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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Senate Passes Pension Funding Technical Corrections

On December 18, the U.S. Senate approved an amendment to a Federal Aviation Administration funding extension bill (H.R. 4915) making technical corrections to the defined benefit pension plan funding provisions of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PRA 2010). This law allows an extended period for single-employer 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).

Specifically, the technical corrections measure includes:

- Amendment of the definition of an eligible plan year;
- Amendment of the definition of an eligible charity plan; and
- Suspension of certain funding level limitations, including amendment of Social Security level-income options.

The effective dates for these amendments would be retroactive, taking effect as if originally included in PRA 2010.

The measure also includes an amendment for multiemployer pension plans addressing the optional use of 30-year amortization periods. These provisions would take effect as of the first day of the first plan year beginning on or after June 30, 2008, except that any election a plan sponsor makes pursuant to this section or the amendments made thereby that affects the plan's funding standard account for any plan year beginning before October 1, 2009, shall be disregarded for purposes of applying the provisions of Section 305 of ERISA and Section 432 of the Internal Revenue Code to that plan year.

The House of Representatives was unable to reach agreement with the Senate on this matter before the end of the 111th Congress, effectively killing the bill. These provisions will now have to be reintroduced and addressed in the 112th Congress.

Congress Enacts Tax Package with Mass Transit Parity Provision

On December 15, the U.S. Senate formally approved the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act (H.R. 4853), legislation to extend the Bush-era tax cuts for an additional two years. The House of Representatives approved the measure on December 16 and the President signed the bill into law on December 17.

H.R. 4853 includes a one-year extension of the increase in the fringe benefit for mass transit, making it equal to the fringe benefit provided for parking. Without this extension, the maximum monthly transit benefit allowed by federal law will decrease from $230 to $120. The increase in the benefit was originally provided through a provision of the American Recovery and Reinvestment Act (ARRA) to match the maximum allowable parking benefit of up to $230 per month. Many employers provide this benefit to employees or make the purchase of mass transit fares available on a pre-tax basis.

Letters Circulating Requesting Information on 401(k) Plans

Senate Special Aging Committee Chairman Herbert Kohl (D-WI) has sent a series of letters to a number of large employer plan sponsors of 401(k) plans, retirement plan providers and asset

managers requesting specific information about their defined contribution plans. The letters are particularly seeking information on the fund offerings within these plans (such as stable value funds) in which the underlying investments involve securities lending. Redacted versions of the letters are available here and here.

Congressional interest in this issue stems from a May 2009 Wall Street Journal article, 401(k)s Hit by Withdrawal Freezes, which discusses whether withdrawal restrictions relating to 401(k) plans were caused by issues related to securities lending programs with cash collateral reinvestments.

It is unclear at this time whether Kohl is gathering information for development of a specific legislative measure, but there has been a significant increase among policymakers in broadening the definition of fiduciary and expanding disclosure requirements since the financial crisis in late 2008. As we have previously reported, the U.S. Department of Labor has issued proposed regulations to expand the definition of the term "fiduciary" and interim final regulations disclosure to defined contribution plan participants; the Securities and Exchange Commission has begun an examination of stable value funds pursuant to the Dodd-Frank financial services reform legislation; and so-called "stock drop" lawsuits (such as Citigroup Pension Plan ERISA Litigation) alleging breach of fiduciary duty.

Congress Enacts Doc Fix with Health Insurance Subsidy Recapture

On December 8, the U.S. Senate approved a "doc fix" measure that would prevent a scheduled reduction in Medicare reimbursement levels to physicians. The House of Representatives approved the legislation on December 9 and President Obama signed the bill into law on December 15

Without legislative action, a 23 percent reduction in payment levels would have gone into effect on January 1, 2011..

The one-year extension of current levels contained in the Medicare and Medicaid Extenders Act (H.R. 4994) is estimated to cost nearly $20 billion over the next two years. To defray this cost, the measure includes a number of provisions to raise federal revenue. Most notable is a recapture of the health insurance subsidy tax credit provided under the Patient Protection and Affordable Care Act (PPACA). Under the health law, eligibility for a household income-based premium subsidy is based on prior year income. But if an individual's actual income in the year during which they received the premium subsidy would have made the individual ineligible for assistance, the person is subject to a recapture tax in the subsequent tax year. (The COBRA premium subsidy works in a similar manner.) An official Senate Finance Committee summary of the bill is also available.

Previously, the amount required to be repaid by the individual was limited to $250 for individuals and $400 for families for those at or below 400 percent of the Federal Poverty Level (FPL). The provision in H.R. 4994 increases the existing limits of $250 and $400 and replaces the across-the-board structure with a scaled structure that starts with lower limits for those with lower incomes, according to the following chart:

Income Level	Recapture amount
100-200% FPL	$300 for an individual, $600 per family
200-250% FPL:	$500 for an individual, $1,000 per family
250-300% FPL	$750 for an individual, $1,500 per family
300-350% FPL	$1,000 for an individual, $2,000 per family
350-400% FPL	$1,250 for an individual, $2,500 per family
400-450% FPL*	$1,500 for an individual, $3,000 per family*
450-500% FPL*	$1,750 for an individual, $3,500 per family*

*While subsidies are only available to individuals and families with incomes below 400% FPL, the above recapture penalties would apply to individuals who received subsidies, yet were not eligible for ANY subsidies based on their income. As noted above, currently individuals with incomes above 400% FPL would have to pay back ALL of the insurance subsidy amounts they received in error.

Public Pension Transparency Bill Introduced in House

On December 2, the Public Employee Pension Transparency Act (H.R. 6484) was introduced in the House of Representatives by Devin Nunes (R-CA), Paul Ryan (R-WI) and Darrell Issa (R-CA). The bill would expand transparency requirements from state and local public pension plans and prohibit the federal government from providing any financial assistance or bailouts to public pension funds in the future.

H.R. 6484 was not considered in the remaining weeks of this Congress but could be reintroduced next year. Ryan and Nunes both serve on the House Ways and Means Committee, to which the bill has been referred for initial review.

RECENT REGULATORY ACTIVITY

Agencies Issue Request for Information on Value-Based Insurance Design and Preventive Services

On December 28, 2010, the Departments of Health and Human Services, Labor and Treasury ("Agencies") jointly issued a Request for Information (RFI) on how group health plans and

health insurance issuers can employ value-based insurance design (VBID) in the coverage of recommended preventive services.

Under Public Health Service Act ("PHSA") Section 2713 as added by PPACA and implementing interim final regulations (IFR), nongrandfathered group health plans (GHPs) and insurance are permitted to utilize value-based insurance designs (VBID) to provide first-dollar coverage for The Agencies recently released Part V FAQ guidance which confirms that VBID includes the use of copayments to steer patients towards a particular high-value setting, such as an ambulatory care setting, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the high-value setting. The Agencies are developing additional guidelines regarding the utilization of value-based insurances by GHPs and health insurance issuers with respect to preventive care.

To inform future guidance, the RFI solicits additional information on specific examples and best practices of VBID for recommended preventive services, as well as data used to support and inform VBID benefit design, measurement, and evaluation in the context of recommended preventive services. The RFI requests comments generally on VBID in the context of preventive services, as well as on 14 specific questions:

1. What specific plan design tools do plans and issuers currently use to incentivize patient behavior, and which tools are perceived as most effective (for example, specific network design features, targeted cost-sharing mechanisms)? How is effective defined?
2. Do these tools apply to all types of benefits for preventive care, or are they targeted towards specific types of conditions (for example, diabetes) or preventive services treatments (for example, colonoscopies, scans)?
3. What considerations do plans and issuers give to what constitutes a high-value or low-value treatment setting, provider, or delivery mechanism? What is the threshold of acceptable value? What factors impact how this threshold varies between services? What data are used? How is quality measured as part of this analysis? What time frame is used for assessing value? Are the data readily available from public sources, or are they internal and/or considered proprietary?
4. What data do plans and issuers use to determine appropriate incentive models and/or amounts in steering patients towards high-value and/or away from low-value mechanisms for delivery of a given recommended preventive service?
5. How often do plans and issuers re-evaluate data and plan design features? What is the process for re-evaluation?
6. Are there particular instances in which a plan or issuer has decided not to adopt or continue a particular VBID method? If so, what factors did they consider in reaching that decision?
7. What are the criteria for adopting VBID for new or additional preventive care benefits or treatments?
8. Do plans or issuers currently implement VBIDs that have different cost-sharing requirements for the same service based on population characteristics (for example, high vs. low risk populations based on evidence)?
9. What would be the data requirements and other administrative costs associated with implementing VBIDs based on population characteristics across a wide range of preventive services?
10. What mechanisms and/or safety valves, if any, do plans and issuers put in place or what data are used to ensure that patients with particular co-morbidities or special circumstances, such as risk factors or the accessibility of services, receive the medically

appropriate level of care? For example, to the extent a low-cost alternative treatment is reasonable for some or the majority of patients, what happens to the minority of patients for whom a higher-cost service may be the only medically appropriate one?
11. What other factors, such as ensuring adequate access to preventive services, are considered as part of a plan or issuer's VBID strategy?
12. How are consumers informed about VBID features in their health coverage?
13. How are prescribing physicians/other network providers informed of VBID features and/or encouraged to steer patients to value based services and settings?
14. What consumer protections, if any, need to be in place to ensure adequate access to preventive care without cost sharing, as required under PHS Act section 2713?

IRS Releases Notice 2011-02 Clarifying PPACA Section 162(m)(6)

On December 22, the Internal Revenue Service (IRS) released Notice 2011-02 clarifying Internal Revenue Code Section 162(m)(6) as added by the Patient Protection and Affordable Care Act (PPACA). Section 162(m)(6) imposes a $500,000 deduction limit on remuneration of some individuals by certain Covered Health Insurance Providers (CHIPs).

Notice 2011-02 addressed five areas of Section 162: definition of a CHIP and an "Applicable Individual", setting a de minimis rule for CHIP qualification in 2010-2012, detailing the treatment of reinsurance premiums, and announcing an effective date of plan years beginning on or after January 1, 2010. Of particular interest for many companies, the de minimis rule clarifies that an entity will not be subject to the deduction limit in 2010, 2011 or 2012 if the premiums it receives from health insurance are less than 2 percent of gross revenues for the year in question. For years after 2012, the premiums it receives from health insurance that is "minimum essential coverage" as defined under the health reform law must be less than 2 percent of gross revenues for the year in question. In addition, the notice clarifies that an individual is not covered by the deduction limit if he or she is an independent contractor with respect to whom a compensation arrangement would not be subject to Code Section 409A, the tax code provision that generally governs the taxation of deferred compensation (basically excepting arrangements with independent contractors providing substantial services to multiple unrelated customers).

The Treasury Department and the IRS also announced that comments on Notice 2011-02's content and Section 162(m)(6)'s application generally would be accepted until March 23, 2011. Those commenting are encouraged to provide specific information regarding: treatment of captive insurance companies; stop loss insurance; effectiveness of Notice 2011-02's de minimis rule or possible alternatives; the CHIP definition's application in cases of mergers, acquisitions or reorganizations; and whether rules applying to allocating deferred compensation to a particular year should be similar to those found in IRS Notice 2008-94, Q&A 9 (remuneration by TARP recipients, see pages 16-20).

Treasury Department Issues Notice Addressing Compliance Concerns Related to PPACA Nondiscrimination Rules

On December 22, 2010, the Treasury Department (Treasury) and the Internal Revenue Service (IRS) issued Notice 2011-1 providing that sanctions (including, for example, the $100/day excise tax under the Internal Revenue Code) will not apply for purposes of the new nondiscrimination rules for insured group health plans (as enacted by the Patient Protection and Affordable Care Act (PPACA)) unless and until regulations or other administrative guidance of general applicability is issued. Notice 2011-1 provides important and welcome relief for employer sponsors of insured plans.

PPACA amended the Public Health Service (PHS) Act to extend the Internal Revenue Code Section 105(h) nondiscrimination rules to insured health plans. PPACA prohibits fully-insured group health plans from discriminating in favor of highly compensated individuals with respect to eligibility and benefits. These requirements apply to non-grandfathered plans and are effective for plan years beginning on or after September 23, 2010. The rules of Section 105(h) continue to apply to any self-insured plan regardless of whether the plan is a grandfathered plan.

Noting that comments raised "fundamental concerns about plan sponsors' ability to comply with Section 2716 without regulatory guidance...", and because regulatory guidance is essential to the operation of the statutory provisions, Notice 2011-1 states that Treasury and IRS, as well as the Departments of Labor and Health and Human Services "have determined that compliance with Section 2716 should not be required (and thus, any sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability has been issued under section 2716." The notice further states that "in order to provide insured group health plan sponsors time to implement any changes required as a result of the regulations or other guidance, the Departments anticipate that the guidance will not apply until plan years beginning a specified period after issuance."

Notice 2011-1 requests comments by March 11, 2011, regarding the new rules generally, and with respect to the following:

- The basis on which the determination of what constitutes nondiscriminatory benefits under Section 105(h)(4) should be made and what is included in the term "benefits." For example, is the rate of employer contributions toward the cost of coverage (or the required percentage or amount of employee contributions) or the duration of an eligibility waiting period treated as a "benefit" that must be provided on a nondiscriminatory basis?
- The suggestion made in previous comments that the departments have the authority to provide for an alternative method of compliance with Section 2716 that would involve only an availability of coverage test.
- The application of Section 2716 to insured group health plans beginning in 2014 when the health insurance exchanges become operational and the employer responsibility provisions (Section 4980H of the Code), the premium tax credit (Section 36B of the Code), and the individual responsibility provisions (Section 5000A of the Code) and related PPACA provisions are effective.
- The suggestion in previous comments that the nondiscriminatory classification provision in Section 105(h)(3)(A)(iii) could be used as a basis to permit an insured health care plan to use a highly compensated employee definition in Section 414(q) of the Code for purposes of determining the plan's nondiscriminatory classification.
- The suggestion in previous comments that the nondiscrimination standards should be applied separately to employers sponsoring insured group health plans in distinct geographic locations and as to whether application of the standards on a geographic basis should be permissive or mandatory.
- The suggestion in previous comments that the guidance should provide for "safe harbor" plan designs. Specifically, comments are requested on potential safe and unsafe harbor designs that are consistent with the substantive requirements of Section 105(h).
- Whether employers should be permitted to aggregate different, but substantially similar, coverage options for purposes of Section 2716 and, if so, the basis upon which a "substantially similar" determination could be made.
- The application of the nondiscrimination rules to "expatriate" and "inpatriate" coverage.
- The application of the nondiscrimination rules to multiple employer plans.

- The suggestion in previous comments that coverage provided to a "highly compensated individual" (as defined in Section 105(h)(5)) on an after-tax basis should be disregarded in applying Section 2716.
- The treatment of employees who voluntarily waive employer coverage in favor of other coverage.
- Potential transition rules following a merger, acquisition, or other corporate transaction.
- The application of the sanctions for noncompliance with Section 2716.

Agencies Release Part V FAQ Guidance for PPACA, Mental Health Parity and HIPAA Wellness Rule Implementation

On December 22, the Departments of Health and Human Services, Labor and Treasury ("agencies") jointly issued FAQs About the Affordable Care Act Implementation Part V and Mental Health Parity Implementation, the latest in a series of FAQs related to implementation of the Patient Protection and Affordable Care Act (PPACA). Previously issued FAQs include Part I released on September 20, 2010; Part II released on October 8, 2010; Part III released on October 12, 2010; and Part IV, released on October 29, 2010.

The Part V FAQ guidance addresses a range of PPACA implementation issues related to value-based design and preventive care coverage; automatic enrollment; 60-day prior notice for material modifications to plans or coverage; dependent coverage to age 26; and grandfathered health plans. The guidance also includes four FAQs regarding the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and four questions related to HIPAA nondiscrimination regulations for wellness plans.

The Part V FAQs specifically addresses the following PPACA implementation issues related to employer-sponsored coverage:

- Preventive care and VBID. Under Public Health Service Act ("PHSA") Section 2713 as added by PPACA and implementing regulations, nongrandfathered health plans and insurance are permitted to utilize value-based insurance designs (VBID) to provide first-dollar coverage for certain preventive care service. The FAQ guidance confirms that this includes the use of copayments to steer patients towards a particular high-value setting, such as an ambulatory care setting, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the high-value setting. The guidance indicates that the agencies will be issuing an Request for Information on ways the agencies can encourage VBID in the context of preventive services.
- Compliance date for automatic enrollment for large employers. PPACA generally requires employers with more than 200 full-time employees, "[i]n accordance with regulations promulgated by the Secretary [of Labor]," to automatically enroll any new full-time employees in available employer-sponsored coverage. The FAQs confirm that the Department of Labor's Employee Benefits Security Administration (EBSA), in conjunction with the Treasury Department (Treasury), will develop such regulations and until such regulations are issued, employers are not required to comply. The Department of Labor intends to complete the rulemaking by 2014 and will work with stakeholders to obtain the data and information it needs to develop regulations.
- 60-day material modification notice. PHSA Section 2715 provides that not later than 12 months after the date of enactment of PPACA, the departments must develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits

and coverage under the applicable plan or coverage and, not later than 24 months after the date of enactment, plans and issuers must begin to provide the summary pursuant to the standards. PHSA Section 2715(d)(4) generally provides that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. The FAQs clarify that group health plans and issuers are not required to comply with the 60-day prior notice rule until they are required to provide the summary of benefits and coverage pursuant to the standards issued by the agencies. The agencies have not yet issued those standards.

- Adult child coverage. PPACA requires plans that provide dependent child coverage to make such coverage available to all qualifying children through age 25 ("adult children") and generally prohibits a plan from providing different benefits to any adult children based on age. The FAQs clarify that a plan may impose age-based rules regarding benefits and coverage (such as an increased copayment for physician visits for individuals over age 19) so long as the age-based rules apply broadly to all plan participants, including employees, spouses, etc., and are not limited in application to adult children above or below a specified age.
- Grandfathered health plans. The FAQ guidance provides that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, the cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. The guidance further clarifies that if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.

The Part V FAQs also address MHPAEA implementation. Highlights include:

- Confirmation that group health plans of small employers of 50 or fewer employees are exempt from the MHPAEA.
- Clarification that MHPAEA requires that criteria for medical necessity determinations made under a plan or insurance coverage with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. It further clarifies that documents with information on the medical necessity criteria for both medical and mental health /substance use disorder benefits are plan documents, and under ERISA, must be furnished within 30 days of request.
- Provision of an interim enforcement safe harbor for MHPAEA's increased cost exemption for plans that make changes to comply with the law and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or at least 1 percent in any subsequent plan year. The exemption lasts for one year, generally after which the plan must comply again.

The agencies also explain in the FAQ guidance that they intend to propose regulations related to PHSA Section 2705 regarding nondiscrimination and wellness. New PHSA Section 2705 largely incorporates the provisions of the departments' joint 2006 final wellness nondiscrimination regulations with a few clarifications and changes so that the maximum reward

that can be provided under a health-contingent wellness program increases from 20 percent to 30 percent. This change is effective in 2014. The agencies are also considering what accompanying consumer protections may be needed to prevent the program from being used as a subterfuge for discrimination based on health status. The guidance includes FAQs regarding wellness programs and the application of the 2006 HIPAA nondiscrimination rules

IRS Provides Transition Relief for Puerto Rican Plan Spinoffs

On December 16, the Internal Revenue Service (IRS) released Revenue Ruling 2011-01, which modifies the rules for group trusts described in Revenue Ruling 1981-100 and extends the time allowed to spinoff Puerto Rican participants in a U.S. qualified plan into a separate Puerto Rico plan until December 31, 2011 (from the earlier deadline of December 31, 2010). The guidance also indicates that the IRS anticipates issuing guidance on whether the Puerto Rican plan's trust (a "Puerto Rico trust") may participate in a group trust and, until that guidance is issued, the Puerto Rico trust may continue to participate in the group trust if either (1) the Puerto Rico trust was participating in the group trust as of January 10, 2011, or (2) the Puerto Rico trust holds assets that had been held by a U.S. qualified plan immediately prior to the transfer of those assets to the Puerto Rico trust pursuant to the transition relief in Rev. Rul. 2008-40 (as modified by the current revenue ruling).

IRS Revenue Ruling 2008-40 provided transition relief, permitting spinoffs to be made on or before December 31, 2010, without adversely affecting qualified status and without future taxation to residents of Puerto Rico. Rev. Rul. 2011-1 allows such spinoffs to occur on or before December 31, 2011.

Many employer sponsors of qualified plans that cover residents of Puerto Rico are considering whether to spin off assets and liabilities associated with the residents who are covered by their US/Puerto Rico dual tax-qualified plans to separate plans and trusts that are qualified only in Puerto Rico. Such spinoffs are intended to avoid potential US tax compliance problems under Revenue Procedure 2004-37, including whether US withholding is required for distributions to residents of Puerto Rico. Whether a newly created Puerto Rican plan and trust can participate in a group trust or master trust is an important factor that may have a bearing on a plan sponsor's decision about whether to proceed in this manner.

Groom Law Group previously prepared a summary of Puerto Rican plan issues.

PBGC Issues Reportable Events Guidance

The Pension Benefit Guaranty Corporation (PBGC) has issued Technical Update 10-4, providing guidance (for plan years beginning in 2011) on compliance with the "reportable events" requirements of ERISA Section 4043 and PBGC's proposed regulations modifying these requirements. The new guidance addresses (1) funding-related determinations for purposes of waivers, extensions, and the advance reporting threshold test; and (2) missed quarterly contributions.

The PBGC published the proposed regulations to reflect changes resulting from the Pension Protection Act of 2006 (PPA) and eliminate most automatic waivers and filing extensions provided under the prior reportable events regulations. Technical Update 10-4 reveals that "PBGC does not expect to issue a final rule before the beginning of 2011," making interim guidance necessary.

Regarding funding-related determinations for purposes of waivers, extensions, and the advance reporting threshold test, the guidance provides in general that for purposes of the reportable events regulation, a plan's unfunded vested benefits (UVBs) and the value of its assets and vested benefits are determined for a plan year beginning in 2011 in the same manner as for variable-rate premiums (VRPs) for the preceding plan year.

Regarding missed quarterly contributions, the technical update provides in general that for purposes of the reportable events regulation, if a required quarterly contribution for the 2011 plan year is not timely made to a plan, and financial inability to make the contribution is not the reason for not making the contribution, the reporting requirement under the proposed reportable events regulation (1) is waived if the plan has fewer than 25 participants for the prior plan year, and (2) if the plan has at least 25 but fewer than 100 participants for the prior plan year, will be considered satisfied if a simplified notice is filed with PBGC by the time the first missed-quarterly reportable event report for the 2011 plan year would otherwise be due.

HHS Issues Supplemental Guidance for 'Mini-Med' Plans

On December 9, the U.S. Department of Health and Human Services (HHS) issued new guidance regarding limited benefit (also known as "mini-med") health plans that feature low premiums and low annual limits. The interim final regulations (IFR) for patient protections under the Patient Protection and Affordable Care Act (PPACA) provide for the HHS Secretary to establish a program under which the requirements related to restricted annual limits may be waived if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums. HHS provided this waiver process on September 3.

Pursuant to supplemental guidance issued on November 5, as a condition of receiving a waiver from the annual limits requirements, a group health plan or health insurance issuer must provide a notice informing current and eligible participants and subscribers that the plan or policy does not meet the minimum annual limits for essential benefits and has received a waiver of the requirement. The first piece of the new guidance issued on December 9 provides model language to meet these requirements. According to the news release, "the supplemental guidance requires health plans with waivers to tell consumers if their health care coverage is subject to an annual dollar limit lower than what is required under the law. Specifically, the notice must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies."

The second piece of the December 9 guidance addresses circumstances under which issuers in the group and individual markets that have obtained a waiver of the annual limit requirement for certain policies may sell new policies that do not comply with annual limit restrictions. The November 5 guidance created a process for applying for annual limit waivers. The new guidance: (1) clarifies that waivers of annual limit restrictions pursuant to the waiver authority in the IFR generally apply only to policies already in place before September 23, 2010; and (2) specifies two limited circumstances under which issuers in the group and individual markets that have obtained a waiver of the annual limit requirement for certain policies may sell new policies that do not comply with annual limit restrictions under the IFR waiver authority.

Treasury, IRS Issue Priority Guidance Plan for 2010-2011

On December 7, the U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) released their 2010-2011 Priority Guidance Plan, listing those issues that will be the subject of formal guidance during the next year. The plan contains 310 projects to be completed through June 2010, including 30 items addressing retirement benefits (Pages 4-6 of the document) and

25 items addressing executive compensation, health care and other benefits – including items related to implementation of the Patient Protection and Affordable Care Act (PPACA) (Pages 6-8). A number of these items have already been completed, as indicated in the priority plan.

Other areas addressed in the plan include consolidated returns; corporations and their shareholders; excise taxes; exempt organizations; financial institutions and products; gifts, estates and trusts; insurance companies and products; international issues; partnerships; subchapter S corporations; tax accounting; tax administration; tax-exempt bonds and other general tax issues. An appendix also lists additional routine guidance that is published each year.

IRS Provides Guidance on Multiemployer Plan Amortization Period Extensions

The Internal Revenue Service (IRS) has issued Revenue Procedure 2010-52, guidance that describes the procedure by which a plan sponsor of a multiemployer pension plan may request and obtain approval of an extension of an amortization period, pursuant to Section 431(d) of the Internal Revenue Code. The guidance also includes a model notice of application for amortization extension.

Presidential Commission Fails to Approve Final Deficit Reduction Report

On December 3, The National Commission on Fiscal Responsibility and Reform failed to ratify the final report released on December 1. Under the terms by which the commission was established, the final report had to be ratified by at least 14 of the 18 commissioners before it would be formally brought before Congress for its consideration. However, the report garnered only 11 votes of approval.

RECENT JUDICIAL ACTIVITY – No Activity This Month