryover of up to $500 in unused flexible spending account contributions to subsequent plan years. This carryover feature is optional and cannot be implemented if the plan also contains a grace period feature.

3.8% Net Investment Income Tax

The 3.8% net investment income tax under the Affordable Care Act applies to individuals, estates and trusts that have certain investment income above certain threshold amounts. Taxpayers with incomes or an adjusted gross income (AGI) over $200,000 who file individually or $250,000 for married couples filing jointly could be subject to this tax.

FICA Medicare Tax

The FICA Medicare tax rate increase under the Affordable Care Act is still applicable. FICA taxes are comprised of Social Security and Medicare taxes. This change increases the employee's portion of the FICA Medicare tax from 1.45% to 2.35% for wages over $200,000 ($250,000 for married couples filing jointly). An employer is required to collect the employee's portion of this FICA Medicare tax.

Annual Notices

Plan sponsors should ensure that all required annual notices have been provided. Examples of required annual notices include the Medicaid/SCHIP State Premium Assistance Subsidy notice, the Women's Health and Cancer Rights Act Notice, and the Newborns' and Mothers' Health Protection Act. These notices can be incorporated into the terms of the Summary Plan Description (SPD).

Marketplace Exchange Notice

Plan sponsors should develop a strategy for providing notice to new employees of the existence of the Health Marketplace Exchanges (Exchange). Employees may be eligible for a subsidy under the Exchange if the employer's share of the total cost of benefits is less than 60% and the employee's income falls within 100% to 300% of the federal poverty line. Plan sponsors should alert employees that, if the employee purchases a policy through the Exchange, he or she will lose the employer contribution to any health benefits offered by the employer.

COBRA

Initial Notice
An initial notice is required to be provided to covered employees, their dependents and spouse explaining COBRA rights and obligations. The general notice must be provided within the first 90 days of coverage. A plan can satisfy this requirement by including the general notice in the plan's SPD and giving the SPD to the employee and to the spouse within this time limit. The United States Department of Labor (DOL) has developed a model general notice that satisfies the general notice requirement.

COBRA Qualifying Event Notice
Once a qualified beneficiary experiences a qualifying event, a COBRA qualifying event notice must be provided. For some qualifying events, the plan sponsor is required to notify the plan of the qualifying event (e.g. termination or reduction in hours of employment of the covered employee, death of the covered employee, or a covered employee's becoming entitled to Medicare).

For these events, the plan sponsor has 30 days after the event occurs to provide notice to the plan. For other qualifying events, the covered employee or one of the qualified beneficiaries is responsible for notifying the plan (e.g. divorce, legal separation, or a child's loss of dependent status under the plan).

COBRA Election Notice
A third required notice is the COBRA election notice. After receiving a notice of a qualifying event, the plan must provide the qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The DOL has developed a model COBRA election notice.

COBRA Notice of Unavailability of Continuation Coverage
If the plan denies a request for continuation coverage or for an extension of continuation coverage, the plan must give the individual a notice of unavailability of continuation coverage. The notice must be provided within 14 days after the request is received, and the notice must explain the reason for denying the request.

COBRA Notice of Early Termination of Continuation Coverage
Continuation coverage must generally be made available for a maximum period (18, 29, or 36 months). If the plan terminates continuation coverage early, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Notice of Conversion
Some insured plans offer conversion rights (i.e., the right for a COBRA beneficiary to convert his or her coverage to an individual insurance policy). If such conversion rights apply, a notice of conversion must be provided to affected qualified beneficiaries.

HIPAA Privacy Notice

This notice should be distributed to participants once a new participant joins the plan. Distribution should also be made once every three years or more frequently if there have been material changes in the Privacy Policy.

FMLA General Notice

Employers are required to post a notice explaining the Family Medical Leave Act's (FMLA's) provisions and procedures, and if it has eligible employees, provide notice to each employee through an employee handbook, written guidance, or to new employees upon hire. A model notice is available on the DOL website.

USERRA Notice

A Uniformed Services Employment and Reemployment Rights Act (USERRA) notice of rights is required to be posted on an employer's premises. A model notice is available on the DOL website. In addition, individualized notices of an individual's right to elect continuation coverage under USERRA are strongly recommended, but not required. This would include such things as election and payment procedures, and notification that coverage will be terminated due to the nonpayment of premiums.

Production of Requested Documents

The Plan Document is the formal underlying document that dictates the governance terms of the plan for each type of ERISA coverage (e.g. medical, vision, dental, life, disability, etc.). Note, in some instances the Plan Document and SPD are the same document.

The SPD provides a summary of the ERISA coverage details and is provided automatically to plan participants. It must be drafted in a manner that would enable the average participant to understand their benefits, rights, and obligations under the plan. (Plan participants include active participants, beneficiaries, COBRA beneficiaries, and retirees (if applicable)).

Confirm the Plan Document is up-to-date, or if it is part of the SPD, the entire document is up-to-date. If requested by a plan participant, copies of the SPD or combined Plan Document and SPD must be furnished no later than 30 days after a written request is received. For new participants, it must be distributed to those participants within 90 days of the individual becoming covered by the plan. If the plan is new, the plan has up to 120 days after becoming subject to ERISA to distribute the SPD to participants. If the plan is updated, the updated SPD must be furnished every five years; otherwise, the SPD must be furnished every 10 years. Other documents may need to be made available for examination by participants, upon request. In some circumstances (but not all), disclosure obligations can be met if the documents are electronically posted on an intranet.

The summary of material modifications (SMM) is automatically provided to plan participants and describes the material modification to a plan and changes to the SPD. If an updated SPD is distributed to plan participants, this document is not required. Plan participants (who are not provided an updated SPD) must be provided an SMM not later than 210 days after the end of the plan year in which a change is adopted. If benefits or services are materially reduced, plan participants must be provided with a summary of material reduction of benefits notice within 60 days from adoption of the change. If, however, the amendment is to a term or condition in the SBC (see above), then the plan sponsor must provide the SMM 60 days in advance of the amendment.

July 31, 2018 – Deadline to Pay PCORI Fee for 2017 Plan Year

The Patient-Centered Outcomes Research Institute (PCORI) fee is assessed on self-insured and fully-insured health plans to fund research regarding patient-centered outcomes for medical treatment. The PCORI fee is due the July 31 following the end of the plan year for which the fee is collected. For policy and plan years ending after September 30, 2017, and before October 1, 2018, the applicable dollar amount is $2.39. Plan sponsors of self-insured health plans pay the fee by filing IRS Form 720.

July 31, 2018 – Deadline for the Form 5500 for a Calendar Year Plan with No Extension

The Form 5500 is the annual report for certain ERISA plans.

Note that Form 5500 filing requirements vary according to type of plan and size of plan sponsor. The Form 5500 is due seven months after the end of the ERISA plan year unless an extension has been granted. An extension for two and one-half months is available. For calendar year plans, the deadline is normally July 31 of the following year, or October 15 if an extension has been obtained.

September 30 – Deadline to Provide SAR (if No Form 5500 Extension Granted)

For plans that complete the Form 5500 annual report, the SAR is provided automatically to plan participants and includes a summary of the Form 5500 and statement of right to receive annual report.

SARs should be distributed to plan participants within nine months after the end of the plan year. Calendar year health and welfare plans that were not granted an extension to file the Form 5500 have until September 30 to furnish the related SAR to plan participants.

October 14 – Deadline to Provide Medicare Part D Notice of Creditable Coverage

Group health plans (whose policies include prescription drug coverage) are required to notify Medicare eligible individuals whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. There are two disclosure requirements. First, a written disclosure notice must be sent to all Medicare eligible individuals annually who are covered under the plan's prescription drug coverage, prior to October 15 each year. Additional notices are required at various times for various reasons (e.g., when a Medicare eligible individual joins the plan, to Medicare eligible active working individuals and their dependents, to Medicare eligible COBRA individuals and their dependents, to Medicare eligible disabled individuals covered under the prescription drug plan and to any retirees and their dependents).

Second, the plan must complete the Online Disclosure to CMS Form to report the creditable coverage status of the prescription drug plan. The Disclosure should be completed annually no later than 60 days from the beginning of the plan year (i.e. the contract year or renewal year), within 30 days after termination of the prescription drug plan, or within 30 days after any change in creditable coverage status. A model notice is available on the CMS website.

December 15 – Deadline to Provide SAR (if Form 5500 Extension Granted)

Calendar year health and welfare plans that were granted an extension to file the Form 5500 have until December 15 to furnish the related SAR to plan participants.

Qualified Retirement Plans

Effective January 1, 2017, the IRS eliminated the more than seven decade old determination letter program for individually-designed qualified plans and replaced it with remedial amendment relief. Remedial amendment relief provides plan sponsors with a grace period for adopting an amendment to retroactively conform the plan document to past administrative practice. Plan sponsors are required by law to adopt remedial amendments as a means of curing failures in the present which, if left untreated, will become qualification failures at the end of the grace period.

Remedial amendments are an important internal control for fixing issues before they are discovered during the annual plan audit or by a plaintiff's attorney, and for preventing expensive IRS and DOL audit sanctions. The failure to adopt remedial amendments causes plan qualification failures which may be correctable under the IRS' Employee Plans Compliance Resolution System (EPCRS). It also creates a risk of exposure for the plan sponsor if a failure is discovered during the annual plan audit, by a plaintiff's attorney, or by the IRS or DOL on audit.

2017 Remedial Amendments – Before December 31 (Calendar Year Plans)

Employers should adopt remedial amendments before the end of 2017. The transitional remedial amendment grace period ends on December 31, 2017 (and generally allows the plan sponsor to adopt remedial amendments for changes in design and administration that took effect after a plan's final determination letter application filing and prior to January 1, 2017). In addition, the December 31, 2017 deadline applies with respect to changes in plan design and administration that took effect in 2017.

Plan documents should be reviewed in light of administrative procedures to determine whether remedial amendments need to be adopted for the following:

- Plan design and administrative changes that took effect since the plan's final determination letter filing, including changes effective in 2017.
- Plan design and administrative changes made pursuant to a change in law, including provisions added to the IRS Cumulative List of Required Changes since the plan's final determination letter filing and the 2017 IRS Operational Compliance List.

Monitor Changes in Plan Design/Administration – Prospective

Going forward, employers should take care in monitoring changes in plan design and administration and changes to the law. Plan sponsors should adopt new internal controls and procedures as a means of adapting to the elimination of the determination letter program.

The following internal controls can assist with satisfying a plan sponsor's obligation to maintain practices and procedures for helping to ensure the law is satisfied.

- Review changes to the law to determine whether plan operation changed. The plan sponsor is required to adopt an amendment that conforms the plan document to plan operation.
- Direct service providers responsible for plan administration to provide regular updates on any change in how the plan is operated. This information is essential to evaluating whether a remedial amendment is a permissible cure for failing to administer the plan in accordance with the legal plan document.
- Review past plan administration for purposes of determining (among other things) whether or not the service provider failed to follow the terms of the plan document. Particular attention should be paid to areas the IRS and DOL have traditionally focused on during a plan audit.

EPCRS Corrections

Employers should use EPCRS (which may require a formal IRS filing) to correct issues that are not eligible for remedial amendment relief. The correction method should comply with the rules and procedures under EPCRS and put the participants in the position they would have been in but for the failure. EPCRS conditions eligibility for the self-correction program on establishing practices and procedures designed to promote and facilitate overall compliance, such as the steps outlined above for adopting remedial amendments and monitoring changes in plan design and administration.

Annual Plan Audits for Form 5500 – 2018

The IRS and DOL have emphasized the importance of implementing internal controls designed to satisfy the legal requirements under ERISA and the IRC. Adapting to the new regulatory environment is essential, especially without IRS determination letters.

The first annual plan audit following the elimination of the determination letter is fast approaching. The American Institute of Certified Public Accountants (AICPA) is considering proposed changes that would mandate an expanded review by the plan auditor, including a review of whether the plan was operated in accordance with the legal plan document and disclosure of the findings in the audit report. Identifying and curing the failure to satisfy the law minimizes risk and exposure. Taking action in the present to fix past failures is an essential part of preventing the adverse consequences that are likely to arise in the future if a failure is discovered by the plan auditor, a plaintiff's attorney or during an IRS or DOL audit.

For a more in-depth analysis of the recent changes to the qualified retirement plan regulatory system, please click here. (Article originally appeared in *Tax Notes*).

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