Reinhart

July 2011 Employee Benefits Update

SELECT COMPLIANCE DEADLINES AND REMINDERS

New Form 8955-SSA Due Date Extended to January 17, 2012

The Internal Revenue Service (IRS) simultaneously published the 2009 Form 8955-SSA (Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits) and extended the due date for filing both the 2009 and 2010 Form 8955-SSA. The new due date for the 2009 and 2010 Form 8955-SSA is the later of (1) January 17, 2012 or (2) the due date that generally applies for filing the Form 8955-SSA for the 2010 plan year (the last day of the seventh month following the last day of the plan year, plus extensions). The January 17, 2012 due date may not be extended by filing Form 5558.

The IRS expects to publish the 2010 Form 8955-SSA soon, but the instructions for the 2009 Form 8955-SSA permit a plan sponsor to include the 2010 participants on the 2009 form.

Reporting Cost of Employer-Sponsored Health Coverage for 2012 Form W-2

The Patient Protection and Affordable Care Act (PPACA) requires that the aggregate cost of applicable employer-sponsored coverage be reported on an employee's Form W-2. This requirement first applies to the 2012 tax year, which means that employers will need to track this cost for reporting on the 2012 Form W-2 (generally issued in January 2013). The IRS published Notice 2011-28 (the Notice) to provide employers with needed guidance on this requirement. Importantly, the Notice excludes certain coverage from the "aggregate cost" calculation and exempts some employers from the requirement altogether.

- Until further guidance is issued, an employer can exclude the cost of coverage under a multiemployer plan; a health reimbursement arrangement; a stand-alone dental or vision plan; or a self-funded group health plan that is not subject to COBRA (e.g., a church plan) from its calculation of the "aggregate cost" of coverage.
- Until further guidance is issued, employers who were required to file fewer than 250 Form W-2s in the preceding calendar year are excluded from the reporting requirement.

POSTED:

Jul 1, 2011

RELATED PRACTICES:

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

RELATED PEOPLE:

Rebecca E. Greene
https://www.reinhartlaw.com/people/rebecca-greene

- Employers do not need to report the aggregate cost for individuals who would not otherwise receive a Form W-2 (such as a retiree or a COBRA qualified beneficiary), or for employees who terminate employment during the year and request their Form W-2 prior to the end of the calendar year.

The Notice also clarifies certain methodologies for calculating the aggregate cost, such as:

- When and how to include the amount of a health flexible spending arrangement in the aggregate cost.
- Alternative methods to calculate the aggregate cost of coverage for insured plans, plans that subsidize the COBRA premium, and plans that use a composite COBRA premium.

RETIREMENT PLAN DEVELOPMENTS

Wisconsin Adopts Federal Tax Law for In-Plan Roth Conversions

As part of the 2011-2013 Wisconsin Budget Bill, Wisconsin also amended state tax law to adopt the federal tax rules applicable to in-plan Roth conversions. In-plan Roth conversions allow 401(k) and 403(b) plan participants to transfer funds from a non-Roth account within the plan to a Roth account within the plan. Prior to this amendment, Wisconsin residents who took advantage of the in-plan Roth conversion were subject to Wisconsin tax penalties. The amendment is retroactive and therefore applies to participants who elected in-plan Roth conversions in 2010 as well.

The amendment was necessary to conform Wisconsin law to federal law. Federal law was modified to allow plan participants to make in-plan Roth conversions effective after September 27, 2010. If the conversion was made in the 2010 tax year, a special federal tax incentive applied. Although the conversion of pre-tax contributions to Roth after-tax contributions requires the payment of income tax on the converted amount, the special federal tax incentive allowed those participants who made the conversion in 2010 to defer that tax by reporting half of the income in 2011 and half in 2012. However, at the time, there was no corresponding state tax law change in Wisconsin. Therefore, Wisconsin residents who made in-plan Roth conversions in 2010 were required to pay a 2% penalty on excess contributions and (if the participant was under 59 ½) a 3.3% penalty for early distribution in 2010 plus all income generated by the conversion. The 2%

excess contribution penalty is cumulative; it applies each year until the excess is withdrawn.

The June 2011 amendment changed Wisconsin law retroactively to match federal law in all respects. Participants who paid the now-repealed Wisconsin tax for 2010 can apply for a refund by filing an amended 2010 Wisconsin tax return.

PBGC Finalizes Rule for Terminating Underfunded Plans in Bankruptcy

On June 14, 2011, the Pension Benefit Guaranty Corporation (PBGC) published its final rule on the termination of an underfunded pension plan when the sponsor is in bankruptcy. The final rule is substantially the same as the proposed rule published in 2008. The Pension Protection Act of 2006 (PPA) amended the rules for a single-employer pension plan termination when the contributing sponsor is in bankruptcy. After PPA, the relevant date for determining guaranteed benefits and those benefits in "priority category 3" (*e.g.*, benefits already in pay status that exceed the maximum guarantee) are fixed on the bankruptcy filing date, not the plan termination date. The PBGC proposed regulations in 2008 to clarify the new rules for terminating underfunded plans in bankruptcy.

The final regulations clarify that the bankruptcy filing date is treated as the termination date for purposes of determining the participant's service and compensation; the maximum guaranteed benefit; the relevant date for measuring any phase-in of guaranteed benefits; what benefits are nonguaranteed supplements; the relevant date for determining whether a participant has a non-forfeitable right to an early retirement subsidy or disability benefit; and the relevant year for the start of an applicable look-back period. The plan termination date remains the relevant date for other purposes, such as valuation of plan assets.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Wisconsin Changes Tax Rules for Adult Dependent Children

Wisconsin law currently requires insured health plans and governmental self-insured plans with dependent coverage to cover an adult dependent child up to age 27. On June 26, 2011, Wisconsin enacted the 2011-2013 Budget Bill (2011 Wisconsin Act 32), which changed this requirement. Effective as of January 1, 2012, these plans that allow dependent coverage will be required to offer health plan coverage of an adult dependent child only up to age 26.

Consequently, beginning in 2012, Wisconsin insurance law will be generally

consistent with federal law under PPACA with regard to age limitations, marital status and other employer coverage for the health coverage of adult children. However, one major difference remains. Wisconsin insurance law continues to allow health coverage for a child who is a full-time student beyond age 27 if that child was called to active military duty while under age 27 and was attending an institution of higher learning on a full-time basis prior to being called to active military duty.

Tax conformity issues related to coverage of adult children under group health plans have not been resolved by the enactment of the 2011-2013 Budget Bill. Unlike federal tax law after PPACA, Wisconsin tax law continues to require children under age 27 to satisfy the requirements for a qualifying child or a qualifying relative under Internal Revenue Code (Code) section 152 to be considered a tax dependent. Consequently, if an employee enrolls an adult child in his or her employer's group health plan and the child does not satisfy the requirements under Code section 152, the employer must impute income to the employee for the fair market value of coverage paid by the employer and withhold Wisconsin state tax. This Wisconsin state tax treatment would also apply to any pre-tax contributions paid by the employee for health coverage of a dependent child through a cafeteria plan.

PPACA Annual Limit Waiver Program Undergoes Significant Changes

On June 17, 2011, the Department of Health and Human Services (HHS) issued new guidance substantially revising the annual limit waiver program under PPACA. PPACA generally prohibited plans from imposing annual limits on essential benefits beginning with the 2014 plan year. Until then, plans can impose only restricted annual limits that equal or exceed a specified threshold ($750,000 for the 2011 plan year, $1.25 million for the 2012 plan year and $2 million for the 2013 plan year). PPACA simultaneously authorized HHS to grant waivers of the new restricted annual limit requirements to plans that could prove that compliance would result in a significant decrease in access to benefits or a significant increase in premiums. This waiver program would allow these plans to continue their current, lower annual limits until the 2014 plan year.

Under the original program, the waiver was valid for one plan year and the plan sponsor would be required to reapply for the waiver annually. Under the new guidance, HHS has announced that it will no longer accept new waiver applications after September 22, 2011. Plans that have already received a waiver can obtain an extension of the waiver that will allow it to remain in effect until the

2014 plan year if the plan sponsor submits an extension application (the Waiver Extension Form) to HHS by September 22, 2011. If the Waiver Extension Form is accepted, the plan sponsor would be required to provide an annual update to HHS by the end of each calendar year and to provide an annual notice to participants.

HHS Revises External Claims Review Requirements Under PPACA

On June 22, 2011, HHS, IRS and the Department of Labor (collectively, the Departments) amended the PPACA internal claims and appeals and external review regulations and issued a new Technical Release 2011-02 (the Technical Release) that provides new guidance on external review. The Technical Release also updates the content requirements of the initial and final adverse benefit determinations notices.

PPACA mandated new internal claims and appeals and external review processes for nongrandfathered plans only. The Departments published interim final regulations implementing this requirement last fall, which were described in more detail in our August 2010 Employee Benefits Update. Significant changes to the internal claims and appeals requirements include:

- Urgent Care Notifications. Plans have up to 72 hours (not 24) after receipt of an urgent care claim to adjudicate the claim, provided the plan defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care."
- Additional Notice Content. The requirement to include diagnosis and treatment codes and their corresponding meanings in the notices of initial and final adverse benefit determinations has been eliminated in response to privacy concerns. However, plans must now notify claimants that they can request the diagnosis and treatment codes, and their corresponding meanings, in all notices of initial and final adverse benefit determinations.
- Culturally Appropriate Notices. The Departments revised the threshold triggering the requirement to provide notices in a non-English language. If the claimant lives in a county in which 10% or more of the population speaks the same non-English language, the notice must include a statement that notices are available in that non-English language upon request. Whether a county has a 10% or more population of non-English speakers is determined by the United States Census Bureau American Community Survey data. In addition, plans must now provide a customer assistance process (such as a telephone hotline)

with oral language services in the relevant non-English language. However, plans no longer need to track who has requested non-English notices and provide all notices thereafter in that language.

- Deemed Exhaustion of Internal Claims and Appeals. The Departments added an exception to the strict compliance standard for failure to follow the plan's claims and appeals regulations. The failure will not trigger a deemed exhaustion of the internal claims and appeals process if the failure is de minimis, non-prejudicial, due to good cause or matters beyond the plan's control, in the context of an ongoing good faith exchange of information with the claimant, and not reflective of a pattern or practice of noncompliance.

Changes to the external review requirements include the following:

- Scope of External Review. Until further guidance is published, the Departments narrowed the scope of claims eligible for external review to claims that involve medical judgment, as determined by the independent review organization (IRO), and rescissions of coverage. This change applies to claims initiated after September 20, 2011.
- Binding Determination. Plans must provide benefits pursuant to an IRO decision without delay and regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.
- Deadline to Contract with IROs. To be eligible for the safe harbor from enforcement, plans must contract with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012.
- Assignment Process. Plans may use an alternative method for assigning IROs (other than random or rotating assignment), but the plan must document how the selected method is random, independent and without bias.
- Revisions to Model Adverse Benefit Determination Notices. The Departments added a model sentence to their model adverse benefit determination notice for plans to use if they meet the new threshold for non-English language notices. The model sentence has been provided in all four languages that meet the threshold throughout the country: Spanish, Tagalog, Chinese and Navajo.

IRS Finalizes Six-Month Extension for Health Plan Excise Tax Filings

On June 24, 2011, the IRS published final regulations providing an automatic six-month extension for filing Form 8928, which is used to report excise taxes for health plans that fail to comply with certain requirements. To receive the automatic six-month extension, the group health plan sponsor must submit Form 7004 by the original deadline for filing the Form 8928 (which varies depending on the failure giving rise to the excise tax). The sponsor will also need to submit payment of the excise tax along with the Form 7004 because the IRS did not extend the time for payment of the tax.

Form 8928 is used to report excise taxes due when a group health plan sponsor fails to comply with the following Code requirements: Code § 4980B (COBRA continuation and pediatric vaccine coverage requirements); Code § 4980D (failure to comply with HIPAA portability and nondiscrimination, the Newborns and Mothers Health Protection Act and the Mental Health Parity Act); Code § 4980E (failure to make comparable Archer medical savings account contributions); and Code § 4980G (failure to make comparable HSA contributions).

For failures under Code §§ 4980B and 4980D, the original deadline for the Form 8928 (and the appropriate excise tax payment) is the due date for filing the sponsor's federal income tax return. For failures under Code §§ 4980E and 4980G, the original deadline for the Form 8928 (and the appropriate excise tax payment) is the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made.

Ninth Circuit Reverses Course; Allows Suit Against Entity That Is Not Plan Administrator

On June 22, 2011, the Ninth Circuit overruled its prior precedent and held that a plan participant could sue an entity other than the plan or the plan administrator for benefits under ERISA section 502(a)(1)(B). *Cyr v. Reliance Standard Life Insurance Company*.

Laura Cyr was employed by Channel Technologies, Inc. (CTI) and was eligible to participate in the long-term disability benefit plan maintained by CTI and insured by Reliance Standard Life Insurance Company (Reliance). Although CTI was the official "plan administrator" for ERISA purposes, Reliance made all claims decisions under the plan. Cyr applied for, and was granted, long-term disability benefits under the plan based on her last salary of $85,000. Cyr later sued CTI for gender discrimination based on unequal pay and was awarded a retroactive salary adjustment to $155,000. Cyr requested that Reliance increase her long-

term disability benefits based on her retroactively adjusted salary, but Reliance did not make the adjustment (there is some confusion regarding why the adjustment was not made; Reliance admitted that it lost Cyr's claim file).

Cyr sued Reliance, the plan and CTI as the plan administrator under ERISA section 502(a)(1)(B) for an increase in her long-term disability benefit based on her revised salary. Despite Ninth Circuit precedent to the contrary, the district court held that Reliance could be sued under this provision of ERISA even though it was not the plan or the plan administrator. The Ninth Circuit, reversing its prior precedent, agreed and held that potential liability under ERISA section 502(a)(1)(B) is not limited per se to the plan and the plan administrator, as long as the party being sued is a proper defendant and that party's individual liability can be established.

New York Becomes Sixth State to Permit Same-Sex Marriage

Effective on July 24, 2011, same-sex marriage became legal in the state of New York. New York is the latest state to permit same-sex marriage, joining Connecticut, Iowa, Massachusetts, New Hampshire, Vermont and the District of Columbia. Sponsors of self-funded health plans that cover participants in any of these states should confirm that the plan's definition of spouse for dependent coverage purposes reflects corporate intent regarding the potential coverage of same-sex spouses (e.g., a plan that defines a "dependent spouse" for eligibility purposes as a "legal spouse" may have to provide coverage to a same-sex spouse).

HIPAA Electronic Data Interchange Rules Effective January 1, 2012

In our February 2009 Employee Benefits Update, we reported that HHS had finalized updated code sets and standards for electronic data interchange. The final regulations require covered entities to use the Tenth Revision of the International Classification of Diseases (ICD-10) code set to report health care diagnoses and inpatient hospital procedures. The final updates to the electronic transaction standards are required to support the new code sets and contain structural and technical improvements.

Compliance with the updated electronic transaction standards is required by January 1, 2012 (small health plans have until January 1, 2013 to comply with the new standard for Medicaid pharmacy subrogation transactions). All covered entities, including small health plans, must be using the new ICD-10 code sets by October 1, 2013.

GENERAL DEVELOPMENTS

IRS Proposes Revisions to Compensation Deduction Rules for Equity Compensation

On June 23, 2011, the IRS proposed two amendments to the current regulations under Code section 162(m). Code section 162(m) limits a publicly traded company's annual compensation deduction for compensation paid to the CEO and the three other highest paid officers (excluding the principal financial officer) to $1 million. The $1 million deduction limit does not apply to "qualifying performance-based compensation." To be considered "qualifying performance-based compensation," the equity plan must now state the maximum number of shares that could be issued under the plan to each individual employee and disclose to shareholders the methodology that will be used to set the exercise price of any option or right granted under the plan. Equity plans currently must specify only the aggregate limit of shares that may be awarded under the plan to all participants.

In addition, the proposed regulations clarify the scope of the transition rule for companies that become public. The transition rule excludes from the $1 million deduction limit any compensation from the exercise of stock options, stock appreciation rights or restricted stock granted before or shortly after the company becomes public. The proposed regulations clarify that this transition rule does not apply to other types of equity compensation, including restricted stock units and phantom stock. Although the preamble to the proposed regulations states that the IRS is not intending to change the substantive law, it is important to note that the IRS reached the opposite conclusion in a 2004 private letter ruling, where it found that restricted stock units were eligible for the transition relief. These regulations serve as a reminder that private letter rulings are only binding on the IRS with respect to the party to whom the ruling is issued."