Proskauer

Year-End Roundup For Employee Benefit Plans - What Needs To Be Done Now?

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As the end of the year approaches, employers should review their employee benefit plans and arrangements to ensure compliance with any modifications that must, or should, be made before the end of the year. The following is an overview of the top benefits issues that employers should consider. Of course, the actual amendments or other actions required depend on the particular plans involved and whether any previous action already has been taken. Nevertheless, now is a good time to review what has been done this year and complete any year-end action items.

Considerations for Tax-Qualified Retirement Plans

Cycle E Filing

In accordance with the IRS cyclical submission process for submitting a tax-qualified plan for a determination letter as to its continuing tax-qualified status under Section 401(a) of the Internal Revenue Code of 1986, as amended (the "Code"), employers in "Cycle E" must submit their tax-qualified plans to the IRS no later than January 31, 2011. The staggered submission system is based on the last digit in the employer identification number ("EIN"). Plans in the current cycle (Cycle E) are those plans maintained by employers with an EIN that ends with either 0 or 5. In preparing a plan for submission with a determination letter request, the plan must be amended and restated to comply with the 2009 Cumulative List published by the IRS. Employers with EINs that end in either 0 or 5 should prepare their qualified plan submissions to the IRS for favorable determination letters.

The HEART Act

The Heroes Earnings Assistance and Relief Tax Act of 2008 (the “HEART Act”) includes several employee benefit-related changes applicable to eligible military personnel, as well as their families. The HEART Act requires that tax-qualified retirement plans treat participants who die on or after January 1, 2007 while performing qualified military service as dying “in service” for purposes of entitlement to any death benefits under the plan. The HEART Act also provides for continued vesting credit during the period of the qualified military leave for individuals who die in military service. In addition, the HEART Act requires that military wage differential payments (if paid) be included in the definition of “compensation” for plan purposes. Tax-qualified plans must be amended to reflect these provisions of the HEART Act by the end of the 2010 plan year.

Funding-Based Restrictions on Defined Benefit Plans

Code Section 436 (which became effective for plan years beginning after December 31, 2007) imposes certain funding-based restrictions on benefit payments and limits certain plan amendments in the event that the funding of a defined benefit pension plan falls below a certain level. The restrictions that apply are determined by the plan’s Adjusted Funding Target Attainment Percentage (“AFTAP”). If a plan’s AFTAP is less than 80 percent, the plan cannot be amended to increase benefits. If a plan’s AFTAP is less than 80 percent but at least 60 percent, the maximum amount the plan may pay as an accelerated benefit (such as a lump sum) or use to purchase an annuity as an irrevocable commitment to provide benefits is generally 50 percent of the lump sum benefit. If the AFTAP is less than 60 percent, then the plan may not pay any lump sum distribution or other accelerated payment. Last December, the IRS extended the deadline to amend defined benefit plans to comply with Code Section 436 until the last day of the 2010 plan year.

An additional consideration for Code Section 501(c)(3) employers is the recently enacted Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (the "Act") which contains provisions providing for pension funding relief. Pursuant to the Act, certain provisions of the Pension Protection Act of 2006 ("PPA"), including the new funding rules and the restrictions under Code Section 436, will not apply to "eligible charity plans" until January 1, 2017. Based on the broad language of the Act, an "eligible charity plan" is a defined benefit plan maintained for the benefit of multiple entities, all of which are Code Section 501(c)(3) organizations (even if they are in the same controlled group). Technical corrections have been introduced in Congress that would significantly limit the type of plans to be treated as eligible charity plans. Code Section 501(c)(3) employers that maintain defined benefit plans will need to monitor the status of the proposed technical corrections and will need to consider whether their defined benefit plans must be amended to comply with Code Section 436 this year.

Code Section 402(f) Notices

Code Section 402(f) requires that a terminating qualified plan participant must be informed in writing of his or her right to roll over an eligible rollover distribution. The "rollover notice" required by Code Section 402(f) must include the tax implications of receiving the distribution (rather than rolling it over) and certain other information. A plan administrator is deemed to have complied with the requirements of Code Section 402(f) if it provides the applicable model notice published by the IRS. In Notice 2009-68, the IRS issued two updated safe harbor Code Section 402(f) notices that address recent changes in the law – one of which is recommended for distributions from a non-Roth account and the other is recommended for distributions from a Roth account. Plan administrators should ensure that their Code Section 402(f) notices comply with the new requirements. For more information about these new requirements for Code Section 402(f) notices, see our previous client alert: IRS Offers Insight on Recent Guidance Relating to Retirement Plan Distributions.

Diversification Requirements for Employer Securities

On May 19, 2010, the IRS published final Treasury regulations under Code Section 401(a)(35) regarding the diversification requirements applicable to employer securities held in defined contribution plans. Generally, Code Section 401(a)(35) requires defined contribution plans offering investments in employer securities to permit participants, alternate payees and beneficiaries of participants to diversify the portion of their defined contribution plan accounts holding employer securities into alternative investments within certain specified time periods. Under the regulations, with regard to the portion of a participant's account holding employer securities that was acquired with employee contributions, the right to reinvest such funds in alternative investments must be provided immediately. With regard to employer contributions, a precondition of up to three years of service may be imposed for the right to reinvest such funds in alternative investments, except with regard to a beneficiary of a deceased participant. The final Treasury regulations under Code Section 401(a)(35) are effective for plan years beginning on or after January 1, 2011 (for prior plan years, a plan may rely on either Notice 2006-107, the proposed Treasury regulations, or the final Treasury regulations to satisfy Code Section 401(a)(35)). Sponsors, fiduciaries and administrators of defined contribution plans that hold publically traded employer securities should review their plan documentation, communications and practices to ensure compliance with the final Treasury regulations and amend as needed. For more information about the diversification requirements in the final Treasury regulations under Code Section 401(a)(35), see our previous client alert: Final Regulations Regarding Diversification Requirements for Defined Contribution Plans Holding Employer Securities.

Dual-Qualified Plans

Revenue Ruling 2008-40 provides that an employer maintaining a dual-qualified plan (*i.e*., a plan that is qualified under both Code Section 401(a) and Section 1165 of the Puerto Rico Internal Revenue Code) cannot transfer the assets and liabilities of that dual-qualified plan to a Puerto Rico-only qualified plan on or after January 1, 2011 without triggering a taxable distribution to a participant in the Puerto Rico-only qualified plan. However, Revenue Ruling 2008-40 will not apply to transfers before January 1, 2011, provided that the transfer otherwise satisfied Code Section 414(l) requirements for mergers, spin-offs and asset transfers. Employers maintaining dual-qualified plans may wish to consider transferring any assets of a dual-qualified plan to a Puerto Rico-only plan or splitting their plans into separate United States-only and Puerto Rico-only qualified plans prior to January 1, 2011.

Rollovers of Death Benefits by Nonspousal Beneficiaries

The PPA included a provision allowing nonspousal beneficiaries who receive death benefits to roll over their plan distributions into an individual retirement account ("IRA") or Roth IRA if certain requirements are met. The Worker, Retiree and Employer Recovery Act of 2008 ("WRERA") made the nonspousal rollover provision mandatory for plan years beginning after December 31, 2009. Accordingly, plans that have not yet been amended to allow for nonspousal rollovers should be amended before the end of the year.

Required Minimum Distributions

Section 401(a)(9) of the Code requires that participants in tax-qualified retirement plans generally begin taking required minimum distributions ("RMDs") by the April 1st following the calendar year in which they attain age 70 ½ or, if later, the year in which they retire from the plan sponsor, with certain limited exceptions for 5 percent owners. WRERA permitted the suspension of RMDs from defined contribution plans for the 2009 calendar year. Although this change was effective for 2009, defined contribution plans must be amended by the end of the 2011 plan year to reflect operational compliance with the suspension of RMDs. Although this amendment is not required to be made until next year, employers may wish to make such amendments now, particularly if their plans need to be amended for any other reason. For more information about the suspension of RMDs, see our previous client alert: IRS Offers Insight on Recent Guidance Relating to Retirement Plan Distributions.

Discretionary Amendments

Discretionary plan amendments (*i.e.*, amendments that are not legally required) to tax-qualified retirement plans (including 401(k) plans, defined benefit pension plans (including cash balance plans), ESOPs, money purchase pension plans and discretionary profit-sharing plans) must generally be adopted by the last day of the plan year in which they become effective. If an employer implemented any *discretionary* design amendments for the 2010 plan year, the affected plan or plans should be amended before the end of the 2010 plan year. Employers should also be mindful that any discretionary amendments to a defined benefit plan that has the impact of significantly reducing the rate of future benefit accruals must be communicated by prior notice to plan participants in accordance with Section 204(h) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Considerations for Non-Qualified Deferred Compensation Arrangements

Code Section 409A Corrections

Non-qualified deferred compensation arrangements are subject to the restrictions of Code Section 409A. A violation of Code Section 409A causes an acceleration of income recognition, a 20 percent additional tax and a penalty interest tax. On January 5, 2010, the IRS issued Notice 2010-6, which contains a voluntary document correction program under which employers may correct certain Code Section 409A plan document failures to avoid or reduce the penalty taxes incurred for a violation. In many cases, even when the IRS's correction program is followed, affected employees will be required to include in income 25 percent or 50 percent of the amount that would have been recognized had no correction been made. However, Notice 2010-6 provides transition relief that in certain cases eliminates penalties for document failures that are corrected before January 1, 2011. Employers are encouraged to review their non-qualified deferred compensation plans and consider whether they should correct any Code Section 409A document failures during the period of transitional relief under Notice 2010-6. For more information about the correction program under Notice 2010-6, see our previous client alert: IRS Relief and Voluntary Correction Program for Certain Section 409A Document Failures.

Separately, employers should consider the Code Section 409A operational correction program in Notice 2008-113. Under this guidance, the IRS provides limited relief from Code Section 409A tax consequences where operational errors are self-corrected. The most favorable relief available is for errors that are corrected within the same tax year as the year they occurred. In many cases, relief is lost if an error is not corrected in the tax year after it occurred. Therefore, it is advisable for employers to identify any Code Section 409A operational errors now so that they may be fixed before the end of the year under Notice 2008-113 without penalty.

Considerations for Health and Welfare Benefit Plans

Health Care Reform

The recent enactment of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") includes changes that require implementation before year-end and, in some cases, these changes will require notices during upcoming open enrollment. The impact of many of these changes will depend on whether the relevant group health plan is grandfathered. For further discussion of the rules regarding grandfathering status, please see our prior client alert: Health Care Reform: Grandfathered Health Plan Interim Final Regulations Released on this issue.

- **Dependents.** Group health plans must be updated to expand health coverage to dependent children through age 26. Grandfathered group health plans may choose to limit the extension of coverage to dependent children up to age 26 to those who are not eligible for other employer coverage (other than a plan of the other parent's employer). This rule is generally effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans); however, some plans may have voluntarily applied this rule early. Although cafeteria plans generally cannot be amended retroactively, cafeteria plans through which group health plan coverage was available and that made this change effective in 2010 are allowed to adopt a retroactive amendment by December 31, 2010 to reflect this coverage.
- **Plan Exclusions and Rescission Limited.** Under the Affordable Care Act, group health plans, including grandfathered group health plans, are no longer permitted to exclude preexisting conditions for children under age 19 (or for any group health plan participant effective as of the first plan year in 2014). Additionally, with limited exceptions, group health plans, other than health flexible spending

arrangements, may not impose annual or lifetime limits on “essential benefits,” or terminate coverage retroactively, except in the case of fraud or an intentional misrepresentation of material fact. These changes should be reflected in open enrollment material and other plan communications for the 2011 plan year.

- **Special Enrollment Rights.** Group health plans must provide special enrollment rights for children who had previously aged-out (or were otherwise excluded before age 26 on account of factors such as financial dependency, marriage or student status) and are now eligible for coverage. In many cases, employers expect to provide notice of this enrollment right with open enrollment materials. In addition, the actual enrollment opportunity has to be made available for at least 30 days beginning no later than the first day of the first plan year beginning on or after September 23, 2010. Similar notice and enrollment rights must be made available for participants or their dependents now eligible for coverage due to the elimination of lifetime limits.
- **Over-the-Counter Drugs.** Effective January 1, 2011, health care flexible spending arrangements may no longer reimburse expenses on a tax-favored basis for over-the-counter drugs without a prescription. Health care flexible spending account plans will need to be amended to reflect this limitation, and participants will need to be informed of this change during open enrollment so that they may plan accordingly.
- **Claims Review Procedures.** Plan sponsors of group health plans that are not grandfathered are subject to new claims and appeals and external review procedures for plan years beginning on or after September 23, 2010. These group health plans will need to be updated to comply with these new requirements, and the new rules have to be communicated to participants.
- **Preventive Care and Patient Protections.** For post-September 22, 2010 plan years, non-grandfathered group health plans will be required to cover certain preventive health services and to eliminate cost-sharing requirements for these services. Group health plans will be required to provide participants with the ability to select their primary care physicians and obtain obstetrical/gynecological services without prior authorization. Additionally, non-grandfathered group health plans that provide any benefits with respect to emergency hospital services will not be allowed to require prior authorization. Also, if the emergency services are provided out-of-network, they need to be covered in the same way as in-network emergency services, and these services will be subject to certain cost-sharing limitations. Again, these changes should be communicated in open enrollment material as appropriate and included in plan documents.
- **Tax Reporting.** Effective for tax years beginning after December 31, 2010, the aggregate cost of employer-sponsored health coverage must be reported for tax

purposes on Form W-2. Plan sponsors must inform payroll and third party administrators of their new tax reporting obligations and coordinate with them to ensure compliance with these new reporting obligations. There are many open questions concerning this reporting requirement, and guidance is expected in the near future to explain how employers are to comply.

For more information about the Health Care Reform Act, please see the client alerts previously published by our Health Care Reform Task Force.

Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008, effective for plan years on or after October 2, 2009, requires establishing full parity between mental health/substance abuse benefits and the medical and surgical benefits offered under a group health plan. Final regulations issued in 2010 clarify many of the rules on mental health parity. Compliance with these final regulations is required for plan years beginning on or after July 1, 2010. Calendar year plans need to consider appropriate changes effective January 1, 2011. For more information on the Mental Health Parity and Addiction Equity Act of 2008, please see our previous client alert: Interim Final Regulations for the Mental Health Parity and Addiction Equity Act of 2008.

For more information regarding any of the issues in this year-end roundup, contact any member of our Employee Benefits, Executive Compensation & ERISA Litigation practice group.

Related Professionals

- **Ira G. Bogner**
  Managing Partner
- **Andrea S. Rattner**
  Partner