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CHURCH PLANS AND ERISA CAUGHT IN THE CROSSHAIRS

Over the last several years, questions have arisen surrounding what entities can qualify for ERISA's church plan exception. As background, a church plan, unless it elects to be subject to ERISA, is exempt from ERISA. For ERISA purposes, a church plan is defined as "*a plan established and maintained by a church; or, a plan established by a church and maintained by a tax exempt organization, the purpose of which is the administration and funding of the plan that is controlled by or in association with the church*".

Numerous rulings, information letters and opinion letters released by both the Internal Revenue Service and the Department of Labor in the past couple decades have stated that plans sponsored by affiliates of a church such as hospitals or schools, as long as they are sufficiently controlled by the church, can qualify for ERISA's church plan exception. This concept has been challenged several times.

On December 2, 2016, the Supreme Court granted writs of certiorari in three cases from the Third, Seventh and Ninth Circuits. The cases are ***Saint Peter's Healthcare System v. Kaplan***, ***Advocate Health Care Network v. Stapleton*** and ***Dignity Health v. Rollins***, and have been consolidated for Supreme Court hearing purposes. In a nutshell, the challenge in these cases is that participants of the retirement plans in question claim that they should be covered by ERISA's funding rules, applicable to plans subject to ERISA. The Supreme Court will review whether church-affiliated institutions, hospitals in these cases, are entitled to the church plan exemption under ERISA. The Supreme Court has scheduled a hearing for this consolidated case on March 27, 2017 and is expected to opine on the matter later this year.

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In a separate matter that will be clearly impacted by the ruling from the above-mentioned Supreme Court case relates to dispute involving a denial of benefits under an insured long-term disability plan administered by Prudential and maintained by a university affiliated with the Catholic Church (*Durham v. Prudential Life Ins. Co. of America*, No. 16-8202 (C.D. Cal. Feb. 10, 2017).

Any church affiliated entity that believes it is entitled to claim church plan status should keep an eye on developments in this area.

Participant Money: Treat with Upmost Care

Generally, ERISA places certain standards upon plan sponsors for administering a benefit plan. Specifically, participant contributions to a plan must be applied only to the payment of benefits and reasonable administrative expenses of the plan. When employees make a premium contribution through salary reduction, the contribution becomes a plan asset as soon as the contribution can be "reasonably" segregated from the employer's general assets and the money must be placed in trust without delay or paid to an insurer. The intent of this rule is to ensure that the money be used strictly for the benefit of plan participants and beneficiaries, and not to inure to the benefit of others including the plan sponsor. Note, there is non-enforcement guidance contained in DOL Technical Release 92-01 for contributory welfare benefit plans for participant contributions when made through the terms of an IRC Section 125 (cafeteria) plan. This non-enforcement guidance does not, however, provide an exception to the fiduciary duties nor does it provide an exception to the exclusive benefit rule, i.e., all plan assets must be used for the exclusive benefit of plan participants and beneficiaries.

A recent court case (*In re Harris*, 2017 WL 65392 (B.A.P. 8th Cir. 2016) highlights the importance of these rules. In this matter, a plan sponsor collected participant contributions on a monthly basis to pay premium for a group health plan. The plan sponsor placed these monies into its general accounts rather than segregating them into a separate trust and used some of the monies to pay other corporate expenses, including the CEO's home equity loan. Over a period of 10 months, the premium payments were not remitted timely and checks bounced. Coverage under the plan for the participants was eventually canceled.

The Department of Labor filed a lawsuit against the plan sponsor alleging he violated ERISA by failing to remit the withheld health care premiums and thus, breached his fiduciary duty of loyalty to the plan participants. The District Court entered judgment in favor of the DOL in the total amount of $67,839.60.

Applicability Date of Fiduciary Advice Rules Extended

As follow-up to last month's *Benefit Beat* article, ***Fiduciary Advice Rules Under Review***, the Department of Labor's Employee Benefit Security Administration (EBSA) released a proposal to extend the applicability date of its fiduciary advice rules. These rules were to become applicable on April 10, 2017; however, President Trump called for an updated economic and legal analysis concerning the likely impact of these rules.

On March 2, 2017, EBSA published **proposed rules** that would provide a 60-day extension of the applicability date of the fiduciary rules to June 9, 2017. EBSA is inviting public comments on market responses of fiduciary rules on a broad range of issues including:

- Anticipated changes in consumer demand for investment advice and investment products, pricing of investment products, and types and pricing of advisory services;
- Whether implementing the current rules would lead investors to shift investments between asset classes or types, or lead to an increase or reduction in commissions, loads, or compensation arrangements for advisory services surrounding the sale of insurance products; and
- Whether the rules would generate innovations or changes in the delivery of financial advice or investor education, both in terms of access and content.

Comments on the proposal to extend the applicability date for 60 days must be submitted to EBSA by March 17, 2017. The deadline for submitting comments regarding the updated economic and legal analysis described in the President's Memorandum is April 16, 2017.

Coordinating Retroactive Medicare Coverage and Health Savings Accounts

Under the current eligibility rules for contributing to health savings accounts (HSA), an individual becomes ineligible to make an HSA contribution on the first day of the month that he/she becomes covered by Medicare. If the individual is merely eligible for Medicare, but has not yet enrolled in Medicare, then HSA contributions can continue to be made. However, this could become problematic in the event that Medicare coverage is made retroactive.

The Internal Revenue Service addressed this matter in a recent pronouncement (**Information Letter 2016-0082**). This Letter affirms that when an individual delays applying for Medicare and that Medicare coverage is made retroactive, then the individual must figure out how many months of the year in question he/she is actually HSA-eligible. The HSA contribution for that year must be pro-rated accordingly.

If, for example, an individual enrolls in Medicare during October, 2017 and if the Medicare coverage is made retroactive to April 1, 2017, then the individual would only be HSA-eligible for three months of 2017 (January, February and March). In this scenario, the maximum contribution that a single individual could contribute for the 2017 tax year would be $1,099.98, which equates to one quarter of the annual statutory limit of $3,400, plus one quarter of the $1,000 catch-up contribution.

If the individual in this scenario ends up contributing too much to the HSA, then he/she could withdraw the excess monies, together with earnings thereon. As long as this is accomplished prior to the individual's tax filing due date with extensions, then no excise tax would be imposed; however, withholding of employment taxes would be assessed.

COBRA: Court Finds Error in Small Employer Threshold

Employers who sponsor group health plans and who employ 20 or more employees on 50% of its business day in the preceding year are required to offer COBRA continuation coverage to covered individuals who lose coverage due to certain qualifying events. Certain group health plans are exempt from the COBRA law including small employer plans. For purposes of the small employer plan exception, a small employer is one who normally employed fewer than 20 common law employees on a typical business day in the calendar year.

It is important to note this determination is based on the number of employees employed, not the number of participants in the plan. A part-time employee is counted as a fraction of a full-time employee, calculated as a ratio of the number of hours an individual works, over the number of hours considered to be a full-time employee. For example, a 20-hour per week employee is considered one-half of an employee, if full-time is considered 40 hours per week

A recent court case emphasizes the importance of calculating the number of employees to meet the small employer exception. In ***Virciglio v. Work Train Staffing LLC*** (2016 WL 7487725, 11th Cir. 2016), an employee, who was covered under his employer's group health plan, had his employment terminated with the resulting loss of coverage. He was not provided COBRA information from his employer, and thus, failed to elect continuation coverage, and then sued the company for failure to provide him with COBRA information, along with other employment-related discriminatory complaints. His company, a staffing firm, argued that it was exempt from COBRA under the small employer exception and thus, was not required to provide COBRA information.

However, the court determined that the staffing company collectively had far more than 20 employees and thus, failed to meet the small employer exception criteria. Further, the court determined that even though the company's staffing workers were outsourced to other job sites, they remained employees of the company.

As a reminder, at the beginning of each calendar year, small employers should review their employee census for the prior calendar year. If the employer employed 20 or more common law employees on at least 50 percent of the typical business days in the preceding calendar year, the employer would likely be subject to the COBRA law unless one of the other exceptions applies.

QSEHRA Notice Delay

At the end of 2016, the 21st Century Cures Act established the ability of small employers to establish a qualified small employer health reimbursement arrangement (QSEHRA); see a summary of these plan designs from our prior CBIZ ***Benefit Beat*** **article** and CBIZ ***Health Reform Bulletin***. A QSEHRA is a stand-alone health reimbursement arrangement that can be used to reimburse individual market health premium.

To be eligible to establish a QSEHRA, the employer must employ fewer than 50 full-time employees on business days during the preceding calendar year (i.e., not subject to the Affordable Care Act's employer shared responsibility provisions) and the employer must maintain no other group health plan coverage.

Employers establishing a QSEHRA are required to provide a written notice to eligible employees about the availability of the program. The law required this notice to be provided annually, no later than 90 days prior to the beginning of the program year. On February 27, 2017, the IRS issued guidance (**IRS Notice 2017-20**) that extends the time period in which an employer must provide the initial written notice to its eligible employees. The period for providing the notice to employees is now extended from March 13, 2017 to 90 days following issuance of additional guidance. The concern is that employers do not have enough information to know what information needs to be included in the notice; therefore, there will be no requirement to provide a notice until 90 days following additional guidance issued by the Internal Revenue Service.

Updated IRS Publications

The IRS has recently updated several publications that may be of interest to employers:

- **Publication 15-B**, *Employer's Tax Guide to Fringe Benefits* (for use in 2017). This publication provides information for employers on the tax treatment of various fringe benefits including health care coverage and health savings accounts, cafeteria plans, dependent care assistance, educational assistance, group term life, and transportation expenses, among other types of benefits.

- **Publication 969**, *Health Savings Accounts and Other Tax-Favored Health Plans* provides an overview of various tax saving vehicles used to offset health care costs including health savings accounts, medical savings accounts, health flexible spending arrangements and health reimbursement arrangements.

- **Publication 502**, *Medical and Dental Expenses*. For certain purposes, this publication can be used to determine expenses that are reimbursable from plans such as flexible medical spending accounts and health savings accounts; though, it is important to note that there are differences between deductible expenses and those reimbursable from such plans.

- **Publication 503**, *Child and Dependent Care Expenses*. Note: exercise caution when relying upon this publication, because the dependent care credit is different from the dependent care assistance credit.

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