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WELCOME RELIEF FOR SELF-CORRECTING PLAN LOAN FAILURES

On April 19, 2019, the Internal Revenue Service (IRS) issued Revenue Procedure 2019-19 in which it expanded the Employee Plans Compliance Resolution System (EPCRS) to allow self-correction of certain plan loan failures. As a result, sponsoring employers are no longer required to file a Voluntary Correction Program (VCP) submission to the IRS and pay the VCP fee with respect to certain plan loan issues.

Expansion of Self-Correction Programs for Certain Plan Loan Failures

Under the Revenue Procedure, if a loan is in default after the passage of the cure period because of the failure to make timely payments (but before the maximum period for repayment expires), the following self-correction options are available:

- make a lump sum payment for the missed installments, adjusted for interest;
- re-amortize the outstanding loan balance; or
- a combination of the above two options.

Moreover, in the event of a failure to obtain spousal consent of participant loans, the plan may simply notify the participant and spouse (who was married to the participant at the time of the loan) and obtain the required consent. However, if consent cannot be obtained, self-correction is not available.

Furthermore, if the number of plan loans to a participant exceeds the number of loans permitted by the plan, the plan sponsor must adopt a retroactive plan amendment to conform the written plan document to the plan's operation. The self-correction is only available if both the amendment and amended plan comply with the qualification requirements under the Internal Revenue Code, and the excess plan loans do not discriminate in favor of highly compensated employees.

Other Plan Loan Failures

Not all plan loan failures can be self-corrected. The following most common section 401(a) plan loan failures must still be corrected through VCP:

- When a plan loan exceeds the maximum dollar amount available for a loan
- When the loan terms do not satisfy repayment requirements stipulated

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by the IRS (i.e., loan that exceeds the maximum loan period)

In order to take advantage of the new loan self-corrections, plan sponsors should take quick action as soon as a loan repayment issue is identified.

EXPANSION OF THE IRS' DETERMINATION LETTER PROGRAM TO COVER MERGED PLANS

On May 2, 2019, the Internal Revenue Service (IRS) issued Revenue Procedure 2019-20 in which it provided a limited expansion to its determination letter program. The procedure allows for submissions by individually designed statutory hybrid plans beginning Sept. 1, 2019, and ending Aug. 31, 2020, and individually designed merged plans on an ongoing basis. Prior to the issuance of this Revenue Procedure, the IRS only permitted determination letter applications for initial plan qualification and for qualification upon plan termination. Among others, this Revenue Procedure provided important guidance to employers involved in corporate transactions such as mergers and acquisitions with regard to merged plans.

Merged Plans

A merged plan results from the merger or consolidation of two or more plans (maintained by previously unrelated entities) into a single, individually designed plan in connection with a corporate merger, acquisition or other similar business transaction.

Beginning Sept. 1, 2019 and on an ongoing basis, the IRS will accept a determination letter application that satisfies the following requirements with respect to a merged plan:

- the plan merger must occur no later than the last day of the first plan year that begins after the plan year in which a corporate merger, acquisition or other similar business transaction occurred, and
- the determination letter application must be submitted within a period beginning on the date of the plan merger and ending on the last day of the first plan year of the merged plan that begins after the date of the plan merger.

Statutory Hybrid Plans

A statutory hybrid plan is a defined benefit plan that contains a statutory hybrid benefit formula. The IRS will review determination letter applications for these plans for a 12-month period beginning Sept. 1, 2019 and ending Aug. 31, 2020.

DEPARTMENT OF LABOR ISSUES UPDATED SUMMARY ANNUAL REPORT FOR RETIREMENT PLANS

On May 30, 2019, the Department of Labor (DOL) released an updated model Summary Annual Report (SAR) for retirement plans, which includes minor

changes to the current form. The form may be found under the Model Notices tab on the DOL website. The SAR for a plan year provides a summary of information filed on that plan year's Form 5500. The SAR must be distributed by the last day of the ninth month following the end of the plan year. However, if an extension to file the Form 5500 is obtained, the SAR must be distributed no later than two (2) months following the extension period.

These deadlines are summarized below:

Plan Year	Form 5500 Due Date	SAR Distribution Deadline	Extended SAR Distribution Deadline
Calendar Year	July 31	September 30	December 15
10/1 – 9/30	April 30	June 30	September 15

The model SAR for welfare benefit plans did not change.

NEW HEALTH REIMBURSEMENT ACCOUNT RULES PROVIDE ADDITIONAL FLEXIBILITY TO EMPLOYERS

On June 20, the Internal Revenue Service (IRS) and Departments of Labor and Health and Human Services (Departments) issued final regulations addressing two types of health reimbursement arrangements (HRAs) – Individual Coverage HRA (ICHRA) and Excepted Benefits HRA (EBHRA). The IRS and the Departments indicated that additional guidance will be issued regarding how an ICHRA may be used to avoid all employer mandate penalties under the Affordable Care Act (ACA). In addition, the IRS indicated it plans to issue proposed regulations regarding how an ICHRA may satisfy the nondiscrimination rules under Section 105(h) of the Internal Revenue Code.

Individual Coverage HRA

The new rules allow certain HRAs to be integrated with individual health insurance or Medicare and reimburse premiums for this coverage. Under prior guidance from the IRS and the Departments, an HRA could not be integrated with individual market insurance for purposes of satisfying the ACA's market reform requirements, namely the annual dollar limit on essential health benefits. If the following requirements are satisfied, the ICHRA may be integrated with individual health insurance for purposes of satisfying the ACA.

- Employees and dependents covered by the ICHRA must be enrolled in either individual health insurance or Medicare and must provide substantiation of that coverage.
- An employer cannot offer, to the same class of employees, both ICHRA

coverage and traditional group coverage.

- If an employer does offer a class of employees ICHRA coverage, the coverage must be offered on the same terms to all employees within the class.
- The amount available under the ICHRA may increase based on an increase in the participant's age, but the maximum amount available to an older employee may not exceed three times the amount made available to the youngest employee.
- Employees must receive notice, at least 90 days before the beginning of each plan year, that participation in the ICHRA will make them ineligible for a premium tax credit on the ACA Exchanges.

The new rules allow employers to divide employees into nine specified classes, including full-time, part-time, salaried and non-salaried. In addition, when certain conditions are met, employers with ICHRAs can allow employees to use pretax cafeteria plan salary deductions to pay any portion of their individual insurance premiums that are not covered by the ICHRA.

The final regulations also amended ERISA's definitions of "employee welfare benefit plan" and "welfare plan" to exclude, when requirements are met, the individual health insurance that is funded by an ICHRA. Note, however, this change only applies to the individual insurance—not to the HRA.

Excepted Benefits HRA

The new rules allow employers that offer traditional group health plans to provide an EBHRA with an annual contribution (not including carryovers) of up to $1,800 to reimburse for certain qualified medical expenses such as premiums for vision, dental and short-term limited-duration insurance. Because these benefits are excepted benefits under ERISA, the EBHRA is not subject to Public Health Services Act mandates. As a requirement, an employer must offer traditional group health plan coverage to EBHRA participants. Additionally, participants may carry over prior-year amounts, but amounts available under other HRAs or account-based group health plans are counted toward the $1,800 limit. EBHRAs must be available on the same terms to similarly situated people. Finally, an EBHRA cannot be offered to an employee who is offered an ICHRA.

While additional guidance is needed to determine if these new HRAs provide a viable alternatives for employers, this new guidance offers a move toward this additional flexibility in the group health plan space.