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Five Steps for Retirement Plan Success

At a recent virtual PLANADVISER national conference, panelists identified five ways plan sponsors can refocus their goals for plan significance and success.

1. **Market Your Plan –** Plan sponsors are becoming more paternalistic, and therefore reaching out more to help participants make informed decisions concerning their retirement. Plan sponsors should ask themselves, "Is the plan currently being marketed to participants as a valuable component of the company's employee benefits package? If not, how can we better promote the plan?"
2. **Focus on Benefit Adequacy –** Participants need to be educated to the realities of retirement planning. Oftentimes participants have expectations that are not entirely realistic, including the appropriate deferral percentage. Plan design can be a key element in dealing with this issue (e.g., automatic enrollment and automatic escalation features)

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Five Steps for Retirement Plan Success *continued*

3. **Understand Plan Costs –** Plan costs should be readily available, transparent, and meaningful to both plan sponsors and plan participants. Pending final regulations are anticipated to play a major role in ensuring that this happens.
4. **Evaluate Your Target Date Funds* –** Don't get too caught up with returns alone. Consider risk levels, glide paths and equity/bond exposures before deciding on a target date fund series that best reflects the needs of your participant demographic. [*The target date is the date of expected withdrawals at retirement; the fund is not guaranteed at the target date or any other time. These funds are subject to risk, including the loss of principal.]
5. **Maximize Plan Design –** What is the goal of this plan? Is it maximizing financially sound retirement experiences for participants? If so, how can you pursue this goal? Whatever the goal, plan design may be a key ingredient in achieving success (e.g., increase your match, shorten the eligibility period or eliminate loan provisions).

Your retirement plan consultant is ready to assist you with all aspects of achieving plan success, from enhancing investment opportunities for participants to helping plan sponsors meet their fiduciary duties. Remember, your retirement plan can be a powerful recruiting tool and it is the one benefit that your employees will utilize throughout their lifetime.

Supplemental Benefits as Excepted Benefits Under HIPAA

HIPAA's pre-existing condition exclusion, nondiscrimination and special enrollment requirements, commonly known as HIPAA's portability provisions, generally apply to group health plans and health insurance issuers offering group health insurance coverage. However, if all benefits under a plan or coverage are considered excepted benefits, then the plan does not have to comply with HIPAA's portability provisions. Supplemental benefits are one category of excepted benefits.

HIPAA defines supplemental excepted benefits as those provided under a separate policy, certificate or contract of insurance that are either Medicare or TRICARE supplemental programs or "similar supplemental coverage provided to coverage provided under a group health plan." The statute is less than clear on what constitutes "similar supplemental coverage." However, related Department of Labor (DOL) regulations have established safe harbor requirements that, if met, will qualify "similar supplemental coverage" as excepted benefits. To qualify, the plan must satisfy all of the following requirements.

First, the coverage must be provided under a separate policy, certificate or contract of insurance. Thus, any type of supplemental plan that is self-insured does not qualify.

Second, the policy, certificate or contract must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or that are under common control are considered a single entity.

Third, the policy, certificate or contract must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. A policy, certificate or contract that becomes secondary or supplemental only under a coordination of benefits provision does not qualify.

Fourth, the cost of coverage under the supplemental policy, certificate or contract must not exceed 15 percent of the cost of primary coverage. Cost is determined in the same manner as for COBRA purposes, less the 2 percent administrative fee.

Fifth, the supplemental policy, certificate or contract must not differentiate among individuals as to plan eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

The above safe harbor requirements provide clear guidance for determining whether supplemental coverage may be considered excepted benefits for purposes of HIPAA. Plan sponsors should review any supplemental health coverage purchased to assure that it qualifies under the above DOL safe harbor. Supplemental coverage that deviates from the above requirements will likely be subject to DOL scrutiny and enforcement.

What Are the Triggering Events and the Maximum Coverage Periods Under COBRA?

Employers subject to COBRA must offer a COBRA election to qualified beneficiaries when there is a triggering event listed in the statute that causes – or will cause – the individual to lose plan coverage. Both the triggering event and subsequent loss of coverage must occur within the maximum coverage period. It is important to note that not all losses of health coverage are caused by triggering events, and in these situations COBRA would not be offered. If the triggering event does cause a loss of coverage, then there is a COBRA qualifying event and the individual and/or dependents should be provided with a COBRA election notice.[1]

1. Treas. Reg. §54.4980B-4, Q/A-1(a) and Q/A-1(d)

What Are the Triggering Events and the Maximum Coverage Periods Under COBRA? *continued*

There are seven triggering events that will result in COBRA being offered if they result in a loss of coverage. The longest period for which COBRA coverage must be provided is called the maximum coverage period, and is based on the particular qualifying event. Below is a list of the qualifying events and the maximum coverage periods provided under COBRA:

	Triggering Event	Maximum Coverage Period
1.	Voluntary or involuntary termination of the covered employee's employment other than by reason of gross misconduct	18 months
2.	Reduction of hours of the covered employee's employment	18 months
3.	Divorce or legal separation of the covered employee from the employee's spouse	36 months
4.	Death of the covered employee	36 months
5.	A dependent child ceases to be a dependent under the generally applicable requirements of the plan	36 months
6.	A covered employee becomes entitled to benefits under Medicare	36 months
7.	An employer's bankruptcy, but only with respect to health coverage for retirees and their families[2]	For the duration of the retiree's life

The maximum coverage period is generally measured from the date of the triggering event rather than from the participant's election date.[3] However, if a covered beneficiary loses coverage on a date later than the triggering event date (sometimes called a "deferred loss of coverage"), then a plan may instead measure the maximum coverage period from the loss of coverage date, but only if the deadline for sending COBRA notices is also measured from the loss of coverage date.[4]

Note that an employee who terminates employment or has a reduction in hours and meets specific requirements for a disability extension is entitled to a maximum COBRA period of up to 29 months.

For more COBRA information, please contact your advisor.

2. ERISA §603
3. ERISA §602(2)
4. ERISA §607(5)

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