

ASSOCIATION OF EMPLOYEE BENEFIT PLANNERS OF NEW ORLEANS

LEGISLATIVE UPDATE

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HEALTH CARE REFORM DEVELOPMENTS

IRS, HHS and DOL Jointly Issue Interim Final Regulations On Dependant Coverage For Children Until Age 26

For plan years starting on or after September 23, 2010, healthcare reform legislation mandates that group health plans offering dependent coverage make that coverage available for adult children until age 26. Jointly issued interim final regulations, effective July 12, 2010, clarify this coverage requirement. Factors like residency, student status, employment and financial dependence cannot determine a child's eligibility even for adult children. Nor can plans vary the terms of coverage based on a child's age until age 26. Although the regulations do not require plans to cover a child's spouse or children, children under 26 previously dropped because of age can re-enroll. Children who become eligible for coverage under the new regulations must receive written notice of their enrollment rights on or before the first day of the first plan year starting on or after September 23, 2010 and must have at least 30 days to enroll irrespective of any open enrollment period. Notice may be provided to the employee. If elected, coverage must be effective not later than the first day of the plan year. Children enrolling in group health plans under these regulations are treated as HIPAA special enrollees. If a parent must be enrolled in the plan for a child to take part in the special enrollment, that parent must be allowed to enroll. Further, enrolled parents may switch benefit options to match the option chosen by the child, and the child cannot be required to pay more for coverage than similarly situated children under 26. Under recent healthcare reform legislation, grandfathered group health plans are exempt from the requirement to cover children under age 26 if the child is eligible for another employer-provider's group health plan. However, the regulations clarify that

adult children eligible under the plans of both parents may not be excluded from coverage under either plan because the child is eligible to enroll in the plan of his or her other parent's employer.

Notice 2010-38–IRS Provides Guidance On Tax Treatment Of Dependent Health Care Coverage

Healthcare reform legislation required group health plans offering dependent coverage for children to provide such coverage until age 26 and extended the income exclusion for medical care reimbursements to employee's children through the end of the year in which the child attains age 26. New guidance clarifies the tax treatment of employer-provided benefits for children. These tax treatment changes are effective March 30, 2010 (whereas the extension of coverage for children until age 26 is effective for plan years on or after September 23, 2010). The medical care reimbursement exclusion applies to children, step-children, legally adopted children, children placed with employees for adoption and eligible foster children under age 27 during the entire tax year even if the child is not the employee's tax dependent. Employer-provided health or accident coverage for an employee's child under 27 at the end of the tax year is excluded from the employee's gross income. Employers may allow employees to begin making pre-tax salary reductions to health FSAs, HRAs and cafeteria plans immediately for children under 27 provided that the plan is retroactively amended before December 31, 2010. Coverage and reimbursements for an employee's child are excluded from wages for FICA and FUTA purposes.

Notice 2010-44–IRS Issues Guidance On The New Small Employer Health Care Tax Credit

Healthcare reform legislation created a small business healthcare tax credit. For taxable years beginning in 2010 through 2013, Employers generally are eligible if they have with less than 25 full-time equivalent employees, pay average annual wages of less than \$50,000 per full-time employee, offer health coverage to employees and contribute at least 50% of the premium cost. The new guidance clarifies that certain individuals are disregarded when determining the number of full-time equivalent employees and details the equivalencies an employer may use in its calculation. The guidance also clarifies that some of the premiums paid are not counted in determining the tax credit. Further, tax credits or premium subsidies paid by states to employers or insurance companies on the employer's behalf generally will not reduce the amount of an employer's premium payment when calculating the tax credit. The guidance also provides transition relief for 2010.

Revenue Ruling 2010–13–IRS Issues Average Small Group Market Premium Chart To Calculate Small Business Health Care Tax Credit

Under healthcare reform legislation, eligible small employers making non-elective contributions to their employee's health insurance premiums may receive a small business tax credit. For taxable years before 2014, small business may receive a maximum credit of 35% of

the lesser of (a) the amount of non-elective contributions paid by the eligible small employer on behalf of employees during the tax year and (b) the amount of non-elective contributions the employer would have paid if each employee were enrolled in a plan that had a premium equal to the *average premium* for the small group market in the state in which the employer offers health insurance coverage. This new chart provides the average premium to use in the tax credit calculation under prong (b).

HHS Final Interim Rules Detail Requirements For Receiving Federal Reimbursements Under The Early Retiree Reinsurance Program.

Under health care reform legislation, employers with health plans covering retirees between age 55 and 64 can receive reimbursements for 80% of those retirees' claims between \$15,000 and \$90,000. New HHS interim final regulations provide guidance and clarification on this program (known as the "Early Retiree Reinsurance Program"). Early retirees are defined as employer-sponsored health plan participants over age 55 who are not active employees and ineligible for Medicare. Spouses and other dependents (as defined by the plan) are included. The regulations broadly define health benefits but exclude HIPAA excepted benefits. Costs open to reimbursement include co-pays and deductibles paid by early retiree. To qualify for the reimbursement, plans must include programs and procedures that generate cost savings for participants with chronic and high-cost conditions. The plan and sponsor also must become certified by HHS by submitting an application to the agency. According to the regulations, the sponsor must use the reimbursement to lower health benefit premiums or costs and/or lower costs for plan participants. The reimbursement cannot be used for general revenue. Under a transition rule, sponsors may make claims for plan years beginning before June 1, 2010 and ending on or after that date. But costs incurred before June 1, 2010 only satisfy the \$15,000 cost threshold. (i.e. only costs incurred from June 1 to December 31 are actually reimbursed).

HHS Issues Interim Final Rule Regarding Web Portal Data

Under healthcare reform legislation, HHS must make an internet "web portal" available to the public by July 1, 2010, usable by individuals and small business to access information regarding insurance coverage options in their states. The website must include information on eligibility, availability, cost sharing and premiums and also will post information regarding the retiree reinsurance program and the small business insurance tax credit created by recent healthcare reform legislation. Effective May 10, 2010, HHS issued an interim final rule identifying the categories of information that HHS will require from insurers, states, associations, and high risk pools. "Summary" information, including product name and geographic availability regarding insurance, must be provided to HHS by May 21. Additional information, including detailed pricing and benefit information must be provided to HHS by September 3 so that HHS may update the web portal by October 1, 2010. The information generally will be updated annually.

OTHER DEVELOPMENTS

DOL And SEC Jointly Issue Investor Bulletin On Target Date Retirement Funds

The agencies have posted a 4-page investor bulletin on their websites designed to help plan participants and other investors understand the risks associated with target date retirement funds. The bulletin illustrates that funds targeted toward the same date may differ widely in asset allocation and risk level and offers general advice in selecting a target date retirement fund appropriate for each individual.

IRS Issues Additional FAQs For HIRE Act

On May 6, 2010, the IRS posted additional frequently asked questions and answers (FAQs) on its webpage: FAQs About the Payroll Tax Exemption and Qualified Employers; FAQs About Qualified Employees; FAQs About Claiming the Payroll Exemption.

IRS Employee Plans Compliance Unit Launches 401(k) Compliance Check Questionnaire Project

The IRS will send 1,200 randomly selected 401(k) plans that filed a Form 5500 return in 2007 a 46-page questionnaire covering compliance issues. Although not an IRS audit or investigation, participation is not voluntary and failure to respond within 90 days or provide complete information may result in an IRS enforcement action.

IRS Revenue Procedure 2010-22—HSA Contribution Limit And HDHP Minimum Deductible And Out-Of-Pocket Maximums For 2011 Unchanged From 2010

The recently released revenue procedure left cost-of-living adjusted HSA contribution limits and HDHP minimum deductible and out-of-pocket maximums unchanged from the 2010 levels. Thus, the new HSA limit for individual HDHP coverage remains \$3,050 while the limit for family HDHP coverage remains \$6,150. The 2010 minimum required deductible for individual HDHP coverage remains \$1,200 while family HDHP coverage remains \$2,400. Likewise, the 2011 maximum limit on out-of-pocket expenses for individual HDHP coverage remains \$5,950 while the limit for family HDHP coverage remains \$11,900.

IRS Issuing Final Regulations On Diversification Requirement For Defined Contribution Plans Holding Publically Traded Employer Securities

The newly issued final regulations regarding diversification requirements for defined contribution plans holding publically traded employer securities relate to the diversification requirements under § 401(a)(35) of the Pension Protection Act (PPA) and generally follow previously issued guidance (IRS Notice 2006-107 and Notice 2009-52). The new regulations are generally effective for plan years beginning on or after January 1, 2011 and will require plans

to adopt interim or discretionary amendments on or before the last day of the plan year beginning on or after January 1, 2010. The new regulations clarify the manner in which employees may diversify their investments by trading employer stock.

Pension Benefit Guaranty Corporation ("PBGC") Is Waiving Certain Penalties And Extending Certain Deadlines In Response To The Severe Storms And Flooding That Recently Occurred In Mississippi, Kentucky, Alabama And Tennessee.

<http://www.pbgc.gov/practitioners/law-regulations-informal-guidance/disaster-relief-announcements>

New E-Signature Option For Electronically Filed Form 5500s

Under EFAST2, Form 5500s must be filed electronically for the 2009 plan year. While plan administrators originally had to obtain their own PIN to electronically sign 5500s and could not share their PIN with third party preparers, the latter may now obtain their own EFAST2 signature and submit Form 5500s on behalf of plan administrators. To do so, a third party preparer must receive written authorization to electronically file from the plan administrator, the administrator must manually sign a copy of the Form 5500 and the third party preparer must attach to its electronic submission a pdf copy of the first two pages of the signed form.

DOL Updates Website To Reflect 2010 Continuing Extension Act's Extension Of The COBRA Subsidy Eligibility Period To May 31, 2010.

The DOL has posted five updated Model COBRA Notices. The Model Updated General Notice is sent to qualified beneficiaries who have any qualifying event from September 1, 2008 through May 31, 2010 and have not been provided an election notice. The Model Notice of New Election Period is for individuals who are not currently enrolled in COBRA who experienced a qualifying reduction of hours from September 1, 2008 through May 31, 2010 and also experienced a termination of employment from March 2, 2010 through May 31, 2010. The Model Supplemental Information Notice is for individuals enrolled in COBRA due to a qualifying event related to a termination of employment occurring between March 1, 2010 and April 14, 2010 if (1) notice regarding the premiums subsidy was not given and (2) a reduction of hours occurring between September 1, 2008 and May 31, 2010 was followed by a termination on or after March 2, 2010 and before May 31, 2010. The Model Notice of Extended Election Period is for individuals not currently enrolled in COBRA who had a qualifying termination of employment between April 1, 2010 to April 14, 2010 and who were provided notice which did not include updated information about the extension of the subsidy under the Continuing Extension Act. Finally, the Model Updated Alternative Notice is for insurers who offer group health coverage subject to comparable state continuation coverage requirements updated for the Continuing Extension Act extension. The DOL also has posted an Application for Expedited

Review of a Denial of COBRA Premium Reduction, a Fact Sheet, and Frequently Asked Questions.

Supreme Court Creates New Standard For Receiving Attorneys' Fees Under ERISA

In *Hardt v. Reliance Standard Life Ins. Co.*, the U.S. Supreme Court ruled that ERISA litigants who are not prevailing parties nonetheless can recover attorneys' fees if they achieve “some degree of success on the merits.” In *Hardt*, a participant sued her employer’s LTD plan’s insurer after being denied benefits. The trial court found compelling evidence that the participant was disabled and remanded the case to the insurer. The trial court also awarded the participant attorneys’ fees and costs after the insurer granted the participant benefits, reasoning that the participant was a “prevailing party.” The Fourth Circuit overturned the trial court’s granting of attorneys’ fees, but the Supreme Court reversed, holding that courts are permitted to award attorneys’ fees at their discretion as long as a claimant shows some degree of success on the merits. Because the trial court found compelling evidence that the participant was disabled, and the participant consequently achieved some success on the merits, the High Court found no abuse of discretion in awarding attorneys’ fees.