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GRS INSIGHT

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IRS Issues First Operational Compliance List

In This Issue

In connection with the changes to the Internal Revenue Service (IRS) determination letter program, the IRS will publish an Operational Compliance List as an aid to sponsors in determining what rules they should be following as of the effective date of the change, even if such date is before the required amendment must be adopted. The IRS issued the first Operational Compliance List for individually designed plans on February 27, 2017.

The Operational Compliance List is an annual list that will cover changes in qualification requirements that are effective during a calendar year. Specifically, the list: 1) identifies matters that may require either mandatory or discretionary amendments; 2) may contain other significant guidance that affects plan operations; and 3) will be available solely on the IRS website. Importantly, the IRS notes that the Operational Compliance List is not intended to be a comprehensive list of all IRS guidance or other legislation that could affect a plan. For example, the list will not include periodic changes such as COLAs.

While the Operational Compliance List contains limited qualification requirements that are effective in 2017, a few could affect governmental plans, including:

- ***Partial Annuity Distribution Options*.** For defined benefit plans that permit partial annuity distributions, the final regulations under Section 417(e) of the Internal Revenue Code of 1986, as amended (the "Code") change the way such benefits are calculated for annuity starting dates on or after January 1, 2017. For example, under the regulations, if a member elects a partial lump sum and adjusted life annuity, the plan should calculate the partial lump sum under Code Section 417(e) and the annuity using factors designated by the plan.
- ***Cash Balance/Hybrid Plans*.** Final regulations provide guidance regarding certain amendments to applicable defined benefit plans,

including cash balance plans. These final regulations permit a plan sponsor of an applicable defined benefit plan that does not comply with the market rate of return requirement included in previous regulations to amend their plan to change to an interest crediting rate that is permitted under the previously issued final hybrid plan regulations without violating the anti-cutback rules of Code Section 411(d)(6). Such an amendment must be adopted on or before the first day of the first plan year that begins on or after January 1, 2017.

A few additional items that could affect governmental plans were effective in 2016, including:

- ***Normal Retirement Age*.** Proposed regulations were issued under Code Section 401(a), providing rules relating to the determination of whether the normal retirement age under a governmental pension plan satisfies the requirements of Code Section 401(a) and whether the payment of definitely determinable benefits that commence at the plan's normal retirement age satisfies these requirements. The rules are effective for employees hired during plan years beginning on or after the later of: a) January 1, 2017; or b) the close of the first regular legislative session of the legislative body with the authority to amend the plan that begins on or after the date that is three months after the final regulations are published. However, a governmental plan sponsor may elect to apply these rules to earlier periods.
- ***Hurricane Matthew*.** Relief was provided for taxpayers to use qualified employer plan assets to alleviate hardships caused by Hurricane Matthew. Relief was also provided from certain verification procedures that may otherwise be required with respect to loans and hardship distributions. To make a loan or hardship distribution pursuant to the relief provided in this announcement, a qualified employer plan that does not provide for them must be amended no later than the end of the first plan year beginning after December 31, 2016. These qualifying hardship distributions were only permitted to be made from October 4, 2016 (October 3, 2016, for Florida) through March 15, 2017.
- ***Louisiana Storms*.** Relief was also provided for taxpayers to use qualified employer plan assets to alleviate hardships caused by the storms and flooding in Louisiana that began August 11, 2016. Relief was also provided from certain verification procedures that may otherwise be required with respect to loans and hardship distributions. To make a loan or hardship distribution pursuant to the relief provided in this announcement, a qualified employer plan that does not provide for them must be amended no later than the end of the first plan year beginning after December 31, 2016. These qualifying hardship distributions were only permitted to be made from August 11, 2016 through January 17, 2017.

New Flexibility in Substantiating Hardship Distributions

The IRS recently issued new guidance for its auditors regarding the information required to substantiate safe harbor hardship distributions. For plans (including governmental plans) that rely on the regulatory "safe harbor," the guidance applies to the support documentation for the necessary to meet "an immediate and heavy financial need" requirement, and is effective February 23, 2017 for 401(k) plans and March 7, 2017 for 403(b) plans (including audits open as of such dates).

Background

Generally, distributions of deferrals and certain other amounts are prohibited from 401(k) and 403 (b) plans before a participant either terminates employment with the plan sponsor or reaches age

59 ½. However, these plans may permit a distribution before age 59 ½ to a participant who incurs a financial hardship. A distribution qualifies as a hardship distribution if two requirements are met: 1) the distribution is made on account of an immediate and heavy financial need; and 2) the distribution is necessary to satisfy the financial need. (*See* Treas. Reg. Sec. 1.401(k)-1(d)(3)). A distribution will be deemed to be an immediate and heavy financial need under IRS regulations if it is on account of: (i) medical expenses; (ii) costs to purchase a home; (iii) tuition payments; (iv) payments to prevent eviction; (v) funeral expenses; or (vi) expenses for home repair. However, IRS rules have not addressed the processes needed to support these determinations.

New Guidelines

The new IRS guidance addresses only the first test, providing that plan sponsors and administrators are not required to acquire and retain "source" documents (*i.e.*, the actual documents that reflect a participant's immediate and heavy financial need). Rather, it provides that a plan may rely on a participant's summary of the source documents. There is flexibility in the form of the summary, as it may be obtained via "paper, electronic format, or telephone records."

However, to rely on this new guidance, the plan must provide notice to a participant obtaining a hardship distribution. The notice must include certain required information including: 1) the permissible sources for the hardship distribution; 2) that he or she must retain the source documents; and 3) that the distribution is subject to taxation. The new guidance also lists the information that must be included in the summary obtained from the participant, with different content required for each of the deemed hardship events, available at: https://www.irs.gov/pub/foia/ig/spder/tege-04-0217-0008.pdf.

In the course of an examination/audit, a summary provided by a participant may be reviewed by the IRS agent. If the summary is determined to include all required information, the agent can conclude that the hardship distribution was proper, with no further support required. In contrast, if the agent determines that the summary does not include the required information (i.e., it is incomplete or inconsistent on its face), the agent may request the source documents underlying the hardship request. The IRS may also request source documents if an employee has received more than two hardship distributions in a plan year, provided that there is not adequate explanation for the multiple distributions (e.g., adequate explanation includes follow-up medical or funeral expenses or tuition on a quarterly school calendar). Finally, the new guidance provides that, if an administrator is responsible for obtaining the summary, the administrator must provide the plan sponsor at least annually with information describing the hardship distributions made during the plan year.

One concern to note is that the new guidance does not describe the consequences to a plan for a participant's failure to retain the source documents (or if the source documents do not support the hardship), should the IRS request such documents. Presumably, the consequences for a plan would depend on the plan's overall compliance with the new guidance.

Reporting Penalty Relief for De Minimis Errors

The IRS issued Notice 2017-09 providing guidance to implement the safe harbor reporting relief provided under the Protecting Americans from Tax Hikes Act of 2015 (the "PATH" Act). The Notice clarifies the relief from the reporting penalties under Sections 6721 and 6722 of the Internal Revenue Code of 1986, as amended (the "Code"), for information returns with *de minimis* errors. This relief applies to 2016 forms (which are filed/furnished in 2017), and forms for any years thereafter. To the extent that a 2016 information return contains a de minimis dollar amount error,

payors should consider this relief prior to issuing corrected returns.

Prior Rules

If an information return was: 1) furnished or filed late or not at all; 2) contained incorrect information; or 3) was incomplete, the payor was potentially subject to a penalty of $500 (indexed) per return/ per year ($6M (indexed) maximum) for failure to properly file and furnish the information return to the IRS and the payee. An error in any amount was considered consequential and could result in a penalty. While an exception could be requested based on reasonable cause, this typically required (in part) that the payor file/furnish a corrected form/statement, with no additional relief for a small error.

New Relief

In the case of certain de minimis errors, the PATH Act provides a safe harbor from penalties for failure to file correct information returns and failure to furnish correct payee statements. As provided in IRS Notice 2017-09, the safe harbor applies to any information return listed under Code Section 6724(d) (e.g., W-2 or 1099 series). The safe harbor provides relief for an information return/payee statement that contains incorrect or incomplete information relating to a dollar amount, where no single amount in error differs from the correct amount by more than $100 ($25 in the case of an error with respect to an amount of tax withheld). The safe harbor does not provide relief for intentional errors (whether or not the amount otherwise qualifies as de minimis) or where a payor fails to file an information return or furnish a payee statement (even if the amounts to be reported would otherwise be under the de minimis threshold). Under this relief, the error is not required to be corrected, subject to a payee's election, and no penalty is imposed. However, the Notice permits a payor to file corrected information returns and payee statements even if the payee does not make an election out of the safe harbor.

Payee "Election Out"

Notwithstanding this relief, and subject to the requirements outlined below, a payee may elect to opt-out of the safe harbor, requiring that the form be corrected by the payor to avoid potential penalties. If the payor furnishes a corrected payee statement to the payee, and files a corrected information return with the IRS within 30 days of the date of the payee's election (or such later date where specific rules provide for additional time), the error will be treated as due to reasonable cause and not willful neglect and the payor will avoid reporting penalties under Code Sections 6721 and 6722. If those requirements are not met, the reporting penalties may be imposed.

The Notice sets forth a number of requirements that must be followed in order for a participant to elect out of the safe harbor:

- ***Form of Election.*** The election must be in a form reasonably prescribed by the payor, and the payee must be furnished with written notification of such method before the date the payee makes the election. For example, the payor may require that the election be made in writing, on-line (electronic) or by telephone. An on-line (electronic) option cannot be the sole method to make the election. If the payor does not prescribe a form of election, the default method is in writing to the payor's address appearing on a payee statement (or as otherwise directed by the payor after the payee makes an appropriate inquiry).
- ***Restrictions on the Election.*** The payor may not impose any other prerequisite, condition or time limitation on the payee's ability to request a corrected payee statement.
- ***Time for Making the Election and Duration.*** A payee may make an election with respect to payee statements required to be furnished in the calendar year that the election is made, and for

any succeeding calendar years. For example, the payee can elect any time in 2017 to have the 2016 W-2 corrected, and this election can apply to all future W-2s to the payee. The election applies to both the payee statement and the related information return to be filed with the IRS. The IRS notes that nothing in the guidance prevents a payee from also requesting that the payor file a corrected information return or furnish a corrected payee statement required to be filed or furnished in a calendar year preceding the calendar year in which the payee makes the election.

- ***Information to Be Included in the Election.*** In the election, a payee must: 1) clearly state the payee is making the election; 2) provide the payee's name, address, and taxpayer identification number; 3) identify the type of payee statement(s) and account number(s), if applicable, to which the election applies; and 4) if the payee wants the election to apply only to the year for which the payee makes the election, state that the election applies only to payee statements required to be furnished in that calendar year. If the payee does not identify the type of payee statement and account number or does not identify the calendar year to which the election relates, the payor must treat the election as applying to all types of payee statements the payor is required to furnish to the payee for the calendar year in which the payee makes the election and in any succeeding calendar years.
- ***Revocation.*** The payee may revoke an election at any time by providing written notification of revocation to the payor. A revocation will apply to all information returns/payee statements of the type set forth in the revocation required to be filed or furnished on or after the date the payor receives the revocation (unless and until the payee makes a new election).
- ***Recordkeeping.*** The payor must retain records of any election, or revocation of an election, for as long as that information may be relevant to the administration of any internal revenue law.

It is expected that regulations will be issued to incorporate these provisions, and will include a requirement for payors to notify payees of this relief and the ability to elect out of it. The regulations may also exclude certain types of returns to prevent abuse of this relief.

The American Health Care Act

On March 6, 2017, House Speaker Paul Ryan released the American Health Care Act (AHCA), a budget reconciliation bill to repeal and replace parts of the Affordable Care Act. The House was scheduled to vote on the AHCA on March 24, but at the eleventh hour, Speaker Ryan pulled the vote because there was not enough Republican support to pass the bill. Nevertheless, it is helpful to understand the AHCA provisions because the AHCA will likely be the basis for any future bill on which the House votes.

Some of the key provisions include:

- Reduces the employer and individual mandates to zero, effective in 2016. However, associated reporting under Code Sections 6055 and 6056 remains. In addition, adds a continuous coverage requirement under which issuers in the individual market must impose a 30% premium surcharge on individuals who have not been enrolled in continuous coverage.
- Retains the vast majority of the Affordable Care Act's market reforms, but changes the age variance for rating factors from 3 to 1 to 5 to 1. Also, provides flexibility for issuers by eliminating the actuarial value (AV) metallic tiers.
- Modifies the premium tax credits for a 2-year transition period from 2018 – 2019. During the transition period, individuals can use the tax credits for most individual coverage purchased both on- and off-exchange, but can only receive an advance payment of the tax credits for on-exchange coverage. Also, in 2019, bases the tax credit amount on age in addition to income level.

- Beginning in 2020, replaces the tax credits with new tax credits that can be used for the purchase of most individual coverage for individuals who meet certain requirements, such as not being eligible for employer coverage or certain government coverage (i.e., Medicare and Medicaid). The tax credits will range from $2,000 - $4,000 and will be based on age, with the credits phasing out at income over $75,000 (or $150,000 for joint filers). The maximum tax credit for a family is $14,000.
- Requires employers to report on their employees' Form W-2 each month that the employee is eligible for coverage under the employer's group health plan.
- Makes significant changes to HSAs, FSAs and HRAs, including:
    - Tax on amounts distributed from an HSA not used for medical expenses is decreased from 20% to 10%.
    - HSAs, FSAs and HRAs may reimburse over-the-counter medicines and drugs without a prescription.
    - Eliminates the limit on pre-tax salary reduction contributions to an FSA.
    - Increases the HSA contribution limit to match the out-of-pocket maximum limit.
- Repeals many of the Affordable Care Act's tax provisions, such as:
    - Repeals the limitation on deduction of compensation paid by health insurers over $500,000.
    - Repeals the fee on prescription medications and medical devices.
    - Repeals net investment tax and Medicare tax increase.
    - Delays the Cadillac tax to 2026.
    - Repeals the elimination of the deduction for Medicare Part D-related expenses.
    - Reduces the income threshold for the medical expense deduction from 10% to 5.8%.

Wellness Program Update – EEOC v. Flambeau

On January 25, 2017, the U.S. Court of Appeals for the Seventh Circuit affirmed the lower court's dismissal of the case filed by the Equal Employment Opportunity Commission (EEOC) against Flambeau, Inc. alleging that Flambeau's wellness program violated the Americans with Disabilities Act (ADA).[1] Unfortunately, the application of the "bona fide benefit plan" safe harbor to wellness programs is still unclear because the court did not address the merits of the case and instead dismissed the case on the grounds that it was moot or the relief sought by the EEOC was not available.

As background, Flambeau required employees to take a health risk assessment (HRA) and biometric screening to participate in its health plan. An employee was unable to timely complete the HRA and biometric screening, and Flambeau terminated his health coverage. After the employee filed complaints with the Department of Labor (DOL) and the EEOC, Flambeau reinstated the employee's insurance retroactively once he completed the assessment and screening. Flambeau then ended the mandatory assessment and screening. The EEOC sued Flambeau alleging the mandatory HRA and biometric screening violated the ADA's prohibition of involuntary medical exams.

In December 2015, the lower court, relying on an earlier case, *Seff v. Broward County*,[2] dismissed the case on the basis that Flambeau's wellness program did not violate the ADA because the HRA and biometric screening fell under the ADA's bona fide benefit plan safe harbor. The bona fide benefit plan

[1] *EEOC v. Flambeau, Inc.*, No. 16-1402 (7th Cir. Jan. 25, 2017).
[2] *Seff v. Broward County*, No. 11-12217 (11th Cir. Aug. 20, 2012).

safe harbor exempts employer activities to the extent they relate to the establishment or administration of "the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks."[3]

In concluding that the relief sought by the EEOC was no longer available or the case was moot, the Seventh Circuit pointed to the fact that the employee who lost coverage did not incur any compensatory damages or emotional distress. The Seventh Circuit also found that the EEOC's claim for injunctive relief was moot because Flambeau terminated its program for substantiated cost reasons before the EEOC filed suit. Specifically, the court said that "neither party to this case has any longer a serious stake in its outcome" and "[t]he genuine statutory issues should be decided by a court in a case where the answer will matter to the parties." The Seventh Circuit also said that it would not be appropriate for it to address the application of the bona fide benefit plan safe harbor based on the "outdated legal landscape" because the EEOC filed its appeal before it issued its final regulations on the requirements for a voluntary wellness program under the ADA. In the final regulations, which the EEOC issued in May 2016, the EEOC states that the bona fide benefit plan safe harbor does not apply to wellness programs.

Although the outcome of the case was positive for the employer, Flambeau, it still leaves open the question of whether employers can rely on the bona fide benefit plan safe harbor with respect to their wellness programs or whether the courts will defer to the EEOC's regulations stating that it does not apply to wellness programs. Note that at least one other federal court, in *EEOC v. Orion Energy Systems, Inc.*,[4] rejected the employer's argument that the bona fide benefit plan safe harbor immunizes wellness plans from ADA scrutiny.

CMS Market Stabilization Guidance

On February 17, 2017, the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services issued a proposed rule and delayed critical qualified health plan (QHP) certification dates, and on February 23, 2017, CMS announced it was extending its transitional plans (also known as "grandmothered" plans) policy through December 31, 2018.

Under the proposed rule, the Trump Administration is seeking to make administrative changes to provide more flexibility to states and health insurance issuers and encourage issuers to participate in the individual and group markets in 2018. The provisions proposed in this rule attempt to stabilize the health insurance market, in an effort to ensure continuity of care until Congress acts to pass legislation. The changes have generally been welcomed by issuers. However, it is not clear that the changes will be enough to shore up the risk pools for 2018.

In summary, the proposed rule would:

- Allow health insurance issuers in the individual and group markets to collect premiums for prior unpaid coverage (for up to 12 months), before enrolling a policyholder in a plan with the same issuer.

Shorten the 2018 open enrollment period to run from November 1, 2017 – December 15, 2017, instead of November 1, 2017 – January 31, 2018.

- Narrow special enrollment periods (SEPs) by:
    - Expanding pre-enrollment verification in the Federal Exchanges to all individuals attempting to enroll via SEPs beginning June 2017.
    - Limiting the ability of an existing enrollee to change plan metal levels mid-year if enrolling via an SEP due to adding a dependent.

[3] 42 U.S.C. § 12201(c)(2).
[4] *EEOC v. Orion Energy Systems, Inc.*, No. 14-CV-1019 (E.D. WI September 19, 2016).

  - Adding additional parameters around the minimum essential coverage (MEC), marriage, permanent move, and exceptional circumstances SEPs.

- Broaden the de minimis ranges of actuarial value (AV) levels from +/-2 percentage points to +2/-4 percentage points, for platinum, gold, and silver plans (other than silver cost-sharing reduction (CSR) variations), and from +5/-2 percentage points to +5/-4 percentage points for some bronze plans.
- For the 2018 plan year, defer to the states' network adequacy reviews, where appropriate.
- For the 2018 plan year, require an issuer to demonstrate that it has a network with at least 20% (as opposed to 30%) of participating Essential Community Providers (ECPs). Issuers would also be able to write in ECPs under certain circumstances.

In addition, while CMS does not propose requirements to ensure continuous coverage, CMS asks for comment on policies to promote continuous coverage, while remaining consistent with existing law. On April 18, 2017, CMS published the final rule.

CMS also modified the QHP calendar and transitional policy guidance to:

- Delay the initial QHP application submission window to end on June 21, 2017.
- Require signed QHP agreements, confirmed plan lists, and final plan crosswalks be provided to CMS by September 27, 2017.
- Permit states to allow issuers to continue offering grandmothered plans for policy years beginning on or before October 1, 2018, provided that all policies end by December 31, 2018.

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