August 2013 Employee Benefits Update

POSTED:

Aug 27, 2013

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Business Associate Agreements Entered into in 2013 Must Be Revised Before September 24, 2013

Before September 24, 2013, all business associate agreements (BA) entered into after January 25, 2013 must be updated to comply with the final rule implementing the Health Information Technology for Economic and Clinical Health (HITECH). However, BAs that were entered into prior to January 25, 2013 and were compliant at the time of execution need not be revised for HITECH until September 23, 2014.

2013 Participant Fee Disclosure Can Be Delayed

As described in more detail below, the Department of Labor (DOL) has formally permitted plan sponsors to delay the 2013 participant fee disclosure by up to six months to allow plan sponsors to align the annual distribution deadline with other plan disclosures, like participant benefit statements or annual enrollment materials.

SBCs Must Be Updated for Coverage Beginning on January 1, 2014

On April 23, 2013, the DOL released a new model Summary of Benefits and Coverage (SBC) that plans should use when drafting updated SBCs that include new required information. These updated SBCs should be sent to plan participants with open enrollment materials in anticipation of open enrollment. Plan sponsors are required to provide an SBC annually. For plans with open enrollment, the SBC must be provided with open enrollment materials. For plans that do not have open enrollment, the SBC must be provided at least 30 days prior to the beginning of the plan year.

RETIREMENT PLAN DEVELOPMENTS

PBGC Issues Proposed Regulations Regarding Premiums and Payments

On July 29, 2013, the Pension Benefit Guarantee Corporation (PBGC) issued proposed regulations that would simplify and streamline various aspects of the payment of employer premiums. If finalized, the proposed rules would take effect beginning in 2014.

Currently, PBGC premium payment due dates are based on employer size. The proposed rule would alter the current payment schedule and provide that all employer premium payments, regardless of employer size, would be due 9 1/2 calendar months following the beginning of the premium payment year (October 15 for calendar-year plans). For new or newly covered plans, the proposed rule provides that the first payment is due within 90 days after coverage begins.

Additionally, the proposed rule also alters the premium due date for terminating plans. Under the proposed rule, the premium due date for a terminating plan's final year would be the earliest of (a) the normal premium due date, (b) the last day by which the post-distribution certification can be filed without penalty, or (c) the date when the post-distribution certification is actually filed.

DOL Allows Employers to Delay Distribution of the 2013 Participant Fee Disclosure

On July 22, 2013, the DOL released Field Assistance Bulletin No. 2013-02 (FAB) establishing a temporary non-enforcement policy that allows plans to reset the date by which they would otherwise need to provide participants with the 2013 participant fee disclosure.

Administrators of participant-directed individual account plans are required to disclose to plan participants and beneficiaries certain detailed investment-related information about a plan's investment alternatives. Under the final regulations, the first disclosure was due during 2012 (by August 30, 2012 for calendar-year plans). A plan administrator would then be required to publish an updated chart "at least annually thereafter." The regulations define "annually" to mean at least once within any 12-month period. Thus, a plan administrator would be required to publish its second disclosure within 12 months following the publication date of the 2012 disclosure.

Plan administrators notified the DOL that the August 30 date does not correspond with the due dates of any other ERISA-required disclosures and that ongoing compliance would result in administrative burdens and extra costs to plans. In response, the DOL issued the current FAB allowing plan administrators to make the second required disclosure (for 2013) within the 18 months following the date that the 2012 disclosure was issued. This temporary non-enforcement policy effectively allows a plan to align the due date for the participant fee disclosure with the due dates for other required disclosures. For plan administrators who may have already furnished the 2013 disclosure, or have

already expended plan funds preparing the disclosure, those plans may provide the 2014 disclosure within 18 months following the date the 2013 disclosure is sent.

The DOL continues to review options for longer-term solutions, including a 30- or 45-day window within which plan administrators would be allowed to furnish the required comparative chart.

IRS Delays Implementation of FATCA

On July 12, 2013, the Internal Revenue Service (IRS) released Notice 2013-43 (Notice) announcing that the IRS and the Department of Treasury (Treasury) intend to amend final Treasury regulations implementing the U.S. Foreign Account Tax Compliance Act (FATCA). The delay means that multinational employers with U.S. citizens participating in foreign retirement plans will not be required to begin required withholdings until July 1, 2014.

FATCA generally imposes a 30% withholding requirement on most interest and dividends paid by U.S. payors to non-U.S. retirement plans unless such non-U.S. plans are exempt or specifically listed in an Intergovernmental Agreement for the Implementation of FATCA (IGA). FATCA was scheduled to take effect beginning on January 1, 2014. The Notice modifies the implementation date so that U.S. payors will be required to begin the 30% withholdings for all applicable payments after June 30, 2014.

Non-U.S. financial institutions are able to register as a foreign financial institution (FFI) and enter into FATCA agreements, exempting account holders from the 30% withholding. However, in order to register and be deemed a compliant FFI, an institution's jurisdiction must first enter into an IGA. The Notice recognizes that the IGA process has not progressed as quickly as hoped. Thus, in addition to jurisdictions that have signed and implemented an IGA, some jurisdictions will be deemed to have implemented an IGA such that FFIs will be allowed to register and be deemed compliant prior to the July 1, 2014 withholding implementation date. However, a jurisdiction may be removed from the list of deemed compliant jurisdictions if the jurisdiction fails to perform the steps necessary to bring the IGA into force within a reasonable period of time.

IRS Releases Static Mortality Tables for 2014-15

The IRS has released updated static mortality tables for use during 2014-15. These tables may be used in (1) calculating single employer defined benefit funding

targets, (2) calculating multiemployer defined benefit liabilities, and (3) determining minimum present value under Internal Revenue Code (Code) section 417(e)(3) for distributions with annuity starting dates that occur during stability periods beginning in years 2014 and 2015.

DOL Amends Definition of "Ratings Agency" for Purposes of Plan Investment in Asset-Backed and Mortgage-Backed Securities

On July 9, 2013, the DOL issued a final amendment to Prohibited Transaction Exemption 2007-5 (Exemption) that replaces the prior definition of "ratings agency" with a new generic definition. The new definition changes the circumstances under which retirement plans may invest in asset-backed and mortgage-backed securities.

Fiduciaries of employee benefit plans that invest plan funds in mortgage-backed or asset-backed securities must comply with fiduciary and prohibited transaction rules under both ERISA and the Code. The Exemption allows investment in these otherwise prohibited securities provided that the securities are rated above a threshold level. Fiduciaries are required to confirm that the agency providing the rating for mortgage-backed or asset-backed securities transactions meets certain requirements.

The final amendment to the Exemption amends the definition of "ratings agency" by providing that a "ratings agency" is a credit rating agency that:

- The SEC currently recognizes as a nationally recognized statistical ratings agency;
- Indicated on its most recently filed SEC Form NRSRO that it rates "issuers of asset-backed securities"; and
- Has, in the 12 months prior to the initial issuance of the securities, provided at least three "qualified ratings engagements." A qualified ratings engagement is one:
  - Requested by an issuer or underwriter of securities in connection with the initial offering of the securities;
  - For which the ratings agency is compensated for providing ratings;
  - Which is made public to investors generally; and
  - Which involves the offering of securities of the type that are granted relief by the underwriter exemptions.

DOL Releases Advisory Opinion Clarifying Status of Revenue Sharing Assets

On July 2, 2013, the DOL released Advisory Opinion 2013-03A clarifying that revenue sharing assets not actually received by a plan are not plan assets for ERISA purposes. The subject of the Advisory Opinion, Principal Financial Services (Principal), is a recordkeeper of 401(k) and other participant-directed plans and receives payments from some plan investments in the form of Rule 12b-1 fees, shareholder or administrative service fees and similar payments. Generally, Principal (and other recordkeepers like Principal) have kept these fees and, according to agreements with individual plans, either credited them to offset a plan's expenses or deposited them into an account maintained on behalf of the plan for use in paying plan expenses. Principal asked the DOL to clarify whether these funds were plan assets for ERISA purposes, thus triggering ERISA's trust requirement and prohibited transaction restrictions.

The DOL determined that, under these circumstances, the payments were not plan assets. Consistent with prior opinions, the DOL noted that plan assets should be identified on the basis of "ordinary property rights." Thus, the DOL determined, because the plan never actually received the revenue sharing payments, and the revenue payments were either applied to the plan as credits or held in a Principal-controlled account, the payments are not plan assets. However, the DOL also concluded that the plan's contractual right to receive the revenue sharing payments was a plan asset. Thus, should the recordkeeper fail to apply the payments in fulfillment of the recordkeeper's contractual duty, the plan's claim for credits or payments would be a plan asset.

Additionally, the DOL noted that plans entering into these types of revenue sharing arrangements are still subject to general ERISA prudence requirements, including the ability to periodically monitor the arrangement, including amounts credited to the plan and/or applied to plan expenses. Finally, the DOL also noted that the arrangement would be subject to ERISA section 408(b)(2) enhanced disclosure requirements.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Announces Delay of ACA Employer Reporting and Fee Provisions

On July 9, 2013, the IRS issued Notice 2013-45 (Notice) delaying the effective date of the Patient Protection and Affordable Care Act (ACA) employer shared responsibility requirements, also known as the "pay or play" rules. These rules will now apply in 2015. Accordingly, employers will not be subject to the penalties for failing to offer coverage to full-time employees in 2014.

The Notice confirms that proposed rules for the information reporting provisions for self-funded plans and insurers are expected to be published this summer and that information reporting will be optional for 2014. The Notice also reiterates that, because the information reporting is optional for 2014, it is not feasible to determine which employers would owe employer shared responsibility penalties for 2014 and, therefore, no employer shared responsibility penalties will be assessed for 2014.

The Notice also confirms that individuals' eligibility for premium tax credits continues to depend on whether employer sponsored coverage is affordable and provides minimum value. Finally, the Notice reiterates that the transition relief for the information reporting and employer shared responsibility penalties has no effect on the effective date or application of other ACA provisions.

HHS Releases Final Exchange Verification Rule

On July 15, 2013, the Department of Health and Human Services (HHS) issued final rules setting forth how exchanges will verify eligibility for advance payment of premium tax credits. Exchange applicants are disqualified from receiving premium tax credits if they are enrolled in or eligible for affordable employer-provided group health coverage that provides minimum value. Because some applicants will also be eligible for advance payment of premium tax credits, exchanges will be required to verify, at the time of application, whether an applicant is enrolled in or eligible for employer coverage.

In general, the exchanges will verify an applicant's status by reviewing the applicant's attestation and verifying the applicant-provided eligibility information using available data from approved electronic sources or the Small Business Health Operations Program operating in the same state as the exchange.

If data is not available from approved sources, the exchange will generally be required to verify the submitted information by conducting a manual verification for a "statistically significant" random sample of applicants (manual verification). During manual verification, employers may be required to provide information to the exchange. Employers will have 90 days to respond to an information request. There is currently no penalty for an employer who fails to respond. However, should an employer fail to respond, the information in the applicant's attestation will be presumed to be correct.

HHS Continues to Take Steps to Help Ensure Consumer Protections in the Exchange

On July 12, 2013, HHS released a final rule applicable to Exchange Navigators, Non-Navigator Assistance Personnel and Application Counselors. Although the final rule does not apply directly to plan sponsors, plan sponsors should familiarize themselves with the Exchange process and terminology should participants approach them with questions.

The final rule finalizes the requirement that exchanges must have a certified application counselor program. It also creates conflict of interest training and certification. Finally, the final rule identifies a list of entities that are ineligible to become Navigators or Non-Navigator Assistance Personnel. Although the Navigator training portion of the final rule generally does not apply to state-based exchanges, the final rule does encourage state-based exchanges to adopt training programs similar to those established by the final rule.

The final rule provides that Navigators and non-Navigator assistants in federally-facilitated and partnership exchanges must be certified including: receiving training regarding qualified health plan options and all insurance affordability programs provided by a state; passing a certification exam and receive continuing education; and becoming certified or re-certified annually.

The final rule also identifies certain entities that are ineligible to become Navigators or non- Navigator assistants because of inherent conflicts of interest. The precluded entities include health or stop-loss insurers (including their subsidiaries or associations). Other entities, while not precluded from becoming Navigators, will be required to disclose potential conflicts of interest. These entities include: companies offering lines of insurance outside health and stop-loss; those with employment relationships with an insurer within the last five years; and those whose spouse or domestic partner has an employment relationship with an insurer, stop-loss insurer or affiliate.

Finally, the final rule provides that federally facilitated and partnership exchanges, as well as state-based exchanges receiving federal establishment funds, must provide culturally and linguistically appropriate assistance services and ensure access for disabled persons. This requirement includes providing access to these services without cost.

CMS Releases FF-SHOP Technical Guidance

On July 5, 2013, HHS released technical guidance, in the form of questions and answers, applicable to the Federally-Facilitated Small Business Health Options Program (FF-SHOP). The guidance gives a clearer picture of how FF-SHOPs will

operate and helps eligible employers to begin planning for the first FF-SHOP open enrollment period (November 15, 2013 through December 15, 2013).

Employers with an average of 50 or fewer employees may participate in the SHOP system. Some states have elected to implement their own SHOP system, while the federal government will establish the FF-SHOP system in others. For example, the FF-SHOP system will operate in Wisconsin, Illinois, Indiana and Michigan while Minnesota will operate its own SHOP. This guidance applies only to the FF-SHOP.

Among other things, the guidance clarifies that:

- Premium rate factors will be determined by the employer's principal business address, not the employee's home address;
- Employers will not be allowed to offer varying coverage for different classes of employees;
- Employers may cover retirees through the FF-SHOP, but retirees must pay the same contribution rate as active employees;
- COBRA enrollees are eligible for FF-SHOP coverage and may be included in minimum participation counts;
- Insurers will be required to add domestic partners as dependents to the employee's coverage, if the employer provides for such coverage; and
- Employers will be notified 90 days before FF-SHOP coverage ends, allowing them to make decisions regarding continuing coverage. If an employer elects to remain with the same plan as the previous year, renewal will happen automatically.

Court Orders Employer to Pay $1.8 Million Fine for Failure to Provide COBRA Notices

Recently, a federal district court held Visteon, the employer and administrator of the company's group health plan, liable for $1.8 million because it failed to monitor its third-party COBRA administrator, who failed to provide hundreds of terminated employees with COBRA election notices. *Pierce v. Visteon Corp.*, 2013 WL3225832 (S.D. Ind. 2013).

Visteon, as the group health plan administrator, used separate third-party administrators (TPA) for payroll, benefits and COBRA administration. When an employee was terminated, a local human resources official entered that information into a timekeeping system. The information was then automatically passed electronically from TPA to TPA, each of whom was tasked with various elements of the termination process. Neither the local HR official nor the TPA

reported terminations to Visteon, and the COBRA TPA did not report when COBRA election notices had been sent.

Visteon argued that whether the COBRA election notices were sent was out of its control and thus it could not be held liable for statutory damages. The court disagreed, ruling that Visteon had either willfully violated COBRA notification provisions, or was willfully negligent in its duties as plan administrator. The court specifically noted that the $1.8 million fine should act as a deterrent to other large employers using a TPA to meet statutory COBRA obligations.

Health Insurer Fined $1.7 Million for HIPAA Violation

On July 11, 2013, HHS announced that WellPoint Inc., the second largest U.S. health insurer, had agreed to pay a $1.7 million fine because its online application database allowed access to the protected health information of 612,402 individuals during a period from October 2009 until March 2010. This data included names, dates of birth, addresses, Social Security numbers, telephone numbers and health information.

The HHS Office of Civil Rights found that WellPoint violated HIPAA privacy and security laws because it did not:

- Adequately implement policies and procedures for authorizing access to the online application database;
- Perform an appropriate technical evaluation in response to a software upgrade to its information systems; or
- Have technical safeguards in place to verify the person or entity seeking access to electronic protected health information maintained in its application database. HHS reiterated that HIPAA covered entities should "take caution when implementing changes to their information systems, especially when those changes involve updates to Web-based applications or portals that are used to provide access to consumers' health data using the Internet."