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RECENT LEGISLATIVE ACTIVITY

GAO Report Examines Multiemployer Pension Plans

The Government Accountability Office (GAO) issued the report **Private Pensions: Changes Needed to Better Protect Multiemployer Pension Benefits**. The report, requested by Representative George Miller (D-CA), chairman of the House of Representatives Education and Labor Committee, examines:

- the current status of nation's multiemployer plans;
- the steps PBGC currently takes to monitor the health of these plans;
- the structure of multiemployer plans in other countries; and
- statutory and regulatory changes that could help plans provide participants with the benefits they are due.

The report finds that "Most multiemployer plans report large funding shortfalls and face an uncertain future," particularly in light of the recent economic recession. The private pension systems in the countries GAO studied face short-term and long-term challenges similar to those that U.S. multiemployer plans currently face, including plan funding deficiencies and an aging workforce.

Ultimately, GAO concludes that Congress should consider ways to eliminate duplicative reporting requirements and establish a shared database. GAO also recommends that the Pension Benefit Guaranty Corporation (PBGC), the Internal Revenue Service and the U.S. Department of Labor work together to improve data collection and monitoring efforts. In appendices to the GAO report, agency representatives each agree to improve their coordination efforts. The report also notes that "without additional options to address plan underfunding or to attract new employers to contribute to plans, plans may be more likely to require financial assistance from PBGC. Additional claims would further strain PBGC's insurance program that, already in deficit, it can ill afford."

The Financial Accounting Standards Board (FASB) recently issued an exposure draft proposing new financial reporting disclosure rules for entities that participate in multiemployer pension and other postretirement benefit plans, including retiree medical plans. Currently, employers are required to disclose the total contributions made to multiemployer plans but not the plans' funding status. The proposal substantially increases these requirements to "help users of financial statements better assess the potential risks faced by employers participating in multiemployer plans." These expanded disclosures include a description of the plans in which the employer is involved, the employer's contractual commitments to the plans, and the expected impact of participating in the plans on the employer's future cash flows (including the potential impact of plan withdrawal obligations). FASB recently elected to postpone the original effective date until the organization concludes its deliberations regarding the exposure draft.

Legislation Introduced to Repeal PPACA 1099 Reporting Requirements

On November 12, U.S. Senate Finance Committee Chairman Max Baucus (D-MT) released a draft of the Small Business Paperwork Relief Act (S. 3946), legislation to repeal Form 1099 reporting requirements as enacted within the Patient Protection and Affordable Care Act (PPACA). These reporting requirements are set to go into effect in January 2012.

Form 1099 reporting was originally designed and included in PPACA to improve tax compliance and thereby raise revenue. However, many small business owners have expressed concern that the filing process will represent an unreasonable paperwork burden. The National Federation of Independent Business released a statement in support of Baucus' proposal, noting that "Repealing the 1099 provision would eliminate a mountain of expensive paperwork on small business."

It is unclear if the legislation will be reintroduced in the 112th Congress.

RECENT REGULATORY ACTIVITY

HHS Issues MLR Requirements under PPACA with Flexibility for Expatriate, Mini-Med Plans

On November 22, the U.S. Department of Health and Human Services (HHS) released interim final regulations (IFR) regarding medical loss ratios (the percentage of a plan's premium revenues that pay for medical services) under the Patient Protection and Affordable Care Act (PPACA).

According to the official announcement, HHS regulations will "require insurers to spend 80 to 85 percent of consumers' premiums on direct care for patients and efforts to improve care quality." If insurance companies fail to adhere to these standards, they will be required to provide a rebate to their customers starting in 2012. The new MLR requirements apply solely to insured health coverage and do not apply to coverage that is self-insured. HHS also released an official fact sheet on the new requirements.

The interim final regulations are based on a model regulation developed by the National Association of Insurance Commissioners (NAIC). Under the regulations, insurers are required to report aggregate premium and expenditure data for each market, with an exception for so-called "expatriate" and "mini-med" plans. For these two categories of plans, insurers will be allowed to report their experience separately, subject to a special MLR calculation intended to provide temporary relief from the general rule.

Expatriate Plans

Although the NAIC did not make a formal recommendation on this subject, in an October 13 letter to Secretary Sebelius, the NAIC recommended that the Secretary exclude expatriate plans—health insurance provided to U.S. citizens who are living or working abroad – from the new requirements. The regulation accelerates data collection and creates a special methodology that follows this recommendation to the extent permitted by PPACA.

Mini-Med Plans

HHS is allowing the same treatment for mini-med plans to permit this type of coverage to continue until 2014, when state insurance exchanges will be established.

The regulations are effective January 1, 2011. Comments on the IFR are due 60 days after publication in the Federal Register.

IRS Extends PPA Deadline for Certain Retirement Plan Amendments

On November 30, the Internal Revenue Service (IRS) issued Notice 2010-77, which extends the deadline for amending defined benefit plans to meet certain requirements added by the Pension Protection Act of 2006 (PPA), and subsequently modified by the Worker, Retiree, and Employer Recovery Act of 2008 (WRERA), and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA).

The deadline is now extended to the last day of the first plan year that begins on or after January 1, 2011 and applies to:

- Funding-based limits on benefits and benefit accruals under Sections 401(a)(29) and 436 of the Internal Revenue Code.
- Most new PPA requirements for cash balance and other hybrid plans under Code Sections 411(a)(13) and 411(b)(5) (but no extension for the new hybrid plan anti-whipsaw rule contained in Section 411(a)(13)(A)).

The notice also stated that the additional extension of time to amend also applies for the purpose of a plan's eligibility for the relief from the requirements of 411(d)(6) (which generally prohibits amendments that decrease a participant's accrued benefit) described in Notice 2009-97, issued in December 2009. This earlier notice provided the extension of time to amend the plan as well as anti-cutback relief through the last day of the first plan year beginning on or after January 1, 2010.

Notice 2010-77 explained that the extension for amendments to reflect the PPA funding-based limits on benefits and benefit accruals was provided because the final Section 436 regulations published in October 2009 did not include changes made by WRERA and PRA, and the IRS wanted to give plan sponsors time to take into account the WRERA and PRA changes to Section 436.

Final and proposed hybrid plan regulations were published October 19, 2010. The regulations are proposed to be effective for plan years beginning on or after January 1, 2012, and the IRS indicates that the extensions provided in the notice were tailored to the expectation that this will be the effective date of the regulations once they are finalized.

IRS Expands Relief for NQDC Plan Document Corrections

On November 30, the Internal Revenue Service (IRS) issued Notice 2010-80, providing new relief for nonqualified deferred compensation (NQDC) plans that voluntarily correct failures to comply with the document requirements under 409A of the Internal Revenue Code. The notice effectively expands the relief provided earlier this year under Notice 2010-06.

Under Code Section 409A(a), amounts deferred under a NQDC plan are includible in income unless statutory requirements, generally relating to the time and form of payment of amounts deferred under the plan, are met both in form and operation. By making corrections, employers can avoid/reduce the current income inclusion and additional taxes applicable under the section.

Most notably, Notice 2010-80:

- Provides relief from the service provider information reporting requirements under Notice 2010-6 for corrections made under the transition relief ending December 31, 2010; and

- Provides relief from the requirement that service recipients provide certain information to service providers under Notice 2008-113 for corrections made in the same taxable year as the failure occurs.

Notice 2008-113 provided guidance for corrections of certain Section 409A violations that would allow taxpayers (participants) to obtain relief from the full application of the income inclusion and additional taxes.

In addition, the notice:

- Clarifies that the types of plans eligible for relief under Notice 2010-6 include a nonqualified plan linked to a qualified plan or another nonqualified plan, provided that the linkage does not affect the time and form of payments under the plans;
- Expands the types of plans eligible for relief under Notice 2010-6 to include certain stock rights that were intended to comply with the requirements of Code Section 409A(a) (rather than be exempt from those requirements); and
- Provides an additional method of correction under Notice 2010-6 for certain failures involving payments at separation from service subject to the requirement to submit a release of claims or similar document; and provides transition relief permitting the correction of such failures that were in effect on or before December 31, 2010 (including relief from the service provider information reporting requirements).

DOL Proposes New Rules for QDIAs, Target Date Funds

On November 29, the U.S. Department of Labor (DOL) released proposed regulations regarding target date funds (TDFs) which would amend the DOL final regulations of October 2007 on qualified default investment alternatives (QDIAs) (the amendment also requires disclosure of additional information for other QDIAs) as well as the October 2010 final regulations addressing fiduciary requirements for fee disclosure to participants in participant-directed individual account plans (such as 401(k) plans). The DOL is also expected to issue separate guidance soon which will provide tips for plan fiduciaries on the selection and monitoring of TDFs.

Qualified Default Investment Alternatives

The proposed amendments to the QDIA regulations are intended to provide more specificity as to the information that must be disclosed about all QDIA investments, with a further level of detail required specifically when the QDIA is a TDF. The proposal would require that the QDIA notice include the first five elements below for all QDIAs and the sixth element for TDFs that are QDIAs:

1. Name of the investment's issuer.
2. Description of the investment's objectives or goals.
3. The investment's principal strategies (including a general description of the types of assets held by the investment) and principal risks.
4. The investment's historical performance data (e.g., 1-, 5-, and 10-year returns) and, if applicable, any fixed return, annuity, guarantee, death benefit or other ancillary features; as well as a statement indicating that an investment's past performance is not necessarily an indication of how the investment will perform in the future.
5. The investment's fees and expenses including any fees charged directly against the amount invested in connection with the acquisition, sale, transfer of, or withdrawal; any

operating expenses (e.g., expense ratio); and any ongoing expenses in addition to annual operating expenses (e.g., mortality and expense fees).

6. The notice for TDFs used as QDIAs must include the following to the extent not already disclosed under the other requirements:

    a. An explanation of the asset allocation, how the asset allocation will change over time, and the point in time when the investment will reach its most conservative asset allocation, including a chart, table, or other graphical representation that illustrates the change over time; b. If the QDIA is named, or otherwise described, with reference to a particular date (e.g., a target date), the notice must explain the age group for whom the investment is designed, the relevance of the date, and any assumptions about a participant's or beneficiary's contribution and withdrawal intentions on or after that date; and c. A statement that the participant or beneficiary may lose money by investment in the QDIA, including losses near to, and following, the retirement date, and that there is no guarantee that investment in the QDIA will provide adequate retirement income.

The Securities and Exchange Commission (SEC) has also released a proposed rule that changes the rules applicable to mutual fund advertising and marketing materials to add new disclosure requirements for TDFs. There are some similarities between the SEC's proposed rule on marketing and the DOL's proposed disclosure rule. A major difference is that the SEC's proposal will apply only to registered funds (e.g., mutual funds) while the DOL proposal will apply to all target-date investment options (e.g., collective funds).

Under the DOL proposed rule, the disclosure notice is also required to describe the rights of participants and beneficiaries to direct the investment of the assets automatically invested in the QDIA into other investment alternatives available under the plan and, if applicable, a statement that certain fees and limitations may apply in connection with the transfer. The notice must also include an explanation of where the participants and beneficiaries can obtain additional information concerning the QDIA and other investment alternatives available under the plan.

Participant Fee Disclosure

The proposed amendments to the fee disclosure regulations fill in the section previously reserved in that regulation by requiring expanded disclosures to participants about TDFs. These expanded disclosures under the participant disclosure regulations would apply whenever a TDF is offered in the plan menu. The information required to be disclosed closely tracks the newly expanded QDIA notice for TDFs and the preamble indicates this is to ensure that consistent information on TDFs is furnished to defaulted participants and to participants who give investment directions.

The DOL proposes that the amendments to the regulations would be effective 90 days after publication of the final rule in the Federal Register. Written comments to DOL on this issue are due within 45 days after formal publication of the proposed regulations, expected on November 30 (making the comment due date January 14, 2011).

IRS Issues Guidance Regarding In-Plan Roth Conversions

On November 29, the Internal Revenue Service (IRS) issued Notice 2010-84, guidance relating to rollovers from 401(k) and 403(b) plans to designated Roth accounts within the same plan. Under Section 2112 of the Small Business Jobs Act, signed into law by President Obama earlier

this year, participants are allowed to make rollovers from their 401(k) and 403(b) plans to their designated Roth accounts ("in-plan Roth rollover") after September 27, 2010.

Key provisions of this guidance include the following:

- Retroactive amendments are permitted. Generally, plans can be retroactively amended by December 31, 2011, to permit rollovers during the 2010 plan year. However, the Roth contribution program must be operationally in place by the effective date of the Roth rollover provisions (eligible employees are given an opportunity to elect on that date to have designated Roth contributions made to the plan).
    - The extension of time applies to a plan amendment that (1) permits elective deferrals to be designated as Roth contributions (but see limitation in preceding paragraph), (2) provides for the acceptance of rollover contributions by the designated Roth account, and (3) permits in-plan Roth rollovers (including amendments described in the following paragraph).
- "Distribution" rights may be limited. A plan may be amended to add an in-plan Roth direct rollover option for amounts that are permitted to be distributed under the Internal Revenue Code (Code) but that have not been distributable under more restrictive terms contained in the plan. In addition, the amendment is not required to permit any other rollover or distribution option for these amounts.
    - As under current law, pre-tax elective deferrals are only permitted to be distributed if the participant has a severance from employment, reached age 59-1/2, has died or become disabled, or receives a qualified reservist distribution. Thus, an amendment permitting the in-plan Roth rollover prior to any of these events (but after a period of years) would need to exclude pre-tax elective deferrals.
- An in-plan Roth direct rollover is not treated as a distribution for the following purposes:
    - Plan loans (balance of rolled over loan is treated as amount of rollover);
    - Spousal consent;
    - Participant's consent of distribution in excess of $5,000 (notice of right to defer is not triggered); and
    - Elimination of optional forms of benefit (distribution rights are preserved).
- Other Miscellaneous Provisions:
    - A plan that permits in-plan Roth rollovers must update the distribution (402(f)) notice accordingly (and sample language is provided).
    - Recharacterization of an in-plan Roth rollover is not permitted.
    - Splitting the taxable amount between 2011 and 2012 is the default treatment for rollovers during 2010.
    - Rollovers may be accomplished either through the in-plan Roth direct rollover or by a distribution of the funds to the individual who then rolls over the funds into the designated Roth account within 60 days.
    - There are special income acceleration rules for 2010 in-plan Roth rollovers if the participant defers income to 2011 and 2012 and subsequently takes a distribution prior to 2012.
    - There are special rules relating to the application of the 10 percent premature distribution penalty for distributions allocable to the taxable amount of an in-plan rollover made within the preceding 5 years.
    - Surviving spouses or alternate payee spouses can elect an in-plan Roth rollover.
- The guidance contains ordering rules for distribution of Roth amounts following an in-plan Roth rollover (including an example).

Notice 2010-84 follows the IRS' November 22 announcement on its "Changes to Current Tax Forms, Instructions, and Publications" website that the 20 percent income tax withholding requirement will not apply to in-plan Roth IRA rollovers. The IRS website contains reporting instructions for both the in-plan conversion and a subsequent distribution of designated Roth amounts that includes monies from an in-plan conversion. Both are reported on (separate) Form 1099-Rs.

IRS Issues Guidance on Multiemployer Defined Benefit Plan Funding Relief

On November 26, the Internal Revenue Service (IRS) issued Notice 2010-83, guidance on funding relief for multiemployer plans as enacted under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA 2010).

PRA 2010 provides single-employer and multi-employer funding relief in the form of an extended period for defined benefit plans to amortize "the shortfall amortization base" (i.e., the portion of the funding shortfall that is recognized in any one year under the funding rules).

Notice 2010-83 provides, in question-and-answer format, guidance on the following subtopics:

- The extended 29-year amortization period for eligible net investment losses
- Asset valuation rules (under which plans can recognize eligible net investment losses in the actuarial value of plan assets over a period of up to 10 years (rather than the general five-year limit) and the actuarial value is subject to an 80-130 percent asset value corridor (rather than the general 80-120 percent corridor)
- The solvency test required to obtain relief
- Restrictions on plan amendments increasing benefits
- Decision to apply the special funding rules
- Notification to participants, beneficiaries, and the PBGC
- Certification of status under Internal Revenue Code Section 432
- Form 5500 requirements

DOL Proposes Defined Benefit Plan Model Annual Notice Requirements

On November 18, the U.S. Department of Labor (DOL) issued proposed regulations that would implement the annual funding notice requirement under ERISA, as amended by the Pension Protection Act of 2006 (PPA) and the Worker, Retiree, and Employer Recovery Act of 2008 (WRERA). DOL also issued a fact sheet on the proposed regulations and model notices for both single-employer and multiemployer plans.

As amended, Section 101(f) of ERISA generally requires the administrators of single- and multiemployer defined benefit plans to furnish an annual funding notice to the Pension Benefit Guaranty Corporation (PBGC), participants, beneficiaries, and others. In addition, the PPA shortened the time frame for providing funding notices and enhanced the notice content requirements; a funding notice must include, among other information, the plan's funding target attainment percentage or funded percentage, as applicable, over a period of time, as well as other information relevant to the plan's funded status.

This document also contains proposed conforming amendments to other regulations under ERISA, such as the summary annual report regulation, also required by PPA. The proposed regulation would affect plan administrators and participants and beneficiaries of defined benefit

pension plans, as well as labor organizations representing participants and beneficiaries and contributing employers of multiemployer plans.

DOL issued Field Assistance Bulletin (FAB) 2009-1 on February 11, 2009, providing interim model notices and guidance under the program, announcing a "good faith" enforcement policy and providing technical assistance in the form of questions and answers. Much of the guidance in FAB 2009–01 has been incorporated into the proposed regulations. That guidance remains in effect until DOL adopts final regulations.

Obama Administration Requests Information Regarding PPACA Federal External Review Process

On November 18, the U.S. Departments of Labor (DOL) and Health and Human Services (HHS) issued a request for information (RFI) seeking information to assist them in planning and developing the federal external review process established under PPACA in advance of one or more Requests for Proposals (RFPs).

These departments (along with the U.S. Treasury Department) issued interim final regulations under the Patient Protection and Affordable Care Act (PPACA) providing for a federal external review process in instances where there is no applicable state process. Under Section 2719 of the Public Health Service Act (as amended by PPACA) and the interim final regulations, DOL and HHS are directed to plan and develop a federal external review process and may contract for services required to fulfill the statutory and regulatory requirements.

The agencies may contract for services to implement the statutory and regulatory requirements of the federal external review process. The RFI (which is intended to inform future RFPs) invites comment from all stakeholders on a range of related operational issues including qualifications, infrastructure, data collection and performance evaluation of IROs. According to the RFI, the agencies plan to ensure uniform and consistent processes for external review by independent review organizations (IROs) within geographic areas and across the nation. Comments on the RFI were due by December 8, 2010.

DOL Launches Employee Contributions Enforcement Initiative

On November 16, the U.S. Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) announced a series of enforcement actions to protect contributions made by employees and matching contributions promised by their employers. According to a news release, "The Contributory Plans Criminal Project is the agency's first criminal national enforcement project targeting persons who commit fraud and abuse against participants and beneficiaries of contributory employee benefit plans, including 401(k)s, and contributory health plans." A fact sheet on retirement security initiatives is also available.

As part of this effort, DOL has filed 24 separate civil lawsuits in federal district courts alleging breach of fiduciary duty relating to instances at small, local companies where workers had contributions to their pension or health plans withheld from their paychecks but the employers did not deposit those contributions in the plans, instead using the funds for their own purposes or other purposes unrelated to the plans.

The project also includes an educational campaign component in the form of a fact sheet, Ten Warning Signs That Your 401(k) Contributions Are Being Misused.

PPACA Grandfather Plan Regulations Amended to Allow Change in Carrier

On November 15, the U.S. Departments of Labor (DOL), Treasury and Health and Human Services released an amendment to the previously issued interim final regulations (IFR) implementing the "grandfather" provisions of the Patient Protection and Affordable Care Act (PPACA). The departments also issued a fact sheet along with the amendment.

As we have previously reported, certain group health plans or insurance coverage existing on the date of enactment of the PPACA (March 23, 2010) are not required to comply with certain requirements (for example, the requirement for coverage of preventive care at no cost to the participant or insured). The IFR set out the specific requirements that a group health plan or insurance carrier must observe in order to maintain status as a "grandfathered" plan. In general, the rules provide that grandfather plans will lose their status if "they choose to make significant changes that reduce benefits or increase costs to consumers."

The new amendment clarifies that an insured group health plan does not lose grandfathered status merely by changing issuers or insurance contracts. Under the IFR, the act of changing issuers or contracts alone would have resulted in a loss of grandfathered status. The departments cited several reasons for the amendment, noting:

- the prior rule treated self-insured group health plans better because it allowed such plans to change benefit administrators and/or to insured coverage without affecting grandfathered status;
- the prior rule would unnecessarily restrict the ability of issuers to reissue policies to current plan sponsors for administrative reasons unrelated to any change in the underlying terms of the health insurance coverage without loss of grandfather status (for example, to transition the policy to a subsidiary of the original issuer or to consolidate a policy with its various riders or amendments); and
- the prior rule would give issuers undue and unfair leverage in negotiating the price of coverage renewals with the sponsors of grandfathered health plans, and that this interferes with the health care cost containment that tends to result from price competition.

The amendment makes clear that an insured group health plan that changes issuers and/or contracts must continue to fully comply with the prior rules regarding changes that result in grandfathered plan status. Sponsors considering changing issuers or insurance contracts will need to ensure that all benefits provided under the contract in effect on March 23, 2010, remain in effect following any such change. Additionally, careful attention should be paid to the cost-sharing features associated with the new insurance contract and/or issuer to ensure that grandfathered plan status is not disturbed.

The amendment applies to such changes to group health insurance coverage that are effective on or after November 15, 2010, the date the amendment to the interim final regulations was made available for public inspection. According to the departments, the amendment does not apply retroactively to such changes to group health insurance coverage that were effective before this date. The amendment explains that for this purpose, the date the new coverage becomes effective is the operative date, not the date a contract for a new policy, certificate or contract of insurance is entered into. Therefore, for example, if a plan enters into an agreement with an issuer on September 28, 2010, for a new policy to be effective on January 1, 2011, then January 1, 2011, is the date the new policy is effective and, therefore, the relevant date for purposes of determining the application of the amendment to the interim final regulations. If,

however, the plan entered into an agreement with an issuer on July 1, 2010, for a new policy to be effective on September 1, 2010, then the amendment would not apply and the plan would cease to be a grandfathered health plan. The departments have specifically invited comment on the prospective effective date of the rule and how that affects plans with different plan years.

EEOC Finalizes Genetic Information Nondiscrimination Regulations

On November 9, the Equal Employment Opportunity Commission (EEOC) issued final regulations implementing Title II of the Genetic Information Nondiscrimination Act of 2008. These regulations implement and clarify various provisions of Title II of the statute. The EEOC has also made available a series of background questions and answers as well as additional questions and answers for small businesses.

Title I of GINA prohibits employer-sponsored group health plans and health insurers providing group and individual health insurance from restricting enrollment or adjusting premiums based on genetic information or requiring or requesting genetic testing. Civil penalties are added to ERISA and the Public Health Service Act for violations of the new rules, in addition to remedies available under previous law. Title II of GINA prohibits use of genetic information in the employment context, restricts the deliberate acquisition of genetic information by employers and other entities covered by Title II, and strictly limits such entities from disclosing genetic information. (The U.S. Departments of Labor, Treasury and Health and Human Services adopted interim final regulations on Title I of GINA in October 2009.)

As explained in the preamble and Question 14 of the background questions and answers document, GINA and the regulations permit a covered entity to acquire genetic information about an employee or his or her family members when it offers health or genetic services, including wellness programs, on a voluntary basis. The individual receiving the services must give prior voluntary, knowing, and written authorization. (The regulations clarify that such authorization may be provided in electronically). While individualized genetic information may be provided to the individual receiving the services and to his or her health or genetic service providers, genetic information may only be provided to the employer or other covered entity in aggregate form.

The Commission concludes that it would not violate Title II of GINA for a covered entity to offer individuals an inducement for completing a health risk assessment that includes questions about family medical history or other genetic information, as long as the covered entity specifically identifies those questions and makes clear, in language reasonably likely to be understood by those completing the health risk assessment, that the individual need not answer the questions that request genetic information in order to receive the inducement." The regulation provides two examples to illustrate this approach to health risk assessments. The preamble also states that "Title II allows covered entities to offer financial inducements for participation in disease management programs or other programs that encourage healthy lifestyles, such as programs that provide coaching to employees attempting to meet particular health goals. To avoid a violation of Title II of GINA, however, covered entities who offer such programs and inducements to individuals based on their voluntarily provided genetic information must also offer the programs and inducements to individuals with current health conditions and/or to individuals whose lifestyle choices put them at risk of acquiring a condition."

DOL to Hear Testimony on Plan Fees for Health & Welfare Plans

The U.S. Department of Labor has announced a hearing to consider issues relating to the disclosure of fee, conflict of interest and other information by service providers to group health,

disability, severance and other employee welfare benefit plans under ERISA Section 408(b)(2). This hearing is apparently the first step in developing fee disclosure requirements for health and welfare plans as the agency has already done for retirement plans.

DOL issued interim final regulations that would require service providers to give retirement plan fiduciaries written disclosures of certain fee and services information necessary to assist plan fiduciaries in assessing the reasonableness of compensation or fees paid by the plan, as well as the potential for conflicts of interest. These regulations relate only to fee disclosure for retirement plans, as the health and welfare section was reserved.

The purpose of the hearing is to collect information, related data and views regarding the application of the standards in the interim final regulations to welfare benefit plans.

IOM Commences Study on PPACA "Essential Benefits Package"

In other health care reform implementation news, the Institute of Medicine (IOM) – an independent, nonprofit organization that provides policy recommendations to the public – has begun the process of developing standards for the "essential health benefits" package established to define the mandatory coverage requirements under the Patient Protection and Affordable Care Act (PPACA). The IOM has been specifically asked by U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius to study the issue.

According to the IOM website, "the IOM will not define specific service elements of the benefit package. Instead, the IOM will review how insurers determine covered benefits and medical necessity and will provide guidance on the policy principles and criteria for the Secretary to take into account when examining qualified health plans for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life. "The IOM will also offer advice on criteria and a process for periodically reviewing and updating the benefits package.

IRS Bulletin: Some Form 5558 Extension Requests May Have Been Inadvertently Denied

The November 5, 2010 "Special Edition" of the Internal Revenue Service (IRS) Retirement News for Employers newsletter reveals that some employee benefit plan sponsors have erroneously received notice that their Form 5558 applications have been denied. The Form 5558 is typically used to obtain an extension for filing the Form 5500 Annual Return/Report of Employee Benefit Plan.

"The IRS Ogden Campus received numerous Forms 5558 from the practitioner community. Some Forms 5558 were inadvertently denied and plan sponsors received extension denial letters (CP 216H, Application for Extension of Time to File an Employee Plan Return Denied - Not Timely)," the newsletter says. If you believe you received a CP 216H Notice in error, please respond by enclosing the denial letter and proof that the original Form 5558 was postmarked timely (for example, with an express mail or certified mail receipt) and send to: Ogden Accounts Management Center, EP Accounts Unit, Mail Stop 6270, Ogden, UT 84201.

If you received a CP 213N, Form 5500 Late Return, proposed penalty notice indicating Form 5500 was not timely filed, in error, please respond by following the instructions in the notice.

Additional PPACA FAQ Guidance Released

The Departments of Health and Human Services, Labor and Treasury jointly issued "Frequently (FAQs) About the Affordable Care Act Implementation Part IV", the latest in a series of FAQs relating to implementation of the Patient Protection and Affordable Care Act (PPACA). Previously issued FAQs include Part I released on September 20; Part II released on October 8, and Part III released on October 18, 2010.

Today's guidance contains two questions addressing grandfathered plans and one question related to plans that reimburse expenses for special treatment and therapy for eligible employees' children with physical, mental or developmental disabilities:

- Question (1) clarifies that a grandfathered plan is compliant with PPACA's disclosure requirement if it includes the model disclosure language in the agencies' interim final regulations (or a similar statement) when ever a summary of the benefits under the plan is provided to participants and beneficiaries. Other communications may include a disclosure statement (for example, Explanations of Benefits (EOBs)) but are not required to do so.
- Question (2) addresses individual health insurance policies that were in place on March 23, 2010, and that had a feature that allowed a policy holder to elect an option that would allow a reduced premium in exchange for higher cost sharing. The FAQ clarifies that the grandfathered status of the plan would be unaffected if the policy holder exercised the option after March 23, 2010.
- Question (3) addresses plans that reimburse expenses for special treatment and therapy of eligible employees' children with physical, mental or developmental disabilities. The treatment or therapy is not covered by the employer's primary medical plan or plans, is operated separately from the primary medical plans; and limits total benefits for any eligible child to a specified lifetime dollar limit. The FAQ clarifies that, in the case of plans described in the FAQ, the agencies will treat as a reasonable good faith interpretation of PPACA Section 2711 a plan sponsor's position that such plans do not violate the lifetime limit prohibitions of PPACA.

RECENT JUDICIAL ACTIVITY – NO ACTIVITY TO REPORT THIS MONTH