Reinhart

August 2010 Employee Benefits Update

POSTED:

Aug 16, 2010

RELATED PRACTICES:

Employee Benefits

https://www.reinhartlaw.com/practices/employee-benefits

SELECT COMPLIANCE DEADLINES AND REMINDERS

Summary Annual Report Deadline for Calendar Year Defined Contribution Plans

Plan administrators of defined contribution plans have nine months after the end of a plan year to provide participants and beneficiaries with a summary annual report (the SAR). The SAR summarizes the plan's latest annual report/return (Form 5500). For plan years ending December 31, 2009, the deadline for providing the SAR is September 30, 2010. However, if the filing deadline for a plan's Form 5500 is extended, the deadline for providing the SAR is extended by two months.

Administrators of defined benefit plans are not required to provide SARs for plan years beginning after December 31, 2007. Instead, some of the information on the SAR is included in the plan's annual funding notice. The annual funding notice for defined benefit plans must be provided within 120 days following the end of the plan year.

Summary Plan Information Deadline for Calendar Year Multiemployer Defined Benefit Plans

Multiemployer defined benefit plans are required to provide a summary report to each union and employer contributing to the plan within 30 days of the due date of Form 5500, including extensions. This report must include certain information that multiemployer pension plans are also now required to report on Form 5500, such as employers contributing more than 5% of total contributions, information on amortization extensions and the plan's funded status, the number of participants with no contributing employer, the number of contributing employers, and the number of employers that withdrew during the plan year and related withdrawal liability.

Medicare Part D Deadlines

All group health plans that offer prescription drug coverage to Medicare eligible employees (under either an active plan or retiree plan) must provide the annual creditable coverage disclosure notice to Medicare-eligible participants and dependents no later than November 15, 2010. The model notice can be accessed through the CMS website.

Form 5500 Filing Deadline for Calendar Year Plans with Extensions

If a plan administrator filed Form 5558 with the Internal Revenue Service (IRS) on or before July 31, 2010 for a calendar year plan, the plan's Form 5500 filing deadline is extended to October 15, 2010. The Plan sponsor does not need to attach a copy of Form 5558 to the annual return under EFAST2. However, the plan sponsor must keep a copy of the Form 5558 that was filed with the IRS in the plan's records.

RETIREMENT PLAN DEVELOPMENTS

DOL Issues New Rules on Fee Disclosure

The Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) released interim final regulations under ERISA section 408(b)(2). The interim final regulations require certain service providers to employer sponsored retirement plans to disclose information to assist plan fiduciaries in assessing the reasonableness of contracts or arrangements, such as the reasonableness of the service provider compensation and potential conflicts of interest.

The interim final regulations apply only to defined benefit and defined contribution plans. However, the final rule reserves a section of the regulations for application of the rules to health and welfare plans. Proposed regulations and a proposed class exemption were originally issued in December 2007.

Covered service providers that must comply with the disclosure requirements include those that provide the following:

- Certain fiduciary or registered investment advisory services
- Recordkeeping or brokerage services to a participant-directed individual account plan in connection with the investment options made available under the plan (but only the first level of investment and not the underlying investment within the investment product)
- Certain other services for which indirect compensation is received

However, a service provider is not subject to the disclosure requirements unless the service provider reasonably expects to receive $1,000 or more in compensation in connection with providing one or more services.

The interim final rule requires that all direct compensation (received from the

plan) must be disclosed. A covered service provider generally may disclose direct compensation as the total for all services or as itemized charges (except that specific disclosure is required for recordkeeping services). The final rule also requires disclosure of indirect compensation, including identification of the services provided and the payor of the indirect compensation. The interim final rule contains a de minimis exception for nonmonetary compensation of $250 or less in the aggregate during the term of the contract or arrangement.

Disclosed information must be provided to plan fiduciaries prior to entering into the contract or arrangement and within 60 days of any change in the information previously provided. The disclosure must be written, but a formal written contract or arrangement delineating the disclosure obligations is not required.

The interim final rule is effective July 16, 2011. Service providers must be in compliance with the regulations as of the effective date, even with regard to preexisting contracts.

IRS Issues Guidance on the Special Funding Rules for Defined Benefit Plans

The IRS issued two notices that provide guidance on the availability of special funding rules for single-employer and multiemployer defined benefit plans.

Notice 2010-55 provides guidance on the availability of the special funding rules for single-employer defined benefit plans under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA) for a plan year for which Form 5500 (and Schedule SB) has been filed. Under the notice, if a plan year ends before guidance is issued, the plan sponsor may elect to use an alternative amortization schedule pursuant to PRA without regard to whether Form 5500 has been filed for that year. The notice also describes anticipated future guidance with respect to an election to use the special funding rules. Future guidance may address, among others, calculation of alternative amortization schedules and the effect on funding balances, and the procedures for making the election to use an alternative amortization schedule.

Notice 2010-56 provides guidance on the availability of the special funding rules for multiemployer defined benefit plans under the PRA for a plan year for which Form 5500 (and Schedule MB) has been filed. Specifically, if an applicable plan year ends before guidance is issued, the special funding rules may be applied for the applicable plan year without regard to whether the plan sponsor has filed the Form 5500 for that plan year. The notice states that anticipated future guidance may address, among others, the requirement to notify participants and

beneficiaries of the application of the special rules and the effect of application of the special rules on the certification of funded status (for example, endangered, critical or neither), including certifications already made.

Impact of the Dodd-Frank Wall Street Reform and Consumer Protection Act

On July 21, 2010, President Obama signed into law the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Act). The Act impacts employee benefit plans in several ways. One key aspect of the Act relates to swaps (a broad range of over-the-counter transactions) and other derivatives. "Swap dealers" and "major swap participants" are subject to various responsibilities. Employee benefit plans are excepted from the definition of "major swap participant." However, as investors, employee benefit plans are impacted by this regulation of counterparties to plan transactions. These rules may affect the structure, terms, conditions and costs of swap transactions and may require additional representations and information from plans.

The Act also creates a new Bureau of Consumer Financial Protection (the Bureau). The Bureau has authority to regulate financial products and services. It is possible that the Bureau will have authority over matters related to employee benefit plans. The Bureau's regulation of plan service providers creates the potential for multiple and conflicting regulations to the extent the Bureau's authority overlaps with the DOL and the IRS. The full effect, if any, of this portion of the Act is unclear.

Court Rejects the "Prudent Investor Rate" in Favor of the PBGC Discount Rate

A district court rejected the prudent investor rate theory and applied the Pension Benefit Guaranty Corporation (PBGC) discount rate to determine the amount of a PBGC termination liability claim. Wolverine, Procter & Schwartz, *LLC v. Lynn F. Riley*, 2010 WL 1236298 (D. Mass. 2010). This case demonstrates a recent trend among courts. In the 1990s and 2000s, several courts found that an unfunded benefit liability claim may be recalculated in bankruptcy using a "prudent investor rate" to determine the present value of plan liabilities. Using the prudent investor rate in these cases resulted in a significantly lower PBGC claim for unfunded benefit liabilities. More recently, however, courts rejected the prudent investor rate theory and applied the PBGC discount rate to determine the amount of unfunded benefit liabilities. Historically, the assumptions in the regulations, particularly the discount rate assumption, have been conservative. A lower, more conservative

discount rate results in a higher liability value.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Guidance Issued on Preventive Care for Non-grandfathered Health Plans

The Department of Health and Human Services (HHS), the DOL and the Treasury released interim final regulations regarding coverage of preventive health services under the Patient Protection and Affordable Care Act (PPACA). Under PPACA, group health plans and health insurance issuers that are not grandfathered health plans, or that lose their grandfathered health plan status, are required to provide certain preventive care items and services with no cost sharing (such as copayment, co-insurance or deductibles) effective as of the first plan year beginning on or after September 23, 2010.

Under the interim final regulations, required and preventive care items or services that must be provided without cost sharing include:

- Evidence based recommended items or services in the U.S. Preventive Services
- Task Force with a rating of A or B.
- Immunizations for children, adolescents and adults included in the Centers for Disease Control and Prevention's Immunization Schedules.
- Evidence-informed preventive care and screening supportive by the Health Research and Services Administration for infants, adolescents, children and women.

A complete list of recommendations and guidelines that are required to be covered without cost sharing can be found here.

The preventive care services that must be offered with no cost sharing may change from time to time. The applicable standards for a given plan year are those in effect at least one year prior to the beginning of the plan year. Thus, for a plan year beginning January 1, 2011, a plan must comply with the standards issued prior to January 1, 2010. In addition, if a particular standard is revoked by the agencies, plans will not be required to continue covering the affected service or item at 100%. However, plans will be required to provide participants at least 60 days advance notice before changing how the service is treated.

A plan may not implement cost sharing for preventive services provided in a

physician office setting if the primary purpose of the visit is preventive care. However, an office visit copayment or other applicable cost sharing can be imposed in situations where the preventive services are not billed separately and the primary purpose of the office visit is for other than preventive care. Further, network plans may implement cost sharing for out-of-network preventive care.

DOL Issues Model Notices on Dependent Coverage, Lifetime Limits and Patient Protections

The DOL issued model notices for three PPACA requirements that take effect for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

- *Dependent Coverage*. Under PPACA, group health plans that offer dependent coverage must continue making such coverage available for adult children until age 26. Group health plans must provide notice to such a child who is not enrolled and provide an opportunity to enroll. The notice may be included with the plan's enrollment materials provided the disclosure is prominent.
- *Lifetime Limits*. Group health plans cannot impose a lifetime limit on the dollar value of "essential health benefits." Under PPACA, group health plans must provide notice to participants that lifetime limits no longer apply. The notice may be provided to a participant on behalf of the participant's dependents and can be included with the plan's enrollment materials provided the statement is prominent.
- *Patient Protection*. Group health plans are required to provide notice to participants of their rights to (1) choose a primary care provider or a pediatrician from the plan's network or (2) obtain obstetrical or gynecological care without prior authorization. The notice must be provided whenever the plan or issuer provides a participant with an Summary Plan Description (SPD) or other similar description of benefits under the plan or coverage.

Guidance Issued on Claims and Appeals Rules for Non-grandfathered Health Plans

HHS, DOL and the Treasury released an interim final regulation regarding the claims and appeals procedure requirements under PPACA. Under PPACA, group health plans and health insurance issuers that are not grandfathered health plans, or that lose their grandfathered health plan status, are required to comply with specific internal claims and appeals procedures and external review

processes, effective as of the first plan year beginning on or after September 23, 2010.

- *Internal Claims Review*. Non-grandfathered group health plans must have an internal claims review process that complies with the DOL claims procedures requirements under ERISA and comply with additional requirements under the interim final regulations. These additional requirements include, among others, that a plan notify a claimant within 24 hours for urgent care claims, take steps to avoid conflicts of interests in the appeals process and ensure independence and impartiality of the individuals making claims decisions, and comply with the new notice requirements.
- In addition, if a plan fails to comply with all of the internal review requirements, the claimant is deemed to have exhausted the internal claims and appeals processes.
- *External Review Process*. Plans that are already subject to existing State external review process requirements must continue to follow the applicable State process, provided the State process complies with the minimum consumer protections of the National Association of Insurance Commissioners (NAIC) Uniform Model Act. Plans that are not subject to state insurance regulation, such as self-funded plans, must comply with a Federal external review process that will be detailed in future guidance. The standards in the Federal process will be similar to those in the NAIC model.
- *Notice Requirement*. PPACA requires plans to provide notice to participants of the applicable review processes and the availability of assistance. The DOL intends to issue model notices.

HHS Posts New Guidance on the Early Retirement Reinsurance Program

HHS issued the final application, instructions and updated frequently asked questions (FAQs) that provide significant details on the early retiree reinsurance program under PPACA. The final applications and instructions are substantially the same as the draft application issued in early June, but the FAQs provide important new guidance on how the application must be completed. The FAQs clarify that the first come, first served process applies to claim submissions and reimbursements, but not for applications.

In addition, the FAQs confirm that the reimbursements can be used to (1) reduce the plan sponsor's health benefit premiums or costs; (2) reduce plan participant

health premium contributions, deductibles, copayments and other out of pocket costs; or (3) reduce any combination of the plan sponsor and participant costs. However, a plan sponsor that uses some or all of the reimbursements to reduce participant out-of-pocket costs must do so for all plan participants and not just early retirees. The FAQs are available ~~here~~.

DOL Provides Enforcement Safe Harbor for Determining Parity for Outpatient Benefits Mental Health and Substance Abuse Benefits

On July 1, 2010, the DOL posted a new FAQ on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The FAQ creates an enforcement safe harbor that allows plans to divide outpatient benefits into subclassifications for the purpose of assessing parity under MHPAEA. MHPAEA generally prohibits financial requirements and treatment limits on mental health and substance abuse disorder benefits that are more restrictive than the predominant financial requirements or treatment limits that apply to all or substantially all medical and surgical benefits. Interim final regulations released in February 2010 created six classifications that must be tested to assure that a plan meets the MHPAEA standards. Two of the classifications are in-network out patient coverage and out-of-network outpatient coverage.

Until final rules are issued, the enforcement safe harbor allows a group health plan to divide its outpatient benefits into the following two subclassifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits and (2) all other outpatient items and services. Plan sponsors that have already conducted mental health parity testing and concluded that the plan could not charge a copayment for office visits for mental health or substance abuse disorders may want to revisit this issue in light of the new FAQ.

HHS Proposes Amendments to HIPAA Regulations

The Office for Civil Rights (OCR) of HHS issued a proposed rule setting forth modifications to the Privacy, Security and Enforcement rules issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The proposed rule implements the changes to HIPAA that are contained in the Health Information Technology for Economic and Clinical Health Act (the HITECH Act). Key items under the proposed rule include the following:

- Revising the definition of business associate to include patient safety organizations, health information organizations, E-prescription gateways,

persons who facilitate data transmission, vendors of personal health information and subcontractors of a covered entity

- Amending the definition of protected health information (PHI) to provide that the privacy and security rules do not protect individually identifiable health information of persons who have been deceased for more than 50 years
- Defining electronic media to reflect the current National Institute of Standards and Technology definition, including intranets and voice technology digitally produced from information systems and transmitted by phones
- Amending the definition of workforce to clarify that the term includes employees, volunteers, trainees and other persons whose conduct in the performance of work for a business associate is under the direct control of the business associate
- Holding a business associate contractually liable, not only for improper uses and disclosures of PHI, but also for compliance with all other requirements of the Privacy Rule that pertain to the performance of the business associate's contract
- Requiring material changes to the notice of privacy practices, including a statement that describes the uses and disclosures of PHI that require an individual's authorization
- Providing that the noncompliance penalties could be imposed on covered entities and business associates for the acts of their agents, including workforce members and subcontractors acting within the scope of the agency

OCR proposes a 180-day period beyond the effective date of the final rule by which covered entities and business associates are expected to be in compliance with the proposed rule, unless otherwise specified. In addition, the proposed rule includes a one-year transition period for compliance with the business associate contract changes. The one-year period is in addition to the 180-day compliance period. Thus, covered entities and business associates have one year past the compliance date to renew or modify existing contracts to meet the new requirements. However, if contracts are renewed or modified following the compliance date or prior to the end of the one-year period, contracts would need to be compliant as of the time of the renewal or modification.

Company Settles in First-Ever State HIPAA Privacy Suit

HealthNet of Connecticut, Inc. agreed to pay $250,000 to resolve a HIPAA privacy lawsuit by the State of Connecticut. HITECH gave state attorney generals the power to bring a civil action on behalf of state residents when the attorney general believes they have been victims of a HIPAA violation. The Connecticut Attorney General sued HealthNet of Connecticut, Inc. in January 2010 over a major data breach that the insurer suffered in May 2009.

GENERAL DEVELOPMENTS

DOL Issues Additional EFAST2 FAQs

The DOL issued a set of 16 new FAQs addressing the process for obtaining electronic signatures under EFAST2, the electronic filing system required for 2009 plan year filings of Form 5500 (due in 2010 for most plans). The new FAQs address who must register, the registration process, the personal nature of credentials, forgotten information, and expiration of credentials. The FAQs are available on the DOL website.

Court Did Not Use Deferential Review Because Plan Document Was Silent

The Eighth Circuit Court of Appeals held that a grant of discretionary authority in a SPD did not warrant a deferential judicial review for abuse of discretion when the plan document was silent. *Jobe v. Med. Life Ins. Co.*, 598 F.3d 478 (8th Cir. 2010). As background, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that courts should review a denial of benefits under a de novo standard unless the plan provides to the contrary and grants the fiduciary the discretionary authority to make benefit determinations. If a plan fiduciary can demonstrate an appropriate grant of discretionary authority, then decisions are entitled to be reviewed using the arbitrary and capricious or abuse of discretion standard.

The Eighth Circuit's decision highlights a growing judicial trend that in order to receive *Firestone* deference, discretionary authority cannot be conferred in an SPD alone when a clear grant of such authority does not exist in the plan document. Plan sponsors should confirm that the plan document, and not just the SPD, provides discretionary authority to the plan sponsor to interpret the terms of the plan.

SEC Adopts Rules Regarding “Pay-to-Play” Practices

The Securities and Exchange Commission (SEC) adopted new rules that are designed to curtail "pay-to-play" practices by investment advisers seeking to

manage money for state and local governments. The three key prohibitions under the new rules are as follows:

- Investment advisers cannot provide advisory services for compensation for two years after the adviser or certain of its executives or employees makes a political contribution to an elected official who is in a position to influence the election of the advisor for government business
- An advisory firm and certain of its executive employees cannot solicit or coordinate campaign contributions from others for an elected official who is in a position to influence the hiring of the advisor to handle funds of the state or locality. The new rules also prohibit the solicitation and coordination of payments for political parties in the state or locality where the advisor is seeking business
- An adviser cannot pay a third party, such as a solicitor or placement agent, to solicit a government client on behalf of the investment advisor unless the third party is an SEC-registered investment advisor or broker-dealer subject to similar "pay-to-play" restrictions

These rules are effective September 13, 2010.