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June 2011 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

IRS Announces Extension of Form 8955-SSA Deadline

Form 8955-SSA (Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits) replaced Form 5500, Schedule SSA for plan years beginning on or after January 1, 2009. The modified due date for filing both the 2009 and 2010 Form 8955-SSA is the later of (1) January 17, 2012, or (2) the due date of the 2010 Form 5500 (including extensions.) The January 17, 2012 due date, however, cannot be further extended by filling Form 5558.

The Internal Revenue Service (IRS) has release the 2009 Form 8955-SSA and is expected to publish the 2010 form within the next few weeks. Plan administrators may either combine plan year 2009 and 2010 data on the 2009 Form 8955-SSA or file separate Forms 8955- SSA for each year. The IRS has also provided technical specifications for electronic filing of Form 8955-SSA in Revenue Procedure 2011-31. The new Form 8955-SSA is discussed in greater detail in the April 2011 Employee Benefits Update.

2010 Form 5500 Deadline Approaching

Plan administrators generally have seven months after the end of a plan year to file Form 5500. For plan years ending December 31, 2010, the deadline for filing Form 5500 is August 1, 2011. Plan sponsors who extended their corporate federal income tax return deadline can receive an automatic extension until September 15, 2011, if certain criteria are satisfied. Otherwise, plan administrators can apply for a deadline extension until October 15, 2011 by filing Form 5558 on or before August 1, 2011 (the plan's regular filing deadline).

Annual Benefit Statement for Defined Contribution Plans With Plan-Directed Investments

Administrators of defined contribution plans who do not allow participant investment direction must provide an annual benefit statement to participants and beneficiaries by the date on which Form 5500 is filed by the plan (but no later than the due date, including extensions, for filing Form 5500) for the plan year to which the benefit statement relates. For a calendar-year plan, the 2010 benefit statement is due by the earlier of (1) the actual filing date of the 2010 Form 5500

or (2) August 1, 2011 (the plan's regular filing deadline) unless a Form 5500 deadline extension applies.

Summary of Description of Material Modifications for Calendar-Year Plans

Plan administrators of employee pension and welfare benefit plans must provide a summary description of any material modifications to the plan and changes in the summary plan description (SPD) to each participant covered under the plan and to each beneficiary receiving benefits under the plan. Administrators must provide this summary no later than 210 days after the close of the plan year in which the modification or change was adopted (for example, July 29, 2011 for calendar-year plans). However, the summary of material modifications (SMM) or changes to the information in the SPD does not need to be provided separately if the changes or modifications are described in a timely SPD.

RETIREMENT PLAN DEVELOPMENTS

DOL Proposes to Delay Effective Date for Participant-Level Fee Disclosures to April 30, 2012

The Department of Labor (DOL) proposed to amend its final participant-level disclosure regulation to extend the transition provision to allow employers sufficient time to obtain information from service providers. The final rule applies to plan years beginning on or after November 1, 2011 and requires employers to disclose information concerning plan and investment costs to participants. The final rule includes a 60-day transition provision, which the DOL proposes to extend to 120 days. When finalized, the proposed amendment would allow employers 120 days to furnish initial disclosures to participants. Under the proposed rule, the first participant-level fee disclosures for calendar-year plans would be required on or before April 30, 2012.

The DOL also issued a proposed notice to delay the effective date of interim final regulations under ERISA section 408(b)(2), which require retirement plan service providers to disclose comprehensive information about fees and potential conflicts of interest to plan fiduciaries. The interim final rules were scheduled to apply to plan contracts for services in existence on or after July 16, 2011. The DOL previously announced its intention to extend this deadline to January 1, 2012, and the extension will be official when the proposed rule is finalized.

The DOL notes that these extensions will ensure that service providers and employers have the time needed to comply with the disclosure requirements

following the publication of the final rule.

Seventh Circuit Reverses Kraft Case for Insufficient Documentation of Fiduciary Decisions

In *George v. Kraft Foods Global, Inc.*, 2011 WL 1345463 (7th Cir. 2011), participants alleged that Kraft breached its fiduciary duties by not taking action to reduce or eliminate

"transactional drag" and "investment drag" in two unitized company stock funds. The participants further alleged that excessive fees were paid to the plan's recordkeeper and that Kraft breached its fiduciary duties by failing to obtain competitive bids for recordkeeping services on a periodic basis.

"Transactional drag" results from transaction costs incurred by the fund when participants buy and sell stock. These costs are charged against the overall fund instead of being allocated to the accounts of participants who initiate the transactions. "Investment drag" occurs because the common stock fund includes a cash buffer, which is used to facilitate immediate distributions and provides a hedge against declines in stock value, but arguably decreases the overall return on investments in the fund.

The district court granted summary judgment for Kraft on both claims. The court found that the plan fiduciary had weighed the costs and benefits of methods to reduce transactional and investment drag and reasonably concluded that the costs of these solutions outweighed the benefits. The court also found that Kraft had prudently relied on its consultants' advice regarding the reasonableness of recordkeeping fees.

The Seventh Circuit reversed, finding no evidence in the record that the plan fiduciaries ever engaged in a review of and made an actual determination on transactional and investment drag, despite all the documentation of related discussions. The Seventh Circuit also held that the district court erred in determining that the fiduciaries had satisfied their duty of prudence by relying on the advice of consultants at the summary judgment stage. The Seventh Circuit remanded the case to the district court for further proceedings and for consideration on whether the fiduciaries had made a decision on transactional and investment drag and whether circumstances would have caused a prudent fiduciary to make a decision on such matters.

Reinhart Comment: This case underscores the importance of documenting all

fiduciary decisions, including decisions not to act. Documentation should be contemporaneous to the decision and include the basis for the decision as well as a description of the process by which the decision was reached.

HEALTH AND WELFARE PLAN DEVELOPMENTS

CMS Issues Guidance on Medical Loss Ratio Requirements for Insurers

The Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS) issued 17 questions and answers addressing medical loss ratio (MLR) requirements for health insurers. This new guidance clarifies provisions in the December 2010 final regulations implementing the requirement under the Patient Protection and Affordable Care Act (PPACA) that insurers 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. The questions and answers clarify that insurers should report experience of mini-med and expatriate plans separately from other plans. The guidance also addresses issues relating to reimbursement of clinical services and treatment of a third-party vendor's activities that improve health care quality.

CMS Issues Revised Medicare Part D Creditable Coverage Notices

CMS has updated its model creditable coverage notices to reflect changes in the Medicare Part D enrollment period. The final regulations issued in April 2011 modified the timeframe for notifying participants whether a group health plan's prescription drug coverage is considered "creditable" for purposes of Medicare Part D. The enrollment period was changed from November 15 through December 31 to October 15 through December 7. The revised model notices can be used immediately and are available on the CMS website.

IRS Seeks Comments on Potential Approaches for Implementing PPACA's Employer Shared Responsibility (Play or Pay) Provisions

The IRS issued Notice 2011-36 (the Notice) detailing potential approaches that could be incorporated in future proposed regulations and requesting comments on PPACA's employer shared responsibility provisions (sometimes referred to as the "play or pay" mandate), effective in 2014.

- Employer Shared Responsibility Provisions. As background, PPACA requires "applicable large employers" (50 or more full-time employees) that do not offer minimum essential health care coverage to employees and dependents to pay an annual excise tax of $2,000 per employee if at least one full-time employee

receives a federal tax credit for coverage through an exchange. In addition, applicable large employers that offer coverage that is deemed unaffordable under PPACA (employee premiums of more than 9.5% of household income), or that does not satisfy PPACA's minimum actuarial value test, must pay an annual excise tax of $3,000 for each full-time employee who receives a federal tax credit for exchange coverage (up to a maximum penalty of $2,000 per full-time employee over the 30-employee threshold).

- Definitions of Employer, Employee and Hour of Service. The Notice discusses definitions of "employer," "employee" and "hours of service" and notes that these definitions and the rules for calculating hours of service will generally conform to well-established definitions and rules applicable to employer-provided health and pension plans. The Notice proposes that "employer" would mean the entity that is the employer under the common-law test and the controlled group rules of Code sections 414(b), (c), (m) and (o). The Notice also proposes that "employee" would mean a worker who is an employee under a common-law test (excluding leased employees), with a special rule for seasonal employees. Finally, the Notice proposes that "hours of service" would mean actual hours worked plus hours for which an employee is entitled to payment for periods during which no work was performed (vacation, holiday, illness, etc.). For hourly employees, hours of service would be calculated based on employer records. For non-hourly employees, hours of service could be calculated based on actual hours or using a days-worked or weeks-worked equivalency method.
- Applicable Large Employer. The Notice describes a process for determining whether an employer is an applicable large employer and therefore subject to PPACA's employer shared responsibility provisions. An applicable large employer is an employer that employed at least 50 full-time employees (including full-time equivalents) on business days during the preceding calendar year. A full-time employee with respect to a given month is an employee who is employed at least 30 hours per week (or, under the Notice's proposed rule, at least 130 hours in a calendar month). An employee who is not considered a full-time employee is taken into account to determine full-time equivalences. Full-time equivalences are determined by calculating the aggregate hours of service (up to 120) for non-full-time employees and dividing the total hours by 120.
- The Notice also indicates that the IRS is considering proposing alternatives to a month-by-month determination of full-time employees and describes a look-back/ stability period safe harbor that would provide certainty as to which employees are considered full-time for a particular coverage period.
- Request for Comments. The IRS has requested comments on the potential

approaches described in the Notice. The IRS also requested comments on the 90-day limitation on any waiting period for group health plans under PPACA, including comments on which employees are subject to the limitation, when the waiting period may apply and how the 90-day limitation should be calculated.
- ***Reinhart Comment***: Although the Notice is not considered official IRS guidance, it describes potential approaches that the IRS may incorporate into future proposed regulations and provides insight into issues the agencies are currently reviewing relating to certain PPACA requirements.

HHS Issues Proposed HIPAA Privacy Rule on Accounting of Disclosures under HITECH Act

HHS issued a proposed rule modifying the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's standard for an accounting of disclosures of protected health information (PHI). The proposed rule implements changes to HIPAA under the Health Information Technology for Economic and Clinical Health Act (the HITECH Act) that requires covered entities and business associates to account for disclosures of PHI to carry out treatment, payment and health care operations (TPO) through an electronic health record. Key items under the proposed rule include the following:

- New Right to an Access Report. The proposed regulation divides the existing HIPPA Privacy Rule into two separate rights for individuals: (a) the right to an accounting of disclosures and (b) the right to an access report (including electronic access to both workforce members and persons outside the covered entity). The access report would provide information on who has accessed electronic PHI, including accesses for TPO.
- Changes to Accounting Requirement. The proposed rule makes several changes to the existing accounting of disclosures standard. Specifically, in accordance with the HITECH Act, the proposed rule reduces the accounting period from six years to three years and reduces the response period from 60 days to 30 days (with a 30-day extension). The proposed rule also limits the accounting of disclosures to a designated record set and provides an explicit list of the types of disclosures that must be included.
- The proposed modifications to the accounting standards are expected to be effective 240 days after the date the final regulations are published. HHS proposes that covered entities and business associates provide an access report beginning January 1, 2013 for electronic designated record set systems acquired after January 1, 2009 (January 1, 2014 for systems acquired before January 1, 2009). Comments on the proposed regulations are due August 1,

2011.

District Court Holds That Wellness Program With Financial Penalty Satisfies ADA

The federal district court for the Southern District of Florida ruled that a wellness program requiring employees to complete a health risk assessment and a finger-stick blood test or pay a $20-per-pay period penalty was permissible under the Americans with Disabilities Act (ADA). *Seff v. Broward County*, No 10 cv 61437 (S.D. Fla. Apr. 11, 2011). As background, the ADA generally prohibits employee medical examinations or inquiries that are not job-related and consistent with business necessity. Exceptions to this prohibition exist for "voluntary wellness programs" and "bona fide benefit plans" that are based on underwriting risks, clarifying risks or administering risks.

The district court found that the wellness program administered and paid for by Broward County's insurer was a term of the County's health plan. The court then held that the wellness program satisfied the safe harbor provision for bona fide benefit programs because the program was designed to develop and administer present and future benefit plans using accepted principles of risk assessment.

Reinhart Comment: Because the district court relied on the ADA exception for bona fide benefit plans, it avoided reviewing whether the wellness program would be considered "voluntary" under the ADA. The Equal Employment Opportunity Commission (EEOC) has questioned whether a wellness program that imposes a penalty for failing to participate would be truly "voluntary" and it remains to be seen whether the EEOC or other courts will find the rationale in *Seff* persuasive for upholding other wellness programs with penalties for nonparticipation.

IRS Releases HSA Limits for 2012

The IRS issued Revenue Procedure 2011-32, providing the 2012 inflation-adjusted amounts applicable to health savings accounts (HSAs). As background, eligible individuals may make tax-deductible contributions to an HSA, subject to statutory limits. Employers and other individuals may make HSA contributions on an eligible individual's behalf. A person is an "eligible individual" if he or she is covered under a high-deductible health plan (HDHP) and is not covered under any other health plan that is not an HDHP, unless the other coverage is "permitted insurance."

Revenue Procedure 2011-32 makes the following changes for the 2012 calendar

year:

- Annual Contribution Limit. The deduction limit for an individual with self-only HDHP coverage is $3,100 (up from $3,050 for 2011), and the limit for an individual with family HDHP coverage is $6,250 (up from $6,150 for 2011).
- HDHP—Minimum Deductibles and Out-of-Pocket Maximum. An HDHP is defined as a health plan with an annual deductible that is at least $1,200 for self-only coverage (unchanged from 2011) or $2,400 for family coverage (unchanged from 2011). The annual out-of-pocket expenses (e.g., deductibles, co-payments and other amounts, but not premiums) cannot exceed $6,050 for self-only coverage (up from $5,950 for 2011) or $12,100 for family coverage (up from $11,900 for 2011).

Finally, the statutory "catch-up" contribution limit (for eligible individuals age 55 or older) remains at $1,000 for 2012.

GENERAL DEVELOPMENTS

Supreme Court Remands CIGNA Case Addressing ERISA Remedies for SPD Failures

In *CIGNA Corp. v. Amara*, 2011 WL 1832824 (U.S. 2011), current and former employees claimed that CIGNA's communications regarding the conversion of its traditional defined benefit plan to a cash balance plan were misleading and false. The participants alleged that the SPD, SMM and ERISA section 204(h) notice: (1) failed to describe the effect of "wear-away" on benefits, (2) misstated the amount of the initial "deposit" to participants' cash balance accounts and (3) misrepresented that participants would receive the full value of their frozen benefits plus new annual benefit accruals.

The district court agreed with participants and held that CIGNA's descriptions of the cash balance plan were incomplete, inaccurate and misleading. The district court ordered that the plan be reformed to reflect the benefits that were described to participants and that CIGNA pay these greater benefits in accordance with ERISA section 502(a)(1)(B), which permits lawsuits to enforce rights or to recover benefits due under the terms of a plan. The Second Circuit affirmed, but issued no opinion.

The U.S. Supreme Court vacated the district court's decision, holding that the district court did not have authority to reform the terms of the plan under ERISA section 502(a)(1)(B). The Court also held that CIGNA's communications were not

part of the actual plan and could not be enforced as such.

In lengthy dicta, the Supreme Court addressed whether the district court's reformation of the plan could be considered "appropriate equitable relief" permitted under ERISA section 502(a)(3). The Court concluded that the district court's action resembles different remedies traditionally available in a court of equity (contract reformation, estoppel and surcharge) and remanded the case to the district court to determine an appropriate remedy.

Reinhart Comment: This case will likely lead to increased litigation to address fiduciary breaches. In the past, lower courts have construed *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), and later Supreme Court, cases to preclude recovery of monetary relief against fiduciaries under ERISA section 502(a)(3). In *CIGNA*, the Court has strongly suggested that "make-whole" relief in the form of monetary compensation will be available under equitable principles to redress fiduciary breaches.

Supreme Court Declines to Review Verizon Scrivener's Error Case

The U.S. Supreme Court declined to grant certiorari to review a Seventh Circuit case permitting a plan sponsor to correct a drafting error in a cash balance plan. See *Young v. Verizon's Bell Atlantic Cash Balance Plan*, 2010 WL 3122795 (7th Cir. 2010). The case involved the conversion of Bell Atlantic's defined benefit pension plan to a cash balance plan. Under the new plan, a participant's old pension plan benefit was converted to a lump sum value and multiplied by a transition factor to determine the participant's opening account balance.

In converting the pension plan to a cash balance plan, an error arose in the fourth draft of the plan restatement when an in-house attorney restructured the benefit calculation section to a more readable "A times B" format. The attorney inadvertently failed to delete the trailing clause from the previous draft that multiplies the benefit times the transition factor. A literal reading of this provision would require the lump sum value to be multiplied by the transition factor twice, creating a windfall to participants of over a billion dollars in additional benefits. The district court found that the second transition factor was a scrivener's error and granted Verizon's counterclaim for equitable reformation of the plan. The Seventh Circuit affirmed, holding that ERISA section 502(a)(3) authorizes the equitable reformation of a plan that is shown by clear and convincing, objective evidence to contain a scrivener's error that does not reflect the participants' reasonable expectations of benefits. The Supreme Court's decision not to review

the case allows the Seventh Circuit's ruling to stand.

Reinhart Comment: Verizon serves as a reminder to plan sponsors to carefully review plan documents and SPDs for accuracy. While the Seventh Circuit allowed Verizon to reform the plan terms, the court required clear and convincing, objective evidence of the intended plan language. This rigorous standard of proof is intended as a limitation on the availability of equitable reformation and other plan sponsors may not have sufficient evidence to support the correction of a scrivener's error.

Fourth Circuit Rules "Fiduciary Exception" to Attorney-Client Privilege Extends to DOL Subpoenas

In *Solis v. The Food Employers Labor Relations Association and United Food and Commercial Workers Pension Fund*, 2011 WL 1663597 (4th Cir. 2011), the Fourth Circuit ruled that the "fiduciary exception" to the attorney-client privilege applied to DOL subpoenas seeking documents relating to investments managed by Bernie Madoff's firm. The fiduciary exception rule, which has been accepted in other circuits, generally prohibits fiduciaries who obtain legal advice in the course of plan administration from invoking attorney-client privilege against plan beneficiaries.

The DOL served subpoenas on two multiemployer benefit funds as part of an investigation under ERISA section 504(a)(1) into possible mismanagement of fund assets. The funds objected to the production of certain documents claiming attorney-client privilege. The DOL in turn sought judicial enforcement of the subpoenas and the district court held that the fiduciary exception applied and ordered the funds to comply with the subpoenas.

The Fourth Circuit agreed with the district court and held that the fiduciary exception rule applied to the production of documents in response to a DOL administrative subpoena. The Fourth Circuit was not persuaded by the fund's arguments that a DOL investigative action under ERISA section 504 differed fundamentally in terms of evidentiary support, scope, and the availability of procedural safeguards from an enforcement action under ERISA section 502, and therefore, the fiduciary exception should not apply. In upholding the district court's decision, the Fourth Circuit has joined several sister circuits (the Second, Third, Fifth, Seventh and Ninth Circuits) in determining that the fiduciary exception to the attorney-client privilege applies in the context of ERISA plans."