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January 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Cycle B Submission Period Opens February 1, 2012

Effective February 1, 2012, the Internal Revenue Service (IRS) will begin accepting determination letter applications from remedial amendment period Cycle B individually designed plans. In general, Cycle B plans must be submitted for a determination letter no later than January 31, 2013 to rely on the extended period during which qualification amendments may be retroactively adopted. Cycle B plans include those sponsored by employers with employer identification numbers (EINs) ending in a "2" or "7."

Medicare Part D Creditable Coverage Disclosure to CMS Due by March 1, 2012, 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 available on the CMS website and filing the form electronically. The annual filing deadline is 60 days after the first day of the plan year, which is March 1, 2012, 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.

2010 Medicare Part D Subsidy Reconciliation Due April 2, 2012, for Calendar-Year Plans

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 April 2, 2012, for the plan year ending December 31, 2010. If the plan sponsor does not timely submit the reconciliation, the plan sponsor will forfeit the subsidy received for that year.

RETIREMENT PLAN DEVELOPMENTS

IRS Issues Guidance on Determination Letter Program

2011 Cumulative List of Changes in Plan Qualification Requirements

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The IRS issued the "2011 Cumulative List of Changes in Plan Qualification Requirements" as Notice 2011-97 (2011 Cumulative List). The 2011 Cumulative List details the plan qualification requirements for plan sponsors of individually designed plans submitting determination letter requests during Cycle B of the remedial amendment cycle (from February 1, 2012 through January 31, 2013). Generally, a plan falls into Cycle B if it is an individually designed plan and the last digit of the plan sponsor's EIN is a "2" or "7."

The 2011 Cumulative List contains only a handful of new items, including provisions regarding participation in group trusts, readily tradable employer securities and funding rules for multiemployer plans. In addition, all items from the 2005 and 2006 Cumulative Lists have been removed, as these changes were previously reviewed by the IRS during the initial Cycle B submission period.

Changes to Determination Letter Program

On December 16, 2011, the IRS issued announcement 2011-82, outlining changes to the determination letter application process. The changes are intended to improve the IRS' efficiency in processing applications by eliminating features of the determination letter program that provide limited utility to plan sponsors.

- Eliminating Coverage and Nondiscrimination Demonstrations. The IRS has eliminated coverage and nondiscrimination demonstrations (Schedule Q, Elective Determination Requests) for all determination letter applications. In addition, the IRS will no longer review demonstrations regarding the ratio percentage test (Form 5300, line 13 and Form 5307, line 11). As a result of these changes, a determination letter may no longer be relied upon with respect to whether a plan satisfies the requirements of Code sections 401(a)(4), 401(a)(26) and 410(b). The IRS, however, will continue to review whether a plan's benefit or contribution formula satisfies a nondiscrimination design-based safe harbor. These changes are effective February 1, 2012 for most individually designed plans and effective May 1, 2012 for terminating plans and pre-approved plans.
- Changes for Pre-Approved Plans. Effective May 1, 2012, the IRS will only accept Form 5307 applications from volume submitter (VS) plan adopters who have modified the terms of the approved specimen plan, provided such modifications will not cause the plan to be considered individually designed. The IRS will no longer accept determination letter applications on Form 5307 for adopters of master and prototype (M&P) plans or adopters of VS plans with no changes to the pre-approved VS plan. In conjunction with these change, the IRS expects to revise the language of opinion and advisory letters to clarify the

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circumstances in which such letters are equivalent to a determination letter.
- The IRS has also added two new circumstances under which a pre-approved plan must be filed on Form 5300. Effective May 1, 2012, a Form 5300 (instead of Form 5307) must be filed if an employer (1) added language to an M&P plan to satisfy the requirements of Code sections 415 and 416 because of aggregation of plans, or (2) has a pre-approved plan with a normal retirement age earlier than age 62. Use of Form 5300 under these circumstances will not change the plan's six-year remedial amendment period or the cumulative list used for the submission.

Reinhart Comment: Once the changes for pre-approved plans take effect and the IRS makes corresponding changes to opinion and advisory letters, most adopters of M&P plans and certain adopters of VS plans will no longer be able to file for individual determination letters. Fewer applications for pre-approved plans and the elimination of Schedule Q is expected to reduce the time it takes the IRS to review determination letter applications.

DOL Revises Electronic Disclosure Policy for Participant-Level Fee Disclosures

On December 8, 2011, the Department of Labor (DOL) issued Technical Release 2011-03R, which revises and restates Technical Release 2011-03 previously issued on September 13, 2011. The revised technical release clarifies the DOL's interim policy regarding the use of electronic media to satisfy the disclosure requirements under the DOL's final participant-level fee disclosure regulation. Specifically, the guidance clarifies that (1) continuous access websites are permissible under the alternative method described in the technical release if the administrator complies with all other requirements, and (2) the investment-related information under paragraph (d) of the regulation (including the comparison chart) may be furnished as part of, or along with, a pension benefit statement, either electronically under the conditions of the technical release (not the more lenient guidance under Field Assistance Bulletin 2006-03), or in paper form.

For more information on the final participant-level fee disclosure rules and the DOL's interim policy on electronic disclosure, see Reinhart's November 2010 and October 2011 Employee Benefits Updates.

IRS Issues FAQs on Voluntary Classification Settlement Program for Misclassified Workers

As discussed in Reinhart's October 2011 Employee Benefits Update, the IRS has

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created a new program regarding workers misclassified as independent contractors or other nonemployees. The Voluntary Classification Settlement Program (VCSP) allows employers to voluntarily reclassify workers as employees for future tax periods outside of an IRS audit context and without the need to go through normal correction procedures. In new FAQs, the IRS advised that it will not share information about VCSP applications with the DOL or state agencies. The IRS also clarified that an employer who is contacted by the IRS regarding an SS-8 determination letter is still eligible for VCSP, but an audit of a parent, subsidiary or another member of the employer's consolidated group is treated as an audit of the applicant and would make the employer ineligible under VCSP. Finally, the IRS advised that signing the VCSP closing agreement is not an admission of any liability or wrongdoing for prior years and that the rejection of a VCSP application will not automatically trigger initiation of a federal audit. These FAQs are available on the IRS's website.

PBGC Provides Guidance on Funding-Related Reportable Events for 2012 Plan Years

The Pension Benefit Guaranty Corporation (PBGC) issued Technical Update 11-1, providing guidance on complying with the reportable event requirements of ERISA section 4043 for plan years beginning in 2012. As background, certain PBGC reporting requirements or waivers are based on quantities used in calculating variable-rate premium (VRPs). The PPA modified how VRPs are determined and the PBGC has updated its premium rate regulations to reflect these changes. Pending amendment of the reportable event regulations to implement the changes to VRP quantities, the PBGC has issued a series of Technical Updates.

Technical Update 11-1 generally provides that, for purposes of the waivers, extensions and advance reporting, a plan's assets, vested benefits and unfunded vested benefits (UVBs) are determined for a plan year beginning in 2012 in the same manner as for VRPs for the preceding plan year. The Technical Update also provides special rules for small plans (fewer than 100 participants) that fail to make required quarterly flat-rate contributions, provided that financial inability to make contributions is not the reason for the missed contributions.

PBGC Changes Administrative Policy to Reject Amended Premium Filings Based on Recharacterization of Plan Year for Contributions

On December 22, 2011, the PBGC issued a policy statement ending its current practice of permitting refunds of premiums for amended premium filings when

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an employer recharacterizes contributions as attributable to the prior plan year. As background, single-employer defined benefit pension plans covered by the PBGC are required to pay VRPs based on the plan's UVBs for the prior year. During the first eight and one-half months of the plan year, an employer can decide whether contributions made to the plan will be attributed to the current or the prior plan year. If the employer retroactively allocates contributions to the prior year, then the plan's UVBs at the end of the year will decrease, resulting in lower VRPs for the current year.

In the past, the PBGC has accepted amended premium filings based on changes to a plan's UVBs when an employer recharacterizes plan contributions. In changing its position, the PBGC stated that amended premium filings are intended to allow employers to correct mistakes in the data reported in a filing, and that recharacterization of contributions is not an appropriate basis for amending a filing and claiming a refund. According to the PBGC, recharacterization of contributions is a voluntary change in an otherwise valid designation of the plan year for contributions and does not correct a mistake. Although the PBGC will review the facts and circumstances of each case, the PBGC's policy will be to reject amended premium filings and to deny refunds based on recharacterization of contributions.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Provides Guidance on Defining Essential Health Benefits under PPACA

On December 16, 2011, the Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight issued its proposed method for defining essential health benefits under the Patient Protection and Affordable Care Act (PPACA). PPACA section 1302(b) requires HHS to define essential health benefits as they relate to the essential health benefits packages that non-grandfathered plans in the individual and small group markets must offer beginning in 2014.

Generally, PPACA provides that essential health benefits include services falling in the following 10 categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Although

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grandfathered health plans, self-insured group health plans and health insurance coverage offered in the large group market are not required to cover essential health benefits, any plan that offers these benefits must comply with PPACA section 2711, which prohibits lifetime or annual limits on essential health benefits.

HHS intends to propose that essential health benefits be defined by individual states. Each state will select a "benchmark plan," reflecting the scope of services and limits offered by a typical employer plan in that state. HHS notes that this method is based on the approach established by Congress for the Children's Health Insurance Program (CHIP) and certain Medicaid populations. HHS will assess and reevaluate the benchmark process for the 2016 plan year based on evaluation and feedback from this process for the 2014 and 2015 plan years.

Under this proposed method, states will select a benchmark plan from one of the following approved benchmark plans:

- Any of the three largest small group plans in the state by enrollment;
- Any of the largest three state employee health plans by enrollment;
- Any of the largest three federal employee health plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization operating in the state.

A benchmark plan must cover services from all 10 essential health benefit categories. If the selected benchmark plan does not cover all 10 essential health benefit categories, HHS intends to propose that the state must supplement the missing categories using the benefits from any other benchmark plan option. Because habilitative services and pediatric oral and vision are the most commonly noncovered benefits, HHS is considering the options for supplementing the benchmark plan with these services. If a state fails to elect a benchmark plan, the default benchmark plan would be the largest plan by enrollment in the largest small group insurance products in the state.

Reinhart Comment: Several questions remain unanswered regarding the application of the definition of essential health benefits. For example, it is unclear which definition must be used when a plan sponsor has employees in multiple states. In addition, it is uncertain whether state-mandated coverage, such as in-vitro fertilization, could be included in the definition of essential health benefits for purposes of lifetime and annual limits if a state's benchmark plan includes this coverage.

HHS and DOL Issue Guidance on Medical Loss Ratio Rebates

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HHS Final Regulations

HHS issued final regulations on PPACA's medical loss ratio (MLR) requirements for health insurers, which amend the December 2010 interim final regulations. The MLR rules require insurers to provide rebates to enrollees if less than 85% of premium dollars (80% in the small group and individual markets) are spent on clinical services and health care quality improvement. These rules apply beginning in 2011, and the first rebates are due August 1, 2012.

The final regulations address technical changes in calculating and reporting MLRs and the method for distributing rebates to enrollees in group health plans. Specifically, the rules direct insurers to provide rebates to group policyholders (typically the employer) instead of apportioning the rebate between the policyholder and individual subscribers. The final rules correct unintended tax consequences associated with the prior mechanism for distributing rebates. The final rules also require issuers to provide notice of rebates to enrollees and the group policyholder. The notice must include general information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate provided.

DOL Guidance on When MLR Rebates Are Plan Assets Under ERISA

Contemporaneously with the HHS final regulations, the DOL issued Technical Release 2011-04 to provide guidance on when MLR rebates will constitute plan assets under the Employee Retirement Income Security Act of 1974 (ERISA). The DOL advised that if the plan or trust is the policyholder, then the entire rebate would constitute plan assets in the absence of specific plan or policy language to the contrary. If the plan sponsor is the policyholder, then whether a portion of the rebate constitutes plan assets will depend on how costs are shared between participants and the plan sponsor, as well as the terms of the plan and insurance policy. The DOL advised that the terms of the governing plan documents and the parties' understanding and representations will need to be carefully analyzed to determine who is entitled to the rebate. Further, in absence of more direct evidence, the sources of the insurance policy's premium payments could be used to determine the portion of a rebate that constitutes plan assets.

Decisions relating to any portion of a rebate that constitutes plan assets are subject to ERISA's fiduciary requirements. Accordingly, in determining an appropriate allocation method, plan fiduciaries must act prudently, solely in the interest of participants and beneficiaries, and in accordance with the terms of the plan as required under ERISA section 404(a)(1). The DOL advised that a plan

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fiduciary may properly weigh the costs and benefits to the plan as well as the competing interests of classes of participants to decide whether an allocation method is reasonable, fair and objective. For example, a fiduciary may properly allocate all rebate amounts to current participants if the fiduciary determines that the cost of distributions to former participants approximates the amount of the proceeds. Furthermore, if distributing payments to any participants is not cost-effective, the fiduciary may apply the rebate toward future participant premium payments, benefit enhancements or other permissible plan purposes.

Finally, the DOL addressed whether the portion of the rebate that constitutes plan assets must be held in trust as required under ERISA section 403(a). The DOL acknowledged that many group health plans receiving premium rebates do not maintain trusts because all premiums are paid from the general assets of the employer and all benefits are paid from the insurers. The DOL advised that it will not assert a violation of ERISA's trust requirement if the portion of the rebates that are plan assets are used within three months of receipt by the policyholder to pay premiums or refunds. This relief is available for plans that have not established a trust in reliance on Technical Release 92-01.

Reinhart Comment: With rebates due by August 1, 2012, plan sponsors may wish to review plan documents and insurance policies in advance to determine what portion of the MLR rebates will be subject to ERISA's plan asset requirements, and whether any plan amendments are needed regarding the use of plan assets. In addition, it may be helpful for plan fiduciaries to start reviewing allocation methods to ensure that the plan asset portion of any rebate is used within three months of receipt to avoid a potential violation of ERISA's trust requirement.

DOL Proposes Increased Reporting and Enforcement for MEWAs

On December 6, 2011, the DOL proposed two rules pursuant to provisions and new authorities established under PPACA to protect workers and small businesses from health care fraud relating to multiple employer welfare arrangements (MEWAs). The proposed rules require enhanced reporting for MEWAs and increase the DOL's enforcement authority to shut down MEWAs engaged in fraud. Comments on the proposed changes may be submitted to the DOL through March 5, 2012.

Proposed Reporting Changes

The proposed reporting rules would require MEWAs and entities claiming exceptions (ECEs) to register with the DOL via the Form M-1 prior to operating in a

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state or be subject to substantial penalties. The proposed rules would modify the existing annual Form M-1 requirement to include additional custodial and financial information, require electronic filing, and expand the circumstances for special filings. The rules would also require MEWAs to document Form M-1 compliance on the Form 5500 and eliminate the Form 5500 filing exception for insured or unfunded MEWAs with fewer than 100 participants.

Proposed Enforcement Changes

The proposed enforcement rules would permit the Secretary of Labor to issue a cease and desist order when it appears that fraud or other forms of abuse are taking place within a MEWA. According to the DOL, common examples of this type of conduct include a systematic failure to pay benefit claims or the diversion of premiums for personal use. The proposed rules would also allow the DOL to seize the assets of a MEWA if it appears to be in a financially hazardous condition. Prior to the new authorities granted under PPACA, the DOL needed to obtain a court-issued temporary restraining order and preliminary injunction to stop a MEWA's abusive activities, which required a showing of the likelihood of a fiduciary breach and the need for immediate protective action.

IRS Releases 2011 Form 8941 for Small Business Health Care Tax Credit

Employers that pay average wages of less than $50,000 per year and have less than 25 full-time employees may be eligible for a tax credit under PPACA, which is designed to encourage small employers to offer health insurance coverage for the first time or maintain existing coverage. The IRS released the 2011 Form 8941 and Instructions for small businesses and tax-exempt organizations to use to calculate the credit. The 2011 Form 8941 has been shortened as the carryforwards, carrybacks, and passive activity limitations for the credit are now reported on Form 3800. A small business includes the amount of the credit as a general business credit (Form 3800) on its income tax return, while a tax-exempt organization will claim the small business health care tax credit as a refundable credit on Form 990-T.

IRS Provides Guidance on W-2 Reporting of Health Care Costs

PPACA requires employers to include the aggregate cost of applicable employer-sponsored health coverage on Form W-2 beginning with the 2012 tax year (Forms W-2 issued in January 2013). This new reporting requirement is intended to inform employees of the cost of their health care coverage, and does not cause coverage that is excludable from income to become taxable. The IRS issued

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preliminary guidance on how employers should determine and report the cost of coverage in Notice 2011-28 and Notice 2012-9. For more information on the this guidance, see Reinhart's E-Alert "Form W-2 Information Reporting of Health Care Costs."

HHS Issues Final Regulation on CO-OP Program

On December 13, 2011, HHS issued a final regulation implementing the Consumer Operated and Oriented Plan (CO–OP) provisions of PPACA. The CO–OP program provides loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in the Affordable Insurance Exchanges (Exchanges). The program's goal is to create a new CO–OP in every state to expand the number of health plans available in the Exchanges with a focus on integrated care and greater plan accountability. The final rule outlines the following: (1) the eligibility standards for the CO–OP program; (2) terms for loans; and (3) basic standards that organizations must meet to participate in this program and become a CO–OP. The regulation is effective February 13, 2012 and is intended to provide flexibility for eligible organizations to encourage diversity in the organizational design and approach while ensuring that the statutory goals are met.

GENERAL DEVELOPMENTS

Advance Copies of 2011 Form 5500 Released

The DOL, IRS and the PBGC jointly released advance informational copies of the 2011 Form 5500 annual return/report and related instructions. Plan administrators generally have seven months after the end of a plan year to file a Form 5500, although this deadline may be extended. Changes to the Form 5500 for the 2011 plan year are described under "Changes to Note" in the 2011 instructions and include the following:

- Actuarial schedules have been updated for the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010.
- Schedule C instructions have been updated to reflect that payments made by contributing employers or participating organizations to a multiemployer plan should be treated the same as payments made by a plan sponsor.
- Schedule I instructions have been updated for the seven business day safe harbor for small plans (fewer than 100 participants at the beginning of the year) to deposit participant contributions to the plan.

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DOL Advises that Pension Contributions Made from a Labor Management Cooperation Trust Fund Are Not Prohibited Transactions

In Advisory Opinion 2011-10A, the DOL considered whether contributions from a labor management cooperation trust fund to a multiemployer pension plan were prohibited transactions under section 406 of ERISA. The trust fund was jointly established by a union representing cement and concrete workers and an employer association. The trust fund, which is separate from the pension plan, is administered by a joint board of trustees and is funded through employer contributions. The trust agreement sets forth numerous purposes of the fund, including identifying and expanding work opportunities for cement and concrete workers.

One of the goals of the trust fund is to help contractors win construction projects that will employ union members. The trust fund assists contractors in making a competitive bid for projects by paying a portion of the employer's pension plan contributions. For example, the board of trustees may approve the trust fund to pay $2.00 per hour for all hours worked on a project to reduce an employer's contribution to the pension plan from $9.76 per hour to $7.76 per hour.

The DOL noted that it was unable to determine whether the trust fund would be a "party in interest" of the pension plan based on the information provided. Regardless, the DOL advised that a mere cash contribution by the trust fund to the pension plan would not violate ERISA section 406(a) (relating to transactions with a party in interest) because a cash contribution to a plan by a party in interest (or other person) is not a prohibited transaction. The DOL further advised that the contributions would not violate ERISA section 406(b) (relating to self-dealing), provided that the trust fund is not an ERISA "employee benefit plan" and that the assets of the trust fund are not considered "plan assets" under ERISA. The DOL noted that although the submission provided no indication that the trust fund as currently operated is an ERISA plan, the trust agreement contained no explicit limitations that would prevent the fund from providing welfare or pension benefits covered by ERISA in the future.

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