Reinhart

January 2011 Employee Benefits Update

POSTED:

Jan 25, 2011

RELATED PRACTICES:

Employee Benefits

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

SELECT COMPLIANCE DEADLINES AND REMINDERS

Cycle E Determination Letter Filings Due January 31, 2011

Remedial amendment period Cycle E individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2011, to rely on the extended period during which qualification amendments can be retroactively adopted. Cycle E plans include those sponsored by employers with tax identification numbers ending in a five (5) or zero (0).

2010 Tax Information

By January 31, 2011, plans must provide W-2 forms to employees reporting wages and elective deferral amounts. Plans must also file Form 945 to report income withheld from 2010 distributions made and provide Form 1099-R to recipients of 2010 plan distributions.

RETIREMENT PLAN DEVELOPMENTS

PBGC Extends Guidance on Reportable Events for 2011 Plan Years

Under ERISA section 4043, the Pension Benefit Guaranty Corporation (PBGC) must be notified of certain "reportable events." In some cases, advance reporting is required. The reportable events regulation provides for waivers and extensions, some of which are based on quantities used in calculating variable rate premiums (VRP) for the plan year in which the event occurs or becomes effective, calculated as of the "testing date" for that year. The Pension Protection Act of 2006 (PPA) modified the way VRPs are determined and the PBGC implemented those modifications in its premium regulations. The PBGC expects the final rule to be effective sometime in 2011, so interim guidance is necessary. To date, the PBGC has issued four Technical Updates to provide temporary guidance on how to apply the advance reporting threshold test, and the funding-based waivers and extensions, under the reportable events regulation.

Funding-related Determinations for Purposes of Waivers, Extensions and Advance Reporting

The VRP values as of the testing date to be used for an event year beginning in

2011 for purposes of subparts A through C of the reportable events regulation are those determined for premium purposes for the plan year preceding the event year.

Missed Quarterly Contributions for Plans with Fewer than 25 Participants

For plans with fewer than 25 participants and for which a flat-rate premium was payable for the 2010 plan year, the applicable reporting requirement is waived for failure to make one or more required quarterly contributions. This waiver applies only if financial inability to make the contribution is not the reason for one or more missed contributions. Missed Quarterly Contributions for Plans with Between 25 and 100 Participants For plans for which a flat-rate premium was payable for the 2010 plan year, the applicable reporting requirement is satisfied for failure to make one or more required quarterly contributions for the 2011 plan year when the following criteria are met:

- The financial inability is not the reason for the missed contribution.
- By the time the first missed reportable event report for the 2011 plan year would otherwise be due, a notice is filed with the PBGC using the sample language found in Technical Update 09-3.

IRS Issues Guidance on Requests for Extension of Amortization Periods for Multi- Employer Plans

The IRS issued Revenue Procedure 2010-52, which describes how a multiemployer plan sponsor can request an extension under Code section 431(d) of its plan's unfunded liability amortization period. The guidance describes the information a plan sponsor must include in both automatic and alternate extension applications. Applicants must now also notify the PBGC. The IRS issued a Model Notice of Application for Amortization Extension and extended the time plan sponsors have to submit an application to the 15th day of the third calendar month following the last day of the first plan year for which the extension is intended to take effect.

IRS Issues Revenue Ruling Regarding Commingling of Retirement Assets in Group Trusts

Previously, the IRS allowed assets of qualified plans, individual retirement plans, and eligible governmental plans to be pooled in a group if certain conditions were met. The IRS recently issued Revenue Ruling 2011-1, which provides that as of

January 1, 2011, the assets of qualified plans, IRAs and eligible governmental plans can be pooled in a group trust with assets of custodial accounts, retirement income accounts, and governmental plans, and still retain the tax status of the group trust and the separate plans. As with the previous guidance, certain conditions must be met, including that the group trust must maintain separate accounts reflecting each participating plan's interest. The revenue ruling also provides related model language that can be used by group trusts to comply with these provisions.

IRS Issues Notice on Funding Relief for Single-Employer Pension Plans Under PRA 2010

In Notice 2011-3, the IRS provided guidance on special rules relating to funding relief for single employer defined benefit pension plans (including multiple employer defined benefit pension plans) under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA). The guidance is split into ten sections in a question and answer format. A few notable topics are:

General Rules

One of the two alternative amortization schedules can be elected by a plan sponsor for one or two of the plan years beginning in 2008, 2009, 2010 or 2011, as long as the deadline for the minimum required contribution for the plan year occurs on or after June 25, 2010.

Plan sponsors can elect to apply one of two alternative amortization schedules to the shortfall amortization base—either the 2-plus-7-year amortization schedule or the 15-year amortization schedule. The notice further provides how installment amounts for a shortfall amortization base are calculated under each schedule. 3

Elections to Use An Alternative Amortization Schedule

A plan sponsor's election of an alternative amortization schedule after January 1, 2011, must be made by providing written notification of such election to both the plan's enrolled actuary and the plan administrator. The election must be signed and dated by the plan sponsor and include basic identification information for the plan, the election information, and a statement that the plan sponsor will notify the PBGC and plan participants and beneficiaries.

The election must be made by the latest of (a) the last day of the plan year for which the election is made, (b) 30 days after the valuation date for the plan year

for which the election is made, or (c) January 31, 2011.

Notification to Participants, Beneficiaries and the PBGC

Plan sponsors that elect funding relief are required to give notice of the election to the participants and beneficiaries of the plan as well as to the PBGC. Such notice must be provided to participants and beneficiaries of the plan 120 days after the end of the plan year for which an alternative schedule is elected, or by May 2, 2011, if later. If the election for a plan is made simultaneously for two plan years, the notice for both elections can be combined as long as the notice identifies both years for which the election is made. The notice requirements and a model notice are provided in Notice 2011-3. The PBGC must be notified by the later of (a) 30 days after the date the election is made or (b) January 31, 2011.

Reporting Requirements

Plan sponsors who elected an alternative amortization schedule for the 2008 or 2009 plan years do not need to file an amended Form 5500 with a revised Schedule SB. However, the Schedule SB filed for subsequent plan years must accurately state any election.

Additional Topics

Additional topics addressed in the Notice include installment acceleration amounts, excess compensation amounts, excess shareholder payment amounts, eligible charity plans, and transition rules.

IRS Issues 2010 Cumulative List of Changes in Plan Qualification Requirements for Cycle A Individually Designed Plans

The IRS issued its 2010 Cumulative List of Changes in Plan Qualification Requirements to be used by plan sponsors submitting determination, opinion or advisory letter applications for plans beginning February 1, 2011 and ending January 31, 2012. The Cumulative List consists of statutory provisions and associated guidance that reflect changes to plan qualification requirements.

HEALTH AND WELFARE PLAN DEVELOPMENTS

New PPACA Restricted Annual Limits Waiver Guidance

On September 3, 2010, the Department of Health and Human Services (HHS) published guidance on the process a plan must follow to apply for a waiver of the restrictions on the imposition of annual limits on the dollar value of essential

health benefits. On November 5, 2010, supplemental guidance specified that as a condition of receiving the waiver, plans must provide a notice informing current and eligible participants and subscribers that the 4 plan does not meet the minimum requirements for essential health benefits and has received a waiver of the requirements. On December 9, 2010, HHS issued additional guidance on the restricted annual limits waiver. The guidance provides the model language that plans with approved waivers must send to participants within 60 days of December 9, 2010, for plans whose plan year begins prior to February 1, 2011. Approved plans with plan years beginning on or after February 1, 2011 must include the notice in any informational or educational materials and also in any Summary Plan Description. Further information on the limits waiver is available through PLANSPONSOR.

HHS Issues Guidance on Sale of Mini-Med Plans

Previously, HHS issued guidance on the process a group health plan or health insurance issuer must follow to apply for a waiver for a limited benefit plan or "mini-med" plan of the restrictions on the imposition of annual limits on the dollar value of essential health benefits. The waiver does not extend beyond plan or policy years beginning on or after January 1, 2014, except for grandfathered individual market policies.

The new guidance issued on December 9, 2010 clarifies that waivers of annual limit restrictions pursuant to the waiver authority generally applies only to insured policies in place before September 23, 2010. Except for the limited exceptions discussed below, health insurance issuers cannot provide new policies to group health plans or sell new policies in the individual market after September 23, 2010 that do not meet the requirements of the Public Health Service Act (PHS).

The two exceptions to the restriction are state mandated policies and group policies that have policies with waivers and purchase new policies from different issuers that also have waivers. However, if a new policy includes certain changes provided in the grandfather interim final regulations, the plan will continue to cease to be a grandfathered health plan.

Delay of Nondiscrimination Rules for Insured Group Health Plans

On December 22, 2010, the IRS issued Notice 2011-1, which delayed the effective date for the Patient Protection and Affordable Care Act (PPACA) requirement that nongrandfathered insured plans comply with rules "similar to" the nondiscrimination rules of Code section 105(h)(2). The nondiscrimination rules

generally prohibit discrimination in favor of highly compensated individuals in eligibility to participate in benefits provided under health plans. The PPACA nondiscrimination requirement was originally scheduled to go into effect for the first plan year beginning on or after September 23, 2010, but the IRS delayed the effective date until plan years beginning after further regulations have been issued. The IRS has not yet issued regulations addressing what rules "similar to" those in Code section 105(h)(2) will apply to nongrandfathered insured plans. Self-funded plans must still comply with Code section 105(h)(2).

FAQ Regarding Affordable Care Act Implementation Part V and Mental Health Parity Implementation

HHS, the Department of Labor (DOL) and the IRS (the Departments) released additional Frequently Asked Questions (FAQ) addressing questions regarding the implementation of the market reform provisions of the PPACA, the implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and nondiscrimination based on a health factor and wellness program. 5

PPACA Provisions

While much of the information released in the FAQs was not new information, the Departments did delay enforcement of two PPACA provisions.

First, compliance with the requirement that large employers (those with more than 200 full-time employees) automatically enroll new full-time employees and continue enrollment of current full-time employees is delayed until the DOL issues the corresponding regulations, which the DOL intends to issue by 2014.

Second, the PHS requires that if a group health plan or health insurance issuer makes any material modifications in any of the terms of the plan or coverage that is not included in the most recently provided summary of benefits and coverage, notice of the modification must be provided no later than 60 days prior to the date on which such modification will become effective. Plans are not required to comply with the 60-day prior notice requirement for material modifications until plans and issuers are required to provide the summary of the benefits and coverage explanation to the standards issued by the Departments. The Departments have not yet issued the standards.

MHPAEA Provisions

Under the MHPAEA, criteria for medical necessity determinations made under a plan with respect to mental health or substance use disorder benefits must be made available by the plan administration not only to a current or potential participant or beneficiary, but to a contracting provider upon request.

Nondiscrimination Provisions

The Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination in eligibility, benefits or premiums based on a health factor. An exception to this general rule is available for certain wellness programs that discriminate in benefits and/or premiums based on a health factor. For example, wellness programs that require individuals to satisfy a standard related to a health factor in order to obtain a reward. Such rewards are allowable if the program provides certain safeguards, including that the total reward for such wellness programs cannot exceed 20% of the total cost of employee-only coverage under the plan. PPACA revised the PHS to increase the maximum reward that can be provided under a health-contingent wellness program from 20% to 30%. This change is effective in 2014. However, the Departments intend to propose regulations that use existing regulatory authority under HIPAA to raise the percentage for the maximum reward to 30% before the year 2014. Since the Departments are likely to use their regulatory authority under HIPAA, all plans, including grandfathered plans, will be able to take advantage of this modification.

Health Care Law Repeal

On January 19, 2011, the House of Representatives voted to repeal the health care law. This vote to repeal, however, is expected to fail in the Senate and will likely be vetoed by President Obama.

GENERAL DEVELOPMENTS

IRS Issues 2010-2011 Priority Guidance Plan

On December 7, 2010, the IRS issued the 2010-2011 Priority Guidance Plan (Plan). The Plan contains 310 projects that are priorities for the IRS from July 2010 through June 2011. This year's Plan addresses a variety of issues, including recent legislation and the current economic environment. The IRS intends to update and republish the Plan during the year to reflect additional items that become priorities during the year and guidance that the IRS 6 publishes. Projects intended for Employee Benefit topics are listed on pages 4 through 9.

2010 Tax Relief Act Extending Bush-Era Tax Cuts Includes Pension and

Benefit Provisions

Congress passed the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (the 2010 Act). The 2010 Act extends the Bush tax cuts for another two years and includes additional cuts for businesses and individuals.

Individuals

The 2010 Act includes a payroll tax reduction of 2 percentage points on the Social Security tax rate for workers on wages up to the $106,800 taxable wage base for 2011. Taxpayers ages 70½ or older are allowed to make tax-free distributions to charity from their IRAs of up to $100,000 per taxpayer, per year.

EGTRRA Tax Cuts Extended

Certain Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) provisions were set to expire in 2010. The 2010 Act postpones the sunset for another two years.

Removing Genetic Information Placed in Personnel Files Prior to GINA's Effective Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from using genetic information in employment, restricts employers from requesting, requiring, or purchasing genetic information and strictly limits the disclosure of genetic information. However, some employers questioned whether they could be liable under GINA for maintaining files that contained genetic information which was collected prior to GINA. Genetic information placed in personnel files prior to GINA's effective date of November 21, 2009, need not be removed. An employer is not liable under GINA for the mere existence of that genetic information in a personnel file. However, disclosing that genetic information to a third party is prohibited. Additionally, an employer in possession of genetic information about applicants or employees must treat that information the same way it treats medical information generally. It must keep the information confidential. For additional information on GINA, see Reinhart's December 22, 2010 e-alert, "GINA: Final ECOA Regulations for Title II".

DeLuca v. Blue Cross Blue Shield of Michigan, 2010 WL 4961726 (6th Cir. 2010)

Blue Cross Blue Shield of Michigan (BCBS) offers three forms of health coverage, a traditional open access plan, a PPO plan, and a HMO plan. Additionally, BCBS provides claims processing and other administrative services to self-funded plans.

Flagstar Bank contracted with BCBS to administer its self-funded plan. DeLuca was a beneficiary in Flagstar's plan through his wife's participation as an employee of Flagstar. Prior to 2004, the rates paid by BCBS' traditional and PPO plans were lower than the rates paid by the HMO plans. In 2004, in an effort to make the HMO plans more competitive, BCBS negotiated agreements with a number of hospitals, which altered the pre-existing rate agreements for the HMO plans. However, to keep hospital rates budget-neutral, BCBS raised the rates for the traditional and PPO plans. DeLuca filed suit against BCBS for breach of fiduciary duty under ERISA.

The Sixth Circuit agreed with the district court that BCBS did not breach its fiduciary duty because it was not acting as a fiduciary when it negotiated the rates. The court found that BCBS acted in two capacities in its relationship with the Flagstar plan, as plan administrator and claims processor, where it acted as a fiduciary and as a distributor of health-care services, a part of which includes negotiating discount rates for medical services. The court held that BCBS was not acting as a fiduciary when it negotiated the rate changes because those "dealings were not directly associated with the benefits plan at issue but were generally applicable to the broad range of health-care customers." The court distinguished actions taken as administrator of the plan from a business decision which has an effect on an ERISA plan. The court determined that this case fell into the latter standard and thus, BCBS was not subject to the fiduciary concerns of ERISA.