LEGISLATIVE AND REGULATORY UPDATE

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DOL steps up enforcement activity, including health care reform compliance: Group health plans may want to prepare for stepped-up enforcement activity by the US Department of Labor (DOL), which has already sent some employers updated audit letters requesting various plan materials. These requests indicate that DOL compliance audits have expanded, targeting not only ERISA, the Health Insurance Portability and Accountability Act (HIPAA) and other long-standing laws, but also reforms required by the Affordable Care Act (ACA). While employers can't anticipate whether or when a DOL audit may occur, they can take steps to make the process and outcome of a health plan audit as painless as possible. This article reviews the scope of DOL's audit requests, provides background on the underlying legal requirements, and suggests ways to prepare for DOL group health plan audits.

DOL audits target old and new requirements

Recent US Department of Labor (DOL) compliance audits of group health plans focus not only on ERISA, the Health Insurance Portability and Accountability Act (HIPAA), and related laws, but also on the new eligibility, benefit, cost-sharing and operational requirements of the Affordable Care Act (ACA). In addition, DOL's updated self-compliance tool for group health plans, while omitting ACA-related questions, now covers two recently enacted or expanded laws: the Genetic Information Nondiscrimination Act (GINA) and the Mental Health Parity and Addiction Equity Act (MHPAEA).

This expanded scope of enforcement activity is evident in the document requests accompanying DOL's audit letters to group health plan sponsors. The multitude of materials sought include information on the plan's benefits; disclosures and notices; written procedures; and various records and documents demonstrating compliance with ERISA, HIPAA portability and related laws, and the ACA. Charts (below) identify DOL's requested documents and related materials that employers should have ready to show compliance with these laws and provide background information on each requirement. The remainder of this article covers what to expect if DOL's audit turns up a compliance failure and outlines steps employer can take to inventory, assemble and maintain supporting documentation in advance of an audit.

ERISA, HIPAA and related laws

The chart on the next page lists the types of documents DOL requests to assess a health plan's compliance with long-standing ERISA, HIPAA and related laws. The last column gives background information these requirements.

Requirement	DOL-requested and related items	Additional information
ERISA plan documents, summary plan descriptions (SPDs) and related materials	• Plan documents that are consistent with each other and provide required information for participants, such as: o Available benefits o Eligibility terms o Various mandated notices • Materials outlining employer and employee costs for plan coverage	Every employee benefit plan subject to ERISA must have a written plan document and an SPD containing specified provisions.
Contracts	Insured plans: • Group health policies and service contracts for insured plans Self-insured plans: • Administrative-services-only agreements and stop-loss contracts	Sponsors must maintain records showing plan administration complies with plan document.
HIPAA creditable coverage certificates	• Sample certificates of creditable coverage • Written procedures for individuals to ask for certificates • Records about individuals who lost coverage under the plan or requested certificates	Group health plans must provide creditable coverage notices to covered individuals upon loss of coverage (or on request after loss of coverage).
Special enrollment notices	• Sample special enrollment notices • Written procedures for special enrollment	Employees must receive notice of their 30-day right to special enrollment for HIPAA-specified reasons and 60-day right to special enrollment after losing Medicaid or CHIP coverage or becoming eligible for premium assistance for the first time.
Wellness benefit details	• Materials describing any wellness programs offered that reward an individual's ability to meet a health standard • Records showing a reasonable alternative for earning wellness reward is available	Wellness programs can be subject to several different laws, including HIPAA, the Americans with Disabilities Act and GINA.

Requirement	DOL-requested and related items	Additional information
Mental health and substance abuse treatment parity	• Materials explaining mental health and substance abuse benefits • Record of methodology used to determine parity compliance	MHPAEA requires group health plans offering mental health coverage to provide parity between medical/surgical benefits and mental health/substance abuse benefits. Complicated parity rules cover financial requirements (such as cost sharing), quantitative treatment limits and nonquantitative treatment limits.
Newborns' and Mothers' Health Protection Act (NMHPA) coverage and notices Women's Health and Cancer Rights Act (WHCRA) coverage and notices	• Sample notices • SPDs and other documents describing plan benefits	Under these laws' notice and benefit requirements, group health plans must cover hospital stays of at least 48 to 96 hours after childbirth and reconstructive surgery after a mastectomy.
Pre-existing condition exclusion notices and records	• Sample general and specialized notices • Lists of notice recipients • Written procedures • Records related to imposition of pre-existing condition exclusions	Plans that exclude or limit plan benefits for pre-existing conditions for enrollees over age 19 must provide covered individuals a general notice describing each exclusion and how prior creditable coverage could reduce the period of exclusion. Anyone subject to a pre-existing condition exclusion must receive a personalized notice. Plans must eliminate pre-existing condition exclusions for plan years starting on or after Jan. 1, 2014.

ACA's health care reforms

The following chart shows the types of group health plan materials requested in DOL audit letters to demonstrate compliance with various ACA eligibility, benefit, cost-sharing and operational requirements. The last column provides background information on each provision. ACA requirements for all plans are listed first, followed by requirements that only apply to nongrandfathered plans.

Requirement	DOL-requested and related items	Additional information
All plans		
Adult dependents	• Sample of the written notice of initial opportunity to enroll children up to age 26 in dependent coverage	Plans that offer dependent child coverage generally had to provide this notice for the first plan year starting on or after Sept. 23, 2010. Certain exemptions apply until 2014 for grandfathered plans.

Requirement	DOL-requested and related items	Additional information
Rescissions limited to specific situations	• Sample notice of rescission • List of participants and beneficiaries whose coverage was rescinded • Documentation of reason for rescission • Copy of the written notice sent before rescission took effect	Plans may rescind coverage only in certain situations and must provide at least 30 days' advance notice.
Lifetime and annual dollar limit restrictions	For plans imposing lifetime or annual dollar limits since Sept. 23, 2010: • Documentation of the limits applicable for each plan year • Any notice of an annual limit waiver For plans that lifted lifetime dollar limits: • Sample notice informing affected participants and beneficiaries that the lifetime dollar limit no longer applies and otherwise-eligible individuals can re-enroll	Lifetime dollar limits on essential health benefits are now banned, and annual dollar limits on those benefits are being phased out.
Grandfathered plan status documentation	• Notice of grandfather status (if applicable) • SPDs or other materials documenting the plan's terms on March 23, 2010 • Any other documents verifying grandfathered status, including materials showing: o Cost sharing (such as fixed deductibles and contributions for coverage) o Annual and lifetime benefit limits o Any health insurance contract in effect on March 23, 2010	Grandfathered plans claiming this status (and exemption from certain ACA requirements) for any period on or after Sept, 23, 2010, must give participants and beneficiaries a notice and maintain documents relating to grandfathered status.

Nongrandfathered plans only		
Recommended preventive services	• Documents relating to preventive services covered for each plan year since the later of: o Sept. 23, 2010 o Date grandfathered status ended	Nongrandfathered plans must cover certain preventive services in network without cost sharing.
Claims and appeals and external review procedures	• Copies of the plan's internal claim and appeals processes and external review procedures • Relevant notices • Any contract with an independent review organization or a third-party administrator providing external review	Plans must have specific internal claims and appeal procedures and make external reviews available in certain cases.
Parity for certain out-of-network emergency services	• Documents about coverage for out-of-network emergency services	Plans that cover hospital-based emergency services must provide parity in certain benefits for in- and out-of-network emergency services.
Participants' right to choose certain providers in network plans	• Copies of notice of provider-choice rights (generally included in the SPD) • List of participants receiving the notice	Network plans that require designation of a primary care provider (PCP) must inform participants of their right to choose any participating PCP, pediatrician (for a child) or obstetrician/gynecologist (for a woman).

Worst-case scenario: Compliance failures found

Failure to comply with the legal requirements targeted in recent DOL audits can result in significant penalties for plan sponsors and fiduciaries.

Broad range of penalties. Violations of ACA's group health plan standards can give rise to penalties under the Public Health Services Act and ERISA fiduciary liabilities, including civil fines, lawsuits and potential DOL penalties. In addition, failure to comply with group health plan standards under ACA, HIPAA, COBRA or other relevant laws can trigger IRS excise taxes of $100 per affected person for each day of noncompliance.

Potential IRS referral. Although only IRS can impose excise taxes, DOL may refer violations uncovered in its audits to IRS for resolution of any tax issues. If the violation is due to reasonable cause – not willful neglect – the excise tax penalty is capped at either 10% of aggregate health plan costs paid by the employer in the prior year or $500,000, whichever is less.

Potential waiver for reasonable cause. The tax may not apply if the employer can show it didn't know (and, in exercising reasonable diligence, would not have known) about the violation. Likewise, the tax may not apply if the compliance failure was due to reasonable cause rather than willful neglect and corrected within 30 days after the employer first knew (or should have known) that the failure existed. Under existing IRS rules, however, employers must self-report violations and any excise taxes due.

Employer implications

Given the DOL's revamped audit activity, employers should make sure they have documentation and procedures that support group health plan compliance, paying particular attention to health care reform requirements already in effect. Action steps include:

- Inventory and assemble current documentation needed to show compliance (such as plan documents and amendments, written policies, SPDs, employee notices, HIPAA certificates, vendor agreements, eligibility and enrollment procedures, internal claim and appeal processes, and external review procedures).

- Identify sources of reportable information (such as benefit and payroll staff or outside vendors and health insurers), and assess the adequacy of reporting capabilities, including any related contractual obligations.

- Using the DOL audit letter's document list as a guide, determine which materials will demonstrate compliance. If certain items are inapplicable (or unavailable), consider creating and retaining a written explanation documenting the reason.

- Address any compliance gaps identified.

- Contact benefit advisers or legal counsel immediately upon receiving a DOL audit letter.

FTC ramps up enforcement of credit reporting law: Employment background checks that fail to meet the Fair Crediting Reporting Act (FCRA)'s safeguards can lead to significant liabilities, as a recent $2.6 million settlement reached by the Federal Trade Commission shows. Although that case involved a consumer reporting agency, employers using consumer reports to screen applicants or employees face similar risks for failing to follow FCRA standards. In light of increased agency scrutiny of employment screening practices, employers would be wise to review their compliance in this area. **Press release on FCRA settlement (FTC, 8 Aug 2012)**

FMLA rulings guide employers in responding to leave requests: Determining whether an employee's absence falls under the Family and Medical Leave Act (FMLA) can prove challenging for employers, but two recent appellate rulings shed light on this issue. In one case, the 3rd Circuit found an employee's communications gave her supervisor enough details about

her mother's illness to serve as FMLA notice ***(Lichtenstein v. University of Pittsburgh Medical Center, August 3, 2012)***. In the other case, the 7th Circuit reached an opposite conclusion, finding the employee's comments about her family-care issues and possible leave needs were too indefinite and open-ended to trigger FMLA's protections ***(Nicholson v. Pulte Homes Corp., August 9, 2012)***

HHS expands contraceptive coverage delay to more religious employers: More religiously affiliated employers can delay implementing the contraceptive coverage mandate imposed by the Affordable Care Act (ACA), under amended HHS guidance. A safe harbor providing a one-year enforcement delay is now available even to employers that object to some but not all contraceptives or that have offered contraceptive coverage since Feb. 10, despite religious objections. The guidance includes a document that plan sponsors can use to self-certify they qualify for the one-year implementation delay under the safe harbor. **Full text of guidance on contraceptive-coverage safe harbor (CCIIO, 15 Aug 2012)**

Appeals court tosses employee's ADA association discrimination claim: Dismissing a fired employee's claim of association discrimination under the Americans with Disabilities Act (ADA), the 7th US Circuit of Appeals found poor performance justified the termination. The employee had argued that she was fired because of her daughter's disability **(Magnus v. St. Mark United Methodist Church, August 8, 2012)**. However, the ADA doesn't require reasonable accommodation of caregivers' needs, the court pointed out, and her refusal to work weekends was one of several legitimate reasons for the employer's action. Despite this win, ADA's ban on association discrimination and other caregiver rights pose legal risks to employers. **Full text of Q&A on ADA's association provision (EEOC, 2 Feb 2011); Full text of guidance on best practices for workers with care-giving duties (EEOC, 19 Jan 2011); Full text of enforcement guidance on disparate treatment of caregivers (EEOC, 23 May 2007); Full text of Q&As on disparate treatment of caregivers (EEOC, 23 May 2007)**

Guidance clarifies ACA's shared-responsibility rules and group health plan wait periods: Newly released guidance allows employers with part-time or seasonal workers to begin complying with employer shared-responsibility and related provisions of the Affordable Care Act (ACA). Through the end of 2014, employers can rely on safe harbors to identify which employees must be treated as full-time workers for purposes of the ACA's play-or-pay mandate. Related guidance explains the law's limits on waiting periods. Many compliance questions remain unanswered, despite the fast-approaching Jan. 1, 2014, effective date of many ACA provisions. Comments on the new guidance are due Sept. 30. **Full text of Notice 2012-58 (IRS, 31 Aug 2012); Full text of Technical Release 2012-02 (DOL, 31 Aug 2012)**

IRS will no longer forward letters to missing retirement plan participants: Retirement plan administrators no longer have the option of using an IRS letter-forwarding program to locate missing plan participants and beneficiaries, the IRS recently announced in **Revenue Procedure 2012-35**. Set up in 1994, the program helped administrators provide retirement benefits, required notices or other information to individuals with an invalid address in plan records.

Citing the availability of alternative locator services, the IRS will not process these plan-related requests sent on or after Aug. 31. (The IRS will still forward letters that serve a nonfinancial "humane purpose," such as notifying someone of a relative's imminent death.) Since most plan administrators already use commercial locator services to look for missing participants when conducting ongoing plan administration, the change in IRS policy may not be that significant. But the new policy could affect administrators fixing plan errors under the IRS's Employee Plans Compliance Resolution System (EPCRS) or distributing assets from a terminating defined contribution (DC) plan.

Correcting plan errors under EPCRS. When requesting IRS approval of a plan correction under EPCRS, a retirement plan sponsor must certify that it has taken "reasonable actions" to find lost participants owed a corrective amount. Using the IRS letter-forwarding program was deemed to satisfy this requirement and has become a standard reference in many EPCRS applications. EPCRS guidance states, however, that if the IRS letter-forwarding program is unavailable, the sponsor should take "other reasonable actions" to locate lost participants **(See Revenue Procedure 2008-50, Section 6.02(5)(d))**. In future EPCRS guidance, the IRS intends to provide an extended correction period for sponsors affected by this change, according to the Aug. 31 email bulletin.

Notifying participants in terminating DC plans. Under Labor Department guidance, administrators of terminating (or abandoned) DC plans must try to locate missing participants and beneficiaries and notify them of their distribution rights. Even though the IRS program is no longer available, administrators of terminating DC plans apparently may continue to rely on the Social Security Administration's letter-forwarding program – perhaps supplemented by other search options, such as Internet search tools, commercial locator services and credit reporting agencies. (PBGC rules require terminating defined benefit plans to use commercial locator services to find missing participants.

Comprehensive MAP-21 guidance published: With the September 11 guidance on MAP-21 pension funding stabilization, plan sponsors can finalize 2011 and 2012 contributions. Key elements of IRS Notice 2012-61 and PBGC Technical Update 2012-2 are outlined below.

Valuing lump sums. Traditional plans offering lump sums or other accelerated payment forms should value future payments using the "annuity substitution rule." This alleviates concern IRS might revoke the rule, substantially reducing the near-term funding relief provided by MAP-21.

Valuing assets. For minimum funding, maximum tax deduction and PBGC 4010 filing triggers, plan sponsors may choose to use the same asset value, determined using the effective interest rate for minimum funding to discount receivable contributions and, for plans using asset averaging, limiting the expected return to the stabilized third segment rate. Alternatively, sponsors may determine a second asset value using nonstabilized rates for deduction limits or 4010 reporting triggers – and must do so for Section 420 transfers of surplus assets.

Benefit restrictions. The notice clarifies that MAP-21 does not change benefit restrictions, credit balance waivers or 436 contributions while a 2012 presumed adjusted funding target attainment percentage (AFTAP) was in effect. But plans already operating under a certified 2012 AFTAP have two options for moving to MAP-21 stabilized segment rates for 2012 benefit restrictions: Apply the MAP-21 AFTAP (i) retroactively to the initial 2012 AFTAP certification date, or (ii) prospectively from Oct. 1 or, if earlier, the MAP-21 AFTAP certification date. Plans electing retroactive application may revoke credit balance waivers or recharacterize 436 contributions made under the initial 2012 AFTAP certification if no longer needed to avoid restrictions.

Hybrid plan interest-crediting rates. The notice gives administrators of cash balance and other hybrid plans crediting interest based on a funding segment rate the flexibility to interpret whether the plan's rate is based on stabilized or nonstabilized segment rates.

4010 reporting. Plans using stabilized rates for funding must use the funding target determined with nonstabilized segment rates in the 80% funded test. But the asset value – and the funding target for the $15 million shortfall test – may be the amounts determined for minimum funding.

Other topics covered. The IRS notice confirms that plans with delayed PPA effective dates should determine current liability using the stabilized third segment rate. The notice also describes sponsor election procedures and Schedule SB reporting changes.

IRS gives hybrid plans breathing room on market-rate rule, flexibility on segment rates: Final regulations implementing the Pension Protection Act's market-rate rule for cash balance and other hybrid pension plans won't take effect before the 2014 plan year, according to IRS Notice 2012-61. The IRS may soon publish final regulations but apparently wants to allay sponsors' concerns about the need for last-minute compliance changes at 2012 year-end. Notice 2012-61 also explains how the new funding stabilization law (MAP-21) applies to hybrid plans that credit interest based on one of the funding segment rates: Plan administrators generally will have flexibility to interpret their plans to use either stabilized or nonstabilized rates, at least until 2014.

Market-rate regulations won't take effect before 2014

The Pension Protection Act prohibits statutory hybrid plans from crediting interest or indexing benefits at a rate exceeding a market rate of return ("market-rate rule"). The statutory requirements took effect with the 2008 plan year, and final IRS regulations are expected later this year. Some sponsors of cash balance and other hybrid plans were concerned that final regulations might be issued in late 2012, with a 2013 plan-year effective date, leaving sponsors little time to make necessary plan changes.

To allay these concerns, the IRS has announced in Notice 2012-61 that final regulations implementing the market-rate rule won't take effect before the plan year beginning in 2014. In the meantime, sponsors may continue to rely on a good-faith interpretation of the statutory requirements.

Flexibility for plans crediting interest based on funding segment rates

The recent enactment of pension funding stabilization (MAP-21) raised questions for hybrid plans that currently base their interest credit on one of the funding segment rates. Notice 2012-61 generally gives sponsors of these plans leeway to use either stabilized or nonstabilized rates.

Final IRS regulations issued in 2010 deem each of the funding segment rates to be a market rate of return. Thus, a hybrid plan that credits interest based on one of the funding segment rates is deemed to comply with the market-rate rule. In the wake of MAP-21, the question is whether the plan's terms should be interpreted as referring to the MAP-21 stabilized segment rate or the regular, nonstabilized 24-month average rate. (Plans that base the interest credit on one of the Section 417(e) lump sum segment rates don't face the same question because MAP-21 didn't modify the lump sum rates.) Notice 2012-61 offers the following guidance:

- A plan administrator may reasonably interpret a reference to one of the funding segment rates as a reference to either the stabilized segment rate or the nonstabilized segment rate. A clarifying plan amendment reflecting the administrator's interpretation won't violate anti-cutback rules or trigger an ERISA Section 204(h) notice of future benefit reductions as long as the amendment is adopted by the deadline for documentary compliance with the upcoming final market-rate regulations (which won't be earlier than the end of the 2013 plan year).

- If a plan administrator interprets the plan to refer to the stabilized rate, and stabilized rates are used to determine the plan's 2012 minimum required contribution, the plan must credit interest based on the stabilized rate starting the first day of the 2012 plan year. But if the sponsor elects to delay using the stabilized rates for funding and benefit restriction purposes until the 2013 plan year, then the administrator has the choice of crediting interest based on the stabilized rate starting in either the 2012 or 2013 plan year.

The IRS has not said whether the stabilized rates will be treated as market rates under the upcoming final regulations. If not, plans that have credited interest based on the stabilized rates will have to change their interest-crediting rate. Such a change would be covered by the anti-cutback relief that the IRS expects to provide for any change required by the final market-rate regulations.

Any other plan amendment changing between stabilized and nonstabilized interest crediting bases (i.e., a plan amendment that is not clarifying the administrator's interpretation following MAP-21 enactment and that is not required to comply with the upcoming final market-rate rules) will trigger anti-cutback protections and potentially an ERISA Section 204(h) notice of future benefit reductions.

No guidance on using segment rates for annuity conversion

Notice 2012-61 does not address hybrid plans that use one of the funding segment rates to convert the account balance to an annuity. Such plans may be rare, which may be why the IRS guidance doesn't mention them. Even so, such a plan would have to determine whether the plan's reference to the funding segment rate means a stabilized or nonstabilized rate. Administrators should consult with counsel but might conclude that they have flexibility to interpret the plan to refer to either a stabilized or nonstabilized rate. As a policy matter, if it's reasonable to interpret a plan's interest credit this way, it seems reasonable to do so for the annuity conversion rate as well.

Deadline nears for NQDC payments conditioned on employee's release of claims: Employers should immediately review nonqualified deferred compensation arrangements to determine whether the timing of benefit payments may vary based on employee action, such as signing a claims release or non-compete agreement. In the IRS's view, such a provision may trigger penalties under Code Section 409A to the extent it gives employees too much control over the taxable year of payment. The need for urgency stems from IRS transition relief that could require corrective steps by December 31. **See IRS Notice 2010-80 (12/22/2010).**

Medicare prescription drug reminders – notices, disclosures and RDS applications: Employers whose health plans cover prescription drug benefits must soon take action on key Medicare Part D deadlines. Sponsors must tell individuals and the Centers for Medicare and Medicaid Services (CMS) if the plan's drug coverage is "creditable," providing benefits as good as Part D's standard package. In addition, calendar-year plan sponsors participating in the Medicare Part D retiree drug subsidy (RDS) program have less than a month to begin 2013 applications to qualify for partial reimbursement of drug costs.

Part D creditable coverage notices to employees. Before each Medicare annual enrollment period, plan sponsors must distribute a notice describing their prescription drug plans' creditable or noncreditable status. The Medicare annual enrollment period begins on Oct. 15, so employers must confirm that notices will be distributed before that date. Group health plans that cover prescription drug expenses must provide these notices to all covered individuals, including active employees, retirees, COBRA beneficiaries and long-term disabled former employees. Distributing this annual notice also satisfies a plan sponsor's obligation to provide a creditable or noncreditable coverage notice when a participant first becomes eligible for Part D.

Related disclosure to CMS. Using an online form, plan sponsors also must disclose to CMS the creditable status of their prescription drug coverage. The completed form is due within the first 60 days of the plan year (by March 1 for a calendar-year plan). CMS has added a user manual and instructions with screen shots to assist plan sponsors subject to this requirement.

Calendar-year plans' RDS applications due shortly. Employers participating in the RDS program that have calendar-year plans must begin their 2013 applications by Oct. 2, 2012. Once the application is started, the plan sponsor may request a 30-day deadline extension – until Nov. 1, 2012 – to complete the application (including the plan sponsor agreement) and submit a valid initial retiree list. **CMS website on Medicare creditable coverage notices and disclosures**; **Retiree drug subsidy program website**

Final mortality report likely to increase pension and retiree health care costs: Traditional pension plan liabilities could rise 2–4% and retiree health care liabilities 6–9% under new mortality improvement scale BB, published last month by the Society of Actuaries (SOA). The SOA also issued a response to comments on the scale BB exposure draft and updated questions and answers regarding the new scale.

Background. In 2010, the SOA undertook a comprehensive review of recent mortality experience for US pension plans to create a new set of retirement plan mortality tables and mortality improvement scales. The scales are used to project increases in longevity due to improvements in health care and other societal factors. The new tables – expected to be published in late 2013 or early 2014 – will replace the "RP-2000" retirement plan mortality tables published in July 2000, and the associated mortality improvement scale AA, first released in 1995.

Scale BB. The mortality experience data showed that scale AA has significantly understated actual mortality improvements since 2000 for most ages over 55. Rather than waiting to complete the comprehensive review, the SOA has published scale BB as an interim step. Scale BB incorporates actual mortality improvement data through 2007 and an anticipated long-term mortality improvement rate of 1%. The new scale is designed for use with RP-2000 mortality tables. Because static projection techniques commonly used with scale AA are somewhat less reliable when used with BB, the SOA recommends applying the new scale on a fully generational basis (in effect, developing a separate mortality table for each birth year).

Implications for employer accounting. Auditors may press employers to adopt BB and fully generational mortality for accounting purposes as soon as 2012 fiscal year-end. Or auditors may require an analysis supporting why another scale better represents plan participants' recent mortality experience. It's not clear whether auditors will permit other approaches, such as modifying scale BB to use a future long-term mortality rate other than 1% or using BB to project mortality improvement from 2000 to 2007 and scale AA to project improvement beyond 2007.

Implications for funding and minimum lump sums. The IRS has already published 2013 mortality tables – developed using scale AA – for funding and minimum lump sums. When (if ever) the IRS might move to scale BB is unclear. The agency might use BB to develop 2014 prescribed mortality assumptions or continue using AA until the SOA publishes updated retirement plan mortality tables.

Projected 2013 retirement plan, saver's credit, IRA and other benefit-related limits: With the publication of the August CPI-U, Mercer has projected 2013 Internal Revenue Code limits for qualified retirement plans, the saver's credit, IRAs, Roth IRAs, Archer medical savings accounts, parking and transportation benefits, and long-term care plans. The adoption assistance exclusion will revert to the 2001 level if Congress does not extend higher inflation-indexed limits enacted in the Economic Growth and Tax Relief Reconciliation Act of 2001. This article summarizes these 2013 projections, showing adoption assistance amounts with and without an EGTRRA extension. It also shows the 2013 health savings account and high-deductible health plan amounts announced by the IRS in April and Medicare Part D prescription drug program amounts announced by the Centers for Medicare and Medicaid Services in April.

Qualified retirement plan limits

Mercer projects that most 2013 qualified retirement plan limits will increase from the 2012 values because of a projected 1.4% – 1.6% increase in third-quarter CPI-U from 2011 to 2012. The IRS is expected to announce the 2013 limits on Oct. 16, 2012, following the announcement of the September CPI-U. The values shown below are *estimated* amounts, determined using the cost-of-living adjustment methods described in the tax code, CPI-U values through August 2012 and Mercer's projected CPI-U values for September 2012. Although final qualified retirement plan limits will depend on the actual CPI-U for September, rounding rules enable us to project most rounded limits now. Where certain limits are too close to the rounding breakpoint to predict accurately, we show both possible values

Code Section limit	Projected 2013	2012	2011
401(k), 403(b) and eligible 457 plan elective deferrals (and designated Roth contributions)	$17,000 or $17,500	$17,000	$16,500
414(v)(2)(B)(i) catch-up contributions (plans other than SIMPLE plans)	5,500	5,500	5,500
408(p)(2)(E) SIMPLE plan elective deferrals	12,000	11,500	11,500
414(v)(2)(B)(ii) SIMPLE plan catch-up contributions	2,500	2,500	2,500
408(k)(2)(C) SEP minimum compensation	550	550	550
415(b) defined benefit maximum annuity	205,000	200,000	195,000
415(c) defined contribution maximum annual addition	51,000	50,000	49,000
401(a)(17) and 408(k)(3)(C) compensation	255,000	250,000	245,000
401(a)(17) compensation for eligible participants in certain governmental plans in effect July 1, 1993	380,000	375,000	360,000
414(q)(1)(B) highly compensated employee and 414(q)(1)(C) top-paid group	115,000	115,000	110,000
416(i)(1)(A)(i) officer compensation for top-heavy plan key employee definition	165,000	165,000	160,000

Treas. Reg. Section 1.61-21(f)(5) control employee for fringe benefit valuation purposes			
Officer compensation	100,000	100,000	95,000
Employee compensation	205,000	205,000	195,000
409(o)(1)(C) tax-credit ESOP limits for lengthening the distribution period	1,030,000 or 1,035,000	1,015,000	
Five-year maximum balance			985,000
One-year extension	205,000	200,000	195,000
430(c)(7)(D)(i)(II) excess compensation threshold	1,066,000	1,039,000	1,014,000

Saver's credit

Mercer's projections of the adjusted gross income levels at which a tax credit is available for employee contributions to a qualified retirement plan or IRA ("saver's credit") reflect the 2.6% 2011 to 2012 increase in the average CPI-U for the 12 months ending Aug. 31.

Saver's credit adjusted gross income (AGI) thresholds (Section 25B)	Projected 2013	2012	2011
50% saver's credit if AGI is no more than			
Married filing jointly	$35,500	$34,500	$34,000
Head of household	26,625	25,875	25,500
Other filing status	17,750	17,250	17,000
20% saver's credit if AGI is more than threshold for 50% credit but no more than			
Married filing jointly	38,500	37,500	36,500
Head of household	28,875	28,125	27,375
Other filing status	19,250	18,750	18,250
10% saver's credit if AGI is more than threshold for 20% credit but no more than			
Married filing jointly	59,000	57,500	56,500
Head of household	44,250	43,125	42,375
Other filing status	29,500	28,750	28,250

Traditional and Roth IRA limits

Maximum 2013 deductions for contributions to traditional IRAs and maximum allowable 2013 contributions to Roth IRAs are projected to increase because of the 2.6% 2011 to 2012 increase in the average CPI-U for the 12 months ending Aug. 31, as summarized in the table below. The catch-up contribution limit is not adjusted for changes in the cost of living.

Traditional and Roth IRA limits	Projected 2013	2012	2011
Traditional IRA deduction limits (Sections 219(b)(5) and 219(g)(3)(B))			
IRA maximum deductible amount	$5,500	$5,000	$5,000
IRA catch-up contribution limit*	1,000	1,000	1,000

Applicable dollar amount for determining deductible amount of IRA contributions for active participants in qualified plans			
Married filing jointly or qualifying widow(er)	95,000	92,000	90,000
Other filing status	59,000	58,000	56,000
Spouse (but not taxpayer) is active participant	178,000	173,000	169,000
Roth IRA contribution limits (Section 408A(c)(3)(C)(ii))			
AGI for determining maximum Roth IRA contribution			
Married filing jointly or qualifying widow(er)	178,000	173,000	169,000
Other filing status	112,000	110,000	107,000

* Limit is not adjusted for changes in the cost of living.

HSA and HDHP limits

The IRS announced 2013 inflation-adjusted limits on health savings account (HSA) contributions and high-deductible health plan (HDHP) deductibles and out-of-pocket maximums on April 27, 2012, confirming Mercer's earlier projections (Rev. Proc. 2012-26). The 2013 values (before rounding) reflect the 3.3% increase in the average CPI-U for the 12 months ending March 31, 2012. The catch-up contribution limit is set by statute and does not increase after 2009. The table below shows limits for 2013 and the past two years.

HSA/HDHP limits	2013	2012	2011
Self-only coverage			
Maximum tax-deductible HSA contribution	$3,250	$3,100	$3,050
HDHP minimum annual deductible	1,250	1,200	1,200
HDHP out-of-pocket maximum	6,250	6,050	5,950
Family coverage			
Maximum tax-deductible HSA contribution	6,450	6,250	6,150
HDHP minimum annual deductible	2,500	2,400	2,400
HDHP out-of-pocket maximum	12,500	12,100	11,900
HSA catch-up contribution limit at age 55 or older†	1,000	1,000	1,000

† Value is set by statute and is not adjusted after 2009.

Qualified adoption assistance benefits

The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) substantially increased the income exclusion and starting point of the income phase-out for qualified adoption assistance benefits and indexed these amounts for inflation after 2002. If these EGTRRA provisions are not extended, 2013 adoption assistance limits will revert to pre-EGTRRA values. If the EGTRRA provisions are extended without modification, projected 2013 limits will reflect the 2.6% 2011 to 2012 increase in the average CPI-U for the 12 months ending Aug. 31.

Qualified adoption assistance	Projected 2013 If no EGTRRA extension	Projected 2013 With EGTRRA extension	2012	2011
Exclusion for child with special needs (regardless of expenses incurred)	6,000	12,970	12,650	13,360
Aggregate dollar limit for all taxable years (child without special needs)	5,000	12,970	12,650	13,360
Phaseout begins at AGI of	75,000	194,580	189,710	185,210
Phaseout completed at AGI of	115,000	234,580	229,710	225,210

Other benefit-related limits

Mercer's projected 2013 limits for Archer medical savings accounts (MSAs) and qualified transportation fringe benefits reflect the 2.6% 2011 to 2012 increase in the average CPI-U for the 12 months ending Aug. 31, resulting in modest increases, depending on the limit and applicable rounding rules. Our projected qualified long-term care premium and per diem limits reflect the 4.1% increase in the medical care component of CPI-U from August 2011 to August 2012.

Other benefit-related limits	Projected 2013	2012	2011
Archer MSAs (Section 220(c)(2))			
Self-only coverage			
Minimum annual deductible	$2,150	$2,100	$2,050
Maximum annual deductible	3,200	3,150	3,050
Maximum out-of-pocket limit	4,300	4,200	4,100
Family coverage			
Minimum annual deductible	4,300	4,200	4,100
Maximum annual deductible	6,450	6,300	6,150
Maximum out-of-pocket limit	7,850	7,650	7,500
Tax-free qualified transportation fringe benefits (Section 132(f))			
Monthly parking	245	240	230
Monthly transit passes or commuter highway vehicle transportation	125	125	230
Qualified long-term care limits (Sections 213(d) and 7702B(d)(4))			
Premium limits			
Age 40 or younger	360	350	340
41 – 50	680	660	640
51 – 60	1,360	1,310	1,270
61 – 70	3,640	3,500	3,390
Older than 70	4,550	4,370	4,240
Per diem limit	320	310	300

Medicare Part D prescription drug benefits

Key Medicare prescription drug benefit (Part D) dollar limits are indexed each year to reflect increases in Medicare beneficiaries' average total drug expenses. On April 2, 2012, the Centers for Medicare and Medicaid Services (CMS) released indexed figures for 2013 used for certain retiree drug subsidy purposes. Complete information on the amounts and how they are calculated is available in CMS's announcement released at the same time.

Part D benefits and RDS amounts	2013	2012	2011
Standard Part D benefit			
Deductible	325.00	320.00	310.00
Initial coverage limit	2,970.00	2,930.00	2,840.00
Out-of-pocket threshold	4,750.00	4,700.00	4,550.00
Total covered Part D drug out-of-pocket threshold	6,733.75	6,657.50	6,447.50
Minimum cost-sharing for catastrophic coverage			
Generic/preferred	2.65	2.60	2.50
Other	6.60	6.50	6.30
Retiree Rx subsidy			
Cost threshold (Part D deductible)	325.00	320.00	310.00
Cost limit	6,600.00	6,500.00	6,300.00