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March 2009

EMPLOYEE BENEFITS UPDATE

SELECT COMPLIANCE DEADLINES AND REMINDERS

New COBRA Compliance Requirements Became Effective March 1, 2009

The American Recovery and Reinvestment Act of 2009 (Economic Stimulus Act), enacted on February 17, 2009, imposes two new COBRA compliance obligations on employers, administrators and insurers who provide COBRA coverage: (1) a COBRA premium subsidy and (2) a second COBRA election period. These compliance requirements are generally effective for COBRA premiums charged on or after March 1, 2009.

[Reinhart's February 20, 2009 E-Alert](#) describes these new compliance requirements. Reinhart is currently developing model language for the notice requirements and checklists for compliance with the new rules. The Internal Revenue Service (IRS) released a revised Form 941 (Employer's Quarterly Federal Tax Return) and a series of questions and answers on claiming the payroll tax credit, both of which are available on the IRS's Web site at www.irs.gov/newsroom/article/0,,id=204505,00.html. The Department of Labor (DOL) also updated its Web site at www.dol.gov/ebsa/COBRA.html to include fact sheets, answers to frequently asked questions and posters and flyers addressing the new COBRA compliance requirements.

Group Health Plans Must Comply with New Special Enrollment Rights by April 1, 2009

As discussed in more detail below, on February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (Health Act). Among other provisions, the Health Act creates new 60-day special enrollment rights effective April 1, 2009. Special enrollment notices, summary plan descriptions (SPDs) and plan documents may need to be updated to reflect these new special enrollment rights.

Required Minimum Distribution Deadline is April 1, 2009

Generally, required minimum distributions from qualified retirement, 403(b) and 457(b) plans must begin by April 1 following the later of: (1) the calendar year in which a participant attains age 70 1/2 or (2) if the plan provides, the calendar year in which a participant terminates employment. The required beginning date for 5% owners is not extended by continued employment past age 70 1/2. The Worker, Retiree and Employer Recovery Act of 2008 (Recovery Act) waives required minimum distributions for 2009 from IRAs and most defined contribution plans, such as 401(k) plans. Because the Recovery Act only provides relief for 2009, required minimum distributions for 2008 that are due by April 1, 2009 must be made, or participants and beneficiaries may face a 50% excise tax on the amount not withdrawn.

HSA Contribution Deadline for 2008 is April 15, 2009

The deadline for making contributions for 2008 to a health savings account (HSA) is April 15, 2009. IRS guidance provides that, 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 not later than the original filing deadline (without extensions) for the individual's federal income tax return for that year (*i.e.*, April 15th for calendar-year taxpayers).

Defined Benefit Funding Notice is Due by April 30, 2009 for Calendar-Year Plans

The Pension Protection Act of 2006 (PPA) provides that, effective for plan years beginning after 2007, all defined benefit plans covered by the Pension Benefit Guaranty Corporation (PBGC) must provide an annual funding notice to the PBGC, plan participants and beneficiaries, labor organizations representing plan participants and, for multiemployer plans, contributing employers. The funding notice replaces the summary annual report (SAR), and generally must be provided within 120 days following the end of the plan year (*i.e.*, April 30, 2009 for calendar-year plans). Small plans (*i.e.*, plans with 100 or fewer participants) generally have until the Form 5500 filing date to provide the funding notice. As discussed below, the DOL issued guidance on complying with the funding notice requirement, including two model notices (one for single-employer plans and one for multiemployer plans).

Medicare Secondary Payer Registration is April 2009 for Certain Group Health Plans

As reported in Reinhart's September 2008 Employee Benefits Update {LINK}, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) added new mandatory reporting requirements for group health plans effective January 1, 2009. The MMSEA requires insurers, third-party administrators and fiduciaries or administrators of self-insured health plans to gather information to help the Centers for Medicare and Medicaid Services (CMS) determine when group health plans should pay primary to Medicare. CMS posts guidance on its Web site at www.cms.hhs.gov/MandatoryInsRep/ to implement these statutory reporting requirements, including the deadlines for responsible reporting entities (RREs) to register with CMS. Group health plan RREs, such as fiduciaries or administrators of self-insured health plans and third-party administrators, that do not currently exchange data with Medicare under a voluntary data sharing agreement or voluntary data exchange agreement must register online with CMS between April 1, 2009 and April 30, 2009. More information, including additional reporting schedules, is available on the CMS Web site provided above.

RETIREMENT PLAN DEVELOPMENTS

DOL Provides Guidance on Annual Funding Notice for Defined Benefit Plans

As mentioned above, the PPA amended ERISA to require all PBGC-covered defined benefit plans to provide an annual funding notice in lieu of the SAR, effective for plan years beginning on or after January 1, 2008. Recognizing that the due date of the first funding notice is quickly approaching (*i.e.*, April 30, 2009 for calendar-year plans), the DOL issued Field Assistance Bulletin 2009-01 (the "Bulletin") to provide guidance to plan administrators on complying with the new funding notice requirements. Plan sponsors and administrators should take steps to ensure that they have the information needed to complete the funding notice by the applicable deadline. Late funding notices are subject to \$110 per participant per day penalty.

To briefly summarize, the Bulletin provides guidance on calculating a single-employer plan's "funding target attainment percentage," as well as directives regarding how to determine the value of plan assets and liabilities. Among other topics, the Bulletin also addresses how to state a plan's asset allocation and how to determine whether a plan amendment or other event must be disclosed because it has a material effect on plan assets and liabilities. According to the DOL, a plan administrator will be treated as satisfying the funding notice requirements if the administrator complies with the Bulletin's guidance and follows a good faith, reasonable interpretation of the funding notice requirements with respect to matters not specifically addressed in the Bulletin. The Bulletin also contains separate model funding

notices for single-employer plans and multiemployer plans. Although administrators are not required to use the model notices, the DOL states that use of an appropriately completed model notice will satisfy ERISA's content requirements for the plan funding notice.

IRS Finalizes Regulations on Automatic Contribution Arrangements

The IRS issued final regulations regarding automatic contribution arrangements in 401(k), 403(b) and 457(b) governmental plans. While automatic contribution arrangements have been approved by the IRS and used by plan sponsors for many years, the PPA includes several significant changes encouraging eligible plan sponsors to implement an automatic contribution arrangement, effective for plan years beginning on or after January 1, 2008. Under an automatic contribution arrangement, an employee is automatically enrolled to make deferrals absent an affirmative election to the contrary.

The PPA provides that a 401(k) plan with an automatic contribution arrangement may escape actual deferral percentage (ADP) and actual contribution percentage (ACP) nondiscrimination testing by incorporating design features that satisfy new safe harbor requirements. This type of safe harbor arrangement is called a "qualified automatic contribution arrangement" (QACA). The PPA also provides for another type of automatic contribution arrangement called an "eligible automatic contribution arrangement" (EACA). An EACA has up to six months after the end of a plan year to make corrective ADP/ACP distributions without incurring an excise tax. An EACA may also provide all eligible employees with a 90-day window to withdraw automatic deferrals and related earnings. As summarized in [Reinhart's December 2007 Employee Benefits Update](#), the IRS proposed regulations on automatic contribution arrangements in November 2007. The IRS's final regulations adopt the proposed regulations with some modifications, such as changes reflecting amendments made by the Recovery Act. The final regulations relating to QACAs apply retroactively for plan years beginning on or after January 1, 2008. The final regulations relating to EACAs apply for plan years beginning on or after January 1, 2010, although good faith compliance is required in the interim. Following either the EACA proposed regulations or the final regulations qualifies as good faith compliance. To highlight a few modifications from the regulations' proposed form, the final regulations provide the following administrative guidance for automatic contribution arrangements:

- **QACA—Minimum Contribution Percentage.** Automatic contributions under a QACA must satisfy minimum percentage requirements (*i.e.*, 3% in the initial period, increasing annually by 1% until reaching 6%). The final regulations clarify that the minimum percentage for the initial period is based on when the employee first has default contributions made under the QACA. In addition, the minimum percentage is generally determined based on the number of years since the employee first had default contributions made under the QACA. However, in response to commentators' requests, the final regulations provide that a plan is permitted to give a rehired employee a fresh start if he or she did not have any default contributions made under the QACA for at least an entire plan year.
- **QACA—Uniformity Requirement.** Under a QACA, the automatic deferral percentage must be applied uniformly. The proposed regulations provided that a plan does not fail the uniformity requirement merely because the automatic deferral percentage varies based on the number of years since the date the employee first had default contributions made under the QACA. The final regulations expand on this exception and provide that a QACA may provide for a mid-year increase in the automatic deferral percentage, as long as the percentage is uniform based on the number of years (or portions of years) since an employee first had default contributions made under the QACA and the percentage satisfies the minimum percentage requirement throughout the plan year. According to the regulations' preamble, this allows employers to align increases in the QACA deferral percentage with mid-year salary

increases or performance evaluations.

- EACA–Employee Coverage. Automatic enrollment under an EACA need not apply to all employees eligible to make a deferral election under the plan, but only to those employees specified by the plan document as being covered by the EACA. However, if an EACA covers fewer than all eligible employees under the plan for a plan year, the employer will be unable to take advantage of the extended six-month ADP/ACP correction period.
- QACA & EACA–Initial Notice Timing. An initial participant notice must generally be provided on or before the date an employee first becomes eligible under a QACA or EACA. If it is not practicable for a QACA or EACA to provide an initial participant notice on or before the date an employee becomes eligible to make deferrals under the plan, the notice will be treated as timely if it is provided as soon as practicable after that date and the employee is permitted to elect to defer from all types of compensation that may be deferred under the plan earned beginning on that date. Thus, the notice must be provided prior to the pay date for the payroll period that includes the employee's eligibility date.

Ninth Circuit Recognizes Validity of "Quasi-Marriage" in QDRO Decision

The Ninth Circuit held that a state court order assigning retirement plan benefits to a domestic partner in a "quasi-marital relationship" was a valid qualified domestic relations order (QDRO) enforceable under ERISA. *Owens v. Automotive Machinists Pension Trust*, 2009 WL 57041 (9th Cir. 2009). Under the facts of this case, Phillip and Norma Owens never legally married, but they lived together for more than 30 years, raised two sons together, purchased a home together and held themselves out to the public as a married couple. After the Owens separated, a Washington state court issued an order assigning Norma a 50% interest in Phillip's pension based on their quasi-marital relationship. Although the order purported to be a QDRO, the plan administrator of Phillip's pension disagreed because Norma and Phillip never legally married. Norma filed a declaratory judgment action to enforce the state court order and won at the district court level.

On appeal, the Ninth Circuit noted that, for the state court's order to be a valid QDRO, the order must recognize the right of an alternate payee to receive all or a portion of the benefits payable with respect to a participant under the plan, and it must relate to marital property rights. Because Washington's domestic relations law recognizes quasi-marital relationships for purposes of property division, the Ninth Circuit concluded that the state court order related to marital property rights. The Ninth Circuit also held that Norma qualified as an alternate payee due to her dependent status during her 30-year relationship with Phillip. Thus, the Ninth Circuit affirmed the district court and concluded that the state court order was a valid QDRO enforceable under ERISA.

Seventh Circuit Rules Against Plaintiffs in Excessive Fee Litigation

The Seventh Circuit dismissed 401(k) plan participants' claims that the plan sponsor, trustee and recordkeeper violated ERISA's fiduciary duty requirements by: (1) providing investment options that required the payment of excessive fees and costs and (2) failing to adequately disclose the fee structure to plan participants. *Hecker v. Deere & Company*, 2009 WL 331285 (7th Cir. 2009). The Seventh Circuit's decision in *Hecker* is significant because it is the first major appellate decision addressing recent ERISA excessive fee litigation.

In *Hecker*, Deere & Company (Deere) maintained two 401(k) plans for its employees (collectively, the "Plan"). Fidelity Management Trust Company (Fidelity Trust) served as the Plan's directed trustee and recordkeeper, and Fidelity Management & Research Company (Fidelity Research) was the investment advisor for the Fidelity mutual funds offered as

investment options under the Plan. Plan participants self-directed the investment of their accounts under the investment vehicles offered by the Plan. The Plan's investment options included 23 Fidelity retail mutual funds, two investment funds managed by Fidelity Trust, a Deere stock fund and a Fidelity-operated "brokerage window," which gave participants access to approximately 2,500 non-Fidelity mutual funds. Each investment fund offered under the Plan charged a fee, calculated as a percentage of the assets the investor placed with the fund. According to Plan participants, Fidelity Research shared revenue that it earned from the mutual fund fees with Fidelity Trust. Fidelity Trust in turn compensated itself through those shared fees, rather than through a direct charge to Deere. Plan participants sued Deere, Fidelity Trust and Fidelity Research claiming that these entities breached their ERISA fiduciary duties by failing to adequately disclose the Plan's fee structure to participants and by providing investment options that required the payment of excessive fees and costs.

On appeal, the Seventh Circuit affirmed the district court and dismissed the Plan participants' claims. To highlight some key points, the Seventh Circuit held as follows:

- Fidelity Trust and Fidelity Research were not "functional" Plan fiduciaries because neither had final authority over the selection of Plan investment options. Also, the Fidelity entities did not become ERISA fiduciaries because they determined how much revenue Fidelity Research would share with Fidelity Trust. Once the fees were collected from the mutual fund's assets and transferred to one of the Fidelity entities, they were no longer Plan assets.
- Deere did not have a duty to disclose to participants the revenue-sharing arrangements that existed between Fidelity Trust and Fidelity Research, and such arrangements are not prohibited by ERISA. (Note that recently proposed DOL regulations would require disclosure of revenue-sharing arrangements.) Deere disclosed to participants the total fees for the funds and directed participants to the funds' prospectuses for information about fund-level expenses. According to the court, this was enough.
- There is no room for doubt that the Plan offered a sufficient mix of investments for its participants, with expense ratios ranging between approximately .07% and 1%. The court stated that "nothing in ERISA requires every fiduciary to scour the market to find and offer the cheapest possible fund (which might, of course, be plagued by other problems)."
- ERISA section 404(c) protects a fiduciary that satisfies the criteria of ERISA section 404(c) and includes a sufficient range of investment options, even if it "does not always shield a fiduciary from an imprudent selection of funds under every circumstance that can be imagined."

DOL and PBGC Guidance Regarding Madoff Exposure

The DOL issued guidance regarding the steps fiduciaries should take in connection with employee benefit plans that will likely experience material losses as a result of plan assets being invested with Bernard L. Madoff Investment Securities LLC (Madoff). According to the DOL, such steps may include: (1) requesting disclosures from investment managers, fund managers and other investment intermediaries regarding the plan's potential exposure to Madoff-related losses; (2) seeking advice regarding the likelihood of losses due to investments that may be at risk; (3) making appropriate disclosures to other plan fiduciaries and plan participants and beneficiaries; and (4) considering whether the plan has claims that are reasonably likely to lead to the recovery of Madoff-related losses that should be asserted against responsible fiduciaries or other intermediaries who placed plan assets with Madoff entities, as well as claims against the Madoff bankruptcy estate.

In addition, the PBGC issued a notice to defined benefit plans that may have experienced significant investment losses due to Madoff investments. The PBGC reminds sponsors and administrators of single-employer plans that ERISA section 4043 requires them to notify the PBGC within 30 days of knowing or having reason to know that the plan is unable to pay benefits when due. If a multiemployer plan's trustees believe that benefits cannot be paid when due, or if all (or substantially all) employers cease contributing to the plan, the PBGC reminds the trustees that they have legal responsibilities. These responsibilities may include reducing benefits, assessing withdrawal liability and notifying the PBGC. The PBGC also notes that sponsors and administrators of affected defined benefit plans should consult a qualified advisory regarding recovering Madoff-invested funds.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Expenses Incurred to Father Children are not Deductible as "Medical Care" Expenses

The U.S. Tax Court ruled that a taxpayer's expenses to father children through unrelated egg donors and gestational carriers were not deductible as medical care expenses under Internal Revenue Code (the "Code") section 213(d) because the taxpayer did not suffer from infertility. Under the facts of this case, the taxpayer deducted medical expenses of approximately \$34,000 and \$28,000 on his 2004 and 2005 federal income tax returns, respectively. The taxpayer incurred the expenses by fathering two children through unrelated gestational carriers via the in vitro fertilization (IVF) of an anonymous donor's eggs. The IRS determined deficiencies in the taxpayer's 2004 and 2005 federal income tax returns because, according to the IRS, the expenses incurred in fathering the two children were not deductible as medical care expenses under Code section 213(d).

Code section 213(d) defines the term "medical care" to include amounts paid "for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body." Treasury regulations provide that deductions for medical care are confined strictly to "expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness." In ruling against the taxpayer, the court noted that the taxpayer had no medical condition or defect, such as infertility, that required treatment or mitigation through IVF procedures. The court distinguished an IRS private letter ruling (PLR) concluding that egg donor fees and expenses were deductible under Code section 213(d) because the taxpayer obtaining the PLR had a history of infertility.

CHIP Legislation Creates New Requirements for Group Health Plans

President Obama recently signed the Health Act into law to extend and expand the children's health insurance program (CHIP), a federal and state program designed to provide health coverage for pregnant women and children who do not qualify for Medicaid. The Health Act also contains new requirements for group health plans aimed at coordinating group health plan coverage with CHIP and Medicaid. The Health Act's provisions are generally effective April 1, 2009. Group health plan sponsors and administrators will have to work quickly to implement the Health Act's changes, particularly the new special enrollment rights.

The following paragraphs briefly summarize key provisions of the Health Act impacting group health plans:

- **Premium Assistance Subsidy.** States may elect to offer a premium assistance subsidy for "qualified employer coverage" for low-income children and, in some cases, their families. "Qualified employer coverage" must include an employer premium contribution of at least 40%. Flexible spending arrangements (FSAs) and

high deductible health plans are specifically excluded from "qualified employer coverage." If an employer opts out of receiving the subsidy, a state would pay the subsidy directly to the employee.

- HIPAA Special Enrollment Rights. Group health plans must permit eligible employees and dependents to enroll in two additional situations: (1) if they lose eligibility for Medicaid or CHIP coverage and request enrollment within 60 days after the termination of coverage or (2) if they become eligible to participate in a premium assistance program under Medicaid or CHIP and request enrollment within 60 days after they are determined to be eligible for premium assistance.
- Employee Notices. Employers maintaining group health plans in a state that has a premium assistance program must provide employees with a notice describing the program. The notice can be provided with plan enrollment materials or with the plan's SPD. The DOL and Department of Health and Human Services (HHS) are to issue a model notice on or before February 4, 2010. The notice requirement is effective for plan years beginning after the release of the model notice.
- Disclosure to States. Health plan administrators must disclose to a state, upon request, information about the plan's benefits when the plan covers an employee or dependent who is also covered by Medicaid or CHIP. The DOL and HHS are to work to develop a model coverage coordination disclosure form for this purpose. States may not request the coverage coordination disclosure form until the first plan year that begins after the release of the model form by the DOL and HHS.

Economic Stimulus Act Expands HIPAA's Privacy and Security Requirements

President Obama signed the Health Information Technology for Economic and Clinical Health Act (HITECH) into law as part of the Economic Stimulus Act. The HITECH allocates approximately \$19 billion to health information technology projects, including the promotion of electronic health records. To address concerns about protecting health information, the HITECH greatly expands HIPAA's Privacy and Security requirements. To briefly highlight some key points, the HITECH: (1) makes HIPAA's Privacy and Security standards, as well as the penalties for violating those standards, directly applicable to business associates; (2) requires covered entities to notify individuals, as well as HHS and media outlets in some cases, of security breaches involving unsecured protected health information (PHI); (3) contains new accounting requirements for disclosures made from an "electronic health record"; and (4) enhances HIPAA Privacy and Security enforcement actions; for example, by increasing the civil penalties and mandating HHS compliance audits.

Many of the changes go into effect one year from the date of enactment (*i.e.*, February 17, 2010), although different effective dates apply to certain provisions. For example, the heightened enforcement provisions are effective immediately. Covered entities, such as group health plans and business associates will need to take action to comply with the revised HIPAA Privacy and Security rules. Compliance documents, such as business associate contracts, will likely require revision. Please contact your Reinhart attorney or any member of our employee benefits team for more information.

Economic Stimulus Act Temporarily Increases Limit for Transit Pass/VanPool Benefits

In addition to the changes described above, the Economic Stimulus Act temporarily increases the amount that may be excluded from an employee's income under Code section 132(f) for transit pass/vanpool benefits provided under a qualified transportation plan. Specifically, the Economic Stimulus Act increases the transit pass/vanpool maximum monthly dollar amount from \$120 to \$230, making this limit the same as the limit for qualified parking benefits. This change is effective March 1, 2009 and remains in effect until the end of 2010.

OTHER DEVELOPMENTS

Executive Compensation Limits – Economic Stimulus Act

A primary purpose of the Emergency Economic Stabilization Act of 2008 (EESA), which was signed by President Bush on October 3, 2008, was to provide authority to the Secretary of the Treasury (Secretary) to restore liquidity and stability to the U.S. financial system by establishing the Troubled Asset Relief Program (TARP). Under TARP, the Secretary has the authority to purchase "troubled assets" from "financial institutions." In addition to authorizing the Secretary to purchase troubled assets from financial institutions, the EESA added new Code sections 162(m)(5) and 280G(e), placing limits on executive compensation for financial institutions that participate in TARP. The Economic Stimulus Act expands on EESA's executive compensation limits for entities participating in TARP. For example, the Economic Stimulus Act broadens the scope of EESA's limits on golden parachute payments to senior executive officers. Among other restrictions and limitations, the Economic Stimulus Act also prohibits TARP recipients from paying or accruing any bonus, retention award or incentive compensation to certain covered executives prior to the satisfaction of its TARP obligations. The Economic Stimulus Act gives the Secretary broad authority to develop appropriate safeguards for executive compensation and corporate governance.

This *Headlines in Employee Benefits Law E-Alert* provides general information about employee benefits issues. It should not be construed as legal advice or a legal opinion. Readers should seek legal counsel concerning specific factual situations confronting them.