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THE CICOTTE LAW FIRM, LLC

ERISA AND EMPLOYEE BENEFITS + CORPORATE

June 2012 Newsletter

Inside

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In This Issue

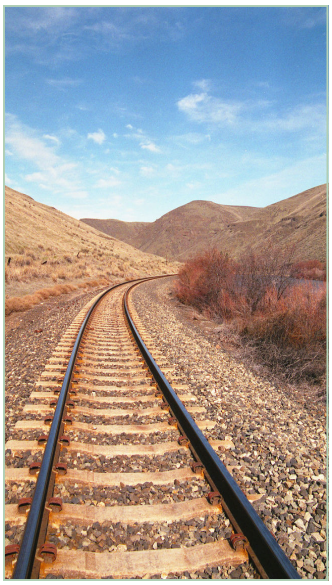
Supreme Court Upholds Affordable Care Act: The Supreme Court has upheld the individual mandate provision of the Affordable Care Act in a complex ruling that struck down other parts of the Act.

IRS Auditing Defined Benefit Plans: The IRS is conducting audits of defined benefit plans to determine compliance with provisions under PPA 2006.

EBSA Provides Further Guidance on SBC Requirements: The Employee Benefits Security Administration recently provided additional guidance in the form of FAQs relating to Summary of Benefits and Coverage requirements.

Health Coverage Reporting on W-2s for 2012 Tax Year: Under the Affordable Care Act certain employers must begin reporting the value of health coverage provided to employees on Form W-2.

IRS Correction Program Available for Late Adopters: Plan sponsors of preapproved defined benefit plans who failed to timely adopt a restated EGTRRA document may correct the failure under the IRS' Voluntary Correction Program.



Supreme Court Upholds Affordable Care Act

In one of the most highly anticipated court decisions in recent history, the U.S. Supreme Court has upheld the challenge to the Affordable Care Act ("ACA") in a 5-4 vote.

The majority of the Court found that the individual mandate requiring individuals to purchase health insurance coverage is valid. An additional argument over Medicaid expansion under the ACA, not directly applicable to employers, plan sponsors, and issuers, was found unconstitutional as it relates to withdrawing States' existing Medicaid funds for failure to comply with Medicaid expansion.

All other provisions of the ACA are valid and will continue to apply. As a result of the Court's finding, employers, plan sponsors, and issuers should continue compliance efforts to satisfy all applicable ACA provisions.

The key ACA provision challenged in the case was the individual mandate, which will require most Americans to maintain "minimum essential" health insurance coverage. Individuals who are not exempt, and who do not receive health insurance through an employer or governmental program, will be required to purchase insurance from a private company.

Beginning in 2014, individuals who do not comply with the mandate must make a "shared responsibility payment" to the IRS with the individual's tax return. The payment will be assessed and collected in the same manner as a tax penalty.

IRS Auditing Defined Benefit Plans for Compliance with PPA 2006

The IRS recently completed and continues to conduct a number of defined benefit plan audits to determine compliance with the Pension Protection Act of 2006 ("PPA"). Plan sponsors should carefully determine whether any of the identified issues apply to their plans and take appropriate corrective action.

PPA 2006 made significant changes to funding requirements and administrative practices for defined benefit plans, including cash balance plans. Some of the changes and additions include: (i) new funding requirements under Code section 430; (ii) restrictions on benefit payments, benefit increases, and accruals under Code section 436 when a plan is underfunded beyond certain thresholds; and (iii) the provision under 401(a)(29) that plans not in compliance with new restrictions under Code section 436 may be disqualified.

Under an IRS examination project, agents began conducting defined benefit plan audits and identified the following issues:

- -Annual funding notices made late or not dated;
- -Elections to use or reduce prefunding and/or carryover balances made late/not dated;
- Elections to use prefunding and carryover balance to meet quarterly contributions made late or elections not specifying the dollar amount(s);
- -Late Adjusted Funding Target Attainment Percentage certification;
- -Actuarial increase for late retirement benefits not made;
- -Assets valued differently for Code section 430 vs. Code section 436;
- -Relative value disclosure notices did not satisfy Treasury Regulations section 1.417 (a)(3)-1(c)(1)(iv);
- -Late contribution payments resulting in liquidity shortfalls;
- -Late quarterly contributions;
- -Inappropriate inclusion of premiums for life insurance policies in target normal cost as plan expenses;
- -Funding in excess of Code section 404(o) limitation;
- -Compensation for purposes of determining the accrued benefit in the valuation does not match the definition per plan terms;
- -Compensation for benefit purposes not defined in the plan;
- -Service incorrectly calculated for benefit purposes; and
- -Incorrect interest rates used for calculating benefits distributions for payment options that are subject to Code section 417(e)(3).

Many of the issues identified by IRS agents are failures to comply with the funding rules and consequently, do not threaten the qualified status of the plan, but may result in assessment of excise tax or penalties. Some of the issues, however, do result in qualification failures, such as a plan not operating in accordance with its specific written terms or in compliance with the requirements of Code section 401(a)(29).

In the event of a qualification failure, plan sponsors may resolve the failure using the appropriate correction program provided by the IRS, and applying the basic correction principles discussed in Revenue Procedure 2008-50.

"In the event of a qualification failure, plan sponsors may resolve the failure using the appropriate correction program provided by the IRS . . . ."

EBSA Provides Additional Guidance on SBC Requirements

The Employee Benefits Security Administration ("EBSA") recently released multiple FAQ documents prepared jointly with the IRS and Department of Health and Human Services. The FAQs clarify final regulations relating to the Summary of Benefits and Coverage ("SBC") requirements that were covered in our March, 2012 newsletter. Because the requirement to provide SBCs becomes generally effective on September 23, 2012, employers and plan sponsors should become familiar with all applicable requirements.

The Departments emphasize in the FAQs that their approach to implementation is focused on providing assistance to plans, rather than imposing penalties. As a result, during the first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations.

One significant topic addressed in the FAQs that may help to reduce cost and simplify the process of providing SBCs to participants is the ability to provide the SBC electronically. With respect to group health plans an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage*, if:

- The format is readily accessible (such as in an html, MS Word, or pdf format);
- The SBC is provided in paper form free of charge upon request; and
- If the SBC is provided via Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (also referred to as the "e-card" or "postcard" requirement) by email.

An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with Department of Labor disclosure regulations. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.

With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless:

- The format is readily accessible;
- If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible;
- The SBC is provided in an electronic form which can be retained and printed; and
- The issuer notifies the individual that the SBC is available free of charge in paper form upon request.

Moreover, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations.

An additional safe harbor was provided by the Departments allowing SBCs to be provided electronically to participants and beneficiaries in connection with online enrollment or online renewal of coverage. In addition, SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request.

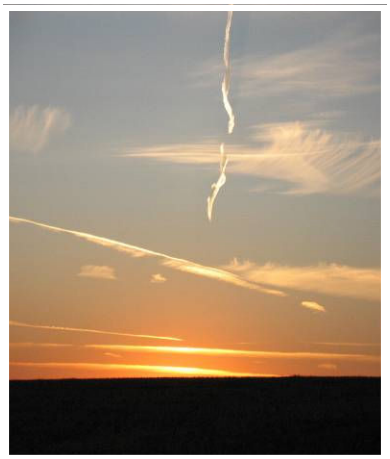
For individual market issuers that offer online enrollment or renewal, the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations.

Additional topics the Departments address in the thirty-eight FAQs include:

- General obligation to provide SBCs,
- Providing SBCs to COBRA beneficiaries,
- Triggering events for SBCs for self-insured plans,
- Varying content or form of SBCs,
- "Carve-out arrangements,"
- Model language

For additional guidance or assistance in complying with the upcoming SBC requirements or preparing an SBC please contact our office.

"[T]he Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations."



Health Coverage Reporting on Form W-2 Required for 2012 Tax Year

The Affordable Care Act ("ACA") requires employers to report the cost of health coverage provided under an employer sponsored group health plan. Employers affected by this requirement include businesses, tax-exempt organizations, and federal, state, and local government entities, except with respect to plans maintained primarily for members of the military and their families. Federally recognized Indian tribal governments are not subject to this reporting requirement.

Although the health coverage reporting requirement under the ACA was scheduled to begin in 2011, the IRS provided transitional relief making it optional for all employers in 2011. For the 2012 tax year, employers that were required to file fewer than 250 2011 Forms W-2 will not be subject to the reporting requirement for 2012 Forms W-2. Future guidance is expected from the IRS to indicate when the requirement will apply for smaller employers; however, large employers filing more than 250 W-2s should prepare for compliance with the reporting requirement.

The reporting is generally for informational purposes only, to show employees the value of their healthcare benefits. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludable from an employee's income.

The value of the healthcare coverage will be reported in Box 12 of the Form W-2, with Code DD to identify the amount. The amount reported should generally include both the portion paid by the employer and the portion paid by the employee. Employers are not required to issue a Form W-2 solely to report the value of the healthcare coverage for retirees or other employees or former employees to whom the employer would not otherwise provide a Form W-2.

Types of coverage that must be reported include (the IRS may revise this list in the future to include additional types of coverage):

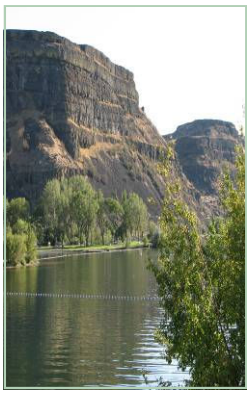
- Major medical;
- Health FSA value for the plan year in excess of the employee's cafeteria plan salary reductions for all qualified benefits (essentially, any employer contribution amount);
- Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer;
- Employee Assistance Plan coverage, but only if a COBRA premium is charged for the coverage;
- On-site medical clinics providing applicable employer sponsored healthcare coverage (*currently only required if employer charges a COBRA premium*);
- Wellness programs providing applicable employer sponsored healthcare coverage (*currently only required if employer charges a COBRA premium*); and
- Domestic partner coverage included in gross income.

The requirement to report the cost of coverage will *not apply* to 2012 W2s for the following types of coverage:

- Dental or vision plan not integrated into another medical or health plan;
- Dental or vision plan which provides the choice of declining or electing and paying an additional premium;
- Heath Reimbursement Arrangement contributions;
- Employee Assistance Plan coverage where the employer *does not* charge a COBRA premium;
- On-site medical clinics where the employer *does not* charge a COBRA premium;
- Wellness programs where the employer *does not* charge a COBRA premium;
- Multi-employer plans; and
- Self-funded plans of employers not subject to Federal COBRA requirements.

In the event the IRS modifies the reporting requirements in future guidance, the requirements will not be applicable until the tax year beginning at least six months after the date of issuance of such guidance.

"The amount reported should generally include both the portion paid by the employer and the portion paid by the employee."



Supreme Court Upholds Affordable Care Act

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The Chief Justice, writing for the majority, concluded the individual mandate must be interpreted as imposing a tax on those who do not have health insurance and that the mandate may be upheld under the Constitution as within Congress' power to "lay and collect Taxes."

Consequently, the "shared responsibility payment" may, for constitutional purposes, be considered a tax; and that tax is one that individuals "may lawfully choose to pay in lieu of buying health insurance."

Because the Court found the individual mandate constitutional it had no reason to consider the constitutionality of other provisions of the ACA. Thus, the ACA and its many requirements will remain in place, for now. However, the debate over health care reform will continue undoubtedly through the presidential election this Fall, and for the foreseeable future.

Many opponents to the ACA are now calling for its repeal and replacement, which could come about, depending on the outcome of elections in the Fall. Any repeal and/or replacement will likely lead to additional legal challenges.

Because no one can predict the eventual outcome of health care reform in the United States with any degree of certainty, employers, plan sponsors, and issuers should move forward with efforts to implement all requirements under the ACA that are applicable to their respective health plans.

IRS Correction Program Available for Sponsors Who Failed to Timely Adopt EGTRRA Plan Document

Plan sponsors using pre-approved defined benefit pension plans should have adopted an updated version of the plan by April 30, 2012. If you are a plan sponsor who failed to sign an EGTRRA plan document by the April 30 deadline, the IRS will permit you to file a submission under its Voluntary Correction Program ("VCP") to restore the tax-qualified status of the plan.

The IRS provides a VCP submission kit to assist plan sponsors with completing the required forms. In addition to completing the required forms, the plan sponsor must provide a brief description of the changes in administrative procedures it has implemented or will implement to prevent this type of failure from occurring in the future.

Should you need guidance correcting this or any other type of plan failure, please contact our office for assistance.

About the Cicotte Law Firm

The Cicotte Law Firm is located in Kennewick, WA, and represents employers in several states in all aspects of benefits law, handling diverse employment, labor, tax and corporate matters.

The Firm's practice covers all areas relating to employee benefits, including designing "defined contribution-style" health plans (HRAs, HSAs, & FSAs), assistance with COBRA, HIPAA, ARRA, and PPACA issues, advising on fiduciary responsibilities, maintaining legal compliance with non-discrimination requirements, analyzing unusual benefit claims, representing employers in labor relations matters where pension or welfare benefits are involved, advising on the federal tax implications of complex benefits-related issues, and examining the ERISA status of compensatory arrangements.

Other practice areas vital to corporate function available at the Firm include corporate formation, corporate compliance, negotiations, mergers and acquisitions, SEC compliance, and HR liaison activities.

The Firm is also able to assist companies with licensing agreements, non-compete agreements, and nondisclosure agreements.

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