February 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

EBSA Issues HIPAA Compliance Form M-1 for MEWAs

The Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) has issued Form M-1 for 2011. The form is filed annually by Multiple Employer Welfare Arrangements (MEWAs) providing health benefits with the DOL to show compliance with certain Health Insurance Portability and Accountability Act (HIPAA) provisions, including the portability and general renewability requirements, mental health parity requirements, and the Genetic Information Nondiscrimination Act (GINA).

The 2011 Form M-1 contains new provisions added by the Patient Protection and Affordable Care Act (PPACA), including prohibitions on lifetime limits, restrictions on annual limit, and coverage of dependent children until their 26th birthday. The filing deadline for the form is March 1, 2012, though a 60-day extension to May 1, 2012 is available.

March 30 Deadline for ERRP Full-Replacement Claims List Submission

The Department of Health and Human Services (HHS) is requiring plan sponsors who have received reimbursements under the Early Retiree Reinsurance Program (ERRP) to submit a full-replacement claims list by March 30, 2012 to support the reimbursements they have received. The claims list must be "error-free," meaning that it must pass the automated edit system implemented by ERRP. Absent the submission of an error-free claims list, procedure to recoup the funds paid to the plan sponsors will be initiated.

RETIREMENT PLAN DEVELOPMENTS

Meeting Your Fiduciary Duties Under the New Fee Disclosure Regulations

The Employee Retirement Income Security Act of 1974 (ERISA) prohibits any contract or arrangement with an employee benefit plan unless the services, the contract and the compensation are reasonable and necessary. Last week, the DOL issued final regulations under ERISA section 408(b)(2) (the Regulations) providing that contracts or arrangements are not reasonable unless the service provider adequately discloses all fees and compensation received in connection

with the arrangement. Under the Regulations, certain "covered service providers" to retirement plans - health and welfare plans are currently not included - must describe the services provided to the plan and the compensation received by the covered service provider.

The final Regulations postpone the effective date to July 1, 2012, allowing covered service providers and plans additional time to prepare for compliance under the Regulations.[1] Covered service providers are required to issue the initial disclosures by July 1, 2012. Plans must be prepared to review and respond to the covered service provider disclosures.

Call to Action for Responsible Plan Fiduciaries

If a covered service provider fails to comply with the Regulations, the contract or arrangement will not be considered reasonable, potentially exposing **BOTH** the plan fiduciaries and the service provider to the prohibited transaction rules and related excise taxes. Plan fiduciaries with the authority to enter into a contract or arrangement on behalf of the plan may be considered exempt from the prohibited transaction if they take certain actions specified in the Regulations. These "responsible plan fiduciaries" must request information from the covered service provider, and, if no response is forthcoming, report the covered service provider to the Department of Labor.

Steps responsible plan fiduciaries should take prior to July 1, 2012 to help identify potential noncompliance:

- Identify all service providers (e.g., consultants, investment managers, accountants, recordkeepers, etc.);
- Locate contracts for each service provider;
- Attempt to identify how each provider is paid based on the information you have prior to receiving the disclosure (e.g., from plan assets, the plan sponsor, investment fees, etc.).

Covered service providers have the responsibility to meet the disclosure requirements, but responsible plan fiduciaries must monitor their compliance and actively report noncompliance to the DOL, or potentially be in violation of the prohibited transaction rules. Reinhart will continue to provide additional guidance and will be available to assist plan fiduciaries in meeting their obligations under the new Regulations.

PBGC Issues First Quarter Interest Rates for 2012

The Pension Benefit Guaranty Corporation (PBGC) released the interest rates it will charge for the calendar quarter beginning January 1, 2012 and ending March 31, 2012. For employer liability, unpaid contributions, and unpaid premiums, the interest rate is 3%; for defaulted or overdue withdrawal liability payments to be charged by multiemployer plans, the rate is 3.25%. Both rates are unchanged from the previous quarter (October 1, 2011 to December 31, 2011).

IRS Releases Covered Compensation Tables for 2012

The IRS has issued its two annual covered compensation tables for the 2012 plan year. The tables are used by defined benefit plans that are integrated with Social Security to determine contributions and permitted disparity.

Defined benefit plans integrated with Social Security may provide participants an additional contribution based on participants' compensation above a certain level without violating antidiscrimination rules. Plans may use covered compensation tables issued by the IRS to determine the amounts of each eligible participant's covered compensation. Participants' covered compensation is computed as the average (without indexing) of the taxable wage base in effect for each calendar year during the 35-year period ending with the last day of the calendar year in which the employee attains (or will attain) social security retirement age. A 35-year period is used for all individuals regardless of their year of birth. In determining an employee's covered compensation for a plan year, the taxable wage base for all calendar years beginning after the first day of the plan year is assumed to be the same as the taxable wage base in effect as of the beginning of the plan year.

The regular compensation table ranges from employee birth years of 1907 to 1979 and later. The IRS also issues a rounded compensation table that ranges from 1937 to 1974 and later. The tables can be found in Rev. Rul. 2012-5, 2012-5 IRB in the Internal Revenue Bulletin.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Issues Publications 502 and 503 for Use in 2011 Tax Returns

The IRS has issued the latest versions of Publications 502 and 503 to be used in preparing federal tax returns for 2011. Publication 502 lists medical expenses that are deductible. Pursuant to Internal Revenue Code section 213(a), a taxpayer may deduct certain medical expenses that have not been reimbursed to the extent

that they exceed 7.5% of the taxpayer's income. Publication 503 contains the requirements taxpayers must fulfill in order to claim the Dependent Care Tax Credit (DCTC) under Code section 21 for expenses incurred from the care of children and dependents.

Publication 502 for 2011 is substantially similar to last year's. Publication 503 contains some changes as to what expenses are deductible. Consumers should consult the particular rules of their health FSAs, HSAs, and HRAs to determine which expenses are eligible for reimbursement.

HHS Issues Interim Final Regulations Adopting HIPAA Transaction Standards for Health Care Electronic Funds Transfer (EFT) and Remittance Advice

HHS issued interim final regulations establishing standards for Electronic Funds Transfer (EFT) as required by section 1104 of PPACA. These regulations, which became effective immediately on January 10, 2012, are now part of HIPAA's standard transactions guidelines. They apply only to transactions between health plans and providers using the Automated Clearing House (ACH) Network, which is the "pipeline" through which EFT travels (e.g., consumers use the ACH Network for direct deposit of their paychecks and to pay bills electronically), and do not apply to other types of health care transactions, such as EFT outside of the ACH Network or plan debit card transactions. The newly-issued regulations do not require the use of EFT payments but are intended to promote and streamline its use.

EFT payments require "remittance advice" to clarify any disparities between the payment amount and the amount charged by the health provider. The amounts may not match due to negotiated discounts or limits under network provider agreements between the health plan and provider, necessitating remittance advice with each payment. Whereas a mailed paper check can contain the proper remittance advice in the same envelope, the electronic file formats used by most EFT transactions do not permit including associated remittance advice, meaning that it has to be sent separately. As a result, many providers do not currently accept EFT payments because of the extra burden of "reassociating" the payments with the separately sent (via paper or electronic means) remittance advice.

The new HHS regulations require that health plans transmitting payments via EFT (1) use a uniform electronic file standard, and (2) include with the EFT a "trace number segment," which is compatible with data sent in electronic remittance

advice, thereby making reassociation of the payment with remittance advice automatic. HHS advises that, although health plans may use their financial institutions to process EFT payments and put the data into the required file format, the health plan remains responsible for compliance, whether the plan is processing payments by itself or through its financial institution. All EFT payments made by health plans must be in compliance with these regulations by January 1, 2014. The text of the new regulations can be found in the Federal Register.

Some Fiscal Year Plans Now Affected by PPACA's 2013 Health FSA Deferral Limit

Beginning in or after "taxable years" on or after January 1, 2013, PPACA caps salary deferrals made to health Flexible Spending Accounts (health FSAs) at $2,500. For some plans with non-calendar year plan years, the $2,500 limit would likely apply for their 2012-13 plan years.

For the purpose of PPACA's $2,500 deferral limit, "taxable year" refers to the employee's tax year, not the plan year. As a result, plans with non-calendar year plan years beginning on or after February 1, 2012 will be affected by the deferral limit, as these plans' years would end on or after January 1, 2013. If these plans currently allow participants to defer more than $2,500 to an FSA, the plans will likely have to adjust the amount they allow their participants to defer each month during their 2012-13 fiscal plan years.

Unfortunately, the IRS has not yet issued guidance explaining how a non-calendar year FSA can comply with the $2,500 health FSA deferral limit for 2012-13 plan years.

Reinhart Comment: There are several possibilities as to how the IRS may treat the deferral limit for the 2012-13 fiscal plan years. One possibility is a pro-rata approach that reduces the monthly amount that participants may contribute from the start of the plan year to conform to the $2,500 limit. A second approach is to allow participants to continue contributing at their current rates into 2013, but to cease deferrals as soon as the deferrals reach $2,500 after January 1, 2013. A third approach would be to "front-load" deferrals during 2012 while conforming to the newly imposed limits in 2013. Ultimately, plans must choose a deferral method that both works for its participants and complies with any subsequent guidance by the IRS as to how it will apply the $2,500 deferral limit for the 2012-13 fiscal plan years.

GENERAL DEVELOPMENTS

IRS Business Mileage Rate Unchanged for 2012

The IRS kept the business mileage rate at 55.5 cents per business mile driven, which is unchanged from its last revision that took effect July 1, 2011. This standard mileage rate, which is used to calculate the costs of operating a car for business purposes, applies to cars, vans, pickup trucks and panel trucks. The IRS announcement can be found on the IRS website.

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[1]The postponement of the final regulations' effective date also postpones the date disclosures under ERISA section 404(a) must be provided by plans to participants to August 30, 2012 (for calendar year plans). Compliance with the ERISA section 404(a) regulations will also be a topic of future Reinhart communications.