October 2010 Employee Benefits Update

EMPLOYEE BENEFITS UPDATE

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SELECT COMPLIANCE DEADLINES AND REMINDERS

401(k) Plan Annual Notices

As year-end approaches, sponsors of calendar-year 401(k) plans should prepare to provide the following annual notices (if applicable):

- *Qualified Default Investment Alternative (QDIA)*. Plans that invest participant contributions in a QDIA because the participant failed to make an investment election must provide an annual notice at least 30 days before the beginning of the plan year.
- *Safe Harbor Notice*. Plan sponsors of safe harbor 401(k) plans must provide an annual notice to plan participants at least 30 and not more than 90 days prior to the beginning of the plan year. The safe harbor notice must describe the safe harbor contribution and other material plan features. The safe harbor notice can be combined with the QDIA notice.
- *Automatic Enrollment Notice*. 401(k) plan sponsors of Eligible Automatic Contribution Arrangements (EACA) and Qualified Automatic Contribution Arrangements (QACA) must provide an annual notice, at least 30 days and not more than 90 days before the beginning of the plan year, to all participants on whose behalf contributions may be automatically contributed to the plan. The Internal Revenue Service (IRS) previously posted a sample notice for these two types of automatic contribution arrangements that can be tailored to each plan. The automatic enrollment notice can be combined with the QDIA notice.

Notice of Creditable Coverage

Health plans must send a notice of creditable coverage at various times to Part D eligible individuals. The annual creditable coverage notice must be sent before November 15, 2010.

The model CMS notice is unchanged.

RETIREMENT PLAN DEVELOPMENTS

President Signs Act Allowing In-Plan Roth Conversions On September 27, 2010, the President signed into law the Small Business Jobs Act of 2010 (the Act). The Act includes two provisions involving Roth accounts. The first provision allows plans to permit distributable portions of 401(k), 403(b), and governmental 457(b) account balances to be converted to a Roth account within the plan. Notably, for plans to permit conversions within the plan, there must be a qualified Roth contribution program in the plan. A plan does not need to require the transfer to a Roth IRA for a conversion. Participants who convert in 2010 have the option to split recognized income between 2011 and 2012. This provision is effective for distributions made after the date of enactment of the Act. The second provision permits participants in governmental section 457(b) plans to treat elective deferrals as Roth contributions effective for taxable years beginning after December 31, 2010. Deadlines for any necessary plan amendments have not been announced.

PBGC Sends Notice Regarding the 2011 Premium Instructions

The Pension Benefit Guaranty Corporation (PBGC) sent a notice to plan administrators and other practitioners who prepare and submit premium filings to the PBGC noting that the PBGC plans to post the 2011 premium instructions on its website by the end of 2010.

The notice lists key items to note for 2011:

- The credit card option for paying premiums is eliminated because of low use.
- The inflation-adjusted per-participant flat-rate premium rates will be determined and posted on the PBGC website in October 2010 and will be included in the online premium instructions.
- The earliest filing due dates are for calendar year plans. The due date for an estimated flat-rate filing is February 28, 2011, for large plans (those with 500 or more participants for the prior plan year). The due date for a comprehensive filing is October 17, 2011, for large plans and mid-size plans (those with 100 to 499 participants for the prior plan year) or April 30, 2012, for small plans (those with fewer than 100 participants for the prior plan year).

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Issues Guidance Regarding the Process for Obtaining Waivers of the Restricted Annual Limits Requirement of PPACA

Reinhart

On September 3, 2010, the Department of Health and Human Services (HHS) issued guidance (the Guidance) regarding the process for obtaining waivers of the restricted annual limits requirement of the Patient Protection and Affordable Care Act (PPACA). PPACA generally prohibits plans from imposing annual dollar limits on essential health benefits. However, plans can impose restricted annual limits on essential health benefits for plan years beginning on or after September 23, 2010, and prior to January 1, 2014. The restricted annual limits cannot be less than the following amounts:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012
- $2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014

Previous guidance noted there would be a program to allow limited benefit or mini-med plans to receive a waiver from the restricted annual limit requirements. While the Guidance does not specifically explain what constitutes a limited benefit or mini-med plan, it notes that these plans often offer lower-cost coverage to part-time workers, seasonal workers, and volunteers with annual limits well below the restricted annual limits set forth above.

The Guidance provides some details requiring how a group health plan can apply for a waiver from the restricted annual limits. The plan must submit an application not less than 30 days prior to the beginning of each relevant plan year. For plan years that begin before November 2, 2010, the plan must submit an application not less than 10 days prior to the beginning of the plan year.

The application must include the following information:

- The terms of the plan program for which the waiver is sought.
- The number of individuals covered by the plan program.
- The annual limit(s) and rates applicable to the plan program.
- A brief description, with supporting documentation, explaining why compliance with the restricted annual limits requirement would result in a (1) significant decrease in access to benefits for individuals currently covered by the plan, or

(2) significant increase in premiums paid by such individuals.

- An attestation signed by the plan administrator or chief executive officer of the issuer of the coverage that certifies that the plan was in force prior to September 23, 2010, and that the application of the restricted annual limits to the plan would result in a (1) significant decrease in access to benefits for individuals currently covered by the plan, or (2) significant increase in premiums paid by those individuals.

Plans should submit the above information to the HHS Office of Consumer Information and Insurance Oversight by mail or e-mail. HHS will process complete applications within 30 days of receipt, or no later than five days in advance of the plan year for plans beginning before November 2, 2010. Plans should retain documents to support the application in case HHS wants to examine the application.

If a plan receives an approved waiver now, it will apply for the plan year beginning between September 23, 2010, and September 23, 2011, only. A plan will have to reapply for each subsequent plan year prior to January 1, 2014.

IRS Issues Notice 2010-59 Regarding Reimbursement for Over-the-Counter Drugs

New Guidance. The IRS recently issued Notice 2010-59 regarding the reimbursement of over-the-counter medicines and drugs by employer-provided health plans. PPACA changed the definition of medical expenses in the Code for purposes of reimbursement of medicines and drugs.

Under the new definition, expenses incurred for medicines or drugs can be paid or reimbursed as a medical expense by an employer-provided plan, including a health FSA or HRA, only if the medicine or drug (1) requires a prescription, (2) is available without a prescription (for example, an over-the-counter medicine or drug) and the individual obtains a prescription, or (3) is insulin. Distributions from HSAs or Archer MSAs for a medicine or drug are considered tax-free qualified medical expenses only if one of these three conditions is met. This change does not affect HSA or Archer MSA distributions for medicines or drugs made before January 1, 2011, nor does it affect distributions made after December 31, 2010, for medicines or drugs purchased on or before that date.

For purposes of the above rule, a prescription is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state

in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

The new rule does not apply to items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Such items may qualify as medical care if they otherwise meet the definition of medical care under the Code, which includes expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. However, expenses for items that are merely beneficial to the general health of an individual, such as an expenditure for a vacation, are not expenses for medical care.

Effective Date. The new rules are generally effective for expenses incurred after December 31, 2010. Expenses incurred for over-the-counter medicines or drugs purchased without a prescription before January 1, 2011, may be reimbursed tax-free at any time, pursuant to the terms of the employer's plan.

Application to Health FSA and HRA Debit Cards. The guidance notes that current debit card systems are not capable of substantiating compliance with the new rules regarding over-the-counter medicines or drugs because the systems are incapable of recognizing and substantiating that the medicines or drugs were prescribed. Therefore, for expenses incurred on and after January 1, 2011, health FSA and HRA debit cards cannot be used to purchase over-the-counter medicines or drugs except as provided below. Debit cards can continue to be used for medical expenses other than over-the-counter medicines or drugs.

The guidance further indicates that to facilitate significant changes to existing systems, the IRS will not challenge the use of health FSA and HRA debit cards for expenses incurred through January 15, 2011, if the use of the debit cards complies with existing guidance.

On and after January 16, 2011, over-the-counter medicine or drug purchases must be substantiated before reimbursement can be made. Substantiation is accomplished by submitting the prescription (or a copy of the prescription or other documentation that indicates a prescription has been issued) for the over-the-counter medicine or drug, and other required information from an independent third party.

Transition Rule for Cafeteria Plan Amendments. Cafeteria plans may need to be amended to conform to the new over-the-counter drug requirements. While

cafeteria plan amendments may not be effective retroactively, an amendment to conform a cafeteria plan to the requirements set forth in Notice 2010-59 that is adopted no later than June 30, 2011, may be made effective retroactively for expenses incurred after December 31, 2010 (or after January 15, 2011, for health FSA and HRA debit card purchases).

Guidance Issued Regarding an Enforcement Grace Period for Complying with the New Internal Claims and Appeals Process

As reported in Reinhart's August 25, 2010, Health Care Reform: Internal Claims and Appeals and External Review Process e-alert, PPACA adds section 2719 to the Public Health Service Act (PHSA), providing new internal claims and appeals and external review processes. This section applies to nongrandfathered health plans as of the first day of the first plan year beginning on or after September 23, 2010. On July 23, 2010, HHS, the Department of Labor (DOL), and the Department of the Treasury (the Departments) jointly issued regulations regarding the new internal claims and appeals and external review processes.

In general, group health plans (and health insurance issuers offering group health insurance coverage) must comply with all the existing requirements for internal claims and appeals, as described in the Employee Retirement Income Security Act claims procedure regulations. The e-alert cited above summarizes six new requirements added by the PPACA regulations.

On September 20, 2010, the Departments issued Technical Release No. 2010-02 which noted that since publication of the regulations regarding the new internal claims and appeals process, some plans and issuers have stated they did not anticipate some or all of the additional standards and need more time to change plan or policy procedures and to modify computer systems in order to be compliant.

Technical Release 2010-02 sets forth an enforcement grace period until July 1, 2011, with respect to some of the additional standards in the regulations in order to provide more time for plans and issuers to be fully compliant. Specifically, with respect to requirements number two (regarding the timeframe for making urgent care claims decisions), number five (regarding providing notices in a culturally and linguistically appropriate manner, and requiring broader content and specificity in notices), and number six (regarding substantial compliance), the DOL and the IRS will not take any enforcement action against a group health plan, and HHS will not take any enforcement action, during the grace period, against a self-funded

nonfederal governmental health plan, that is working in good faith to implement the additional standards but does not yet have them in place. Similarly, HHS is encouraging States to provide similar grace periods with respect to issuers.

Departments Post Frequently Asked Questions (FAQs) Regarding PPACA Regulations

On September 20, 2010, the Departments posted FAQs and answers regarding the PPACA regulations on topics such as (1) grandfathered health plans, (2) claims, internal appeals, and external review, (3) coverage of dependent children, and (4) out-of-network emergency services. Some of the grandfathered health plan FAQs address the steps issuers and employer plan sponsors should take to communicate changes to the plan sponsor contribution rate for purposes of determining whether an insured group health plan is a grandfathered health plan.

Additionally, the FAQ relating to coverage of dependent children states that a plan or issuer may limit health coverage for children until the child turns 26 to only those children who are described in Code section 152(f)(1). This Code section defines children to include only sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

The FAQs also note that the Departments have made revisions to the model notice of adverse benefit determination, which includes a header that reads, "Revised as of September 20, 2010."

HHS Posts Additional Early Retiree Reinsurance Program (ERRP) Guidance

On September 17, 2010, HHS posted additional guidance online encouraging plan sponsors with approved applications to begin taking the following steps to prepare for the ERRP reimbursement process.

Accessing the ERRP Secure Website. The guidance notes that one key preparation step is accessing the ERRP Secure Website (ERRP SWS). Authorized representatives and account managers with approved plan sponsor applications will receive e-mails from the ERRP Center with registration links to register with the ERRP SWS. Authorized representatives and account managers should register as soon as possible because the ERRP SWS will be the primary means of communication to the ERRP Center for reporting data and requesting

reimbursement.

Early Retiree Lists. Plan sponsors should prepare early retiree lists. A plan sponsor will be required to submit an early retiree list to the ERRP Center before a reimbursement request can be submitted. On September 24, 2010, HHS posted additional guidance explaining that there are two primary considerations to determine if an early retiree's costs are eligible for reimbursement under the ERRP. First, the individual that the plan sponsor is claiming must be an early retiree, the determination of which is based on such things as age, plan participation, and employment status. Second, the early retiree or the early retiree's spouse, surviving spouse, or dependent(s) must have accumulated $15,000 or more in plan-reimbursed and/or self-paid claims that are eligible for credit towards the ERRP cost threshold or for ERRP reimbursement.

Cost Data. The guidance notes that to simplify cost data submissions for reimbursement, plan sponsors need only submit claims cost data initially at the plan level, not at the benefit option level or at the medical item or service level. However, plan sponsors must supplement any submitted summary cost data with corresponding claim-level data at a future date to be announced by the ERRP Center. Thus plan sponsors should identify resource(s) to assist with consolidation and reporting of such data if necessary. The ERRP Center will begin accepting eligible summary-level cost data in mid-October. Generally, only those items and services that Medicare would cover are eligible for reimbursement under ERRP. On September 28, 2010, the HHS ERRP Center also published new program guidance describing the types of medical items or services that are generally excluded from Medicare coverage. However, this guidance also describes how some of Medicare's specific limits do not apply in the ERRP.

IRS Releases Form 8941 to Help Small Employers Claim New 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 included in PPACA, which is designed to encourage small employers to offer health insurance coverage for the first time or maintain existing coverage. The IRS posted a draft of Form 8941 on its website that both small businesses and tax-exempt organizations can use to calculate the credit. A small business will then include the amount of the credit as part of the general business credit on its income tax return, while a tax-exempt organization will claim the small business health care tax credit on a revised Form 990-T.