



HR and Benefits Update

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Understanding the Health Care Reform Prohibition on Rescissions

The Patient Protection and Affordable Care Act (PPACA) and corresponding interim final regulations provide that a group health plan or a health insurance issuer offering group or individual coverage must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. The restriction on rescissions is generally effective for plan years beginning on or after Sept. 23, 2010.

The regulations define a “rescission” as a cancellation or discontinuance of coverage that has retroactive effect. Under prior law, a rescission was permissible if an individual made a misrepresentation of material fact, even if the misrepresentation was not intentional. Under the new standard, coverage may not be rescinded unless an individual was involved in fraud or the misrepresentation of material fact was intentional. In other words, misstatements of fact that are inadvertent do not allow a plan to rescind coverage.

Understanding the Health Care Reform Prohibition on Rescissions *continued*

The regulations provide that prospectively cancelling coverage is not a rescission. For example, guidance clarified that plans are permitted to correct errors, such as mistakenly covering a part-time employee, by cancelling coverage prospectively. However, the guidance did state that if a plan covers only active employees and a termination occurs, the plan may retroactively cancel coverage back to the termination of employment date if the employee paid no premiums for coverage after terminating. This may be a relief for human resource professionals who only reconcile and submit eligible individuals to insurers once per month.

PPACA requires advance notice when coverage is rescinded. Specifically, the law prohibits cancellation of coverage unless group health plans and issuers provide at least 30 calendar days prior notice, which is designed to provide individuals and plan sponsors with an opportunity to explore their rights to contest the rescission, or look for alternative coverage, as appropriate.

Finally, if another federal or state law provides stricter standards as to when coverage may be rescinded or canceled, then that stricter law will apply. For example, if a state law provides that rescissions are permitted only in cases of fraud, or only within a contestability period, which is more protective of individuals, that law would prevail.

Plan Sponsor Primer: Retirement Committee Meetings

We often receive questions from our clients regarding the content and timing of retirement committee meetings. Most committees wonder, "How frequently should we meet?" For most, quarterly meetings are sufficient. Plans with minimal activity may be satisfied with one annual meeting, so long as meetings occur with adequate frequency to handle items critical to proper plan management.

The purpose of the committee is to oversee investment and administrative issues. A committee should be formalized via a written document (i.e., committee charter), which identifies the members and establishes specific roles and responsibilities. During the course of each plan year, the committee should:

- **Review and monitor the plan's investments pursuant to procedures contained in the Investment Policy Statement.** This should include selection and replacement when appropriate.
- **Review plan expenses.** The plan committee should understand and determine reasonableness of plan expenses. Recent litigation in this area has reinforced the primacy of this issue for fiduciaries. A complete fee analysis and benchmarking of vendors should occur every three to five years.
- **Review plan services available and those currently being provided.** This is a key component going hand-in-hand with the expense review. Quantity and quality of services provided should certainly be among the factors considered in addressing the appropriateness of expenses. Also, the breadth and scope of services are constantly expanding, and the committee should be aware of those services that may produce a value-added impact on their plan.
- **Consider emerging trends, legislation and external/internal factors that may affect the plan.** Examples include the significant implications of the Pension Protection Act of 2006, Roth 401(k), asset allocation accounts (lifetime/ lifecycle), automatic enrollment/escalation, etc.
- **Review plan demographics.** Are plan provisions understood and being administered properly? How do these provisions compare to industry norms or best practices guidelines? Do plan fiduciaries understand and practice their roles and responsibilities accordingly?
- **Review participant demographics.** Are participants in position to achieve a financially successful retirement experience? Specific items for fiduciary review are participation rates, average deferral rates, appropriate asset allocation/diversification and average account balances.
- **Review participant communication/education programs.** Fiduciaries are required to ensure all participants have sufficient information to make informed investment decisions. Is there evidence this is currently the case? If not, what would be appropriate courses of action?

Be sure to pursue the above actions, and any others, with the appropriate degree of procedural prudence as required of ERISA fiduciaries. Investigate the issues, take the appropriate steps and document the entire process. Your plan consultant is available to assist you in any of the areas identified above.



Compliance FAQ

Question: Is there a deadline for contributions to a Health Savings Account (HSA) for a taxable year? What is the allowable limit?

Answer: While contributions to an HSA can be made in one or more payments during the taxable year, the deadline to make contributions is prior to the time for filing the eligible individual's federal income tax return for that year (without extensions). For individuals, this deadline for 2010 is April 18, 2011, due to a holiday occurring on April 15, 2011. Despite the April 18, 2011, deadline, employers that fund contributions to their employee's HSAs may want to time the contributions for purposes of its own deduction for the year. Thus, employers may need to fund those contributions no later than the employer's tax filing deadline (without extensions), and the date will vary depending on the employer's tax structure. For example, a corporate employer would want to make its contribution by its March 15, 2011, tax filing deadline.

Employers can choose to make lump-sum contributions to employee HSAs, but are also permitted to fund pay-period by pay-period contributions or monthly contributions. However, if an employer is funding a contribution for 2010 before the tax filing deadline in 2011, they must notify both the employee and the HSA trustee or custodian that the contributions relate to the prior year. There is no guidance on how this notification must occur.

HSA contributions made by employers are aggregated with other HSA contributions made by the employee to determine the total allowable contribution. For 2010, the maximum contribution allowed for individuals with single High Deductible Health Plan coverage is \$3,050, and \$6,150 for family coverage. These amounts may be increased by \$1,000 for individuals who turn age 55 or older during the year as a catch-up contribution. There is also a special rule for married individuals, which provides that if either spouse has family coverage, then both spouses are treated as only having family coverage. In other words, a married couple may contribute no more than \$6,150 to an HSA during the year, including any employer contributions. Any available catch-up contributions are not included in this limit. Finally, the HSA contribution limits are calculated on a monthly basis. Therefore, an individual who was not eligible for all 12 months of the year may have a lesser contribution amount and should seek guidance from an accountant in determining the appropriate contribution that may be made, less any employer contributions.

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