Reinhart

January 2013 Employee Benefits Update

Select Compliance Deadlines and Reminders

Cycle B Determination Letter Filings Due January 31, 2013

As noted in December's Employee Benefits Update, the Remedial Amendment Period Cycle B individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2013. Cycle B plans include those sponsored by employers with tax identification numbers (EINs) ending in a "2" or a "7" as well as any multiple employer plans.

Cycle C Submission Period Opens February 1, 2013

Effective February 1, 2013, the IRS will begin accepting determination letter applications from remedial amendment period Cycle C individually designed plans. In general, Cycle C plans must be submitted for a determination letter no later than January 31, 2014 to rely on the extended period during which qualification amendments may be retroactively adopted. Cycle C plans include those sponsored by employers with EINs ending in a "3" or an "8."

Medicare Part D Creditable Coverage Disclosure to Centers for Medicare & Medicaid Services (CMS) Due March 1, 2013 for Calendar Year Plans

Under Medicare Part D regulations, most group health plans offering prescription drug coverage to Part D eligible individuals must annually disclose to CMS whether the coverage is creditable or non-creditable. Group health plan sponsors can comply with the CMS disclosure requirement by completing a disclosure form available on the CMS website (Creditable Coverage) and filing the form electronically. The annual filing deadline is 60 days after the first day of the plan year, which is March 1, 2013 for calendar year plans. In addition, disclosure forms must be filed within 30 days after the termination of a plan's prescription drug coverage or a change in its creditable coverage status.

2011 Medicare Part D Subsidy Reconciliation Due April 1, 2013 for Calendar Year Plans

A plan sponsor that applied for the Medicare Part D Retiree Drug Subsidy must file a reconciliation with CMS no later than 15 months after the end of the plan year, which is April 1, 2013 for the plan year ending December 31, 2011. If the

POSTED:

Jan 21, 2013

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plan sponsor does not timely submit the reconciliation, the plan sponsor will forfeit the subsidy received for that year.

Retirement Plan Developments

IRS Issues 2012 Cumulative List of Changes in Plan Qualification Requirements (2012 Cumulative List) for Cycle C Individually Designed Plans

The IRS issued the 2012 Cumulative List as Notice 2012-76. The 2012 Cumulative List details the plan qualification requirements for plan sponsors of individually designed plans submitting determination letter requests during Cycle C (from February 1, 2013 through January 31, 2014). Generally, a plan falls into Cycle C if it is an individually designed plan and the last digit of the plan sponsor's EIN is a "3" or an "8."

The 2012 Cumulative List contains several new items, including transition relief for certain group trusts, anti-cutback rules for a plan sponsor that is a debtor in a bankruptcy proceeding, the application of QJSA and QPSA rules to annuity contracts purchased under a profit sharing plan, and the application of Internal Revenue Code section 436 to single employer defined benefit plans.

Form 5500 Proposed Notices Eliminated

Beginning January 1, 2013, the IRS will discontinue sending Notice CP-213N (Proposed Penalty Notice for Late Filing of Form 5500, Annual Return/Report of Employee Benefit Plan) and Notice CP-213I (Proposed Penalty Notice for Incomplete Filing of Form 5500). The proposed penalty notices are being eliminated in an effort to reduce processing costs, reduce notices and comply with notice and systems standards. Filers will continue to receive CP-283 (Penalty Charged on Your 5500 Return) if a Form 5500 is filed late or is incomplete.

Department of Labor Issues Proposed Amendments to Abandoned Plan Regulations and Related Prohibited Transaction Exemption

On December 11, 2012, the Department of Labor (DOL) issued proposed amendments to the Abandoned Plan program, which was created by regulations issued in 2006 and included a class prohibited transaction exemption. The Abandoned Plan program was designed to facilitate the orderly, efficient termination and distribution of benefits from individual account pension plans that have been abandoned by their sponsoring employers. The proposed amendments would provide a process for a bankruptcy trustee to terminate the

plan, distribute benefits and pay necessary expenses in a manner that helps the bankruptcy trustee meet its fiduciary obligations. These amendments seek to extend the Abandoned Plan Regulations to plans whose sponsors are in Chapter 7 liquidation with modifications to reflect the differences between abandoned plans and Chapter 7 plans.

Generally, the amendments apply the current Abandoned Plan Regulations to Chapter 7 Plans (a plan whose sponsor is in Chapter 7). The amendments describe when a Chapter 7 plan may be considered abandoned and who may serve as a qualified termination administrator (QTA), the content requirements for the notice of abandonment that must be provided to the DOL, the procedures for winding up a Chapter 7 plan and the potential liability of bankruptcy trustees to these plans.

The DOL also proposed an amendment to class prohibited transaction exemption (PTE) 2006-06, which currently permits a QTA of an individual account plan that has been abandoned to select itself to provide services to the plan in connection with the plan's termination and to pay itself a fee for those services. The amendment to PTE 2006-06 would permit a bankruptcy trustee to qualify as a QTA under the Abandoned Plan Regulations or to appoint an eligible designee to act as QTA. An eligible designee of a bankruptcy trustee is any entity appointed by the bankruptcy trustee or QTA who is eligible to serve as a trustee or issuer of an individual retirement plan and holds assets of the plan or plans sponsored by the entity that is the subject of the Chapter 7 proceeding.

Health and Welfare Plan Developments

IRS Issues Guidance on Additional Medicare Tax

The IRS issued proposed regulations regarding the 0.9% Medicare surtax, which takes effect in 2013. The proposed regulations contain guidance for employers and individuals on the implementation of the tax, including the requirement to file a return reporting the tax, the process for employers to make adjustments of underpayments and overpayments of the tax, and the processes for employers and employees to file claims for refund for an overpayment of the tax.

The additional Medicare tax, enacted as part of PPACA, imposes an additional 0.9% tax on employees whose FICA wages, Railroad Retirement Tax Act compensation, or self employment income exceed the following thresholds: $250,000 for married taxpayers filing jointly; $125,000 for married taxpayers filing

separately; and $200,000 for other taxpayers. There is no additional Medicare tax imposed until income exceeds these thresholds and there is no additional Medicare tax liability owed by employers.

Though an employee's liability for the additional Medicare tax will depend on his or her filing status as well as compensation, an employer is required to withhold the additional Medicare tax on wages it pays in excess of $200,000 in a calendar year, regardless of the individual's filing status or wages paid by another employer. Therefore, an employee could owe more than his/her employer withholds or, in the event of an overpayment, the employee could claim a credit for any additional Medicare tax against the employee's total income tax liability. Employees may request that an employer withhold additional income tax on Form W-4 if they believe they will be subject to the additional Medicare tax but cannot designate a withheld amount specifically as additional Medicare tax. Employees cannot request an employer cease withholding the additional Medicare tax, even if the employee will not owe the tax because of his or her filing status.

IRS Issues Employer Shared Responsibility Proposed Regulations

On December 30, 2012, the IRS issued proposed regulations addressing the employer shared responsibility (pay or play) provisions in PPACA. The proposed regulations incorporate provisions of previously issued guidance and provide guidance on several additional issues.

Employers subject to shared responsibility provisions. The proposed regulations incorporate many of the provisions of Notice 2011-36, which states that an employer will be considered a "large employer" for purposes of this rule if it employs at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 employees. Employers in a controlled group are generally to be considered together to determine whether they employ at least 50 full-time employees. The proposed regulations also contain anti-abuse rules that attempt to thwart methods employers might use to manipulate employment status, such as through the use of temporary staffing agencies.

Determining full-time employees. The proposed regulations state that a "full-time" employee is one who is employed on average at least 30 hours per week. The proposed regulations also incorporate Notice 2011-36's 130-hour standard as the monthly equivalent of 30 hours per week. The proposed regulations omit Notice 2011-36's 160-hour limit on paid leave, so all periods of paid leave must be

included. Additionally, the proposed regulations codify the "look back" method for determining the number of employees.

Required coverage. The proposed regulations require employers to offer minimum essential coverage to at least 95% of full-time employees (or, if greater, five employees) and their "dependents" to avoid the penalty. An employee's "dependents" include a child who is under 26 years of age, but does not include the employee's spouse. Employers that take steps to offer dependent coverage in the 2014 plan year will not be subject to the penalty solely for failing to satisfy this requirement.

Affordability safe harbors. The proposed regulations clarify that the determination of whether coverage will be considered affordable will be based on self only coverage. Coverage will be considered affordable if the employee paid share of premiums does not exceed 9.5% of employee compensation as reported in Box 1 of Form W-2. The proposed regulations provide two additional safe harbors—one based on the rate of pay and the other based on the federal poverty line. Under the rate of pay safe harbor, if the employee's required monthly contribution for self only coverage does not exceed 9.5% of monthly wages, employer coverage would be affordable. In contrast to the W-2 safe harbor, the rate of pay safe harbor permits employers to include elective deferrals in the calculation of total monthly wages. This increase in total wages would increase the denominator used in calculating the cost of coverage as a percentage of monthly wages. Under the federal poverty line safe harbor, if the employee contribution for self only coverage does not exceed 9.5% of the federal poverty line for a single individual, the coverage would be deemed affordable for all employees.

IRS Finalizes Fee Calculation and Reporting for Patient Centered Outcomes Research Institute (PCORI) Fee

PPACA established the PCORI to assist patients, clinicians, purchasers and policy makers in making informed health decisions by advancing comparative clinical effectiveness research. The PCORI is to be funded in part by fees paid by issuers of health insurance policies and sponsors of self insured health plans. The fees apply to policy and plan years ending after October 1, 2012 and before October 1, 2019. For the first year, the fee is set at $1.00 times the average number of covered lives under the policy or plan. For subsequent years, the rate is $2.00, subject to adjustment based on increases in the projected per capita amount of National Health Expenditures. The DOL has indicated that the fee may not be paid

with plan assets.

Plans subject to fees. Generally, PCORI fees are paid on accident or health coverage, though there are exceptions for excepted benefits. The PCORI fee is imposed on the plan sponsor of a self insured plan, or the health insurer in the case of a fully insured plan, maintained for the benefit of employees, former employees (including retirees) or other eligible individuals, to provide accident or health coverage. The regulations confirm that retiree only plans are subject to the fees and that COBRA coverage must be included in calculating the fees. The regulations clarify that fees do not apply to plans (fully insured or self insured) designed to specifically cover employees who are primarily working and residing outside the United States. Additionally, the regulations added an exception for self insured and fully insured plans that provide an employee assistance program, disease management program or wellness program, if the program does not provide benefits in the nature of medical care.

Fee calculation. Self insured plan sponsors can use three methods to determine the average number of covered lives: actual count, snapshot or Form 5500. The regulations note that the Form 5500 method will not be available to sponsors whose Form 5500 is filed on an extended deadline that is later than the July 31 due date for the PCORI fee. Insurers may also use the actual count or the snapshot method for calculating the fees payable that are available to self insured plans. Insurers may also use the "members months" method or the "state form" method. The regulations include examples to illustrate the fee calculations.

Multiple arrangements. If a plan sponsor maintains accident and health coverage other than through an insurance policy and have the same plan year, the arrangements may be treated as a single plan for purposes of calculating the fee. Thus, plan sponsors of such arrangements will pay only one fee for each covered individual, even though the individual may be covered under several arrangements. However, there are situations when the same individual must be taken into account more than once in calculating the fee. This may arise when the individual is covered under both a health insurance policy and a self insured health plan. For example, if an individual is covered by both a major medical insurance policy and a self insured prescription drug program, the individual would be counted by both the insurer and the plan sponsor.

Department of Health and Human Services (HHS) Releases Proposed Regulations on Transitional Reinsurance Program Premiums

The HHS issued additional guidance on the three-year transitional reinsurance program established by PPACA to stabilize premiums for coverage in the individual market during the first three years that the state health insurance exchanges are operational (2014 through 2016). This program is funded through contributions by insurers in the individual, small and large group markets, and by self insured group health plans. HHS estimates that the annual contribution rate for 2014 will be $63 per covered life (employees and their dependents), which will likely be due in early January 2015.

HHS Guidance Addresses Methods for De-identifying HIPAA Protected Heath Information

On November 26, 2012, HHS issued guidance on two methods of de-identifying protected health information (PHI) under the HIPAA Privacy Rule. The HIPAA Privacy Rule permits covered entities or their business associates to create and use information that is not individually identifiable. Health information is not individually identifiable if it does not identify an individual and the covered entity has no reasonable basis to believe it can be used to identify an individual. The HHS guidance provides two methods by which PHI may be de-identified: the Expert Determination method or the Safe Harbor method.

Expert Determination Method. This method requires a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable to apply those principles and methods to determine that there is a very small risk that the information could be used to identify the subject of the information. The expert must document the methods and results of the analysis justifying the determination.

Safe Harbor Method. Under this method, a covered entity is protected if it does not have actual knowledge that information could be used alone or in combination with other information to identify the subject of the information. This method requires the covered entity to remove 18 specific identifiers, including the following:

- Names, telephone numbers, and social security numbers;
- Geographic subdivisions smaller than a state;
- All dates, except years, that are directly related to the individual; and

- Any unique identifying number, characteristic or code, except those otherwise permitted by the HIPAA Privacy Rule.