

## April 2014 Employee Benefits Update

### Employee Benefits Update: Internal Revenue Service (IRS) Issues Guidance on Required Amendments and Retroactive Effect of *US v. Windsor*

On April 4, 2014, the IRS issued Notice 2014-19 (Notice) providing welcomed guidance to qualified retirement plans with respect to the *US v. Windsor* decision in a question and answer format. The IRS subsequently released six additional questions and answers on its website with additional information regarding the Notice. To comply with the new guidance, qualified retirement plans must recognize same-sex spouses as of June 26, 2013 (the date of the Windsor decision). With the proper amendments, plans may, but are not required to, recognize same-sex spouses before June 26, 2013. The guidance also describes when qualified retirement plans are required to amend their plan documents to comply with *Windsor*.

The following is a brief summary of the guidance.

#### Compliance Dates

A qualified retirement plan's operations must generally reflect the outcome of *Windsor* as of June 26, 2013. This means that a qualified retirement plan must treat a same-sex spouse as a "spouse" for purposes of the plan. If desired, a plan may be amended to treat a same-sex spouse as a "spouse" under the plan earlier than June 26, 2013. The IRS also noted, however, that an earlier effective date may be difficult to administer and may create unintended consequences. Accordingly, a plan should carefully review all potential issues before deciding to recognize same-sex spouses prior to June 26, 2013.

The IRS previously issued Revenue Ruling 2013-17, which required qualified retirement plans to treat a same-sex spouse as a spouse under the plan as of September 16, 2013 if the couple was married in a jurisdiction that recognized same-sex marriage, regardless of the couple's state of residence. See our review of Revenue Ruling 2013-17. Thus, Rev. Ruling 2013-17 required plans to use the ceremony rule to decide whether or not to recognize a same-sex spouse as of

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September 16, 2013. The Notice, recognizing the lack of clarity regarding how to decide who was a same-sex spouse prior to Rev. Ruling 2013-17, provides that, prior to September 16, 2013, plans will not be treated as failing to comply with Windsor because the plan relied on the laws of the participant's state of residence to determine whether to recognize a same-sex spouse.

Based on the Notice and prior guidance on this issue, qualified retirement plans must comply with the following operational rules:

1. Between June 26, 2013 and September 16, 2013, plans must treat a same-sex spouse as a spouse for purposes of the plan if the couple was married in a jurisdiction and resided in a state that recognized same-sex marriage at the time; and
2. On and after September 16, 2013, plans must treat a same-sex spouse as a spouse for purposes of the plan if the couple was married in a jurisdiction that recognizes same-sex marriage, regardless of where the couple resides.

If a retirement plan failed to treat same-sex spouses as spouses during these time periods, the new guidance provides that the plan would need to correct the failure using the correction principles under the Employee Plans Compliance Resolution System (EPCRS). For example, if a plan failed to obtain the spousal consent of a same-sex spouse for a distribution in an optional form of payment under a pension plan after June 26, 2013, the plan may remedy the lack of spousal consent under the principles described in section 6.04(1) of Rev. Proc. 2013-12.

### **Plan Amendments**

Whether a plan is required to be amended to reflect the outcome of Windsor depends on the terms of the specific plan. If the plan's terms define a marital relationship based on Defense of Marriage Act (DOMA) or the terms are otherwise inconsistent with the outcome of Windsor or subsequent IRS guidance, the plan must be amended. If a plan's terms are not inconsistent with Windsor or subsequent IRS guidance, the plan is generally not required to be amended. Nevertheless, the plan must be operated in accordance with the decision and agency guidance, so a clarifying amendment may be useful for purposes of plan administration.

The deadline to adopt a plan amendment is the later of: (1) the end of the plan year that the change is first effective; (2) the due date of the employer's tax return for the tax year that includes the date of the change; or (3) December 31, 2014.

For government plans, any amendment is not required to be adopted before the close of the first regular legislative session of the legislative body with the authority to amend the plan that ends after December 31, 2014.

### **Amendments to Defined Benefit Plans Subject to Benefit Limitations**

Code section 436(c) provides that an amendment to a single-employer defined benefit plan that increases the liabilities of the plan cannot take effect unless the plan's Adjusted Funding Target Attainment Percentage (AFTAP) is sufficient or the employer makes an additional contribution. However, the Notice clarifies that pursuant to Treasury Regulation section 1.436-1(c)(4)(iii), a plan amendment described in the Notice that is effective on June 26, 2013 is not treated as an amendment to which Code section 436(c) applies.

Similarly, Code section 432 limits the ability of applicable multiemployer plans to increase liabilities through changes to benefits, benefit accruals or vesting schedules unless certain conditions are met. However, an amendment is permitted if the amendment is required as a condition of qualification under the Code or to comply with applicable law. The Notice specifies that an amendment to comply with *Windsor* is required for compliance under the Code, assuming the amendment does not take effect earlier than June 26, 2013.

### **Open Questions—Health and Welfare Plans**

While the Notice confirmed that the ruling in *Windsor* will not have a retroactive impact on qualified retirement plans before the date of the decision, the Notice did not address what effect, if any, *Windsor* may have on self-funded health and welfare plans or whether health and welfare plans that cover spouses will be required to cover same-sex spouses. The Notice applies to only qualified retirement plans.

## **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 2013



benefit statement is due by the earlier of (1) the actual filing date of the 2013 Form 5500 or (2) July 31, 2014 (the plan's regular Form 5500 filing deadline), unless a Form 5500 deadline extension applies.

### **2013 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, 2013, the deadline for filing the Form 5500 is July 31, 2014. Plan sponsors that extended their corporate federal income tax return deadline can receive an automatic extension until September 15, 2014, if certain criteria are satisfied. Otherwise, plan administrators can apply for a deadline extension until October 15, 2014 by filing Form 5558 on or before July 31, 2014.

## **Retirement Plan Developments**

### **Department of Labor (DOL) Proposes Amendment Service Provider Fee Disclosure Regulation**

On March 12, 2014, the DOL's Employee Benefits Security Administration (EBSA) published a proposed amendment to previously issued regulations under ERISA section 408(b)(2) requiring certain service providers to disclose fees to plan fiduciaries. The proposed rule would require covered service providers to provide a guide to fee disclosure information to permit fiduciaries to easily find relevant service and expense information.

Under the proposed rule, covered service providers who make their disclosures through multiple or lengthy documents would be required to provide a guide to assist plan fiduciaries in locating required information. The guide would direct the fiduciaries on where to find the following:

- A description of services provided;
- A statement concerning services provided as a fiduciary or registered investment advisor;
- A description of all direct compensation, indirect compensation, compensation among related parties, compensation expected to be received upon termination of the contract or arrangement, and compensation for recordkeeping services; and
- Disclosures about investment options required for certain covered service providers.

For each of the required elements, the guide must provide a document and page (or section) reference that would enable the plan fiduciary to quickly and easily find the disclosure. EBSA indicated that hyperlinks would also be acceptable. Any changes to the guide would be required to be disclosed annually.

EBSA indicated that the guide requirements would become effective 12 months after the final rule is published.

## **Eighth Circuit Issues Decision in Excessive Fee Lawsuit**

In a recent decision, *Tussey v. ABB Corp.*, the U.S. Court of Appeals for the Eighth Circuit reversed, in part, a district court's finding that a plan sponsor, ABB, Inc., and its record keeper and investment adviser, Fidelity Management Trust Company and Fidelity Management and Research Company (collectively, Fidelity), violated certain requirements of ERISA. Most significantly, the Eighth Circuit upheld an award of \$13.4 million against ABB related to recordkeeping fees paid to Fidelity but reversed the district court's finding that Fidelity improperly retained float income.

The district court held that ABB violated its fiduciary duties by, among other things, failing to monitor recordkeeping costs, failing to negotiate rebates from Fidelity on behalf of the plan and agreeing to pay Fidelity an amount that exceeded market costs for the services provided to the plan. The court's finding was based on testimony heard at trial, including testimony by an expert who indicated that the per-participant fee charged by Fidelity significantly exceeded the market rate. The court also noted that Fidelity's own documents demonstrate that the revenue it generated from the ABB plans far exceeded the revenue earned from other plans.

In upholding the district court's decision with respect to excessive recordkeeping fees, the Eighth Circuit distinguished cases from other circuits, including the Seventh Circuit's decision in *Hecker v. Deere*, noting that those cases were fact intensive and did not involve the significant allegations of wrongdoing present in this case. Further, the court held that there was ample support in the record to find that ABB paid excessive recordkeeping fees.

While the Eighth Circuit affirmed the finding of excessive recordkeeping fees, the appeals court reversed the district court's ruling that Fidelity had breached its fiduciary duties through its retention of float income, which is income earned from interest-bearing accounts while participant contributions and distributions await investment or distribution. The Eighth Circuit ruled that participants failed



to show that the float income retained by Fidelity was a plan asset in this case and, thus, Fidelity owed no fiduciary duty with respect to float income under ERISA.

## Health and Welfare Plan Developments

IRS Issues Final Regulations on Information Reporting under the ACA The IRS recently issued two final rules addressing the information reporting requirements for certain employers and insurers under the Affordable Care Act (ACA).

The final regulations confirm that an entity required to report under Code sections 6055 or 6056 (or both) must file the required return(s) on or before February 28 (or March 31, if filed electronically) of the year following the year in which minimum essential coverage was provided. The regulations apply for calendar years beginning after December 31, 2014, though reporting for 2014 coverage is voluntary.

Reporting Requirements for Providers of Minimum Essential Coverage. Beginning with the 2014 tax year, health insurance issuers, sponsors of self-insured health plans and government agencies that administer government sponsored health insurance programs (Reporting Entities) must file annual reports providing a list of covered individuals and the months they were covered. This reporting requirement is designed to aid the IRS in determining eligibility for premium tax credits and whether individuals are complying with the ACA's individual mandate.

The final regulations generally adopt the positions taken in the proposed regulations. Most significantly, the final regulations clarify that reporting is not required for certain types of benefits plans, such as onsite medical clinics, Medicare Part B or wellness programs that are an element of other minimum essential coverage.

The final regulations require Reporting Entities to file a return that includes the name, address and taxpayer identification number (TIN) (or date of birth, if a TIN is not available) of the employee, as well as the name and TIN (or date of birth) of each spouse and dependent covered under the plan and the months during which the individual was covered during the year.

Additionally, Reporting Entities must provide a written statement to such employee reported on the return that includes the information reported on the return. These written statements must be provided on or before January 31 of the year following the calendar year the minimum essential coverage was provided.



Reporting Requirements for Applicable Large Employers (ALEs). Code section 6056 requires ALEs (generally, employers with 50 or more full-time or full-time equivalent employees) to provide certain information regarding the health coverage offered to its fulltime employees (those employees who work an average of 30 hours per week).

The final Code section 6056 regulations generally require ALEs to report the same information as that included in the proposed regulations. Unless an ALE chooses one of the alternative methods of reporting (described below), the employer is required to report a month-by-month certification as to whether the employer offered its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage; the number of full-time employees during the calendar year, by calendar month; the months during the calendar year for which minimum essential coverage was available; each full-time employee's share of the lowest cost monthly premium for self-only coverage providing minimum value that was offered to that employee, by calendar month; and the name, address and TIN of each full-time employee during the calendar year and the months, if any, during which the employee was covered under an employer-sponsored plan. The preamble to the final regulations clarifies that multiemployer plans and TPAs can file returns on behalf of ALEs.

ALEs must also provide a written statement to each full-time or full-time equivalent employee that includes the information reported on the return. This written statement must be provided on or before January 31 of the year following the calendar year the minimum essential coverage was provided.

The final regulations include two alternative methods to comply with the Code section 6056 reporting obligation. Certain ALEs may be permitted to elect one of the following alternative methods to report health insurance coverage.

- Certification of Qualifying Offers. Under this alternative method, an employer must certify that it made a qualifying offer of health coverage for all 12 months of the year. A "qualifying offer" is an offer to a full-time employee and the employee's spouse and dependents of minimum essential coverage that provides minimum value and for which the employee's share of the self-only premium does not exceed 9.5% of the single federal poverty level for an individual in the lower 48 states. For those employees who do not receive a qualifying offer for all 12 months of the year, the employer must report all information required under the general method (described above). The IRS has offered transitional relief for 2015 under this alternative method, which

provides that an ALE may meet its reporting obligation if it certifies that at least 95% of its full-time employees (and their spouses and dependents) have received qualifying offers. It appears, therefore, that only employers who offer spousal coverage to some or all full-time employees will be able to take advantage of this alternative.

- **98% Certification.** Under this alternative method, an employer can avoid reporting the number of full-time employees if the employer certifies that it offered minimum essential coverage to at least 98% of all its employees (and dependents), not just full-time employees, and such coverage was affordable and provides minimum value.

**Combined Reporting.** ALEs that provide minimum essential coverage under a self-insured health plan are subject to reporting requirements under both Code sections 6055 and 6056. Under the final regulations, a self-insured ALE will file a combined return for all required reporting under Code sections 6055 and 6056. The IRS is currently preparing draft forms, which will be released in the near future.

## **Department of Health and Human Services (HHS) Issues Final Reinsurance Fee Regulations**

On March 11, 2014, HHS released the final Notice of Benefit and Payment Parameters for 2015 (Final Notice). The Final Notice also clarifies various aspects of the exception from the transitional reinsurance fee (Reinsurance Fee) for self-insured, self-administered plans and finalizes the two-tier payment schedule. Specific payment details have not yet been released but will be addressed in future guidance.

The Reinsurance Fee is a temporary fee charged to health insurance issuers and third-party administrators (TPAs) under the ACA and is intended to help stabilize premiums for coverage in the individual market.

**Exemption for Self-Insured, Self-Administered Plans.** The Final Notice retains the general rule that self-insured, self-administered plans will not be subject to the Reinsurance Fee for the 2015 and 2016 benefit years. This determination, however, does not apply to Reinsurance Fee liability for 2014, regardless of self-administered status. The Final Notice further clarifies the definition of "self-administered." Generally, a self-insured plan must retain administration of "core" plan functions to be considered "self-administered" for purposes of the Reinsurance Fee exception. The Final Notice provides that a plan's "core functions" are claims payment, claims adjudication (including internal appeals)

and enrollment. Thus, a plan that uses a third party for these core administrative tasks generally may not claim an exemption from the Reinsurance Fee. However, the Final Rule provides two exceptions to the "core functions" test. First, a self-administered plan may outsource "core" administrative functions for pharmacy benefits and excepted benefits (as defined by HIPAA) because these benefits are not subject to the Reinsurance Fee. Second, the general "core functions" rule is subject to a "de minimis" exception. Under the "de minimis" exception, a plan may outsource up to 5% of its non-pharmacy/excepted benefits core administrative functions. The 5% calculation may be based on either the total number of the plan's non-pharmacy/excepted benefit claims transactions or the value of the outsourced non-pharmacy/excepted benefit transactions.

Reinsurance Fee Collection Schedule. The Final Notice maintains the twice-yearly Reinsurance Fee collection schedule from the proposed notice for all contribution years (2014–2016). Plans subject to the fee must report enrollment counts by November 15 of each contribution year. Entities that timely report enrollment numbers will receive a Notice of Payment in December of the contribution year. Payment must be remitted within 30 days of receiving the notice. A plan will then receive a second Notice of Payment "in the fourth quarter" of each contribution year showing the amount due for the second Reinsurance Fee installment. This payment is also due within 30 days of receipt of the notice. HHS has determined that for 2014, the first installment will be \$52.50 per covered life and the second installment will be \$11.50.

The Final Notice also clarifies that all plans required to pay the Reinsurance Fee will be required to follow the twice-yearly payment schedule. No entity will be allowed to pay the full fee in December. Additionally, the Final Notice provides that program specifics, including specific timing and the forms to be used by contributing entities, will be provided in future guidance.

Covered Life. The Final Notice reiterates HHS's intent to require only one Reinsurance Fee for each covered life. As such, if an individual is covered by multiple arrangements that would be considered "major medical coverage" subject to the Reinsurance Fee, only one entity must pay a fee for that person. The Final Notice retains the rule that for an individual who (in addition to plan coverage) also has coverage through (1) the individual market or (2) another plan that pays primary to the plan, the plan will not be responsible for paying a Reinsurance Fee for that individual, provided that the other plan is subject to the Reinsurance Fee. For example, if a participant's spouse is covered both by the plan and the spouse's own policy through his/her employer, the plan would

generally not be required to pay the Reinsurance Fee for the spouse because the spouse's employer-provided coverage would pay. However, if the spouse receives coverage through a self-insured, self-administered plan that is exempt from the Reinsurance Fee, the plan would still be required to pay a Reinsurance Fee for the spouse.

To determine Reinsurance Fee responsibility, the Final Notice retains the rule that "the group health plan that offers the greater portion of in-patient hospitalization benefits is deemed the primary plan" and is responsible to pay the Reinsurance Fee for that person. These rules may require plans to coordinate in determining which plan must pay the Reinsurance Fee for a covered life. The Final Notice allows a plan to rely on the written representation from the secondary plan regarding Reinsurance Fee liability. The written representation must specifically state that the secondary plan is responsible for the Reinsurance Fee for the specified individual. This means that a self-insured, self-administered plan should never provide such written assurance because the self-insured, self-administered plan would be exempt from the Reinsurance Fee.

2015 Reinsurance Fee Contribution. The Final Notice sets the Reinsurance Fee for 2015 at \$44 per covered life. The first payment will be \$33 per covered life and will be due in early 2016. A second payment of \$11 per covered life will be due in late 2016.

2015 Premium Adjustment Percentage. In addition to finalizing the rules for the reinsurance payments, the Final Notice also provided the "premium adjustment percentage" for 2015. The premium adjustment percentage is used to determine the amounts by which the employer shared responsibility penalties and the out-of-pocket limit maximums (for non-grandfathered plans) will increase in 2015.

HHS has determined that the premium adjustment percentage for 2015 is 4.213431463%. Accordingly, for 2015:

- The annual employer shared responsibility penalties will increase to \$2,080 for the 4980H(a) penalty (the failure to offer coverage penalty) and \$3,120 for the 4980H(b) penalty (the failure to offer affordable and adequate coverage penalty).
- The maximum out-of-pocket limit that non-grandfathered plans may impose on in-network essential health benefits will be \$6,600 for individual coverage and \$13,200 for family coverage.



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