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February 2010 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Deadline for Adopting and Filing EGTRRA Pre-Approved Plans Is April 30, 2010

The Internal Revenue Service (IRS) has previously issued opinion and advisory letters for pre-approved (*i.e.*, master and prototype and volume submitter) defined contribution plans that were timely filed with the IRS to comply with the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) and other law changes. Employers using a preapproved plan document to restate a plan for EGTRRA, such as Reinhart's EGTRRA volume submitter document, must adopt the EGTRRA-approved plan document by April 30, 2010. Furthermore, plan sponsors seeking determination letters from the IRS must submit applications to the IRS for EGTRRA pre-approved plans no later than April 30, 2010.

Submission Period for Cycle E Individually Designed Plans Opens February 1, 2010

Effective February 1, 2010, the IRS will begin accepting determination letter applications from remedial amendment period Cycle E individually designed plans. In general, Cycle E plans must be submitted for a determination letter no later than January 31, 2011 to rely on the extended period during which qualification amendments may be retroactively adopted. Cycle E plans include those sponsored by employers with employer identification numbers ending in a "5" or "0". In addition, plan sponsors of governmental plans and Cycle D non-calendar year plans that elected to defer submission to Cycle E must submit their plans to the IRS before February 1, 2011.

Mandatory 20% Withholding Applies to 2009 RMDs Paid in 2010

The Worker, Retiree and Employer Recovery Act of 2008 (WRERA) permits participants in defined contribution plans to waive required minimum distributions (RMDs) for the 2009 plan year. Any recipient of a 2009 RMD can roll over that amount to an eligible retirement plan or an IRA. 2009 RMDs paid prior to January 1, 2010 were subject to optional withholding rules. However, RMDs paid between January 1, 2010 and April 1, 2010 are subject to the mandatory 20% federal income tax withholding that applies to eligible rollover distributions.

Medicare Part D Creditable Coverage Disclosure to CMS Due by March 1,

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2010 for Calendar-Year Plans

Under Medicare Part D regulations, most group health plans offering prescription drug coverage to Part D eligible individuals must annually disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is creditable or non-creditable. Group health plan sponsors comply with the CMS disclosure requirement by completing a disclosure form on the CMS Web site and filing the form electronically. The annual filing deadline is 60 days after the first day of the plan year (*i.e.*, March 1, 2010 for calendar-year plans). In addition, disclosure forms must be filed within 30 days after the termination of a plan's prescription drug coverage or a change in its creditable coverage status.

Deadline for Making Corrective Distributions of Failed ADP/ACP Tests Without Excise Tax Is March 15, 2010 for Calendar-Year Plans

Sponsors of calendar-year plans that failed the actual deferral percentage (ADP) test and/or actual contribution percentage (ACP) test for 2009 generally must make any corrective distributions by March 15, 2010 (*i.e.*, 2 ½ months after the end of the plan year) to avoid a 10% excise tax. Plans that include an eligible automatic contribution arrangement may make ADP and/or ACP corrective distributions up to six months after the end of the plan year without incurring the 10% excise tax. Participants are taxed on their ADP and/or ACP corrective distributions in the year the distributions are made, not the year of deferral.

Annual Actuarial Certification of Multiemployer Plan Status Is Due by March 31, 2010 for Calendar-Year Plans

Effective for plan years beginning after 2007, the Pension Protection Act of 2006 (PPA) requires actuaries of multiemployer plans to certify to the IRS and to the plan sponsor: (1) whether or not the plan is in endangered status or critical status for that plan year; and (2) for a plan that is in a funding improvement or rehabilitation period, whether or not the plan is making scheduled progress toward meeting the requirements of its funding improvement or rehabilitation plan. This certification is due no later than the 90th day of each plan year (*i.e.*, March 31, 2010 for calendar-year plans).

AFTAP Certification for Single Employer Defined Benefit Plans Is Due by March 31, 2010 for Calendar-Year Plans

Effective for plan years beginning after 2007, the PPA requires actuaries of single employer defined benefit plans to determine and certify the plan's adjusted

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funding target attainment percentage (AFTAP). If the plan's AFTAP is above 80%, no benefit restrictions will apply to the plan. If the AFTAP is between 60% and 80%, benefit increases are prohibited and partial restrictions apply to certain forms of payment. If the AFTAP is less than 60%, benefit accruals must be frozen and any form of payment that pays out faster than a single life annuity (such as a lump sum) is prohibited.

If the plan's actuary does not complete the certification before the first day of the fourth month of the plan year (*i.e.*, April 1, 2010 for calendar year plans), then the plan's AFTAP is presumed to be 10% less than the prior year's AFTAP until the certification is complete. If the AFTAP is not certified by the first day of the tenth month of the plan year (*i.e.*, October 1, 2010 for calendar year plans), then the plan's AFTAP will be presumed to be below 60% for the remainder of the plan year.

2008 Medicare Part D Subsidy Reconciliation Due March 31, 2010

A plan sponsor that applied for the Medicare Part D Retiree Drug Subsidy must file a reconciliation with CMS no later than 15 months after the end of the Plan Year (*i.e.*, March 31, 2010 for calendar-year plans). If the plan sponsor does not timely submit the reconciliation, the plan sponsor will forfeit the subsidy received for that year.

Revised HIPAA Privacy Notice Is Due by April 18, 2010 for All Health Plans

The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to send a notice of privacy practices to all participants and beneficiaries. The notice requirements became effective for large health plans in 2003 and for small health plans in 2004. At least once every three years thereafter, group health plans should have been notifying participants and beneficiaries of the availability of the privacy notice and how to get the privacy notice.

The Health Information Technology for Economic and Clinical Health Act (HITECH) changed some of HIPAA's requirements affecting the content of the privacy notice. As a result, group health plans are required to send a revised privacy notice to participants and beneficiaries that includes these changes by April 18, 2010, which is 60 days after the first effective date of the applicable HITECH changes (February 17, 2010). The revised privacy notice can be included with other mailings, including mailings that will be sent prior to February 17, 2010, as long as the revised privacy notice states it is effective February 17, 2010.

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The requirement to provide the revised privacy notice will reset the three-year notice cycle for all group health plans. All group health plans, regardless of size, will again be responsible for sending the next reminder in three years. However, group health plans could consider annually mailing the reminder (perhaps with other annual mailings) to ensure that the distribution requirement is satisfied.

If the plan sponsor maintains a Web site with information about the group health plan's benefits, the sponsor must post the revised privacy notice on the Web site and make it available electronically through the Web site in addition to using an appropriate distribution method.

Deadline for Distributing Excess Deferrals Is April 15, 2010

Any elective deferrals exceeding the Internal Revenue Code (the Code) section 402(g) limit for 2009 ($16,500), plus allocable income, must be distributed to affected participants by April 15, 2010 to avoid double taxation.

Deadline for 2009 Annual Funding Notice Is April 30, 2010

All qualified defined benefit pension plans must distribute the annual funding notice to participants, beneficiaries, labor organizations representing participants, the Pension Benefit Guaranty Corporation (PBGC) and, for multiemployer plans, contributing employers, no later than 120 days following the end of the plan year (*i.e.*, April 30, 2010 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.

RETIREMENT PLAN DEVELOPMENTS

DOL Finalizes Safe Harbor Regulation for Contributions to Small Plans

On January 14, 2010, the Department of Labor (DOL) finalized regulations to establish an optional safe harbor for timely deposit of participant contributions to a small employee benefit plan. A small employee benefit plan is a plan with fewer than 100 participants at the beginning of the plan year. This regulation became effective immediately upon publication.

The general contribution deposit rule requires an employer to deposit participant contributions to an employee benefit plan by the earliest date on which they can be reasonably segregated from the employer's general assets. Pursuant to the optional safe harbor, participant contributions to a small employee benefit plan will not be considered a "plan asset" for the period prior to deposit if the

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employer actually deposits the contributions in the plan's account within 7 business days of the date that the contribution is (a) received by the employer (for amounts paid by the participant) or (b) otherwise payable to the participant in cash (for payroll withholdings). If an employer fails to timely deposit participant contributions or loan repayments, the losses and interest on the contributions must be calculated from the actual date on which the contributions or payments could have been reasonably segregated from the employer's general assets, not from the end of the safe harbor period.

The regulation also amends the existing definition of plan assets to include amounts paid by the participant or withheld from the participant's wages for the purpose of repaying a plan loan, regardless of plan size.

IRS Publishes Guidance on HEART Act

The IRS published Notice 2010-15 to provide guidance, in the form of questions and answers, on certain provisions of the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act). The HEART Act generally became effective for plan years beginning on or after January 1, 2009. Plans must be amended to comply with the HEART Act no later than the last day of the first plan year beginning on or after January 1, 2010.

The HEART Act expanded the requirements of the Uniform Services Employment and Reemployment Rights Act (USERRA) The mandatory provisions of the HEART Act requires qualified retirement plan sponsors to: (a) provide to the survivors of participants who die after January 1, 2007 while performing military service to any benefits that they would have received had the participant died while actively employed (except benefit accruals); (b) treat differential wage payments as compensation under the Code; and (c) treat an individual on active duty for more than 30 days as "severed from employment" for purposes of taking a distribution of elective deferrals from a 401(k) plan, a 403(b) plan or a 457(b) plan, even if the individual is receiving differential wage payments. The HEART Act permitted plan sponsors to allow distributions upon a deemed severance from employment.

• Death Benefits. The additional benefits that the plan sponsor must provide to survivors of participants who die while in military service include accelerated vesting, ancillary life insurance benefits and other survivor's benefits that are contingent on a participant's termination of employment due to death. However, the Plan does not have to impute benefit accruals for the period of military service for purposes of determining the deceased participant's accrued benefit.

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However, the plan must impute service credit for the period of military service to the deceased participant for vesting purposes.

- Differential Wage Payments. Differential wage payments are payments made by an employer to an employee who is on active duty for a period of more than 30 days that are equal to some or all of the compensation that the employee would have received from the employer but for the military service. Employers are not required to make differential wage payments; thus, this provision may not impact every plan. However, if differential wage payments are made, then the plan sponsor must treat the differential wage payments as compensation for Code purposes. For example, such payments must be considered compensation under Code section 415(c)(3), which means that the employer must permit the employee to make elective deferrals to a 401(k) plan from differential wage payments. Differential wage payments may, however, be excluded from the plan's definition of compensation for determining benefits and contributions, even if the Plan uses a Code section 414(s) safe harbor definition of compensation. In addition, contributions and benefits provided under the plan as a result of the differential wage payments can be excluded in the plan's nondiscrimination testing, provided that the ability to make contributions based on differential wage payments is provided on reasonably equivalent terms.
- Deemed Severance from Employment. Prior to the HEART Act, USERRA and its predecessors generally required an employer to treat an employee who was in uniformed service as if he were on military leave while long-standing IRS guidance concluded that employees absent for uniformed service were considered terminated. This conflict created confusion as to whether an employee who was absent to perform military service could be considered to have incurred a severance from employment for purposes of distributions from a 401(k) plan, a 403(b) plan or a 457(b) plan. The HEART Act clarified that, for purposes of distributions of elective deferrals, plan sponsors are required to treat individuals who are on active military duty for more than 30 days as having experienced a severance from employment.

The Notice further explains the application of this rule. The plan is not required to provide a distribution of elective deferrals upon a deemed severance from employment, just as the plan is not required to provide for a distribution of elective deferrals upon an actual severance from employment. If the plan does provide for a distribution upon a deemed severance from employment, the

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distribution is treated as an eligible rollover distribution and the employee is prohibited from making elective deferrals to the plan for six months after the distribution. This suspension provision does not apply if the employee has actually severed employment.

The Notice also addresses how a plan sponsor should coordinate distributions if the plan document permits distributions based upon a deemed severance from employment and qualified reservist distributions. Pursuant to the Notice, if a distribution qualifies as both a deemed severance from employment distribution and a qualified reservist distribution, the distribution is treated as a qualified reservist distribution and is not subject to the six-month suspension or the 10% early withdrawal tax.

Supreme Court Denies Review of Hecker v. Deere

The Supreme Court of the United States has refused to hear the plaintiff's appeal in Hecker v. Deere & Company. 2009 WL 331285 (7th Cir. 2009). Consequently, the Seventh Circuit decision in this case will stand, which is significant because Hecker is the first major appellate decision addressing the recent ERISA excessive fee litigation. We previously reviewed the Hecker decision in Reinhart's March 2009 Employee Benefits Update.

As previously reported, the Seventh Circuit dismissed the 401(k) plan participants' claims that Deere had violated ERISA's fiduciary duty requirements by failing to adequately disclose the plan's fee structure and by providing investment options with excessive fees and costs. 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. The Seventh Circuit concluded that Deere had disclosed all fee information that it was required to disclose and had offered a sufficient mix of investments with varying fee ratios.

Kraft Excessive Fee Case Dismissed by District Court in the Seventh Circuit

Following Hecker, the Northern District of Illinois dismissed the 401(k) excessive fee lawsuit brought against Kraft Foods Global Inc. (Kraft) and the Kraft Foods Global Inc. Thrift Plan. The plaintiffs had alleged that the plan's recordkeeper received excessive fees, the plan's trustee should not have received "float" on disbursements and that the offering of two unitized company stock funds, pursuant to which participants own units in the fund rather than shares, was "inherently imprudent."

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On a motion for summary judgment, the court dismissed the case for the following reasons:

- Pursuant to established Seventh Circuit case law, unitized company stock funds are not per se imprudent. In addition, Kraft adequately demonstrated procedural prudence with respect to the decision to offer the unitized company stock funds. Importantly, the court cited Hecker for the proposition that the participants had the opportunity to invest in seven other investment funds if the fees of the stock funds were unacceptable, which the court concluded was a sufficient number to preclude a finding that the fiduciaries breached their duties.
- The plan's fiduciaries acted prudently when retaining, monitoring and disclosing fee information about the plan's recordkeeper. The court determined that Kraft regularly reviewed the contract and, on several occasions, negotiated lower fees for the plan. The court rejected the plaintiff's assertion that the only prudent way to evaluate fees was through a request for proposal (RFP), which was a step that Kraft had not taken.
- The plan's fiduciaries did not breach any duty by allowing the trustee to retain "float," or interest on disbursements. The court concluded that the trustee sufficiently disclosed the circumstances under which float would be earned and retained. Interestingly, the court also notes that Kraft actually received annual reports of the float amounts on disbursement checks which enabled them to evaluate the float as part of the trustee's total compensation.

WELFARE AND FRINGE BENEFIT PLAN DEVELOPMENTS

IRS, DOL and CMS Publish Interim Regulations Under Mental Health Parity Act

On February 2, 2010, the IRS published interim final regulations interpreting the Mental Health Parity and Addiction Equity Act of 2008 (the Act). These regulations are effective April 3, 2010 and apply to non-collectively bargained group health plans for plan years beginning on or after July 1, 2010. The regulations apply to collectively bargained group health plans as of the first day of the first plan year beginning on or after the later of (a) the date on which the last of the collective bargaining agreements in effect on October 3, 2008 (without extensions) terminates or (b) July 1, 2010.

The Act, which applies to employers with 50 or more employees, requires group

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health plans that offer mental health or substance benefits to provide such coverage at the same level as the coverage for medical or surgical benefits. The Act prohibits inequity in financial requirements (*e.g.*, deductibles, copayments, coinsurance and out-of-pocket expenses), treatment limits (*e.g.*, limits on frequency or number of visits) and out-of-network coverage.

The regulations are quite extensive. We are continuing to review the impact of these rules, including the rules applicable to the cost exception. The following summarizes a few of the key items addressed in the regulations:

- Application of the Act. The Act's prohibitions apply separately to each classification of benefits, of which there are six: in-patient, in-network; in-patient, out-of-network; out-patient, in-network; out-patient, out-of-network; emergency care and prescription drugs. The regulations do not permit any other classifications (such as primary care v. specialist). Consequently, a plan could not justify imposing higher co-pays for visits with a psychiatrist on the basis that the plan distinguishes between primary care doctors and specialists.
- Application of Financial Requirements and Treatment Limits. The regulations distinguish among several types of financial requirements and treatment limits, all of which must be analyzed separately. For example, cumulative financial requirements and quantitative treatment limits, which include deductibles, out-of-pocket maximums and annual or lifetime day/visit limits, cannot be applied separately to mental health and substance abuse benefits. Therefore, a combined $500 annual deductible on all medical, surgical, mental health and substance abuse benefits is permissible while a $250 deductible on medical/surgical benefits with a separate $250 deductible on mental health/substance abuse benefits is not. Different rules apply to non-cumulative limits and prescription drugs.
- "Substantially all" Standard. The limits that can be applied to mental health and substance abuse benefits must not be more restrictive than the "predominant" financial requirement or treatment limit applied to "substantially all" of the medical/surgical benefits in the same classification. The regulations provide that "substantially all" means two-thirds. If the limit does not apply to at least two-thirds of all medical/surgical benefits in a classification, then the limit cannot apply to the mental health or substance abuse benefits in that classification. "Two-thirds" is determined on the basis of the dollar amount of all plan payments for medical/surgical benefits to be paid under the plan using any reasonable method.

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CMS Publishes Guidelines for Mandatory Medicare Reporting of HRAs

CMS has revised its Mandatory Insurer Group Health Plan User Guide to address how Responsible Reporting Entities (RREs) should report coverage under a health reimbursement arrangement (HRA). The Medicare, Medicaid and SCHIP Extension Act of 2007 required the RRE of a group health plan to report, beginning in 2009, the group health plan coverage available to all participants and dependents age 55 and older as well as any individual covered by the plan who is known to be entitled to Medicare. However, CMS explicitly exempted HRA coverage from the reporting requirement until 2010.

CMS outlined the rules applicable to HRA reporting in the revised User Guide. First, only HRA coverage with an annual benefit of $1,000 or more must be reported. Second, "free standing" HRA coverage should be reported separate from the group health plan while HRA coverage that is a part of a comprehensive group health plan should be reported as part of the group health plan coverage. Finally, HRA coverage should be reported beginning with the input files submitted in the fourth quarter 2010.

Unlike the initial 2009 reports, which required RRE's to report all coverage retroactive to January 1, 2009, HRA coverage will be reported prospectively only. The RRE should report only individuals with HRA coverage in effect on October 1, 2010 or later. In addition, CMS clarified that an RRE should not report an individual who reaches the annual benefit maximum as "terminated."

If the administrator of the HRA is different than the administrator of the group health plan, the HRA administrator may be an RRE who has not yet registered with CMS. HRA-only RREs may register beginning May 1, 2010. For example, an employer may have an insured health plan, for which the insurance company is the RRE, and a stand-alone HRA that is administered by the Human Resources department. In this case, the employer must register as an RRE and is responsible for reporting the HRA coverage to Medicare.

CMS also made several other minor changes to the User Guide. For example, RREs should now report both the social security number and the Medicare Health Insurance Claim (HIC) number for all individuals who are the policyholder, subscriber or employee for the group health plan coverage. The revised User Guide can be found at [Mandatory Insurer Reporting](#).

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NONQUALIFIED PLAN DEVELOPMENTS

IRS Publishes Plan Document Correction Program Under Code Section 409A

IRS Notice 2010-6 establishes a voluntary correction program allowing sponsors of nonqualified deferred compensation plans to correct certain non-intentional plan document failures under Code section 409A. The publication of this document correction program corresponds with the IRS's latest initiative to increase scrutiny of nonqualified deferred compensation arrangements under Code section 409A. This latest IRS guidance also provides insight into how the IRS interprets the Code section 409A regulations with respect to plan language.

The Notice provides a transitional relief period for corrections made in 2010. Plan sponsors should take this opportunity to review all nonqualified plan documents and correct any identified failures within the transition relief period to avoid the draconian penalties under Code section 409A. If a plan document correction is completed by December 31, 2010, the correction will be retroactively effective to January 1, 2009, thus avoiding the requirement to include any amount in income, except those amounts that must be included under Notice 2008-113 due to any corresponding operational failure.

Similar to the operational failure correction program, the document correction program is limited to a specified list of failures, each of which must be corrected in accordance with a specified methodology. The plan sponsor must also satisfy general eligibility criteria to use the program, such as not being under IRS investigation and correcting all substantially similar document failures at the same time. Examples of the types of correctable document failures include certain impermissible definitions, impermissible payment events, impermissible payment periods or schedules and impermissible deferral elections.

Except for the transition relief for corrections made in 2010, the correction methodologies vary by failure but generally require payment of a portion of the tax required under Code section 409A (usually 50%) plus the additional 20% tax under Code section 409A (but not the premium interest tax), subject to the transition period relief. Most corrections also require notice to the IRS by the employer and the employee.

The Notice also clarifies the IRS's Code section 409A operational failure correction program and provides additional guidance regarding certain commonly used language that will not result in a document failure.

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GENERAL DEVELOPMENTS

DOL Publishes Additional Guidance on Using EFAST2 for Delinquent and Amended Filings

The DOL previously published guidance on how to file a delinquent or amended 2008 Form 5500 return/report through EFAST either electronically until June 30, 2010 or on paper through October 15, 2010. The DOL has updated its EFAST2 frequently asked questions page to explain how to submit delinquent or amended returns for plan years before 2009 through EFAST2.

The plan sponsor, or its agent, must submit a delinquent or amended Form 5500 electronically through EFAST2 for plan years prior to 2009 including delinquent or amended 2008 returns filed after October 15, 2010, using the current filing year Form 5500, schedules, and instructions, except as provided below. The filing should indicate, where appropriate, the plan year for which the annual return/report is being filed. Penalty payments for a delinquent filing should not be made through EFAST2; all payments must be made in accordance with applicable requirements to the IRS or through the DOL's Delinquent Filer Voluntary Correction Program.

Notwithstanding the general rule regarding use of the current-year Form 5500, filers using EFAST2 for delinquent or amended returns must use the following correct-year schedules completed in accordance with the related instructions: Schedule B, SB, or MB; Schedule E; Schedule P; Schedule R and Schedule T. The correct-year schedules and instructions can be found at Form 5500 Series.

DOL Plans to Expand Definition of Fiduciary to Include Investment Advisors

The DOL posted a fact sheet on its Web site addressing the agency's plans to amend the definition of investment fiduciary to include more individuals, including pension consultants. Proposed regulations are currently scheduled to be published in June 2010.

The DOL is concerned that plan fiduciaries often rely on service providers, such as pension consultants and financial asset appraisers, when making investment decisions with respect to plan assets. Although ERISA provides that anyone who provides investment advice for a fee is a fiduciary, the regulations interpreting this provision provide a five-part test that must be satisfied in order for the act of giving investment advice to be considered a fiduciary act. The DOL believes that certain advisory relationships that are not captured by the current rules should

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give rise to fiduciary liability.

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