March 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

April 30th Deadline for Employers to Adopt Pre-Approved Defined Benefit Plans

Employers that sponsor pre-approved defined benefit plans must adopt a restated plan, approved for EGTRRA, by April 30, 2012, to be eligible for retroactive remedial amendment and reliance. The April 30, 2012 deadline also applies to employers who have: (i) individually designed defined benefit plans and (ii) signed Form 8905 (Certification of Intent to Adopt Pre-Approved Plan) prior to the end of their plan's five-year EGTRRA remedial amendment cycle.

HSA Contribution Deadline for 2011 is April 17, 2012

The deadline for making 2011 contributions to a health savings account (HSA) is April 17, 2012. Although the dollar limit on HSA contributions is determined monthly, HSA contributions for a taxable year may be made in one or more payments as long as the payments are not made before the beginning of the applicable tax year and no later than the original filing deadline (without extensions) for the individual's federal income tax return for that year.

Annual Funding Notice Deadline is April 29, 2012

All defined benefit plans must provide an annual funding notice to participants, beneficiaries, the Pension Benefit Guaranty Corporation (PBGC), labor organizations representing participants and beneficiaries and, for multiemployer plans, contributing employers. The annual funding notice must be provided within 120 days following the end of the plan year (for example, April 29, 2012, for calendar year plans). Small plans (plans with 100 or fewer participants) generally have until the Form 5500 filing deadline to provide the annual funding notice.

RETIREMENT PLAN DEVELOPMENTS

Fee Disclosure Compliance Tools

As we reported last month, the Department of Labor (DOL) issued final regulations under the Employee Retirement Income Security Act of 1974 (ERISA) section 408(b)(2) (the Regulations) providing that contracts or arrangements are not reasonable unless the service provider adequately discloses all fees and

compensation received in connection with the arrangement. The final Regulations postpone the effective date to July 1, 2012, allowing covered service providers and plans additional time to prepare for compliance. Covered service providers are required to issue the initial disclosures by July 1, 2012. Plan sponsors should be prepared to review and respond to the covered service provider disclosures. Covered service providers have the responsibility to meet the disclosure requirements, but responsible plan fiduciaries must monitor their compliance and actively report noncompliance to the DOL, or potentially be in violation of the prohibited transaction rules.

Treasury Publishes Regulations on Lifetime Income Options

On February 3, 2012, the U.S. Department of the Treasury (Treasury) and the IRS released a package of proposed regulations and rulings intended to remove impediments and otherwise ease the offering of lifetime income choices for retirees. According to an accompanying Treasury fact sheet on the new regulations and rulings, the package is intended to reduce regulatory barriers in order to increase interest in lifetime income, encourage innovation among stakeholders and expand choices for individuals with a view of promoting greater retirement security.

Determination of Value of Partial Annuities

The first new proposed regulation changes a regulatory requirement to make it simpler for defined benefit pension plans to offer participants the ability to elect to receive a portion of their retirement benefits in an annuity form while also receiving accelerated payments (i.e., a single-sum cash payment) for the remainder of the benefit. Current regulations require the use of the statutorily prescribed actuarial assumptions (interest rates and mortality assumptions) for both portions. This means that the plan is unable to use its regular conversion factors to determine the amount of the partial annuity. The proposed regulations would provide an exception to this rule in the case of a plan with a "bifurcated accrued benefit" (as defined in the proposed regulation). The statutorily prescribed actuarial assumptions would be required to apply only to the portion of the distribution being paid as a lump sum. Plans would be allowed to determine the remainder of the benefit - the partial annuity - using the plan's regular conversion factors. The primary impact of this proposed change would be to make it simpler and easier for a plan to offer an optional form of benefit that is a combination of a single-sum payment and an annuity. To provide for such bifurcated treatment, a plan sponsor would be required to amend its plan to

provide for use of the plan factors that generally apply to annuity distributions instead of the statutorily prescribed actuarial assumptions in these circumstances. A copy of this proposed regulation can be found in the Federal Register.

Longevity Annuities Contracts

Another new proposed regulation expands on the combination approach by removing a regulatory impediment to purchasing a deferred "longevity" annuity. This change would make it easier for retirees to use a limited portion of their savings to purchase guaranteed income for life starting at an advanced age, such as average life expectancy. In general, under the Internal Revenue Code's (Code) required minimum distribution rules, a qualified employer-sponsored retirement plan (a plan qualified under Code section 401(a), Code section 403(b) plans and eligible governmental section 457 plans) and traditional IRAs must begin distributions of a participant's interest soon after reaching the age of 70 1/2. Under the current regulations, defined contribution plans and IRAs determine the required minimum distribution by dividing the employee's entire account balance in the plan by the employee's life expectancy (or that of the employee and a designated beneficiary).

The proposed regulation modifies these required distribution rules in order to facilitate the purchase of deferred annuities that begin at an advanced age. Under the proposed regulation, prior to annuitization, the value of "qualified longevity annuity options" would be excluded from the account balance used to determine required minimum distributions. The proposed regulation sets forth a number of requirements an annuity must satisfy to be considered a "qualified longevity annuity contract," including the requirement that distribution commences no later than after the participant reaches age 85. A copy of this proposed regulation can be found in the Federal Register.

Spousal Protection Rules for Defined Contribution Plans with Deferred Annuity Contract Investment Options

New Revenue Ruling 2012-3 clarifies how profit sharing plans can offer participants the option to purchase deferred annuity contracts and still satisfy the spousal protection rules (the qualified joint and survivor annuity (QJSA) and the qualified preretirement survivor annuity (QPSA) rules) with minimal administrative burdens. These rules require that an employee who elects certain optional forms of benefits obtain the written, notarized consent of the participant's spouse to

that election. The new revenue ruling provides various arrangements permitting employees who are not yet ready to retire to invest their account balances in lifetime income benefits - either on a one-time basis or incrementally over a period of years - under deferred annuity contracts that will begin payments at retirement or later (including longevity annuities). The guidance identifies plan and annuity terms that will automatically protect spousal rights without requiring spousal consent before the annuity begins. When the annuity begins, the insurance company issuing the annuity would assure compliance with the spousal consent rules, thus allowing the plan to avoid being subject to such rules.

Rules for Rollovers to Purchase Annuities

For employers that sponsor both defined contribution plans and a defined benefit plan, new Revenue Ruling 2012-4 clarifies how certain qualified plan rules apply when employees are given the option to use a single-sum payout from the defined contribution plan to purchase an annuity from their employer's defined benefit pension plan. The ruling makes clear that amounts directly rolled over must be treated as mandatory contributions, and the accrued benefit derived from those amounts must be non-forfeitable. Furthermore, the ruling clarifies that the annuity must be at least "actuarially equivalent" to the amount the plan received, based on specified actuarial assumptions. These are the same assumptions that are used to convert annuity benefits to lump sums. The revenue ruling does not apply with respect to rollovers made before January 1, 2013. However, plan sponsors are permitted to rely on the holdings of the ruling with respect to rollovers made prior to that date.

PBGC Releases Policy Statement Providing for Premium Penalty Relief for Certain Delinquent Plans

On February 9, 2012, the PBGC announced a limited window for covered defined benefit plans to pay past-due premiums without penalty. PBGC's regulation on the payment of premiums requires that in addition to the unpaid premiums, a plan that has never paid premiums must pay interest and penalties. In order to encourage plan administrators of covered plans that have not paid any required premiums to come forward, PBGC has adopted a voluntary compliance program to encourage compliance. PBGC will waive premium payment penalties (as well as information penalties under ERISA section 4071 for failure to timely file premium information) for any such plan, if the plan administrator contacts the PBGC by July 31, 2012, pays past due premiums and files certain required information by August 31, 2012. This premium penalty relief does not apply to late payment

interest charges. The PBGC notes that after the end of this relief period, the PBGC will step up its efforts to enforce premium requirements for covered plans that have not paid any required premiums, including assessment of penalties.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Final Summary of Benefits and Coverage Regulations Issued

The Departments of Labor and Health and Human Services and the Internal Revenue Service (the Departments) recently issued final regulations for the summary of benefits and coverage (SBC) required under The Patient Protection and Affordable Care Act (PPACA). Additionally, the Departments issued a template for the Uniform Glossary and a revised template for the SBC. The final regulations are generally similar to the proposed regulations discussed in the September 2011 Employee Benefits Update. However, there are a few notable differences:

- The effective date has been delayed by six months. For plans that use an open enrollment period, the SBC requirement is effective the first open enrollment period beginning on or after September 23, 2012. For plans that do not use an open enrollment period, the SBC requirement is effective the first plan year beginning on or after September 23, 2012.
- Plans will not need to include the cost of coverage in the SBC.
- The SBC now includes only two coverage examples (pregnancy and diabetes management) rather than the three examples that were required under the proposed regulations.
- The Departments have clarified that the SBC can be included in a Summary Plan Description provided certain requirements are met.

Finally, the Departments revised the SBC template to make it more usable for self-funded plans (e.g., removed references to policy years, added references to the plan document, provided a more general statement of when coverage can terminate). For ease of compliance, the Departments have issued the template as a ".doc" so that plans can simply type in the necessary information. The Uniform Glossary remained mostly unchanged, though the Departments added a statement explaining that the terms described may not match what is in the plan documents.

Departments Issue New FAQs Providing New Guidance on PPACA Automatic Enrollment, 90 Day Waiting Periods and Employer Play or Pay

On February 9, 2012, the Departments issued new guidance, in the form of FAQs

(Notice 2012-17), regarding automatic enrollment, the prohibition on waiting periods exceeding 90 days and the employer shared responsibility requirements (the "Employer Play or Pay" rule).

Automatic Enrollment

Generally, PPACA requires employers with 200 or more full-time employees to automatically enroll new full-time employees. The Departments previously advised that they intended to issue guidance by 2014. Now, the Departments note that the automatic enrollment guidance will not be ready to take effect by 2014. Accordingly, until the final regulations are issued, employers will not be required to comply with the automatic enrollment requirement.

90-Day Waiting Periods

For plan years beginning on or after January 1, 2014, PPACA prohibits plans from imposing waiting periods longer than 90 days. PPACA had defined "waiting period" as the period that must pass before an individual is eligible to be covered under a plan. The Departments now intend to retain the existing definition of waiting period found in the HIPAA regulations so that the waiting period begins when an employee is otherwise eligible for coverage. Accordingly, it appears as though plans will be permitted to use an eligibility period plus an up-to-90 day waiting period. The Departments noted that eligibility conditions based solely on the lapse of a time period would be permissible for no more than 90 days. However, the Departments anticipate that upcoming guidance will provide that eligibility periods requiring an employee to complete a specified number of hours of service within a specified period (the guidance gives the example of 12 months) will be permissible provided the cumulative hours of service do not exceed a number of hours to be specified in that future guidance. The Departments also requested comments on how this approach would apply to plans that use an hours bank and plans that credit hours of service from multiple different employers.

The Departments did not directly answer whether the 90-day waiting period applies to part-time employees. However, in an example for the special rule for hours of service requirements, the Departments used a scenario where a plan covers part-time employees after they have worked 750 hours. The Departments stated that as long as any waiting period that is imposed after the part-time employee met the 750 hours requirement was no longer than 90 days, this scenario is acceptable. These statements suggest that the 90-day waiting period

requirement will apply for part-time employees. The Departments also noted that the 90-day waiting period requirement did not require employers to cover part-time employees.

Employer "Play or Pay" Rules

Generally, PPACA requires employers with 50 or more full-time equivalent employees to offer affordable health coverage to their full-time employees (and their dependents) or pay a penalty. The Departments had previously issued a request for comments on possible methods by which to determine whether an employee is a full-time employee. The FAQs indicate that the Departments intend on issuing proposed regulations or other guidance providing the following:

- Employers will be permitted to use an employee's W-2 wages in determining the affordability of employer coverage.
- Employers will be able to use a "look-back/stability period safe harbor" to determine whether a current employee is a full-time employee. The Departments anticipate that the look-back and stability periods will be up to 12 months.
- If a newly hired employee is reasonably expected to work full-time and does work full-time during the first three months of employment, the employer must offer the employee coverage at the end of those three months.
- If an employer cannot reasonably determine whether a newly hired employee is expected to work full-time, the employer will have a three-month period in which to determine the employee's status:
  - If the employee works full-time during the first three months of employment and the employee's hours are reasonably viewed as representative of the average hours the employee will work annually, the employee must be considered a full-time employee. The employer will not suffer a penalty for failing to offer coverage during that initial three-month period.
  - If the employee works full-time during the first three months of employment but the employee's hours are not reasonably viewed as representative of the average hours the employee is expected to work annually, the plan can use an additional three-month period to determine the employee's status. The employer will not suffer a penalty during either three-month period.

Final ERRP Reimbursement Processing

The Centers for Medicare & Medicaid Services (CMS) recently issued an update on Early Retiree Reinsurance Program (ERRP) payment processing. As of February 17, 2012, ERRP has disbursed nearly $4.8 billion and the remainder of the $5 billion is

committed for reimbursements already in process and program administration costs. Accordingly, CMS will begin paying reimbursement requests in accordance with the process it previously established to disburse remaining ERRP funds. CMS also advised that it expects plan sponsors to use any ERRP reimbursement funds as soon as possible, but in no event later than December 31, 2014.

Reinhart Comment: CMS did not provide any indication of how it will track whether a plan sponsor has used the funds by that date. Presumably, this information would be reported in a second round of surveys sent to plan sponsors.

HHS Proposed Method of Defining "Essential Health Benefits" Under PPACA

Health and Human Services (HHS) has issued an informational bulletin describing its proposed method for defining what benefits are included in the categories of essential health benefits established by PPACA. While much of the guidance is directed at how each state will choose its benchmark plan, the guidance includes some information useful for plan sponsors, which is summarized below:

Self-Insured Plans

- The Departments confirmed that self-insured plans are permitted to impose non-dollar limits (e.g., limits on the number of visits or treatments) on essential health benefits provided they comply with other applicable statutory provisions. The Departments also reiterated that self-insured plans may impose annual and lifetime dollar limits on benefits that are not essential health benefits.
- The Departments will consider a self-insured plan to have used a "permissible definition" of essential health benefits if the definition is one "authorized by the Secretary of HHS (including any available benchmark option)." Additionally, HHS notes that the Departments intend to use their enforcement discretion to work with plans that make a good faith effort to apply an "authorized definition" of essential health benefits.

Reinhart Comment: The guidance does not indicate what constitutes a "permissible" or "authorized" definition of essential health benefits. It is unclear whether self-insured plans can continue using the definition of essential health benefits used since the annual and lifetime limits prohibition went into effect, or must follow a benchmark plan. If self-insured plans must follow a benchmark plan, it is unclear whether they can select their own benchmark plan or whether they must follow the benchmark plan chosen by the state (and, if so, which state).

Plans Offering Coverage in Multiple States

Non-grandfathered insured small group market plans that offer coverage to employees in multiple states will be subject to the benchmark plan in the state in which the policy was issued. Grandfathered insured health plans and large-group market coverage will follow the applicable annual and lifetime limits rule (i.e., the rule noted in the second bullet point under Self-Insured Plans, above). The guidance does not indicate what self-insured plans should do in such instance. Presumably, such plans would also follow the applicable annual and lifetime limits rule noted above.

Scope of Benefits (for plans required to offer essential health benefits - i.e. nongrandfathered insured small group market plans)

- A plan can substitute coverage of services within each of the essential health benefit categories as long as the substitutions are actuarially equivalent, based on the standards in the CHIP regulations, and provided that the substitutions do not violate other statutory provisions. HHS notes that the benchmark plan provides a "frame of reference" for the essential health benefit categories.
- A plan must provide benefits that are "substantially equal" in scope and duration to the benchmark plan.
- All benchmark plans will include the preventive health services noted in PPACA (i.e., the preventive health services that non-grandfathered plans must cover without cost-sharing) and will comply with the parity requirements of the Mental Health Parity and Addiction Equity Act.

State Requirements

States must select their benchmark plans in the third quarter of 2012. The benchmark plan will apply for plan years 2014 and 2015. HHS will establish a process for updating the benchmark plans and will revisit this entire approach for plan years starting in 2016.

GENERAL DEVELOPMENTS

U.S. House of Representatives Vote to Repeal CLASS Program

On February 1, 2012, the U.S. House of Representatives voted to repeal the Community Living Assistance Services and Supports (CLASS) Program, a measure included as part of PPACA. The law was designed to establish a voluntary, national insurance program for American workers to help pay for long-term services and supports they may need in the future. In October of 2011, the Secretary of Health

and Human Services had announced that HHS was suspending the implementation of the CLASS program as her department had been unable to find a way to make the program self-sustaining, financially sound for 75 years and affordable to consumers."