

Benefits and Employment Briefing

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“To obtain genuine wisdom, we must work hard in our practice and be in accord with the rules.”

- Venerable Master Hsuan Hua

A quarterly newsletter about employee benefits and current issues

Third Quarter 2010

▶ **PLANNING FOR 2011 OPEN ENROLLMENT**

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▶ **THE FIDUCIARY DUTY TO ASK FOR A BETTER DEAL**

When is it appropriate to accept the sticker price listed on a product without asking the salesman for a better deal? Maybe never, at least if you're a fiduciary of a \$2 billion 401(k) plan spending the participants' money, according to a federal court in California

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▶ **REGULATIONS REQUIRE SPECIFIC DISCLOSURE OF FEES RECEIVED BY SERVICE PROVIDERS**

On July 15, 2010, the Department of Labor issued "interim" final regulations regarding the fee information that service providers must disclose to fiduciaries of ERISA-covered retirement plans

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▶ **PLANS REQUIRED TO COVER PREVENTIVE HEALTH SERVICES**

Among the many changes made by the Affordable Care Act is a requirement that group health plans (other than plans that are "grandfathered" under the rules described in our June 2010 article) provide benefits for a comprehensive list of preventive health services

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PLANNING FOR 2011 OPEN ENROLLMENT

With annual enrollment season fast approaching, now is the time to consider new 2011 disclosure obligations. In particular, with the enactment of the Affordable Care Act (the “Act”), several new notices must be provided to plan participants. Many plan sponsors may want to consider including these new notices in the 2011 open enrollment materials that they send to employees. These notices include:

- **Notice Regarding Grandfathered Status:** Any sponsor that wishes to preserve its plan’s grandfathered status must provide participants with a statement informing them that the plan believes it is a grandfathered health plan under the Act and that, as a result, some of the changes required by the Act may not apply. Because this notice must be contained in all plan materials provided to participants or beneficiaries describing the benefits provided under the plan, it should also be incorporated into a plan’s summary plan description (“SPD”).

If a plan has already lost its grandfathered status, or does not intend to assert that status, no such notice is required. The Department of Labor (“DOL”) has issued a [model notice](#) that plan sponsors may use

to satisfy this requirement. (Please see our [June 2010 Article](#) for additional details on the requirements for, and implications of, maintaining grandfathered status.)

- **Special Enrollment Notice for Dependent Children to Age 26:** Effective for plan years beginning on or after September 23, 2010, both grandfathered *and* non-grandfathered group health plans that offer dependent child coverage must provide such coverage up to a child’s 26th birthday. Moreover, children who previously lost coverage due to reaching the plan’s limiting age, or who were never eligible for coverage, must be given an opportunity to enroll in the plan.

Plan sponsors must provide participants with both a special enrollment notice and at least 30 days to elect coverage. The special enrollment notice may be included with open enrollment materials, but the notice and the enrollment deadline must be prominently displayed. The DOL has issued a [model notice](#) to help plan sponsors comply with this requirement, as well. (Please refer to our [May 2010 article](#) for additional details on the new requirements and guidance applicable to coverage of dependent children.)

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- **Special Enrollment Notice Relating to Lifetime Limits:** Effective for plan years beginning on and after September 23, 2010, *all* group health plans must eliminate lifetime limits on “essential health benefits.” Individuals who are not currently enrolled in a plan because they have previously exhausted the plan’s lifetime limit must be given written notice and an opportunity to re-enroll in the plan (assuming those individuals are otherwise still eligible for coverage). The plan must allow such individuals at least 30 days to enroll.

Technically, this notice need be provided only to individuals who have reached the plan’s lifetime limit. However, plan sponsors might consider including the notice in the plan’s annual enrollment materials. The DOL has also issued a [model notice](#) that provides plan sponsors with language designed to comply with this requirement. (Please refer to our [July 2010 article](#) for more information on the Act’s requirements with respect to lifetime and annual limits.)
- **Patient Protection Notice:** Sponsors of *non-grandfathered* plans must provide a notice describing a participant’s right to select any available participating primary care provider, to designate a pediatrician as a primary care provider, and to obtain obstetrical or gynecological care without preauthorization or referral. While this notice may (and probably should) be included in a plan’s open enrollment materials, it must also be incorporated into the plan’s SPD. And yes, the DOL has issued a [model notice](#) to help plan sponsors comply with this requirement.
- **OTC Drug Reimbursements:** Effective January 1, 2011, account-based reimbursement plans, such as flexible spending accounts and health reimbursement accounts, cannot reimburse participants for expenses incurred for over-the-counter medicines or drugs (other than insulin) without a prescription. Although specific notice of this change is not legally required, plan sponsors should alert employees to this change during open enrollment so that they can make informed decisions as to how much to contribute to their accounts during 2011.
- **Children’s Health Insurance Program Reauthorization Act (CHIPRA) Notice:** Effective for plan years beginning on and after February 4, 2010, employers must notify employees of the potential availability of premium assistance under the Children’s Health Insurance Program. This notice must go to *all* eligible employees residing in any state

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- that offers premium assistance, regardless of whether those employees are actually enrolled in the employer's health plan.

If this notice is combined with annual enrollment materials, the notice must appear separately and in a manner which ensures that employees who may be eligible for the premium assistance could reasonably be expected to appreciate its significance. Not surprisingly, the DOL has issued a [model notice](#) that may be used for this purpose. (Please refer to our [March 2010 article](#) for additional details on the CHIPRA notice).

In addition to these new notices, plan sponsors should not forget to include other existing notices, such as the annual notice regarding Women's Health and Cancer Rights, in their annual enrollment materials.

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GUIDANCE ISSUED ON NEW CLAIMS AND APPEALS PROCEDURES

The health care reform provisions of the Affordable Care Act (the "Act") will require significant changes in the procedures followed by most employer health plans when processing claims for benefits, as well as appeals from denials of those claims. The

only plans that need not comply with these new claims and appeals procedures are those that are "grandfathered" under pre-Act law (in accordance with the guidance addressed in our [June 2010 article](#)). All *non*-grandfathered plans must comply with these expanded claims and appeals procedures as of the first plan year beginning on or after September 23, 2010.

DOL Claims and Appeals Regulations

In general, the Act subjects all employer plans to the existing ERISA claims and appeals requirements (as set forth in Department of Labor ("DOL") regulations found at 29 CFR Section 2560.503-1) – *even* if a plan is *exempt* from ERISA. Such non-ERISA plans would include those sponsored by governmental or church-related employers, as well as any "multiple employer welfare arrangement." Moreover, *insured* plans will remain subject to state insurance requirements, to the extent those requirements are more stringent than the ERISA rules.

Changes to the DOL Regulations

The DOL has stated that it will soon be updating its claims and appeals regulations. As a part of this guidance, however, the following additional requirements have already been grafted onto those regulations:

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1. An “adverse benefit determination” (to which the claims and appeals procedures apply) will include any “**rescission**” of coverage. As defined in recently issued regulations, “rescission” refers to any retroactive termination of health coverage, other than for failure to pay a required premium.
2. The **deadline** for notifying a claimant of the plan’s ruling on an “urgent care claim” (whether adverse to the claimant or not) will be shortened from 72 hours to only 24 hours. The only exception to this 24-hour rule is if the claimant has not yet submitted sufficient information for the plan to determine whether the proposed medical procedure is covered under the plan.
3. Plans will have additional **disclosure obligations** to claimants, including any new or additional evidence considered in connection with a claim. Moreover, if a plan intends to deny an appeal on a rationale *other* than one already given to the claimant, that rationale must be disclosed *before* the appeal is denied. The claimant must then be allowed to respond to that rationale.
4. Plans and their sponsors must take additional steps to avoid **conflicts of interest** on the part of any decision maker.
5. Expanded **notice** rules will apply, including requirements for providing
6. notices in foreign languages, better identifying the claim at issue, explaining any standards used in denying a claim, and describing any internal and external review processes. The agencies responsible for administering the Act will be issuing model notices for this purpose.
7. Plans will now be held to a **strict compliance** standard. Responding to a series of judicial decisions approving of either “substantial compliance” with the claims and appeals regulations or excusing a “de minimis error,” the new rules will allow a claimant to proceed directly to court (or an external review) if a plan fails to comply with every element of the new procedures. Should that occur, a reviewing court is not to defer to the plan fiduciary’s determination.

Coverage During Appeal

The Act also requires that a plan provide continued coverage pending the outcome of any internal appeal procedure. The regulatory guidance appears to limit this requirement to the context of “concurrent care claims,” for which the existing ERISA claims and appeals regulations already require the continued provision of coverage pending the outcome of an appeal. Aside from applying this ERISA requirement to non-ERISA plans, the new rules will allow a claimant who is undergoing a course of

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treatment to proceed directly to the plan's *external* review option – without awaiting a final resolution of the *internal* review process.

External Review Process

The other major change made by the Act – particularly for self-funded plans – involves a requirement that each plan establish an external review process. Most states already require an external review process for *insured* plans, so those plans must simply comply with the state-mandated process.

This will suffice, however, only if that state process meets certain federal standards. These are generally based on a “model act” developed by the National Association of Insurance Commissioners (“NAIC”). Although the federal agencies have concluded that most state laws do meet this standard, some do not. In order to allow those non-compliant states some time to modify their laws, the regulations treat all state external review requirements as complying with the federal standards for plan years beginning before July 1, 2011.

Plans that are not subject to the state insurance requirements (generally because they are self-funded, and therefore protected by ERISA's preemption of state laws) must comply with *federal* standards for an external review process. The same will eventually be true for insured plans in states that do not

bring their external review processes into line with the federal standards.

Those actual federal standards have yet to be developed, although the agencies state that they will be similar to the NAIC rules. Because non-grandfathered, self-funded plans must comply with the federal standards as of the first plan year beginning on or after September 23, 2010, we can assume that the federal agencies will be issuing these standards in the relatively near term.

Conclusion and Recommendations

Given the potentially adverse consequences of failing to comply with each and every requirement in these expanded claims and appeals procedures, plans that are subject to these rules will want to make every effort to come into compliance by the effective date. Moreover, sponsors of *grandfathered* plans will want to take these rules into account when deciding whether to make the effort required to maintain their plans' grandfathered status. Maintaining that status might at least allow these sponsors to postpone the date by which they must comply with these more burdensome rules.

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DEADLINE APPROACHING FOR 2010 PLAN AMENDMENTS

It may be summer now, but sponsors of tax-favored retirement plans should keep in mind the many required amendments for which a year-end deadline is fast approaching. This article highlights some of the more important changes that sponsors must address before the sun sets on 2010.

The HEART Act

As we reported in our [August 2008 article](#), most tax-favored retirement plans must be amended by the end of the 2010 plan year to reflect the mandatory provisions of the Heroes Earnings Assistance and Relief Tax Act of 2008 (the “HEART Act”). HEART Act changes for which amendments are required include:

- An enhanced survivor benefit; and
- New rules governing the treatment of military differential pay.

Many sponsors have already amended their plans for the HEART Act. But as we reported in our [March 2010 article](#), some plans may require a *second* round of HEART Act amendments to address guidance issued by the IRS in [Notice 2010-15](#).

Delayed PPA Deadlines

As we reported in our [December 2009 article](#), the amendment deadline for most changes required by the Pension Protection Act of 2006 (“PPA”) was the last day of the first plan

year beginning on or after January 1, 2009. In [Notice 2009-97](#), however, the IRS extended the deadline for three categories of PPA amendments until the last day of the 2010 plan year. The following changes are affected by this delay:

- For certain *defined contribution* plans that invest in employer stock, new diversification rights for participants;
- For *defined benefit* plans, new funding-based limits on distributions and benefit accruals; and
- For *cash balance* and other hybrid plans, a number of new vesting and other special rules.

PPA Changes for Non-Calendar-Year Plans

As noted above, for most PPA changes the amendment deadline for *calendar-year* plans was December 31, 2009. For *fiscal-year* plans, however, the deadline will fall within 2010 – on the last day of the first plan year that began in 2009.

Discretionary Amendments

In most cases, the deadline for adopting plan-design changes that do not reduce the rate of benefit accruals is the end of the plan year in which they take effect; *i.e.*, such changes may be retroactive to the first day of the plan year. Thus, for most purposes, calendar-year plans must be amended to reflect 2010 design changes by no later than December 31, 2010.

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Some design changes must be adopted, however, *before* the plan year in which they take effect. These include certain changes to safe-harbor 401(k) contributions, as well as certain reductions in the rate of pension accruals. For such design changes to be effective for the 2011 plan year, they must therefore be adopted by the end of the 2010 plan year. (These changes may also require the sponsor to issue participant notices before the amendment is effective.)

Direct Rollovers for Nonspouse Beneficiaries

As a part of the PPA, Congress amended the rollover rules to allow nonspouse beneficiaries to roll death benefits directly into an individual retirement account or annuity. In Notice 2007-7, the IRS interpreted this change as optional on the part of a plan. However, the Worker, Retiree and Employer Recovery Act of 2008 (“WRERA”), which included several technical corrections to the PPA, made clear that this was a *mandatory* change.

Accordingly, all Section 401(a) qualified retirement plans, Section 403(b) plans, and governmental Section 457(b) plans have been required to allow direct rollovers by nonspouse beneficiaries since January 1, 2010. In general, these plans must be amended to reflect this change by the end of the first plan year beginning in 2010.

Cycle E Filing Deadline

In addition to the changes discussed above, individually designed Section 401(a) qualified plans falling within “Cycle E” of the

IRS’s determination letter program must be amended and restated – and have a determination letter application filed with the IRS – by January 31, 2011. The same is true for any governmental plan that chose not to submit a determination letter application during their regular cycle (Cycle C, which closed on January 31, 2009). This Cycle E deadline is unrelated to the plan year on which a plan operates.

As explained in our March 2010 article, a plan falls within Cycle E if the sponsoring employer’s tax identification number ends with either “5” or “0.” The many changes that must be incorporated into a Cycle E plan are listed on the IRS’s 2009 cumulative list of retirement plan changes. Accordingly, the sponsor of any Cycle E plan that has not already begun this review and amendment process should do so without further delay.

What Should Plan Sponsors Do?

The consequences of missing any of the amendment deadlines discussed above could be quite severe: the plan would lose its tax-favored status. Sponsors should therefore carefully review their documents to determine whether they have adopted conforming amendments by the applicable deadlines. Spencer Fane’s Employee Benefits Group is ready to assist sponsors in this review, as well as in drafting any necessary amendments.

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THE FIDUCIARY DUTY TO ASK FOR A BETTER DEAL

When is it appropriate to accept the sticker price listed on a product without asking the salesman for a better deal? Maybe never, at least if you're a fiduciary of a \$2 billion 401(k) plan spending the participants' money, according to a federal court in California. (*Tibble v. Edison International*, 7/8/2010). That's true even if an independent consultant advises you to buy the higher-priced product.

The *Tibble* case was one of many similar lawsuits filed in 2006 and 2007 that challenged 401(k) plan investment options as too expensive. According to plan participants and their attorneys, plan fiduciaries breached their duties under ERISA when they failed to negotiate for lower cost options. *Tibble* is the first of those fee cases to go to trial for which a decision has been reached. (A court in Kansas City continues to deliberate over a case involving ABB Company and Fidelity, which was tried earlier this year.)

In *Tibble*, the participants alleged that the fiduciaries selected retail share classes – rather than less expensive institutional share classes – of three mutual funds made available to participants in the Edison International Plan. The retail share classes of these funds charged fees that were 25 to 40 basis points higher than the fees charged for the otherwise-identical institutional share classes.

Defending their failure to offer the cheaper share classes, the plan's fiduciaries argued that the plan had insufficient assets invested in the funds to qualify for the cheaper institutional share classes. The court was not persuaded. In one instance, the plan satisfied the minimum investment threshold only one month after the fund was first offered, but the fiduciaries never asked the fund provider to make the lower-cost share class available.

The court was even more troubled by the fact that the fiduciaries never even *asked* the fund providers to *waive* the minimum investment requirements. The fiduciaries' own expert witness testified that such waivers are routinely granted, even for plans with just a fraction of the bargaining power of the Edison Plan. This failure to ask for a waiver amounted to a breach of fiduciary duty under ERISA.

The court was equally unimpressed with the fiduciaries' argument that they relied on the advice of an independent consultant when selecting fund options. Although securing the advice of a consultant "is some evidence of a thorough investigation, it is not a complete defense to a charge of imprudence."

In the end, the court agreed with the plan participants, finding the fiduciaries personally liable for the extra expenses associated with the higher-cost funds.

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The lesson: Fiduciaries of *any* plan – whether it has \$2 *billion* or \$2 *million* in assets – have a duty under ERISA to be actively engaged in the process of selecting investment options. At a minimum, fiduciaries should ask whether lower-cost share classes are available, even if their consultant doesn't. If a less expensive share class is available, fiduciaries should ask the fund company to waive any minimum investment threshold that would otherwise prevent the plan from offering that share class.

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REGULATIONS REQUIRE SPECIFIC DISCLOSURE OF FEES RECEIVED BY SERVICE PROVIDERS

On July 15, 2010, the Department of Labor (“DOL”) issued “interim” final regulations regarding the fee information that service providers must disclose to fiduciaries of ERISA-covered retirement plans. This information is intended to assist fiduciaries in assessing the reasonableness of contracts or arrangements for the provision of services to the plan, including the reasonableness of the service provider’s compensation and the potential for conflicts of interest.

Under ERISA, any payment to a service provider out of plan assets is a prohibited transaction unless done pursuant to a

“reasonable” contract or other arrangement. These new regulations provide that a contract for services to an ERISA-covered plan will not be considered “reasonable” unless the service provider discloses, in writing, specific information about the services it will provide, whether it will be providing those services as a fiduciary, and the amount of compensation (direct or indirect) that it will receive in exchange for those services. Failure to comply with these fee disclosure regulations (when they become effective in July of 2011) will have consequences for both the responsible plan fiduciary *and* the service provider.

Fee Disclosure Initiative

These regulations are part of the DOL’s three-pronged approach to fee disclosure. The first prong dealt with the reporting of plan fees on Schedule C to the Form 5500 Annual Report. Those rules became effective for the 2009 reporting year. The regulations issued last month (concerning fee disclosure by service providers) are the second prong. They are scheduled to become effective, for both new and existing service-provider contracts, on July 16, 2011. Guidance on the third and final prong of the fee initiative, which will require specific disclosure of fees (by plan fiduciaries) to plan participants, is expected to be issued later this year.

Covered Plans

The interim final regulations apply solely to

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contracts between service providers and ERISA-covered retirement plans, such as qualified defined contribution plans, qualified defined benefit plans, and Section 403(b) arrangements. Significantly, the regulations do *not* apply to individual retirement accounts or annuities (IRAs), simplified employee pension plans (SEPs), or SIMPLE plans. In addition, the regulations do not apply to governmental plans, church plans, or salary-deferral-only 403(b) arrangements that satisfy a regulatory exemption from ERISA. And unlike the 2007 *proposed* regulations, these interim regulations do not apply to welfare plans.

Covered Service Providers

Under these regulations, a “covered service provider” is a service provider that enters into a contract or arrangement with a covered plan under which the service provider reasonably expects to receive at least \$1,000 in compensation, directly or indirectly, in return for providing one or more of the services described below – regardless of whether the services will be performed (or the compensation received) directly by the covered service provider or by an affiliate or subcontractor. The three categories of covered services are as follows:

1. **Services as a fiduciary or registered investment advisor.** These include services provided:
 - a. directly to the plan as an ERISA fiduciary;
 - b. directly to the plan as an investment advisor registered under the Investment Advisors Act of 1940 or any state law; or
 - c. as a fiduciary to an investment contract, product, or entity that holds plan assets and in which the plan has a direct equity investment.
2. **Certain recordkeeping or brokerage services.** These include recordkeeping services or brokerage services provided to a participant-directed, individual account plan where one or more of the investment alternatives are made available (through a platform or similar mechanism) in connection with such recordkeeping services or brokerage services.
3. **Certain other services for indirect compensation.** These include accounting, auditing, actuarial, appraisal, banking, consulting (as defined below), custodial, insurance, investment advisory (for the plan or its participants), legal, recordkeeping, securities or other investment brokerage, third-party administration, or valuation services provided to a plan for which the service provider (or an affiliate or subcontractor) reasonably expects to receive either (i) indirect compensation (as defined below) or (ii) compensation (from an affiliate or subcontractor) that is set on a transaction basis or is charged directly against the plan's investment and

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4. reflected in the net value of that investment. For purposes of this category of covered services, “consulting” means consulting with respect to investment policies or objectives, or with respect to the selection or monitoring of service providers or plan investments.

Accordingly, the service providers that will be subject to the new fee disclosure requirements include:

1. ERISA fiduciaries (*i.e.*, trustees, plan administrators, investment managers, named fiduciaries, and persons who provide investment advice for a fee) and registered investment advisors that provide services directly to the plan;
2. Companies (*i.e.*, banks, insurance companies, mutual fund companies, brokers, and third-party administrators) that provide recordkeeping and/or brokerage services in connection with making a “platform” of investment options available to participant-directed, individual account plans;
3. Companies or individuals that act in a fiduciary capacity (such as an investment manager or investment advisor) to any investment fund (such as an insurance company separate account or an investment fund that is *not* registered under the ‘40 Act) that holds “plan assets”; and

4. Companies or individuals (such as consultants, TPAs, brokers, or transfer agents) receiving “indirect” compensation in connection with the provision of services to the plan.

Note that most mutual fund companies (and their investment managers) will *not* be covered service providers (unless the company or an affiliate is providing recordkeeping services or is otherwise serving as a fiduciary to the plan), because the underlying investments of a mutual fund are not considered “plan assets” under ERISA. Therefore, the party responsible for disclosing the fees associated with a plan’s mutual fund investment will generally be the service provider that made that investment available to the plan.

Disclosure Requirements

A covered service provider must disclose the following information, in writing, to a responsible plan fiduciary:

1. A description of the services to be provided to the plan;
2. A statement as to whether the service provider (or any affiliate or subcontractor) reasonably expects to provide services as either (i) a fiduciary to the plan, (ii) a fiduciary to an investment fund that holds plan assets, or (ii) a registered investment advisor;

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3. A description of all direct and indirect compensation that the service provider (or any affiliate or subcontractor) reasonably expects to receive in connection with providing the “covered services” described above;
 4. A description of all compensation that will be shared among the service provider and its affiliates or subcontractors, if such compensation is either:
 - a. Set on a transaction basis (such as commissions, soft dollars, or finder’s fees); or
 - b. Charged directly against the plan’s investment and reflected in the net value of that investment (such as 12b-1 fees);
 5. Any compensation that the service provider (or its affiliates or subcontractors) reasonably expects to receive in connection with termination of the contract, and how any prepaid amounts will then be calculated and refunded;
 6. If recordkeeping services will be provided under the contract, the direct and indirect compensation that the service provider (or any affiliate or subcontractor) reasonably expects to receive in connection with those recordkeeping services. If the service provider expects to provide recordkeeping services without explicit compensation for those services (or when any fee for recordkeeping is offset or rebated based on other compensation the service provider may receive), the service provider must provide a reasonable, good-faith estimate of the cost to the plan of the recordkeeping services, including an explanation of how the estimate was derived and a detailed explanation of the recordkeeping services that will be provided; and
 7. service provider may receive), the service provider must provide a reasonable, good-faith estimate of the cost to the plan of the recordkeeping services, including an explanation of how the estimate was derived and a detailed explanation of the recordkeeping services that will be provided; and
 8. A description of the manner in which the compensation will be received (*i.e.*, whether the plan will be billed or the fees deducted from plan accounts).
- If a covered service provider is providing a platform of investment options (or is providing services as a fiduciary to an investment fund that holds plan assets), the service provider must also disclose the following information for each designated investment option:
1. A description of any fees that will be charged against the amount invested in connection with transactions involving the contract (*i.e.*, sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees, or purchase fees);
 2. A description of the annual operating expenses (*i.e.*, expense ratio) if the return is not fixed; and
 3. A description of any ongoing expenses in addition to the annual operating expenses (*i.e.*, wrap fees, mortality and expense fees).

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For service providers providing a platform of investment options, this requirement may be satisfied by providing the disclosure materials of the issuer of the designated investment alternative (*i.e.*, by providing the prospectus of a mutual fund investment option), so long as the issuer of the investment product is not an affiliate of the platform provider, the prospectus or other disclosure materials are regulated by a state or federal agency, and the platform provider is not aware that the materials are incomplete or inaccurate.

When Fee Information Must Be Disclosed (or Updated)

The initial fee disclosure information must be disclosed to the responsible plan fiduciary “reasonably in advance of” the date the services contract or arrangement is entered into (or extended or renewed). Although the fee disclosure must be in writing, it does not have to be part of, or included in, the actual written agreement between the service provider and the plan fiduciary.

The service provider must disclose any *change* in the fee information as soon as practicable, but no later than 60 days from the date on which the service provider is aware of the change. Good-faith errors in disclosing fees will not cause a service agreement to fail to be a “reasonable” contract or arrangement, so long as the service provider corrects the error as soon as practicable, but no later than 30 days

after becoming aware of the error.

Covered service providers must also furnish (within 30 days of receipt of a written request by a responsible plan fiduciary) any information relating to compensation under the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements of Title I of ERISA (such as the information necessary to complete Schedule C to Form 5500).

Key Definitions

Under the regulations, “compensation” is defined as anything of monetary value (*e.g.*, money, gifts, awards, or trips), but does not include non-monetary compensation valued at \$250 or less (in the aggregate) during the term of the contract or arrangement. “Direct compensation” is compensation received directly from the covered plan. “Indirect compensation” is compensation received from any source *other* than the covered plan, the plan sponsor, the covered service provider, or an affiliate or subcontractor of the service provider.

“Recordkeeping services” means services related to plan administration and monitoring of plan and participant transactions. Examples include enrollment, payroll deductions and contributions, offering designated investment alternatives and other plan investments, loans, withdrawals, and

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distributions. This phrase also includes the maintenance of plan and participant accounts, records, and statements.

Consequences of Failure to Follow Disclosure Requirements

As noted above, any contract or arrangement between an ERISA-covered plan and a service provider is a “prohibited transaction” under both ERISA and the Tax Code unless the contract or arrangement is “reasonable.” The regulations now provide that, after July 16, 2011, a contract or arrangement will not be considered “reasonable” unless the service-provider fee-disclosure requirements are satisfied.

There are significant penalties – both for plan fiduciaries and for contracting service providers – if the fee-disclosure requirements of the interim final regulations are not satisfied. A *fiduciary* that causes a plan to enter into an “unreasonable” contract for services to an ERISA-covered plan commits a prohibited transaction under Section 406 of ERISA. Such a violation may subject the responsible plan fiduciary to a 20% civil penalty. A *service provider* that enters into an “unreasonable” contract with an ERISA plan will also have committed a prohibited transaction, and will be subject to a 15% excise tax under Code Section 4975.

Relief for Innocent Fiduciaries

Although these new regulations are quite

stringent, they do offer a bit of leeway for “innocent” plan fiduciaries. If a covered service provider fails to make the fee disclosures required by these regulations, a fiduciary will not be considered to have committed a “prohibited transaction” so long as:

1. The fiduciary did not know that the service provider failed, or would fail, to make the required disclosures, and reasonably believed that the required disclosures had been made;
2. Upon discovering the failure, the fiduciary makes a written request that the service provider furnish the required information;
3. If the service provider fails to comply with such a written request within 90 days, the fiduciary notifies the DOL of the service provider’s failure;
4. This notice satisfies specific content and timing requirements set forth in the interim regulations; and
5. The fiduciary makes a determination as to whether to terminate or continue the contract or arrangement (taking into account the nature of the failure, the availability and cost of replacement service providers, and the service provider’s response to the notification).

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PLANS REQUIRED TO COVER PREVENTIVE HEALTH SERVICES

Among the many changes made by the Affordable Care Act is a requirement that group health plans (other than plans that are “grandfathered” under the rules described in our [June 2010 article](#)) provide benefits for a comprehensive list of preventive health services. Moreover, these benefits must be provided on a first-dollar basis (*i.e.*, subject to no deductible or co-payment) and with no other cost-sharing requirement (such as coinsurance). This requirement applies as of the first plan year beginning on or after September 23, 2010.

Mandated Preventive Services

In general, these mandated preventive services fall within the following three categories:

- Evidence-based items or services carrying a current rating of either “A” or “B” in recommendations made by the U.S. Preventive Services Task Force;
- Immunizations that are recommended for children, adolescents, or adults on the Immunization Schedules maintained by the Centers for Disease Control and Prevention; and
- Evidence-informed preventive care and screenings for infants, children, adolescents, and women, as included in

- comprehensive guidelines issued by the Health Resources and Services Administration.

The complete and updated [list](#) of required preventive services is posted on the HealthCare.gov website.

Concurrent Office Visits

Because preventive care services are typically obtained during the course of an office visit, the regulations contain specific rules as to when a plan may impose cost-sharing requirements in connection with an office visit during which preventive care services are obtained. For instance, if the office visit and preventive care services are billed separately, a plan may impose cost-sharing requirements with respect to the office visit.

The same rule applies if the office visit and preventive care services are not billed separately, but the “primary purpose” of the office visit was *not* to obtain preventive services. However, if the items are not billed separately and the primary purpose of the visit was to obtain preventive care, a plan may not impose any cost-sharing requirements for either the visit *or* the preventive care.

Out-of-Network or Additional Preventive Care Services

In other respects, the regulations are surprisingly supportive of efforts by health plans to contain costs. For instance, if a plan

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has a network of providers, it need not offer these preventive care services on an out-of-network basis. Alternatively, the plan may impose cost-sharing requirements on such services if obtained outside of its network. The same is true for preventive care services that are covered under the plan, but that are not *required* to be provided pursuant to the Act.

Medical Management Techniques

Similarly, a plan is free to use “reasonable medical management techniques to determine the frequency, method, treatment, or setting” for required preventive care services. The only limitation is that those techniques may not conflict with any of the recommendations contained in the applicable guidelines.

Effective Dates and Implementation

Although this new requirement applies to plan years beginning on or after September 23, 2010, the preventive care services required to be provided are those that were officially

recommended at least one year before any plan year commences. Accordingly, the first set of required services are those for which a recommendation was already in place by September 23, 2009. The intent of this one-year lag is to allow plans time to add coverage for any newly recommended services.

Recommended Next Steps

Sponsors of plans that do not intend to retain their grandfathered status will want to review the list of recommended preventive care services and, as necessary, amend their plans to add coverage for any omitted services. Moreover, any cost-sharing requirements applicable to these services will have to be eliminated.

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