February 2011 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Notice of Waiver of Annual Limits Requirement

Under the Patient Protection and Affordable Care Act (PPACA), group health plans that have received a waiver of the restricted annual limits requirements must provide a notice informing participants that the plan does not meet the restricted annual limits for essential health benefits.

For plans with an approved waiver for plan years beginning prior to February 1, 2011, the notice needed to be provided by February 7, 2011. For plans with an approved waiver for plan years beginning after February 1, 2011, the notice must be included in the summary plan description or other benefit descriptions.

PBGC Flat-Rate Premium Filing Due by February 28, 2011, for Large-Size, Calendar Year Plans

Pension plans covered under ERISA section 4021 must annually file premium information with the Pension Benefit Guaranty Corporation (PBGC) and pay the premium due, if owed. Filing due dates differ based on the plan size. For large plans (those with 500 or more participants), the filing is due the last day of the second full calendar month of the plan year, which is February 28, 2011, for calendar year plans.

Medicare Part D Creditable Coverage Disclosure to CMS Due by March 1, 2011, 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 Creditable Coverage disclosure form and filing the form electronically. The annual filing deadline is 60 days after the first day of the plan year, which is March 1, 2011, 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, 2011, 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 2010 generally must make any corrective distributions by March 15, 2011, (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 can 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 distribution in the year the distributions are made, not the year of deferral.
Annual

Actuarial Certification of Multiemployer Plan Status Due by March 31, 2011 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 (a) whether the plan is in endangered or critical status for that plan year and (b) for a plan that is in a funding improvement or rehabilitation period, whether 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, which is March 31, 2011, for calendar year plans.

AFTAP Certification for Single-Employer Defined Benefit Plans Due by March 31, 2011, 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 funding target attainment percentage (AFTAP). If the 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, which is April 1, 2011, 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, which is October 1, 2011, for calendar year plans, then the plan's AFTAP will be presumed to be below 60% for

the remainder of the plan year.

2009 Medicare Part D Subsidy Reconciliation Due March 31, 2011

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, which is March 31, 2011, for calendar year plans. If the plan sponsor does not submit the reconciliation timely, the plan sponsor will forfeit the subsidy received for that year.

Deadline for Distributing Excess Deferrals is April 15, 2011

Any elective deferrals exceeding the Internal Revenue Code (the Code) section 402(g) limit for 2010 ($16,500), plus allocable income, must be distributed to affected participants by April 15, 2011 to avoid double taxation.

Deadline for the 2010 Annual Funding Notice is April 30, 2011

All qualified defined benefit pension plans must distribute the annual funding notice to participants, beneficiaries, labor organizations representing participants, the PBGC and, for multiemployer plans, contributing employers, no later than 120 days following the end of the plan year, which is April 30, 2011 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.

Submission Period for Cycle A Individually Designed Plans Opens February 1, 2011

Effective February 1, 2011, the IRS will begin accepting determination letter applications from remedial amendment period Cycle A individually designed plans. In general, Cycle A plans must be submitted for a determination letter no later than January 31, 2012. Cycle A plans include those sponsored by employers with employer identification numbers ending in a one or six.

RETIREMENT PLAN DEVELOPMENTS

IRS Updates Procedures for Obtaining Determination Letters and Rulings, and Increases Some User Fees

The IRS issued a series of revenue procedures that revise existing procedures for the issuance of rulings and determination letters and also update guidance on the user fee program. Most of the new revenue procedures contain minor modifications to the prior procedures. The following highlights the changes.

Determination Letters for DB-K Plans

The IRS announced that it will begin to issue determination letters for individually designed combination defined benefit and qualified cash or deferred plans (DB-K Plans) under Code section 414(x). A DB-K plan sponsor must submit two Form 5300s and pay two user fees.

User Fees for Requests for Letter Rulings and Determination Letters

Effective February 1, 2011, the IRS increased the following user fees for requests for determination letters and other rulings:

- Form 5300, without general or average benefits test: $2,500 (up from $1,000)
- Form 5300, with general or average benefits test: $4,500 (up from $1,800)
- Form 5310, without general or average benefits test: $2,000 (up from $1,000)
- Form 5310, with general or average benefits test: $4,000 (up from $1,800)

Seventh Circuit Vacates 401(k) Plan Participants' Class Certification

Employees of Boeing Corporation and International Paper filed suit against their respective companies and benefit plan committees, accusing each of causing the plans to pay excessive fees and expenses, including imprudent investment options, and concealing from participants material information regarding plan fees, expenses and investment options. Both cases were heard in the same district court, which certified both classes of plaintiffs. On appeal, Boeing and International Paper argued that the class definition given by the district court did not meet the standards of the Federal Rules of Civil Procedures (FRCP) Rule 23(c)(1)(B), and that the district court erred in concluding the classes met the criteria of Rule 23(a).

Relying on *LaRue v. DeWolff, Boberg & Associates, Inc.*, the Seventh Circuit determined that beneficiaries can resort to ERISA section 502(a)(2) after a breach of fiduciary duty has reduced the value of plan assets in their defined contribution accounts. However, LaRue provided little guidance regarding whether, and under what circumstances, participants and beneficiaries can proceed as a class under FRCP 23. Therefore, the Seventh Circuit held that to determine whether class treatment is appropriate, courts must distinguish between an injury to a person's retirement account that affects only that individual and an injury to one account that qualifies as a plan injury. The second type of injury potentially could be

appropriate for class treatment, while the first type would not.

In reviewing the classes certified by the district court, the Seventh Circuit found the class certifications flawed and vacated the district court's certification order in both cases. However, the court was careful to point out that nothing in its decision "should be understood as ruling out the possibility of class treatment for one or more better-defined and more-targeted classes" of plaintiffs.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Issues Updated Guidance on Use of FSA and HRA Debit Cards to Purchase Over-the-Counter Drugs

The IRS issued Notice 2011-5, which modifies Notice 2010-59 to expand the use of FSA and HRA debit cards to purchase over-the-counter medicine or drugs at the time of sale. Notice 2010-59 restricted the use of FSA and HRA debit cards to require substantiation prior to reimbursement because the IRS believed most systems could not comply with the PPACA requirements to ensure that over-the-counter medicine or drugs are reimbursed only if they are a prescribed drug. Now, Notice 2011-5 provides certain requirements that must be met for the transaction to be fully substantiated at the time and point of sale. Notice 2011-5 is effective for FSA and HRA debit card purchases of over-the-counter medicines or drugs made after January 15, 2011.

Court Holds Employer Not Responsible for Providing COBRA Election Where Third Party Administrator Was Designated Plan Administrator

In *Boddicker v. Esurance, Inc.*, a participant resigned while on FMLA leave but did not receive his COBRA election notice until after he filed suit against his employer because the third-party administrator (TPA) sent the notice to a post office box he no longer maintained. The participant argued that the employer had a duty to oversee the plan administrator or to follow up with the plan administrator to ensure participants receive their COBRA election notices. The district court disagreed, holding that because the employer had designated the third-party administrator as plan administrator, the employer was not responsible for providing the COBRA election notice. Where, as here, the court continued, the employer uses an outside plan administrator, responsibility for COBRA notification is bifurcated: the employer must notify the plan administrator when a qualifying event occurs, but the plan administrator is ultimately responsible for providing the COBRA election notice.

Ninth Circuit Disallows a Health Plan's Lien Against Attorney-Held Settlement Funds

A divided Ninth Circuit three-judge panel held that a plan was not entitled to equitable enforcement of the plan's subrogation right to reimbursement from a plan beneficiary's third-party injury settlement funds. The plan had sued the beneficiary's attorneys under the provision for equitable relief under ERISA section 502(a)(3) to enforce a plan lien for medical benefits paid on behalf of the beneficiary. The attorneys had disbursed the settlement money without paying the plan lien. The district court held that the plan's lien took priority over the attorneys' fees and ordered the attorneys to pay the plan out of the law firm's fees and costs.

On appeal, the plan argued that Sereboff v. Mid Atlantic Medical Services, Inc. overruled an earlier Ninth Circuit case, Hotel Employees & Restaurant Employees Intern. Union Welfare Fund v. Gentner, holding that a plan's lien could not be enforced against an attorney who did not sign the reimbursement agreement or expressly agree to honor the plan's lien. Sereboff, a Supreme Court decision, held that an ERISA plan was entitled to equitable enforcement of its reimbursement rights against identifiable settlement funds held by a beneficiary. Two of the judges on the panel disagreed, holding that Sereboff did not undermine the logic of Gentner, and accordingly reversed the district court's decision.

Court Rules Voluntary Appeals Not Subject to Full and Fair Review

In *DaCosta v. Prudential Insurance Company of America*, a district court dismissed the claimants' argument that voluntary appeals were subject to full and fair review. The claimants argued that the insurer had failed to provide them with sufficient information about its voluntary appeal procedures after the insurer had upheld the benefit denial on appeal. The court held that the Department of Labor's claims regulations do not require voluntary appeals to follow reasonable procedures or provide full and fair review. In so holding, the court rejected another court's contrary holding that voluntary appeals were subject to the full and fair review regulations.

Update on Challenges to the Health Care Reform Law

As noted in the January 2011 Employee Benefits Update, the House of Representatives voted to repeal PPACA, also known as the health care reform law. On February 2, 2011, a similar bid to repeal PPACA failed to pass in the Senate by a vote of 47 to 51.

In the courts, a federal district court judge in Florida ruled on January 31, 2011, that the individual mandate provision in PPACA is unconstitutional and declared PPACA, in its entirety, void. As such, now two courts have upheld PPACA (in Michigan and West Virginia) and two courts have ruled that the law is unconstitutional (in Florida and Virginia). Additionally, on January 26, 2011, a motion to expedite briefing and to schedule oral argument for the appeal of the Virginia district court's ruling was granted. The date for oral argument was tentatively set for May 2011.

Reinhart Comment: Even though the district court judge in Florida ruled PPACA is void, plans should continue to comply with PPACA and implement PPACA mandates until we are told otherwise from Congress or the United States Supreme Court.

GENERAL DEVELOPMENTS

SEC Adopts Say-On-Pay Rules

On January 25, 2011, the SEC adopted the "say-on-pay" rules, implementing a provision in the Dodd-Frank Wall Street reform law. The say-on-pay rules are designed to give shareholders greater input over executive compensation. Shareholders will also get a vote on certain "golden parachute" pay packages in connection with a merger or acquisition, and companies are required to make additional disclosures about such compensation arrangements. The rules provide that shareholders must be given a separate advisory vote in proxy statements to approve the compensation of executives at least once every three years. While the say-on-pay vote is nonbinding, companies will likely want to avoid "no" votes, which could be embarrassing for the company. The rules were approved 3–2, with Republican commissioners dissenting because the rules provide only a two-year, temporary exemption to small public companies."