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April 2013 Employee Benefits Update

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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 the Form 5500 is filed for the plan (but no later than the due date, including extensions, for filing the Form 5500) for the plan year to which the benefit statement relates. For a calendar year plan, the 2012 benefit statement is due by the earlier of (1) the actual filing date of the 2012 Form 5500 or (2) July 31, 2013, (the plan's regular Form 5500 filing deadline) unless a Form 5500 deadline extension applies.

2012 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, 2012, the deadline for filing the Form 5500 is July 31, 2013. Plan sponsors that extended their corporate federal income tax return deadline can receive an automatic extension until September 15, 2013, if certain criteria are satisfied. Otherwise, plan administrators can apply for a deadline extension until October 15, 2013 by filing Form 5558 on or before July 31, 2013.

RETIREMENT PLAN DEVELOPMENTS

DOL Issues Informal Guidance for Fiduciaries Regarding Target Date Funds

The Department of Labor (DOL) issued informal guidance to assist plan fiduciaries in selecting and monitoring target date retirement funds (TDFs) for plans with participant directed investment options. While the guidance is nonbinding on fiduciaries, it demonstrates the DOL's position regarding fiduciary selection and oversight of TDFs. The guidance emphasizes a number of points for fiduciaries to understand and take into account when selecting a TDF for the plan. As discussed in the guidance, fiduciaries should:

- Understand the different glide paths TDFs implement to execute their investment strategies. For example, some TDFs are invested with a strategy

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designed "to retirement" while others are designed "through retirement."

- Conduct due diligence in advance, including analyzing how well a particular TDF's characteristics conform to that plan's participant population.
- Consider whether creating a custom TDF for their plan is appropriate and advisable by weighing the potential advantages with additional costs and administration inherent in a custom TDF.
- Develop employee communications to provide general information about TDFs and how they operate, as well as specific information about the plan's TDFs, for plan participants. The DOL noted that many plan participants do not fully understand TDFs or the amount of their fees in comparison to other funds.

After selecting a TDF, fiduciaries must continue to monitor the selection. Fiduciaries should conduct periodic review of existing TDFs, including their investment fees and expenses, to ensure the TDF continues to be appropriate for the plan and its participants.

IRS Announces New Phone Number to Check the Status of VCP Submissions

The Internal Revenue Service (IRS) issued a new telephone number that individuals (including plan sponsors) can use to check the status of their Voluntary Correction Program (VCP) submissions. An individual can call 626-927-2011 and leave a message with the plan name, his or her name, phone number and the control number listed in the acknowledgement letter (if received). The IRS will then return the call with a status on the VCP submission.

IRS Establishes Pre-Approved Document Program for 403(b) Plans

The IRS recently issued Revenue Procedure 2013-22 establishing a program for the issuance of opinion and advisory letters for Internal Revenue Code (Code) section 403(b) retirement plans. This is the first time the IRS has introduced such a program for 403(b) plans, although it has issued private letters rulings on related issues. Under the new program, the IRS will pre-approve prototype and volume submitter 403(b) plans as meeting the requirements of Code section 403(b) beginning on June 28, 2013. By adopting a plan that has received an opinion or advisory letter under this program, an employer will satisfy the written plan requirement and obtain assurance that the plan meets the requirements of Code Section 403(b). The program does not currently allow plans to apply for individual determination letters.

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DOL Issues Model Supplement for MAP-21 Disclosures

The DOL published a sample supplement to the annual funding notice to assist plan administrators to comply with the disclosure requirements under the Moving Ahead for Progress in the 21st Century Act (MAP-21) in Field Assistance Bulletin (FAB) 2013-01. As discussed in the September 2012 EB Update, single-employer defined benefit plans that may otherwise be subject to higher pension contributions because of historically low interest rates may utilize stabilized discount rates under MAP-21. Plan administrators utilizing the MAP-21 discount rates are required to make additional disclosures in the plan's annual funding notice for plan years beginning in 2012, 2013 and 2014 if: (1) all defined benefit plans of the controlled group covered 50 or more participants in aggregate on any day of the preceding plan year; (2) the stabilized funding target is less than 95% of the regular funding target for the year; and (3) the funding shortfall without stabilization for the year is $500,000 or more.

If these conditions are met, a plan administrator must include additional information in the annual funding notice. The notice must include certain statements providing:

- "MAP-21 modified the method for determining the interest rates used to determine the actuarial value of benefits earned under the plan, providing for a 25-year average of interest rates to be taken into account in addition to a 2-year average;" and,
- "as a result of the MAP-21, the plan sponsor may contribute less money to the plan when interest rates are at historical lows."

The statement may include additional information to the extent necessary or helpful to understand the MAP-21 disclosures. Plan administrators can use the model supplement published by the DOL to meet these requirements, but use of the model is not mandatory. FAB 2013-01 also explains how actuaries should determine comparative figures for the 2013 and 2014 disclosures.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Departments Issue Regulations and Guidance on Multiple ACA Provisions

Once again, the DOL, the Department of Health and Human Services (HHS) and the IRS (collectively, the Departments) issued guidance and regulations on a number of items under the Patient Protection and Affordable Care Act (PPACA or

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ACA) during March 2013.

HHS Issues Final Regulations on Details and Payment Parameters for Reinsurance Programs

HHS released final regulations detailing the payment parameters for three programs designed to stabilize premiums—risk adjustment, reinsurance and risk corridors—that will commence in 2014, as well as provide technical information on many other aspects of premium tax credits, the medical loss ratio program and the Small Business Health Options Program.

While much of the detail applies only to insurers of health plans, a few items are of note for employers sponsoring self-insured plans. Under ACA, self-insured plans as well as insured plans must contribute to a reinsurance program for calendar years 2014 through 2016. The regulations clarify that the self-insured plan, not a third-party administrator, is responsible for the reinsurance contribution. Also, a self-insured plan must make reinsurance contributions for major medical coverage as well as COBRA and retiree medical coverage, but a number of other health coverage options are excluded. Health savings accounts (HSAs), health flexible spending accounts (FSAs), expatriate health plans and prescription drug plans are excluded, as well as health reimbursement accounts (HRAs) that are integrated within other health coverage. In addition, wellness, disease-management and employee assistance programs are excluded if they do not provide major medical coverage.

Each year, HHS will announce the annual per capita contribution rate, which is set at $63 for 2014. Contributing entities must provide enrollment data to HHS by November 15 of each year, and HHS will notify the entity by the later of December 15 or 30 days after notification of the amount of the contribution, with the contribution then due within 30 days. Of note, HHS confirmed in the final regulations that reinsurance contributions may be paid from plan assets (if the terms of the plan so permit) under the Employee Retirement Income Security Act of 1974 (ERISA), and the IRS confirmed that self-insured plan sponsors may treat the contributions as ordinary and necessary business expenses.

Departments Issue Proposed Regulations Implementing the 90-Day Waiting Period Limit

Beginning January 1, 2014, group health plans and insurers will be prohibited from requiring otherwise eligible participants and beneficiaries to wait more than 90 days before health plan coverage is effective. The Departments issued

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proposed regulations to help implement this requirement, building upon two prior DOL technical releases in 2012. Plan sponsors can rely upon the proposed regulations, and, to the extent that final regulations or other guidance is more restrictive on plans and issuers, it will not be effective before January 1, 2015. The regulations confirm that all calendar days are counted in the 90-day period and that coverage must begin no later than the 91st day, regardless of whether that date falls on a weekend or holiday, or is not at the beginning of a month. For example, plans will not be able to commence coverage 90 days following the first day of the month following the date the individual commences employment. However, plans may still use other eligibility conditions, such as job classification or commission requirements, that would extend beyond a 90-day waiting period as long as the conditions are not designed to avoid compliance with the 90-day requirement. Also, certain hours requirements for eligibility are permissible if they meet specified standards within the regulations. Plans may allow employees extra time to elect coverage as long as the coverage is available by the 91st day. Of note, the regulations establish that a "3-month" waiting period is not equivalent to a 90-day waiting period because the period may exceed 90 days.

The regulations also propose eliminating the requirement that plan sponsors provide Health Insurance Portability and Accountability Act (HIPAA) Certificates of Creditable Coverage. The ACA prohibition on exclusions from coverage due to pre-existing health conditions essentially makes the certificates obsolete so plan sponsors will no longer be required to provide them. However, plan sponsors will need to continue to provide the certificates through December 31, 2014 in order to accommodate individuals joining plans in 2014 that do not have calendar year plan years.

IRS Clarifies Employer Play or Pay Transition Rule for Multiemployer Health Plans

The IRS clarified that an employer will not be subject to any penalties under Code section 4980H for employees on whose behalf the employer must contribute to a multiemployer plan, which offers coverage that is affordable and provides minimum value, pursuant to a collective bargaining agreement (CBA). However, this exception does not apply to any employees of the employer who are not covered by a CBA, even if the employee is covered by the multiemployer plan and it also does not apply for employees for whom an employer is not required to contribute to the multiemployer plan, even if the employee is covered by the CBA. For example, if the CBA does not require contributions on an employee's behalf for the first year of employment, but that employee works an average of 30 hours

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per week, the employer could be subject to Code section 4980H penalties for that employee because that employee would not be covered by the transition period relief.

Additionally, the IRS removed the concept of "participation agreements" from the guidance, stating that the transition period applies to employers contributing pursuant to a CBA only. However, the IRS did not explain the reason for this omission. If an employer contributes to a multiemployer plan pursuant to a participation agreement, that employer may not have the benefit of the transition period for its employees who participate in the multiemployer plan pursuant to a written agreement other than a CBA and could be subject to Code section 4980H penalties for those employees.

IRS Issues Proposed Regulations on ACA Annual Fee

The IRS recently proposed regulations on the annual fee imposed beginning in 2014 on covered entities engaged in providing health insurance for U.S. health risks. The fee is directly imposed on insurers; self-insured health plans, government entities, voluntary employee beneficiary associations (VEBAs) and educational institutions are generally exempt. However, unlike other ACA fees, this fee will be applicable to insured dental and vision benefits. In addition, multiple employer welfare arrangements are also subject to the fee.

ACA requires the IRS to collect a total yearly fee across all applicable entities, with the fee assessed in proportion to each entity's share of total net premiums written during the data year, the calendar year prior to the year the fee is due. The total collection for 2014 will be $8 billion, increasing annually to $14.3 billion in 2018. Insurers of health, dental and vision benefits may pass this fee on to the employers sponsoring these plans. The fee is assessed on a graduated scale, resulting in smaller insurers receiving relief. An entity's first $25 million in net written premiums is not taken into account when calculating the fee, so entities with less than this amount will not be assessed any portion of the fee. Also, the IRS will only take into account only 50% of an entity's net written premiums between $25 million and $50 million.

Covered entities must submit a report of the net premiums written during the prior year by May 1 of each year, and the IRS will then issue a Notice of Preliminary Fee Calculation to covered entities subject to the fee. Covered entities can then correct any errors in the IRS calculation, a revised report will be assessed before August 31 and payment must be made no later than September 30.

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Departments Issue Frequently Asked Questions on Expatriate Health Plans

The Departments issued frequently asked questions (FAQs) that exempt certain expatriate health plans from many of ACA's mandates until 2016. Expatriate health plans are insured group health plans that limit enrollment to primarily insureds who reside outside of their home country for at least six months of the plan year (plus any covered dependents) and which are otherwise compliant with applicable pre-ACA requirements under the Code and ERISA. These plans are exempt from certain requirements under ACA including, for example, annual and lifetime limits, preventive services, dependent coverage, summaries of benefits and coverage, appeals and external review and prohibitions on preexisting condition exclusions and excessive waiting periods. The transitional relief applies to plan years ending on or before December 31, 2015.

Departments Extend Deadline for Complying with State External Review Procedures

The Departments also issued transitional relief for health insurance issuers and self-insured plans to implement the external review requirements in states that have not adopted ACA-compliant external review procedures. Under ACA, nongrandfathered group health plans and insurers must provide an external review process that meets either a federal process for self-insured ERISA plans, or a state process for insurers and self-insured non-ERISA plans. Previously, the Departments provided a transition period for states to establish an external review process that meets certain protections of the NAIC Uniform Health Care External Review Model Act, set to expire January 1, 2014. This transitional relief extends that protection until January 1, 2016. States, including Indiana, Minnesota and Michigan, fall within this transitional relief. Some states, including Wisconsin, have not set up a state process so issuers must choose an HHS-administered process or contract with accredited independent review organizations to review external appeals on their behalf.

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