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EMPLOYEE BENEFITS UPDATE

SELECT COMPLIANCE DEADLINES AND REMINDERS

ERRP Applications

The Department of Health and Human Services (HHS) determined that it will stop accepting new Early Retiree Reinsurance Program (ERRP) applications on May 6, 2011. For plans that have yet to apply, the ERRP Center must receive the complete application on or before 5 p.m. Eastern time on May 5, 2011. Any applications received after that time will be rejected.

ERRP is a program added by the Patient Protection and Affordable Care Act (PPACA) intended to provide health plans with reimbursement for a portion of the health-related costs for early retirees and their spouses and dependents.

For additional ERRP-related information, see *HHS Issues New ERRP Guidance Regarding Claims Data Submission* later in this update.

Cafeteria Plan Amendment for Qualified Medical Expenses

Cafeteria plans with health flexible spending accounts must be amended to comply with PPACA's definition of "qualified medical expenses" by June 30, 2011 for calendar year plans. Ordinarily, cafeteria plan amendments must be adopted prior to the effective date of the change, or December 31 for calendar year plans. However, the Internal Revenue Service (IRS) provided a six-month extension for this amendment deadline.

A "qualified medical expense" is considered an expense incurred on or after January 1, 2011 for a medicine or drug that is insulin, or that requires a prescription or is available without a prescription but the individual has a prescription.

W-2 Health Benefits Reporting

The PPACA provides that employers are required to report the cost of employer-provided health care coverage on W-2 forms. This is an optional requirement for all employers for 2011 W-2 forms, which would generally be provided to employees in January 2012. Recent guidance extends this deadline for smaller employers (employers filing fewer than 250 W-2 forms) for 2012 W-2 forms, which would generally be provided to employees in January 2013.

This new reporting is to inform employees of the cost of their health coverage.

RETIREMENT PLAN DEVELOPMENTS

Proposed Regulations on Determining Guaranteed Amount of Unpredictable Contingent Event Benefits

The Pension Benefit Guarantee Corporation (PBGC) issued proposed regulations on how to determine the amount of unpredictable contingent event benefits (UCEB) guaranteed under

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Title IV of the Employee Retirement Income Security Act (ERISA) for single-employer defined benefit plans. The proposed regulations implement section 403 of the Pension Protection Act of 2006 (PPA). Historically, when underfunded single-employer defined benefit plans were terminated, the PBGC guaranteed the payment of a certain level of benefits under the ERISA Title IV termination insurance program. Generally, the PBGC's guarantee of new pension benefits and benefit increases is phased in over a five-year period, beginning on the date the new benefit or benefit increase is adopted or effective.

PPA section 403 and these regulations change the start of the phase-in period for plant shutdown or other UCEBs. The phase-in rules are now applied as if a plan amendment creating a UCEB was adopted on the date the unpredictable contingent event occurred rather than as of the actual adoption date of the amendment. The change applies to benefits that become payable as a result of an unpredictable contingent event that occurs after July 26, 2005. The change results in a lower guarantee of benefits arising from plant shutdowns and other unpredictable contingent events that occur within five years of plan termination. This limit generally serves to protect the PBGC from losses caused by benefit increases that are adopted or effective shortly before plan termination, which may be unfunded liabilities.

IRS Provides Due Date for Filing 2009 Form 8955-SSA

The IRS released Announcement 2011-21, designating that Form 8955-SSA, Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits, generally must be filed by the last day of the seventh month following the close of the plan year. For calendar year plans, the deadline is July 31, with extensions. This is the same filing deadline (and extensions) as Form 5500. Form 8955-SSA replaces Schedule SSA of Form 5500 beginning with the 2009 plan year. Announcement 2011-21 includes special due dates for the 2009 and 2010 plan years. The due dates for the 2009 and 2010 plan year Forms 8955-SSA are the later of (1) the due date that generally applies for filing the Form 8955-SSA for the 2010 plan year, and (2) August 1, 2011. The IRS expects to have the year 2009 Form 8955-SSA available shortly for plans to access and complete. Plan administrators will be permitted to use the 2009 form for year 2010 reporting, pending release of the 2010 Form 8955-SSA. The IRS also expects to have ready a voluntary electronic reporting option for this form.

The IRS also provided relief for plan administrators who have submitted to the IRS a Form 5500 Schedule SSA for the 2009 and 2010 plan years. The IRS will treat a Schedule SSA that is filed with the IRS for the 2009 and 2010 plan years by April 20, 2011 as satisfying reporting requirements, and no Form 8955-SSA will be required to be filed for those plan years.

Federal Judge Dismisses Lawsuit by Pension Plans Against Freddie Mac

A U.S. federal judge recently dismissed a lawsuit against Freddie Mac that claimed Freddie Mac materially misrepresented its exposure to risky mortgage products, leading to investment losses. The lawsuit was brought by a group of pension funds, including Central States, Southeast and Southwest Areas Pension Fund; and National Elevator Industry Pension Plan.

The plaintiffs argued that, following Freddie Mac's disclosure of a $2 billion loss for the third quarter of 2007, the company misrepresented its financial situation. These misrepresentations initially resulted in inflated share prices, followed by sharply declined share prices as Freddie Mac's poor financial situation became clear to the market. Judge John Keenan dismissed the plaintiffs' motion, saying the plaintiffs failed to adequately prove proximate cause between any misrepresentation or misstatement relating to Freddie Mac's exposure to nonprime mortgage loans, accuracy of financial reporting, and its capital adequacy and

economic harm on the plaintiffs. Freddie Mac is a federal agency in the Department of Housing and Urban Development (HUD) that insures residential mortgage loans made by private lenders and sets standards for underwriting mortgage loans.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Issues Fines for HIPAA Privacy Rule Violations

HHS recently issued fines against two violators of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. The first incident pertains to civil money penalties of $4.3 million issued against Cignet Health of Prince George's County, Maryland. HHS fined Cignet $1.3 million for failure to provide patients with access to their medical records as required by the HIPAA Privacy Rule, and $3 million for failure to cooperate with the HHS Office for Civil Rights investigation. The Cignet fine marks the first time that HHS assessed civil money penalties against a covered entity for failure to comply with HIPAA. The violation categories and penalties are based on the increased authority granted under the Health Information Technology for Economic and Clinical Health Act (HITECH).

The second incident involved a resolution agreement between HHS and Massachusetts General Hospital (Mass General) for $1 million to settle potential violations of the HIPAA Privacy Rule. In this incident, an employee of Mass General lost protected health information (PHI) for 192 patients when the employee left the files on the subway while commuting to work. The settlement follows a probe by the HHS Office for Civil Rights that found that Mass General failed to implement "reasonable, appropriate safeguards to protect the privacy of PHI" removed from Mass General's premises and disclosed, potentially violating the HIPAA Privacy Rule.

The HIPAA Privacy Rule requires that a covered entity, upon patient request, provide the patient with a copy of their medical records within 30 days (and no later than 60 days) of the request.

HHS Issues New ERRP Guidance Regarding Claims Data Submission

On March 25, 2011, HHS issued new ERRP guidance regarding claims list submissions. ERRP, established by PPACA, provides reimbursement to participating employment-based health plans for a portion of the costs of health benefits for early retirees and their spouses, surviving spouses, and dependents. The new guidance notifies plans that, beginning in April 2011, the plans will be required to submit a "Claims List" with each reimbursement request. The Claims List will be a cumulative list of all health benefit items or services for which the plan is requesting reimbursement for that plan year. Prior guidance indicated that plans would eventually have to submit detailed claims data in addition to the summary cost data for each reimbursement request.

Plans will submit the Claims List in the same manner as the Early Retiree Lists, either by uploading the Claims List to the ERRP Secure Website or through its mainframe. All Claims Lists greater than or equal to 100 MB in size (which HHS states is a Claims List with approximately 249,000 claim service lines) must be submitted through the mainframe because of upload limitations. Those plans that believe their Claims Lists will reach the size threshold and that do not already use the mainframe system to submit Early Retiree Lists should contact the ERRP Center as soon as possible to begin the mainframe set-up process, as it can take a significant amount of time.

Extension of Internal Claims and Appeals Enforcement Grace Period

The Department of Labor (DOL) released Technical Release 2011-01, further extending the Internal Claims and Appeals enforcement grace period. Interim final regulations issued in 2010 provided enumerated additional standards for internal claims and appeals processes.

Technical Release 2011-01 extends the enforcement grace period for the following internal claims and appeals standards, as numbered in the prior guidance:

- Number 2—regarding the accelerated time frame for making urgent care claims decisions (from 72 to 24 hours);
- Number 5—regarding the obligation to provide notices in a culturally and linguistically appropriate manner;
- Number 6—requiring broader content and specificity in notices;
- Number 7—indicating that substantial compliance with the claims and appeals rules is no longer sufficient to avoid a de novo review.

The grace period for Numbers 2, 5, and 7 is extended until the first plan year beginning on or after January 1, 2012. Regarding Number 6, the grace period for the requirement that claims and appeals denial notices disclose diagnosis codes and treatment codes is extended to the first plan year beginning on or after January 1, 2012. The grace period for the remainder of the Number 6 requirements, including disclosure of information sufficient to identify the claim, the reasons for the adverse benefit determination, a description of available internal and external review processes, and the availability of a consumer assistance program, is extended to the first plan year beginning on or after July 1, 2011.

The DOL also removed the requirement that plans must be working in good faith to implement the internal claims and appeals standards during the extended or the original grace periods.

Reinhart Comment: Those plans that have already begun using the updated explanation of benefits (EOBs) and appeals language reflecting the new internal claims and appeals procedures may want to continue using them. Plans that have not yet begun using the updated EOBs and appeals language may want to consider waiting until the final regulations are issued after the enforcement grace period. However, plans with plan years beginning between July 1, 2011 and January 1, 2012 not currently using updated EOBs and appeals denials should consider updating them because they will be required to comply with that requirement at the beginning of their next plan year.

HHS Releases National Quality Strategy for Quality Improvement in Health Care

HHS released the National Quality Strategy for Quality Improvement in Health Care, as called for by PPACA. The National Quality Strategy is intended to create national goals and priorities to guide local, state, and national efforts to improve the quality of health care in the United States. The Strategy provides the following three aims for the health care system:

- Better Care: Improve the overall quality by making health care more patient-centered, reliable, accessible, and safe.
- Healthy People and Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

The Strategy also establishes six priorities, to help achieve these aims, including:

- Making care safer by reducing harm caused in the delivery of care.

- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

This *Headlines in Employee Benefits Law E-Alert* provides general information and should not be construed as legal advice or a legal opinion. Readers should seek legal counsel concerning specific factual situations confronting them.

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