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December 2011 Employee Benefits Update

POSTED:

Dec 28, 2011

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Cycle A Determination Letter Filings Due January 31, 2012

Remedial amendment period Cycle A individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2012 to rely on the extended period during which qualification amendments can be retroactively adopted. Cycle A plans include those sponsored by employers with tax identification numbers ending in a one or six.

Form 8955-SSA Due Date Approaching

As further discussed in the April 2011 and September 2011 Employee Benefits Updates, plan sponsors are now required to file Form 8955-SSA with the IRS. Form 8955-SSA replaces Schedule SSA that plan sponsors previously filed with Form 5500 to report separated participants with deferred vested benefits. The due date for filing Form 8955-SSA for both the 2009 and 2010 plan years is the later of: (1) January 17, 2012 or (2) the due date that generally applies for filing Form 8955-SSA for 2010. Because of the special extended filing date for the 2009 and 2010 Form 8955-SSA, the January 17, 2012 date will not be eligible for further extensions by filing Form 5558.

The IRS has noted that plan administrators can continue to use the plan year 2009 form for the combined 2009 and 2010 data even though the 2010 form has been released. Plan administrators may use a plan year 2009 form to report information for the 2010 plan year, or combine the information for the 2009 and 2010 plan years on a single plan year 2009 form.

IRS Issues Extension of Amendment Deadline and Sample Amendment for Code Section 436

On November 29, 2011, the IRS issued Notice 2011-96 (the Notice) extending both the deadline to amend a plan to satisfy Code section 436 and the period during which such an amendment is eligible for relief from the anti-cutback requirements of Code section 411(d)(6). In addition, the Notice includes a sample plan amendment that plan sponsors may use in amending plans to satisfy Code section 436.

Code section 436 as added by the Pension Protection Act of 2006 sets limits on

benefit payments and pension accruals for defined benefit plans that are "underfunded." The effective date of Code section 436 was generally January 1, 2008. Pursuant to the Notice, the deadline for adopting an interim amendment with respect to Code section 436 has been extended to the latest of: (1) the last day of the first plan year that begins on or after January 1, 2012, (2) the last day of the plan year for which Code section 436 is first effective for the plan or (3) the due date (including extensions) of the employer's tax return for the tax year that contains the first day of the plan year for which Code section 436 is first effective for the plan. However, in the case of an application for a determination letter for an individually designed plan that is filed on or after February 1, 2012, the restated plan that is submitted with the application must incorporate an interim amendment with respect to Code section 436. Therefore, the filing of the application will accelerate the interim amendment deadline for Code section 436. The deadline to adopt amendments for compliance with Code section 436 may be later for plans subject to collective bargaining agreements and plans sponsored by certain tax-exempt organizations.

Furthermore, the Notice provides that a plan amendment adopted with respect to Code section 436 that eliminates or reduces a Code section 411(d)(6) protected benefit does not cause a plan to fail to meet the anti-cutback requirements of Code section 411(d)(6) if the amendment is adopted by the extended deadline and the elimination or reduction is made only to the extent necessary to enable the plan to meet the requirements of Code section 436. Adoption of the sample amendment by the extended deadline will be deemed to have satisfied this condition.

RETIREMENT PLAN DEVELOPMENTS

PBGC Announces Maximum Insurance Benefit for 2012

On November 23, 2011, the Pension Benefit Guaranty Corporation (PBGC) announced that the maximum insurance benefit for participants in underfunded pension plans terminating in 2012 will be $4,653.41 per month ($55,840.92 per year) for those who retire at age 65. The amount the PBGC pays retirees is based on a formula prescribed by federal law. The amount is higher for those who retire later and lower for those who retire earlier or elect survivor benefits. The increase is not retroactive.

IRS Releases Possible Governmental Plan Guidance

The IRS has published two advance notices of proposed rulemaking relating to the definition of the term "governmental plan" under section 414(d) of the Internal

Revenue Code (Code). The first notice describes guidance under consideration on how to determine whether a retirement plan is a governmental plan (the General Notice). In addition, the principles described in this General Notice could also apply for purposes of certain parallel terms in sections 403(b) and 457 of the Code. The second notice applies additional rules to the definition of an Indian Tribal Government (ITG) governmental plan (the ITG Notice). Each notice contains an appendix setting forth a draft of possible proposed regulations.

Key Provisions Under the General Notice

Definition of "Governmental Plan" and Other Key Terms. The proposed regulations provide the statutory definition of the term “governmental plan” as a plan established and maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of the foregoing. Within this definition, there are several key terms relating to governmental plans, the definitions of which are set forth in the proposed regulations. For example, the proposed regulations propose a facts and circumstances test to determine whether an entity is an "agency or instrumentality" of a governmental entity and describes the multiple factors under consideration for making such a determination.

Rules Relating to "Established and Maintained." The guidance under consideration also describes proposed rules for determining whether a governmental entity has "established and maintained" a plan for purposes of section 414(d) of the Code. The proposed rules provide that a plan is established and maintained for the employees of a governmental entity if: (1) the plan is established and maintained by an employer within the meaning of Treasury Regulation §1.401-1(a)(2), (2) the employer is a governmental entity and (3) the only participants covered by the plan are employees of that governmental entity.

Proposed Effective Date. It is expected that these proposed regulations would not be applicable earlier than for plan years beginning after the date of the publication of the Treasury decision adopting these rules as final regulations in the Federal Register. Because an amendment of a state or local retirement plan generally requires enactment of state legislation, the Department of Treasury and IRS intend to take into consideration the time required to complete the state legislative process when determining an effective date for these regulations.

Key Provisions Under the ITG Notice

As noted above, the IRS also published an advance notice of proposed rulemaking

relating to the definition of an ITG governmental plan. The term "governmental plan," as amended by Pension Protection Act of 2006 (PPA) includes a plan which is established and maintained by an ITG, a subdivision of an ITG or an agency or instrumentality of either, and all the participants of which are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential governmental function). The ITG guidance under consideration describes certain activities that would be deemed to be either governmental or commercial for purposes of section 414(d) of the Code. For example, commercial activities would include operations involving a hotel, casino, service station, convenience store or marina. In addition to listing certain specific activities, a facts and circumstances test would be used to determine whether an activity is a governmental or commercial activity. The ITG guidance under consideration would describe rules for determining whether employees covered by an ITG plan perform substantial services in activities that are governmental or commercial and whether such services would generally be based on the employee's assigned duties and responsibilities.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Supreme Court Agrees to Review Patient Protection and Affordable Care Act's Individual Mandate

The Supreme Court of the United States announced on November 14, 2011 that it would hear arguments on the constitutionality of the individual insurance mandate provision (requiring individuals to buy health insurance by 2014 or pay a tax penalty) under the Patient Protection and Affordable Care Act (PPACA). The Court agreed to hear arguments regarding if the challenge is barred by the Anti-Injunction Act, the severability of the individual insurance mandate from the rest of the law if the mandate is struck down and the constitutionality of the law's Medicaid expansion. Arguments are expected sometime in March 2012.

Informational Reporting Cost of Employer-Sponsored Health Coverage for 2012 Form W-2

Effective for taxable years beginning on or after January 1, 2012 (i.e., beginning with the Forms W-2 issued in January 2013), PPACA requires employers that provide health care coverage to their employees to report the aggregate cost of applicable employer sponsored coverage on Forms W-2. This requirement is for informational purposes only; the cost of coverage is not taxable. The IRS has subsequently issued guidance providing instruction on how to calculate and report the cost of coverage.

To comply with this new reporting requirement, an employer will need to determine the applicable employer-sponsored health coverage for an employee, calculate the aggregate cost of that coverage and then report that cost on the employee's Form W-2. Employers should follow the processes provided in this guidance until the IRS issues further guidance. Note that certain employers are exempt from this requirement for 2012 (and until the IRS issues further guidance), including small employers (those who were required to file fewer than 250 Forms W-2 in the pervious year), employers that provide coverage solely through a health reimbursement arrangement or under a multiemployer plan, and employers that provide coverage under a self-insured group health plan not subject to any federal continuation coverage requirements. In addition, government employers that provide coverage under plans primarily for the military and Indian tribal government employers are exempt from this reporting requirement.

U.S. Department of Health and Human Services Office for Civil Rights Begins Health Information and Privacy and Security Audit Program

The U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) has announced that it is implementing a pilot audit program to perform up to 150 audits of covered entities to assess compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules and breach notification standards. Audits conducted during the pilot phase began in November 2011 and will conclude by December 2012. The audit program is pursuant to the Health Information Technology Economic and Clinical Health Act (HITECH ACT) (part of the American Recovery and Reinvestment Act of 2009), which requires HHS to provide for periodic audits to ensure covered entities and business associates are complying with HIPPA's privacy and security rules and breach notification standards.

Covered Entities and Business Associates Are Eligible for Audits

The OCR is responsible for selection of the entities that will be audited. The OCR has stated that every covered entity and business associate is eligible for an audit. However, the OCR has noted that business associates will be included in future audits, thus implying that business associates will not be included in the pilot audit program. The OCR states that it will attempt to audit a wide range of types and sizes of covered entities—covered individual and organizational providers of health services, health plans of all sizes and functions, and health care clearinghouses may all be considered for an audit.

The Audit Process

Entities selected for an audit will be informed in writing by OCR of their selection and asked to provide documentation of their privacy and security compliance efforts. Every audit will include an onsite visit (generally between 3-10 business days) and result in an audit report. Following the site visit, auditors will develop and share with the entity a draft report. Prior to finalizing the report, the covered entity will have the opportunity to discuss concerns and describe corrective actions implemented to address concerns identified.

Audit Results

OCR will not post a listing of audited entities or the findings of an individual audit which clearly identifies the audited entity. The OCR has stated that audits are primarily a compliance improvement activity. Generally, OCR will use the audit reports to determine what types of technical assistance should be developed, and what types of corrective action are most effective. However, should an audit report indicate a serious compliance issue, OCR may initiate a compliance review to address the problem. 5

Final Early Retiree Reinsurance Program Reimbursement Processing

The Centers for Medicare & Medicaid Services (CMS) announced that as of December 2, 2011 the Early Retiree Reinsurance Program (ERRP) had disbursed nearly $4.5 billion of the $5 billion appropriation. With limited amounts of proceeds remaining for ERRP reimbursement requests, CMS issued an announcement that describes how the reimbursement process will continue until the funds are exhausted. Additionally, based on the availability of the remaining ERRP funds and the rate at which reimbursements have been disbursed, CMS has announced that plans must not submit any claims incurred after December 31, 2011 in the Claims Lists submitted in support of a reimbursement request.

CMS will reject a Claims List in its entirety that includes any claims with an incurred date of January 1, 2012 or after. Finally, CMS has posted information regarding a planned survey of ERRP participating plans. CMS has stated that it will continue to accept reimbursement requests for claims incurred prior to December 31, 2011, but paid after December 31, 2011, even after the $5 billion has been initially disbursed, and will hold each request in the order in which it was received. Plans that have reimbursement requests on hold will receive an e-mail notifying them that CMS has placed their request on hold pending availability of funds. Additionally, such plans will have access to information about the

position of their request in the list of reimbursement requests on hold.

The plan whose reimbursement request initially exhausts the remaining funds will be reimbursed to the extent funds are available. If there are not sufficient funds remaining to fully reimburse the plan, CMS will partially pay the request. CMS will send an e-mail notification of the specific amount paid and the remaining balance each time a partial payment is made. If additional funds become available, CMS will pay the plan the balance of its request. CMS will then use the additional funds to pay plans in the order in which CMS received the reimbursement requests. CMS will disburse funds to honor reimbursement requests in this manner until the funds are entirely exhausted.

Plans remain responsible for submitting updated data to correct any inaccuracies or changes in previously submitted price concession amounts identified by the plan. In addition, plans are still required to submit an error-free Claims List substantiating previous ERRP reimbursements no later than March 30, 2012. If a plan fails to comply with this requirement, CMS will initiate the process to recoup those funds. It is through this process that additional ERRP funds may become available to pay the reimbursement requests received after the $5 billion has been initially disbursed.

Finally, CMS announced that it recently entered into a relationship with a program integrity contractor to conduct audits. CMS will conduct audits of a subset of plans to verify compliance with ERRP rules, including early retiree eligibility, validity of claims and use of ERRP proceeds.

ERRP Participating Plan Survey

Additionally, HHS and CMS have announced that they will conduct a survey of participating plans to collect additional information about their use of ERRP proceeds. Through the survey, HHS intends to collect information on how participating plans have used or will use ERRP proceeds. CMS intends on directing participating plans to respond to the survey only twice per ERRP application—the second survey will be approximately one year after the first survey. CMS will send further information about the survey to plans shortly.

FAQs Part VII About Affordable Care Act Implementation and Mental Health Parity Implementation Released

HHS, the Department of Labor (DOL) and the IRS (collectively, the Departments) released additional Frequent Asked Questions (FAQ) stating that plans are NOT required to comply with PPACA's summary of benefits and coverage (SBC)

requirement until the final regulations are issued and applicable. In addition, FAQ Part VII addressed several issues relating to the implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Previously, plans were required to begin issuing the SBC and the Uniform Glossary on March 23, 2012.

SBC Guidance

The Departments had issued proposed rules and templates for the SBC and Uniform Glossary and had requested comments on each. In the FAQ, the Departments note that they received many comments and that they intend to issue final regulations as soon as possible that take into account those comments. Because PPACA requires plans to provide the SBC and Uniform Glossary in accordance with standards developed by the Departments, the Departments have clarified that plans are not required to comply with the SBC and Uniform Glossary requirement until they have finalized those standards. Finally, the FAQ notes that the Departments anticipate that the final regulations will have an applicability date that will give plans "sufficient time to comply."

MHPAEA Guidance

In addition to rules regarding financial requirements and quantitative treatment limitations, the MHPAEA contains certain prohibitions on plans and issuers imposed non-quantitative treatment limitations. The new FAQ responds to a number of questions regarding these non-quantitative treatment limitations. The new FAQ clarifies that, among other things, a group health plan may not require prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all mental health and substance use disorder benefits, but not require such prior authorization for any medical or surgical benefits. The additional FAQs regarding MHPAEA's non-quantitative treatment limitations also emphasized that under the terms of a plan, the processes, strategies, evidentiary standards and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, those applied with respect to medical and surgical benefits.

GENERAL DEVELOPMENTS

IRS Clarifies That Filing of Extension Requests Is Limited to Three or Fewer Plans Sponsored by Same Employer

The IRS has issued a reminder that Form 5558 can only be used for up to three plans. Filers of Form 5500s can apply for a one-time filing extension by filing Form

5558. If an employer maintains more than one single employer plan and the plan years end on the same date, the IRS generally allows an employer to file a single Form 5558 to apply for extensions to file Form 5500s. However, the IRS has stated they will not process Form 5558s requesting extensions for more than three plans.

The Employee Plans Compliance Unit Begins Form 5500 Non-filer Project

The October 12, 2011 issue of the IRS's Employee Plans News (a periodic IRS newsletter) notes that the IRS's Employee Plans Compliance Unit (ECPU) has begun a Form 5500 non-filer project to promote compliance with Form 5500 filing requirements. According to the newsletter, the EPCU will be sending compliance check letters to plan sponsors for whom they have no record of a Form 5500 or 5500-SF filing with the DOL (or Form 5500-EZ with the IRS) six to nine months after the return's due date. Plan sponsors will be asked to either file the return or explain why they did not file. Plan sponsors who have filed Form 5500s may still receive compliance check letters in some cases where the plan sponsor's Form 5500 information did not match IRS records (in which case, the IRS will simply update its records). In addition to the compliance letter, a failure to file a required return by a plan sponsor will result in the IRS sending a delinquency notice or notices (CP 403 Notice and CP 406 Notice) which will require a response from the sponsor.

Plan sponsors should be aware that the Internal Revenue Code imposes a penalty of $25 a day (up to $15,000) for not filing their Form 5500 return by the required due date. In addition, the DOL may impose civil penalties for the late filing of the same Form 5500 of up to $1,100 per day. The IRS notes that the DOL's Delinquent Filer Voluntary Compliance Program (DFVCP) may be utilized by many plan sponsors who have not filed their Form 5500 by the required due date to substantially reduce DOL penalties and eliminate the IRS penalty under the DFVC Program.