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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Congress Passes Tax Bill to Avert Fiscal Cliff; Includes Roth Conversions, Other Employee Benefit Provisions

The U.S. Senate and House of Representatives have approved and President Obama has signed into law the American Taxpayer Relief Act of 2012 (H.R. 8). (An official summary is also available.)

As has been widely reported, the measure permanently extends ordinary income tax rates for individuals earning less than $400,000 per year (and joint filers earning less than $450,000 per year) and alters capital gains and dividend rates, the estate tax and the Alternative Minimum Tax, while delaying the effective date for automatic "sequestration" spending cuts until March 1.

Most notably for employee benefit plan sponsors, H.R. 8 includes – as a revenue-raising offset provision – a modification to the rules associated with "Roth" conversions within participating defined contribution plans such as 401(k), 403(b) and 457 plans. While current law permits certain participants (i.e., age 59½ or older or after separation from service) to convert distributable pre-tax plan assets to after-tax savings in a separate Roth account within the plan, the new measure effectively eliminates the "distributable" requirement, allowing any pre-tax amount to be converted as long as the plan includes a Roth conversion program and taxes are paid on the converted amount.

H.R. 8 also includes a number of provisions addressing certain "fringe" employee benefits:

- An increase in the pre-tax allowance for mass transit expenses from $125 to $240 (making it equal to the benefit provided for parking) was provided through the end of 2013. This extension, which expired at the end of 2011, is also retroactive to January 1, 2012.
- The increased adoption tax credit and employer adoption assistance programs exclusion, for which employers may exclude up to $10,000 from income taxation, was permanently extended for taxable years beginning after December 31, 2012.
- The tax exclusion for employer-provided educational assistance, under which an employee may exclude from gross income up to $5,250 per year (attributable to undergraduate and graduate education expenses) was permanently extended for academic courses beginning after December 31, 2012.
- The provision permitting eligible employees (age 70½ or older) to make tax-free distributions from an Individual Retirement Arrangement (IRA) to charity (up to $100,000 per year) is temporarily extended for two years
- The bill formally repeals the Community Living Assistance Services and Supports (CLASS) program, the voluntary, federally administered long-term care insurance program established under the Patient Protection and Affordable Care Act (PPACA), and institutes a "Commission on Long-Term Care" that would develop a new comprehensive long-term care plan and possibly make formal recommendations to Congress. The Obama Administration had already suspended implementation of the CLASS program, citing the same concerns about fiscal sustainability.

Lawmakers did not incorporate any tax deduction or exclusion limitations applicable to employee health or retirement benefit plans, as was a possibility under previous legislative proposals.

However, the imminent need to increase the federal debt limit and expiration of the federal government's funding resolution sets up another critical deadline for long-term deficit reduction legislation that may yet include provisions to limit tax incentives for the provision of (and participation in) employee benefit plans.

GAO Report on Tax Expenditures References Health, Retirement Benefit Incentives

On January 8, the Government Accountability Office (GAO) issued a report, Tax Expenditures: Background and Evaluation Criteria and Questions, a "guide" describing criteria for assessing tax expenditures and judging their effectiveness.

Evaluations of this nature will be increasingly important over the coming months, as Congress considers short-term legislation to generate revenue – perhaps to avert spending cuts postponed as part of the recent "fiscal cliff" deal – as well as a more extensive debate over comprehensive tax reform legislation as sought by lawmakers on both sides of the aisle.

The report's listed examples of "tax expenditures" includes exclusions from taxable income (such as the current exclusion of employer-paid health care premium contributions) and deferrals (such as pre-tax contributions to defined contribution arrangements), as well as exemptions, deductions, credits and preferential tax rates. According to the Office of Management and Budget's most recent budget proposal, health and retirement plan contribution incentives respectively constitute the first- and second-largest expenditures in the federal budget.

One of the key questions asked by the report is, "does the tax expenditure generate net benefits in the form of efficiency gains for society as a whole?"

Congress has already begun contemplating modifications to the tax treatment of incentives for sponsorship of (and participation in) employee benefit plans, such as a cap on individual deductions and exclusions or a limit on the excludability of contributions for individuals over a certain income threshold.

New Harkin Health Bill Includes Wellness Program Incentives

A measure introduced on January 22 by Senator Tom Harkin (D-IA), chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee, includes incentives to companies for instituting workplace wellness programs.

According to a summary and news release announcing its introduction, the Healthier Lifestyles and Prevention America (HeLP America) Act (S. 39) "outlines critical public health and prevention initiatives to fight chronic disease, encourage healthier schools, communities and workplaces, and improve physical activity opportunities for individuals with disabilities." Harkin has introduced the bill three times before – in 2009, 2010 and 2011 – in generally the same form. An official summary is also now available.

Title II of S. 39, entitled "Healthier Communities and Workforces," provides for a tax credit of "50 percent of the costs paid or incurred by the employer in connection with a qualified wellness program during the taxable year" (up to $200 per employee for the first 200 employees and

$100 per employee in excess of 200 employees). The provision also sets forth the criteria for a "qualified wellness program," including a "health awareness" component, an "employee engagement" component, a "behavioral change" component and a "supportive environment" component.

The measure would also allow employers to deduct the cost of athletic facility memberships for their employees, up to $900 per employee annually, and exempts this benefit as taxable income for employees.

The measure has been referred to the Senate Finance Committee, which has jurisdiction over tax matters.

RECENT REGULATORY ACTIVITY

PPACA Employer 'Shared Responsibility' Proposed Regulations: Summary & Analysis

The U.S. Treasury Department and Internal Revenue Service (IRS) recently issued proposed regulations implementing the "Employer Shared Responsibility" provisions for employers under Section 4980H of the Internal Revenue Code, as amended by the Patient Protection and Affordable Care Act (PPACA). In conjunction with the proposed regulations, Treasury simultaneously issued a set of 23 Questions and Answers (Q&A).

Generally, the employer shared responsibility provisions require employers to offer "affordable," minimum-value health coverage to their "full-time employees" or pay a penalty, triggered when at least one full-time employee receives a premium tax credit to purchase coverage through a health insurance exchange. As has been established in prior regulations and elaborated upon in the proposed regulations, employers with 50 or more full-time employees (or with a combination of full-time and part-time employees equivalent to 50 full-time employees) are subject to these rules. ("Full-time" has been defined as at least 30 hours per week.)

The Section 4980H shared responsibility provisions are effective for months beginning after December 31, 2013. The proposed regulations include transition relief for fiscal-year (i.e., non-calendar year) plans, as well as other transition rules as noted below. The preamble to the rulemaking states that employers may rely on these proposed regulations for guidance pending the issuance of final regulations or other applicable guidance. It further states that, to the extent future guidance is more restrictive, it will not apply retroactively and employers will be provided with sufficient time to come into compliance with final regulations.

Most notably, the proposed regulations clarify:

- Whether an employer is an "applicable large employer" (and thus subject to Code Section 4980H) is determined across an employer's controlled group.
- The determination of assessable payments and penalties under Code section 4980H does not apply on a controlled group basis, but applies on a company-by-company basis.
- The requirement to offer minimum essential coverage under Code section 4980H(a) applies not only to an applicable large employer's full-time employee, but also the full-time employee's children (within the meaning of Code section 152(f)(1)) up to age 26.

- For purposes of Code section 4980H(b), whether a full-time employee's coverage is affordable is determined by reference to the employee's cost for self-only coverage. Thus, coverage other than self-only coverage need not be affordable to avoid Code section 4980H penalties.
- Three special safe harbors are provided for use by employers in measuring the affordability of employee coverage: the W-2 Safe Harbor, the Rate of Pay Safe Harbor, and the Federal Poverty Line Safe Harbor.
- Proposed rules are provided regarding break in service and change in employment status/position for purposes of applying the measurement and stability period rules in determining full-time employee status.
- Special transition rules, including:
    - For qualifying employers with non-calendar year plans, such employers will not be subject to penalties under Code section 4980H until the first day of the 2014 plan year.
    - Employers may use a 12-month stability period in 2014 so long as they use a transition measurement period that is at least six months long, commences no later than July 1, 2013, and ends no earlier than 90 days before the start of the 2014 plan year.
    - For 2014, an employer will not be subject to penalty under Code section 4980H(a) in 2014 for failing to offer child coverage if it takes steps in 2014 toward complying with this requirement.
    - Beginning in 2015, an employer will be required to assume that, although an employee's hours of service might be expected to vary, the employee will continue to be employed for the full duration of the initial measurement period. Thus, the employer cannot take into consideration the likelihood that the employee's employment will terminate in advance of the end of the initial measurement period in determining whether he or she is a full-time employee. Notwithstanding the transition relief, for purposes of 2014 and beyond, an employer may not consider aggregate employee turnover in determining whether any given employee is a full-time employee.

A comprehensive summary of the proposed regulations, prepared by Crowell & Moring, is attached.

Comments on the proposed regulations are due March 18, 2013. A public hearing to discuss the proposed regulations will be held on April 23, 2013; requests to speak at the hearing and an outline of those remarks are due to IRS by April 3, 2013.

HHS Finalizes HIPAA Privacy Regulations Under HITECH Act, GINA

The U.S. Department of Health and Human Services has released final regulations modifying the HIPAA privacy, security, enforcement, and breach notification rules to correspond with the Health Information Technology for Economic and Clinical Health (HITECH) Act and Title I of the Genetic Information Nondiscrimination Act (GINA).

The HITECH Act, passed as part of the American Recovery and Reinvestment Act of 2009, requires covered entities and business associates to account for certain disclosures of protected health information (PHI) to carry out treatment, payment, and health care operations if such disclosures are "through an electronic health record." Under HITECH, an individual has a right to an accounting of such disclosures made during the three years prior to the request.

Title I of GINA, enacted in 2008, prohibits employer-sponsored group health plans and health insurers providing group and individual health insurance from restricting enrollment or adjusting premiums based on genetic information or requiring or requesting genetic testing.

The final regulations are intended to strengthen the existing privacy and security protections codified under HIPAA in 1996 for individual's health information maintained in electronic health records and other formats. Specifically, the final regulations are comprised of the four separate final rules:

1. Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the HITECH Act, Health Information Technology for Economic and Clinical Health (HITECH) Act, including:
    - making business associates of covered entities directly liable for compliance with certain requirements;
    - strengthening the limitations on the use and disclosure of PHI for marketing and fundraising purposes and prohibiting the sale of PHI without individual authorization;
    - expanding individuals' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full;
    - requiring modifications to, and redistribution of, a covered entity's notice of privacy practices;
    - modifying the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools and to enable access to decedent information by family members or others; and
    - adopting additional HITECH Act enhancements to the enforcement rule not previously adopted in the October 30, 2009, interim final rule, such as the provisions addressing enforcement of noncompliance with the HIPAA rules due to willful neglect.

    Proposed regulations on these provisions were issued on July 14, 2010.

2. A final rule adopting changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act, originally published as an interim final rule on October 30, 2009.
3. A final rule on Breach Notification for Unsecured Protected Health Information under the HITECH Act, which replaces the breach notification rule's "harm" threshold with a more objective standard and supplants an interim final rule published on August 24, 2009.
4. A final rule modifying the HIPAA Privacy Rule, as required by GINA, to prohibit most health plans from using or disclosing genetic information for underwriting purposes, which was published as a proposed rule on October 7, 2009.

The newly released final regulations are effective on March 26, 2013. Covered entities and business associates must comply with the applicable requirements of this final rule by September 23, 2013.

The final regulations do not address the accounting for disclosures requirement in Section 13405 of the HITECH Act, which is the subject of separate proposed regulations published on May 31, 2011 or the penalty distribution methodology requirement in Section 13410(c) of the HITECH Act, which will be the subject of a future rulemaking.

IRS Issues Final Regulations Addressing PPACA Premium Tax Credit for Individuals Related to Enrollees

The Internal Revenue Service (IRS) issued **final regulations** on January 30 addressing the application of the Patient Protection and Affordable Care Act (PPACA) Health Insurance Premium Tax Credit to relatives of eligible enrollees in qualified health plans within health insurance exchanges.

Section 1401 of PPACA amended the Internal Revenue Code to add Section 36B, allowing a refundable premium tax credit to help individuals and families afford health insurance coverage by reducing a taxpayer's out-of-pocket premium cost. Health insurance exchanges will determine whether an individual meets the income and other requirements for advance credit payments (based in part on the affordability of employer-sponsored coverage) and the amount of the advance payments.

The final regulations issued January 30 explains how the IRS will determine whether individuals who may enroll in an employer-sponsored health plan because of their relationship to an eligible employee (a related individual) have "affordable" coverage and under what circumstances they may be eligible to receive the premium tax credit. These matters were left unsettled by prior final regulations addressing the premium tax credit, issued in May 2012.

Ultimately, the IRS adopted the position taken in the proposed rules, that "an eligible employer-sponsored plan is considered "affordable" for related individuals if the portion of the annual premium the employee must pay for self-only coverage (the required contribution percentage) does not exceed 9.5% of the taxpayer's household income.", The final regulations therefore clarify that the affordability standard for employer-sponsored coverage is determined by the availability of affordable *self-only* coverage, not family coverage and individuals with unaffordable family coverage will not be eligible for premium tax credits in the health insurance exchange.

HHS, IRS Propose Regulations Governing Individual Mandate, Minimum Essential Coverage

In proposed regulations released on January 30, federal agencies provided initial guidance on the "shared responsibility" provisions related to the individual mandate to obtain "minimum essential coverage" under the Patient Protection and Affordable Care Act (PPACA).

Section 1501(b) of PPACA added Section 5000A to a new Chapter 48 of Subtitle D of the Internal Revenue Code, effective for months beginning after December 31, 2013, requiring nonexempt individuals to maintain "minimum essential coverage" for themselves and any dependents or make a "shared responsibility payment" with their federal income tax return.

The newly **proposed regulations** issued by the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) set forth standards and processes under which the exchange will conduct eligibility determinations for and grant exemptions from the shared responsibility payment.

These proposed regulations also provide standards for determining whether certain other types of coverage constitute minimum essential coverage and procedures that plan sponsors must

follow for a plan to be identified as minimum essential coverage under Section 5000A. Such eligible coverage includes: Self-funded student health insurance plans, foreign health coverage, refugee medical assistance supported by the Administration for Children and Families, Medicare advantage plans and AmeriCorps coverage. The proposed rule outlines a process in which other types of coverage could seek to be recognized as minimum essential coverage, though employment-based coverage would not be recognized as minimum essential coverage through this proposed process.

Comments on the HHS-CMS proposed regulations will be accepted through Monday, March 18.

Separately, the Internal Revenue Service (IRS) issued a **notice of proposed rulemaking (NPRM)** providing detailed guidance on an individual's liability for the shared responsibility payment for not maintaining minimum essential coverage. These proposed regulations address eligibility, exempt individuals, calculation of the payment and a definition of "minimum essential coverage." This definition of "minimum essential coverage" explicitly includes employer-sponsored coverage (including COBRA coverage and retiree coverage), as well as:

- Coverage purchased in the individual market;
- Medicare Part A coverage;
- Medicaid coverage;
- Children's Health Insurance Program (CHIP) coverage;
- Certain types of Veterans health coverage; and
- TRICARE.

The NPRM also announces a public hearing on this topic, scheduled for May 29. Comments on the NPRM will be accepted through May 2.

The regulatory agencies also issued **a brief fact sheet** and a **questions and answers document** in support of the release.

PPACA FAQs Provide Guidance on Exchange Notice, HRA Coordination, Medicare Part D

On January 24, the U.S. Departments of Labor (DOL), Health and Human Services (HHS) and Treasury released Part XI of their ongoing Frequently Asked Questions (FAQ) series, providing guidance on outstanding Patient Protection and Affordable Care Act (PPACA) implementation issues.

The latest release covers a number of topics with implications for employer sponsors of health coverage. Most significantly, the guidance confirms a delay of the March 1, 2013, deadline for compliance with an employer notice requirement regarding health exchanges and other related information.

Section 18B of the Fair Labor Standards Act (FLSA), as added by Section 1512 of PPACA, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), a written notice providing information on (1) the availability of coverage in state- or federally-based health insurance exchanges, (2) eligibility for a premium tax credit toward the purchase of coverage and (3) the applicable employer contribution toward coverage.

The agencies concluded that the notice requirement should not take effect March 1, 2013 for several reasons, including the need to coordinate with HHS's educational efforts and Internal Revenue Service (IRS) guidance on minimum value. While the guidance does not provide a specific new deadline, DOL expects "the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for exchanges." The guidance further states that "future guidance on complying with the notice requirement under FLSA Section 18B is expected to provide flexibility and adequate time to comply." DOL is considering a number of options to satisfy the notice requirement, including model generic language or allowing employers to use the employer coverage template that will soon be available as discussed in the preamble to recent proposed regulations.

The FAQs also clarify issues related to HRAs, including when an HRA will be considered integrated with other coverage as part of a group health plan. The FAQs also explain when an HRA will satisfy the lifetime and annual dollar limit requirements under Section 2711 of the ACA and the treatment of amounts made available under HRAs that were in effect prior to January 1, 2014.

In addition, the new FAQ guidance also addresses:

- circumstances under which fixed indemnity coverage constitutes excepted benefits;
- compliance by self-insured employer prescription drug coverage under Medicare Part D with the health coverage requirements under the Affordable Care Act when drug coverage is provided through Employer Group Waiver Plans (EGWPs);
- the use of plan assets to pay Patient-Centered Outcomes Research Institute (PCORI) fees.

New Proposed Health Care Regulations Address Exchanges, CHIP

On January 14, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) issued proposed regulations addressing a variety of statutory provisions related to the Medicaid program and Affordable Insurance Exchanges, as enacted under the Patient Protection and Affordable Care Act (PPACA), and the Children's Health Insurance Program (CHIP), as modified by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

The regulations aim to provide states with substantial discretion in the design and operation of a health exchange, including greater standardization and coordination in the subsidy application process (for low- and moderate-income individuals) with Medicaid and CHIP.

Eligibility for subsidized coverage within an exchange is limited to individuals whose household income is 100 percent to 400 percent of the federal poverty level and who do not have access to affordable employer-sponsored coverage (defined as coverage that costs more than 9.5 percent of household income). The proposed regulations require individuals who apply for coverage through an exchange to disclose their access to employer-sponsored insurance.

In April 2012, HHS issued a bulletin, Verification of Access to Employer-Sponsored Coverage, requesting public comment on a proposed interim strategy and regulatory approach for verification of access to qualifying coverage. In this bulletin, HHS proposes to allow exchanges to verify employer-sponsored coverage for this interim period through use of limited pre-enrollment verification based on data sources available to an exchange and a post-enrollment

verification screening process where data sources are not available during the eligibility determination process.

The CMS comment period on the proposed regulations ended February 13, but HHS continues to accept comments on the April 2012 bulletin.

DOL/EBSA Request Comments on Upcoming Survey Project on Retirement Benefit Statements

The U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA), in a January 18 information collection request (ICR), has announced the development of a forthcoming survey project on the subject of retirement accounts generally and benefit statements in particular. The agency is soliciting public comments on the project through March 25, 2013.

As stated in the ICR, "Topics probed in the survey include participants' current allocations to their retirement accounts, their expectations for how long they will need to keep working, their financial goals for retirement, the basis for calculating those goals, how frequently they view their current benefits statement, whether they receive benefit statements in paper or electronic format, and what information from the statements do they primarily focus on. Survey participants will then be provided with two different benefits statements that provide slightly different information and will be asked to answer several questions based on those statements to better assess what they understand about the statements."

The Pension Protection Act of 2006 (PPA) requires ERISA plans to provide participants and certain beneficiaries with individual pension benefit statements. Generally, defined benefit plans must provide the statement every three years (with an annual notice alternative) while defined contribution plans that permit participant direction must provide the statement quarterly. Individual account plans that do not permit participant direction must provide the statement annually.

According to the most recent DOL semi-annual agenda, EBSA is soon expected to release an "advance notice of proposed rulemaking" (ANPRM) that will explore "whether, and how, an individual benefit statement should and could present a participant's accrued benefits in a defined contribution plan (i.e., the individual's account balance) as a lifetime income stream of payments in addition to presenting the benefits as an account balance." It is now expected that the benefit statement requirement itself may be at least temporarily decoupled from the lifetime income disclosure project. In the meantime, DOL issued Field Assistance Bulletin (FAB) 2012-02 in May 2012, providing interim guidance on the form and content of required disclosures.

The ICR also suggests that EBSA may, in developing benefits statement guidance, use this survey to revisit its approach to electronic disclosure of benefit statements. Currently, under DOL Field Assistance Bulletin (FAB) 2006-3, the DOL permits benefit statements to be provided in a very efficient manner, i.e., very generally by making the benefit statements available on a secure website. The FAB 2006-3 rule is much less restrictive than the generally applicable DOL rule on electronic delivery, which very generally permits electronic delivery only if (1) the participant has consented to electronic delivery, or (2) the use of electronic media is an integral part of the participant's job with the plan sponsor.

President's Gun Violence Reduction Proposal Includes Finalization of Mental Health Parity Rules

On January 16, President Obama unveiled a four-point plan to reduce gun violence, developed in response to a recent spate of mass shootings. The plan encompasses various legislative, regulatory and executive actions that the White House will pursue in the coming months.

The fourth point of the president's plan is "increasing access to mental health services." Among the elements proposed is the finalization "next month" of regulations under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Enacted in 2008, the MHPAEA prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or quantitative treatment limitations (such as a limit on the number of outpatient visits or inpatient days covered) that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits.

The U.S. Departments of Labor, Health and Human Services and Treasury released interim final regulations implementing MHPAEA in February 2010. Subsequent guidance has been provided in the form of Frequently Asked Questions:

- Part V FAQs specified small employer exemptions from the law, clarified criteria for medical necessity determinations and provided an interim enforcement safe harbor.
- Part VII FAQs that partially addressed the permissibility of certain non-quantitative treatment limitations imposed by plans.

The President's proposal also notes that the Patient Protection and Affordable Care Act (PPACA) requires all new small group and individual plans to cover ten essential health benefit categories, including mental health and substance abuse services, with a rule defining those essential benefits to be issued next month as well.

PBGC Issues Premium Filing Instructions for 2013

The Pension Benefit Guaranty Corporation (PBGC) has posted the official instructions for the filing of defined benefit plan insurance premium payments for the 2013 plan year.

The "What's New" section of the instructions notes the key changes pursuant to the Moving Ahead for Progress in the 21st Century Act (MAP-21), which increased flat-rate premium amounts for defined benefit plan sponsors (to $42 per participant for single-employer plans and to $12 per participant for multiemployer plans) and temporarily modified the funding rules to stabilize the effect of volatile discount interest rates.

Filings for the 2013 plan year may be made electronically through the My Plan Administration Account (My PAA) system.

IRS Provides Guidance on Transportation Fringe Benefit Parity Extension

The Internal Revenue Service (IRS) has issued guidance on the application of the retroactive increase in excludible transit benefits, as enacted under the American Taxpayer Relief Act of 2012 (H.R. 8) (See earlier story, Page 1).

H.R. 8 provided for increase in the pre-tax allowance for mass transit expenses, making it equal to the benefit provided for parking, through the end of 2013. This extension, which expired at the end of 2011, is also retroactive to January 1, 2012.

IRS Notice 2013-08 clarifies how the increase applies for 2012 and provides a special administrative procedure for employers to use in filing various tax forms to reflect the change.

PBGC Renews Reportable Events Guidance

On January 30, the Pension Benefit Guaranty Corporation (PBGC) issued Technical Update 13-1, guidance addressing the "reportable events" requirements of ERISA Section 4043 and PBGC's proposed regulations modifying these requirements. The issuance effectively extends Technical Update 11-1, issued in December 2011, to apply to the 2013 plan year and thereafter. The guidance addresses (1) funding-related determinations for purposes of waivers, extensions, and the advance reporting threshold test; and (2) missed quarterly contributions.

The PBGC published the proposed regulations to reflect changes resulting from the Pension Protection Act of 2006 (PPA) and eliminate most automatic waivers and filing extensions provided under the prior reportable events regulations. Because PBGC has not yet issued a final rule, the interim guidance is necessary.

EBSA Issues Modifications to Delinquent Filer Voluntary Compliance Program

On January 28, the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) released a notice describing changes to the Delinquent Filer Voluntary Compliance (DFVC) Program related to ERISA plan reporting requirements.

Administrators of employee benefit plans subject to Title I of ERISA who fail to file annual reports on a timely basis can be subject to civil penalties. The DFVC Program, adopted in 1995 and most recently updated in 2002, is intended to encourage delinquent plan administrators to comply with their annual reporting obligations under ERISA by reducing these penalties.

The updated notice incorporates program changes that have been made since the 2002 notice. Most recently, the DFVC Program website was updated to reflect DOL's final regulation mandating electronic filing of annual reports as part of the implementation of a wholly electronic ERISA Filing Acceptance System (EFAST2) for those reports. This notice also describes an existing online penalty calculator and Internet-based payment system for the DFVC Program.

IRS Updates EPCRS Correction Program

On December 31, 2012, the Internal Revenue Service (IRS) issued Revenue Procedure 2013-12, substantially updating the Employee Plans Compliance Resolution System (EPCRS) — a

voluntary correction program through which retirement plan sponsors can fix inadvertent errors without any loss of qualified plan status.

Notable changes to the program include:

- a much more comprehensive correction program for 403(b) plans, including the ability to correct plan document errors;
- corrections for a failure to meet the benefit restrictions for underfunded defined benefit plans under Internal Revenue Code Section 436;
- increased leeway for non-governmental 457(b) plans to use EPCRS-like corrections
- new forms (Form 8950 and Form 8951) for processing Voluntary Correction Program (VCP) submissions, to be used for submissions on or after April 1, 2013; and
- revised procedures for correcting a situation in which individuals are mistakenly excluded from the opportunity to defer to a 401(k) plan, including a safe harbor plan.

The IRS also requests comments on the EPCRS approach to automatic enrollment features and designated Roth contributions. (The American Taxpayer Relief Act, as described in the story above, includes a new Roth conversion provision that could ease the correction of related errors.)

RECENT JUDICIAL ACTIVITY – Nothing to Report This Month