Reinhart

April 2012 Employee Benefits Update

SELECT COMPLIANCE DEADLINES AND REMINDERS

Annual Benefit Statement for Calendar-Year Defined Contribution Plans with Plan-Directed Investments

Administrators of defined contribution plans that do not allow participant investment direction must provide an annual benefit statement to participants and beneficiaries by the date on which Form 5500 is filed by the plan (but no later than the due date, including extensions, for filing Form 5500) for the plan year to which the benefit statement relates. For a calendar year plan, the 2011 benefit statement is due by the earlier of (1) the actual filing date of the 2011 Form 5500 or (2) July 31, 2012, (the plan's regular filing deadline) unless a Form 5500 deadline extension applies.

2011 Form 5500 for Calendar-Year Plans

Plan administrators generally have seven months after the end of a plan year to file a Form 5500. For plan years ending December 31, 2011, the deadline for filing the Form 5500 is July 31, 2012. Plan sponsors that extended their corporate federal income tax return deadline can receive an automatic extension until September 15, 2012, if certain criteria are satisfied. Otherwise, plan administrators can apply for a deadline extension until October 15, 2012 by filing Form 5558 on or before July 31, 2012 (the plan's regular filing deadline).

Adoption of Preapproved Defined Benefit Plans >p>Employers that have pre-approved defined benefit plans must have adopted restated plans approved for the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) by April 30, 2012 to remain eligible for retroactive remedial amendment and reliance.

RETIREMENT PLAN DEVELOPMENTS

Clarification on Reasonable Interest Rate for Participant Loans Certain retirement plans may allow participants to request and receive a loan from their retirement accounts. However, such loans are treated as investments of plan assets and are required to bear a reasonable amount of interest. The Department of Labor (DOL) has issued guidance (DOL Regulation section 2550.408b-1(e)) defining a reasonable rate of interest. However, during a September 2011 phone forum regarding participant loans, an Internal Revenue Service (IRS) representative

POSTED:

May 6, 2012

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indicated that interest rates on participant loans of less than the prime rate plus 2% may not satisfy the "reasonableness" requirement of the Internal Revenue Code. This statement conflicts with the guidance previously issued by the DOL. In a recent edition of "Retirement News for Employers," the IRS clarified that plan sponsors should ask certain questions to determine whether an interest rate is reasonable, including what rates local banks are charging for similar loans to individuals with similar creditworthiness and collateral, and whether the plan rate is consistent with the local rates. The IRS also included examples from DOL guidance to demonstrate how the questions should be answered.

Reporting of Excess Deferrals

Code section 402(g) limits how much compensation a participant may elect to defer to a qualified plan each year. If a participant's elective deferrals exceed the applicable amount for the year, the excess deferral is includible in the employee's income for the year in which it was contributed. The IRS Employee Plans Compliance Unit (EPCU) recently reviewed common problems with reporting excessive elective deferrals in Box 12 of Form W-2. Common issues discovered by EPCU included 403(b) or 457 amounts on the Form W-2 coded as a 401(k) elective deferral and elective deferrals that were excessive and required a distribution to each affected participant along with the filing of Form 1099-R.

Plan sponsors should consider reviewing their W-2 forms for compliance and working with payroll providers to ensure proper reporting.

IRS Reviews Tax Consequences of Plan Disqualification

In its March 20, 2012 Employee Plans Newsletter, the IRS reviewed the five tax effects of plan disqualification. When a tax-qualified retirement plan is disqualified, the plan's trust loses its tax-exempt status. The corresponding effects of disqualification are as follows:

- Employees Include Contributions in Gross Income. Generally, employees would include in their incomes any employer contributions made for the employee's benefit in and after the calendar year in which the plan is disqualified, to the extent the employee is vested in those contributions.
- Employer Deductions are Limited. If an employer contributes to a nonexempt trust, it cannot deduct the contribution until the contribution is includible in the employee's gross income.

- Plan Trust Owes Income Taxes on Trust's Earnings. The plan's trust must file a Form 1041 and pay income taxes on its earnings.
- Rollovers Are Disallowed. A distribution from a disqualified plan cannot be rolled over to another plan or IRA, subjecting the distribution to taxation.
- Contributions Subject to Social Security, Medicare and Federal Unemployment Taxes. An employer's contribution to a nonexempt trust on behalf of an employee can be subject to FICA and FUTA taxation if the employee's interest in the contribution is vested at the time of the contribution. Contributions are also subject to taxes when the employees become vested in such contributions.

Plans that have lost their tax-exempt status must correct the error(s) that caused the plan to become disqualified through the IRS's Voluntary Correction Program before the IRS will re-qualify the Plan.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Final Interim Rule on Health Insurance Exchanges

On March 12, 2012, the United States Department of Health and Human Services (HHS) issued a final interim rule on Affordable Health Insurance Exchanges (Exchanges) to assist states in setting up Exchanges. The final rule combines policies from two Notices of Proposed Rulemaking issued last summer. A few notable provisions are as follows:

- The Establishment and Operation of an Exchange. The final rule outlines the standards for a state to establish an Exchange. A state may structure its Exchange in its own way (e.g., as a non-profit entity, independent public agency, etc.). Additionally, a state may choose to operate the Exchange in partnership with other states as a regional Exchange. Exchanges will perform a variety of functions, including certifying qualified health plans, operating a website to facilitate plan comparisons, determining consumer eligibility and facilitating enrollment. States' plans must be approved by January 1, 2013, but the final rule allows for conditional approval if the state is advanced in its preparation and HHS believes the Exchange will be operational by Fall 2013, in time for enrollment in the Exchanges. The final rule also allows states that are not ready for 2014 to apply to operate the Exchange for 2015 or any subsequent year.
- Health Insurance Plans that Participate in an Exchange. Health plans offered through the Exchanges must be certified as "qualified health plans." To be

certified, health plans must meet minimum standards that are primarily defined in the law. However, the final rule gives Exchanges the ability to establish additional standards for health plans offered in the Exchanges, such as the number and type of health plan choices and standards for health plans. The final rule also allows Exchanges to establish marketing standards to ensure that plans do not market in a way that discriminates against people with illnesses.

- Individual's Eligibility to Enroll in Exchange. The final rule establishes a web-based system through which an individual may apply for and receive eligibility determinations. The final rule outlines standards and processes for Exchanges to determine whether consumers are eligible for all available programs using a single application. Additionally, the final rule allows coordination with Medicaid, CHIP and the Basic Health Program, where applicable.

- Enrollment in Health Plans through Exchanges. The final rule outlines an enrollment process for eligible individuals that uses websites and toll-free call centers to help consumers enroll in coverage. Exchanges will have the option to improve the performance of this system through the design of their website and determine whether to use the single application that will be made available or design a comparable application. Additionally, the final rule provides standards for Exchanges to build partnerships with and award grants to "Navigators" who reach out to employers, employees, consumers and self-employed individuals to perform certain tasks, including public education about qualified health plans and assisting consumers in selecting qualified health plans.

- Employer Eligibility for and Participation in the Small Business Health Options Program. In 2014, Exchanges will operate a Small Business Health Options Program (SHOP) which will provide small employers with additional ways to provide health coverage. The final rule allows Exchanges to determine how a SHOP is structured. For example, the final rule provides Exchanges with the ability to determine the size of a small business that can participate in the SHOP. Until 2016, Exchanges may include businesses with one to 50 employees or one to 100 employees. Beginning in 2016, small businesses may be allowed to participate in the SHOP if they have one to 100 employees. Finally, in 2017, states have the option to let businesses with more than 100 employees purchase coverage through the SHOP. The final rule also provides for a tax credit of up to 50% of premiums for small employers purchasing coverage through a SHOP beginning in 2014 if the employer has 25 or fewer employees,

pays employees an average annual wage of less than $50,000, offers all full-time employees coverage and pays at least 50% of the premiums.

REINHART COMMENT: The final rule provides limited information about the interactions between multiemployer plans and Exchanges. However, the Department of Health and Human Services (HHS) has stated its intention to address issues related to multiemployer plans in future guidance.

Departments Issue New FAQs on SBC Requirements

On March 19, 2012, the DOL, IRS and HHS (the Departments) issued a new set of FAQs (FAQ VIII) that address the Summary of Benefits and Coverage (SBC) requirements. Many of the FAQs concern the content and format of the SBC (e.g., including a foreign language statement, deleting headers and footers) or simply reiterate the rules found in the final regulations. The FAQs provide model language that plans can use if they choose to provide the SBC electronically. The full version of the FAQs is available at DOL.gov but the following are highlights of the guidance:

- The Departments reiterated their position that compliance assistance is a high priority, and that their emphasis is on assisting plan sponsors to comply and not on imposing penalties. Accordingly, the Departments stated that during the first year the SBC requirement is applicable, the Departments will not impose penalties on plans that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations.
- If a plan has entered into a contractual arrangement whereby another party (e.g., a pharmacy benefit manager or managed behavioral health organization) will be responsible for completing the SBC, providing information necessary to complete a portion of the SBC, or to deliver the SBC, until further guidance is issued, the plan will not be subject to an enforcement action, provided:
    - The plan monitors performance under the agreement;
    - If the plan learns of a violation and has the information to correct it, the plan corrects the violation; and
    - If the plan learns of a violation and does not have the information to correct it, the plan communicates with participants and beneficiaries under the plan regarding the violation and takes significant steps as soon as practicable to

avoid future violations.

- REINHART COMMENT: The FAQs do not clarify what type of communication is necessary nor what a "significant" step would entail.

- Where the regulations require an SBC to be "provided" within seven business days, the FAQs clarify that the SBC must be sent within seven business days, not necessarily received within that timeframe.

- The FAQs clarify that COBRA beneficiaries must receive an SBC during open enrollment. However, a qualifying event does not trigger the requirement to send an SBC.

- Grandfathered plans are not required to include the notice of grandfathered status in the SBC, but may choose to include it if they want.

HHS Issues Final Regulations on Reinsurance, Risk Corridors and Risk Adjustments Requirements under PPACA

On March 20, 2012, HHS issued final regulations on the Reinsurance, Risk Corridors and Risk Adjustment requirements under the Patient Protection and Affordable Care Act (PPACA). These requirements are intended to help offset the adverse selection that will occur in the individual market beginning in 2014, when the Exchanges and Individual Mandate become effective.

- Reinsurance Program. PPACA requires the establishment of reinsurance programs to help stabilize premiums in the individual market during the first three years of the Exchanges (2014 through 2016). States can choose to establish one or more reinsurance entities or elect to enter into multi-state reinsurance entity agreements. The reinsurance entity will be responsible for distributing the reinsurance contributions to eligible health insurance issuers. Generally, a health insurance issuer will become eligible for reinsurance payments when its claims costs for an enrolled individual exceed the attachment point set by HHS in the annual Notice of Benefit and Payment (Notice). Issuers can receive reinsurance payments up to the reinsurance cap, also set by HHS in the Notice. States can choose to alter the attachment point and reinsurance cap, but must issue a Notice of its own explaining the same.

- All "contributing entities" must make reinsurance contributions to fund the reinsurance program. A "Contributing Entity" is a health insurance issuer on behalf of insured group health plans or a third-party administrator (TPA) on

behalf of a self-insured group health plan. Health Insurance Issuers will submit their contributions to the reinsurance entity if elected by the state, and TPAs will submit their contributions to HHS. No contributions are required for group health plans that are "excepted benefits plans" under the Public Health Service Act (e.g., limited scope dental and vision, on-site medical clinics). Contributions are required for standalone retiree-only plans.

- Contributions are due on a quarterly basis beginning January 15, 2014. Additionally, Contributing Entities must submit to HHS or the reinsurance entity, as applicable, data required to substantiate the contribution amount. The reinsurance contributions are based on a national rate that will be set by HHS in the Notice for all individuals covered by the plan who reside in a state. However, states can require additional contributions if the state believes such additional funds are necessary for its program.

- Risk Adjustment. States that elect to operate an Exchange are eligible to operate a risk adjustment program. The risk adjustment program will provide increased payments to insurers in the individual and small group markets, both inside and outside of the Exchanges, that attract higher risk enrollees and will reduce incentives for insurers to avoid high risk populations. HHS will administer a state's risk adjustment program if the state does not elect to run an Exchange or a risk adjustment program. The risk adjustment program will begin in 2014 and will continue on a permanent basis. HHS will publish its risk adjustment methodology that all states must follow in the Notice. States may apply for approved alternate risk adjustment methodologies. Any approved alternate risk adjustment methodology will also be published in the Notice.

- Risk Corridors. The risk corridor program is designed to limit the extent of qualified health plan (QHP) insurers' gains and losses. A QHP issuer will receive money from HHS if its allowable costs exceed target amounts. Issuers that have allowable costs below the target amount will pay HHS. "Allowable costs" equal the sum of claims incurred by the QHP issuer for the QHP, expenditures for activities that improve health care quality and for health information technology.

Supreme Court Hears Oral Arguments in HHS v. Florida

On Monday, March 26, 2012, oral arguments began before the United States Supreme Court in HHS v. Florida, the case challenging health care reform. The Court first heard arguments regarding its ability to decide the case at this time

due to the Anti-Injunction Act, which forbids courts to consider lawsuits that aim to prevent a tax from being implemented. The second day of arguments focused on the PPACA individual mandate and whether

Congress has the ability to compel individuals to buy health insurance. On the third day of arguments, the Court heard arguments regarding the need to strike the law in whole or in part if the individual mandate is eliminated, and whether states can be required to expand their Medicaid programs. A ruling is expected from the Supreme Court in June 2012. Departments Issue Advance Notice of Proposed Rulemaking for Organizations that

Object to Providing Contraception Benefits

The Departments issued an advance notice of proposed rulemaking regarding organizations that object to providing contraceptive benefits, as required by PPACA for non-grandfathered plans. The proposed amendments would establish alternative ways to fulfill these requirements when health coverage is sponsored or arranged by an organization that objects to the coverage of contraceptive services for religious reasons, but that is not exempt under the final regulations published February 15, 2012. The Departments are requesting comments as to the possible approaches of defining what entities would qualify for the accommodation and who would administer the accommodation, while ensuring that contraceptive coverage is provided to plan participants and beneficiaries (or, in the case of student health insurance plans, student enrollees and their dependents) without cost sharing. Comments are due on or before June 19, 2012 and will be made available to the public.