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September 2011

EMPLOYEE BENEFITS UPDATE**SELECT COMPLIANCE DEADLINES AND REMINDERS****Medicare Part D Deadlines**

All group health plans that offer prescription drug coverage to Medicare-eligible employees (under either an active plan or retiree plan) must provide an annual creditable coverage disclosure notice to Medicare-eligible participants and dependents no later than October 15, 2011. Group health plans must also provide notices to each new participant who may be Medicare-eligible.

The annual creditable coverage disclosure notice was previously required to be provided no later than November 15 of each year. The Patient Protection and Affordable Care Act (PPACA) moved the Medicare Part D annual enrollment period to October 15 through December 7, beginning in 2011. Under the general rules prescribed by the Centers for Medicare & Medicaid Services (CMS), the annual notice is required to be provided prior to the beginning of the Medicare Part D annual election period. As a result, the creditable coverage disclosure notice for 2011 must be provided by October 15, 2011, one month earlier than in the past.

CMS provides a model notice that can be accessed through the [Centers for Medicare & Medicaid Services](#) website. Plan sponsors should review the model notice to ensure that it accurately reflects the nature of the coverage and the rights that individuals have if they lose coverage.

Cycle A Determination Letter Filings

Remedial Amendment Period Cycle A individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2012. Cycle A plans include those sponsored by employers with tax identification numbers (EINs) ending in a one or a six, as well as any controlled group or affiliated service group plans that have elected Cycle A.

RETIREMENT PLAN DEVELOPMENTS**Use of Pension Protection Act Benefit Statements to Satisfy Individual Statement Requirement**

As further discussed in the [April 2011 Employee Benefits Update](#), plan sponsors are now required to file the Form 8955-SSA with the IRS. The Form 8955-SSA replaces the Schedule SSA that plan sponsors previously filed with the Form 5500 to report separated participants with deferred vested benefits. The 2009 version of the Form 8955-SSA generally tracks the Schedule SSA, with some important differences. For instance, the Form 8955-SSA now asks whether the plan sponsor has provided an individual statement to each participant required to receive a statement, as required by Internal Revenue Code (Code) section 6057(e). Generally, Code section 6057(e) is a long-standing requirement that requires plan sponsors to send out a statement to each participant that will be listed in

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the Form 8955-SSA. The statement must include the information regarding the participant contained in the Form 8955-SSA and, if applicable, a notice to the participant of any benefits that are forfeited if the participant dies before a certain date. Plan sponsors must send this statement prior to the deadline for filing the Form 8955-SSA, which is the later of January 17, 2012 or the due date of the 2010 Form 5500 (including extensions). Plan sponsors can incur penalties up to \$50 per un sent statement.

It is unclear at this time whether a benefit statement, following the Pension Protection Act rules, is sufficient to meet this requirement. One possible method of meeting the individual statement requirement could be to combine the benefit statement with the distribution form. Defined contribution plans may be able to use this method, provided that distribution occurs no later than the year following termination of employment and the distribution forms are sent prior to the deadline for sending the individual statement. In contrast, this method will likely not be available for defined benefit plans. Because defined benefit plans generally do not allow for immediate distribution, they will most likely not send the distribution notice to the participant prior to the deadline for sending the individual statements.

[Reinhart Comment:](#) It is unclear whether the use of two forms would be acceptable to satisfy the individual statement requirement.

Court Upholds Arbitrator's Determination on Withdrawal Liability

The District Court for the Northern District of Illinois recently upheld an arbitrator's determination that the withdrawal liability a multiemployer plan sponsor calculated did not represent the actuary's "best estimate" of anticipated experience under the plan. *Chicago Truck Drivers, Helpers et al v. CPC Logistics, Inc.* The plan sponsor used two methods that utilized different assumptions to determine the unfunded vested benefit liabilities (UVBs): a "modified" method for the funding report and the Segal "Blend" method for the withdrawal liability report. If the UVB calculated using the funding report method was lower than the UVB calculated using the Segal Blend, the Segal Blend UVB would be disregarded and replaced with the funding report UVB in calculating the withdrawal liability.

The parties agreed, and the court concluded, that the Segal Blend always represented the actuary's "best estimate" with respect to withdrawal liability. Employee Retirement Income Security Act (ERISA) section 4213(a) requires plan sponsors to determine withdrawal liability using the actuary's best estimate of anticipated experience under the plan. Accordingly, the arbitrator found, and the court agreed, that by not using the Segal Blend to calculate the plan's overall UVB, the plan sponsor was directly violating ERISA. The plan sponsor has appealed the case to the Seventh Circuit.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Increases ERRP Cost Threshold and Cost Limit Amounts and Extends Deadline for Submitting Claims List

The Department of Health and Human Services (HHS) has issued a notice describing the increased Early Retiree Reinsurance Program (ERRP) cost threshold and cost limit for plan years beginning on or after October 1, 2011.

Plan sponsors can request reimbursement under ERRP for costs paid on behalf of an eligible early retiree. Previously, eligible early retirees must have accumulated between \$15,000 (cost threshold) and \$90,000 (cost limit) in eligible, plan-reimbursed claims during the plan year. Now, for plan years beginning on or after October 1, 2011, the cost threshold has been increased to \$16,000 and the cost limit has been increased to \$93,000. HHS increased the cost threshold and limit as mandated by the ERRP statute and regulations, which require the figures to be adjusted each fiscal year based on the percentage increase in the consumer price index.

Accordingly, plan sponsors with plan years beginning on or after October 1, 2011 will need to revise their system of identifying eligible early retirees to include those individuals who have accumulated between \$16,000 and \$93,000 in eligible, plan-reimbursed claims. Plan sponsors with plan years beginning before October 1, 2011 will continue to use the original cost threshold and limit of \$15,000 and \$90,000, respectively.

In addition, HHS has extended the deadline for submitting a claims list substantiating previous reimbursements. Plan sponsors that requested reimbursement before April 2011, and that have subsequently received reimbursement, must submit an error-free claims list with a reimbursement request before March 30, 2012, substantiating the amount that was reimbursed (previously, the deadline had been December 31, 2011). If a plan sponsor fails to submit the claims list, HHS will consider the previously reimbursed amount to be unsubstantiated and will initiate the process to recoup that money from the plan sponsor. HHS has also issued revised claims list templates and new common questions addressing claims list submission.

Regulations on PPACA's Four-Page Summary of Benefits Issued

PPACA added section 2715 to the Public Health Services Act (PHSA), which requires the Department of Labor, HHS and the IRS (collectively, the Departments) to develop standards for a Summary of Benefits and Coverage (SBC). Effective beginning on and after March 23, 2012, plan sponsors must provide the SBC and Uniform Glossary to participants in addition to the summary plan description (SPD) that plan sponsors already provide. Plan sponsors will also have to provide a Notice of Modifications if the plan sponsor implements any material modification to the Plan that alters the information included in the SBC. Plan sponsors can incur a penalty of up to \$1,000 for each willful failure to send the SBC, Uniform Glossary or Notice of Modifications to participants. These requirements apply to both grandfathered and non-grandfathered plans.

The Departments recently issued regulations describing the SBC, Notice of Modifications and Uniform Glossary requirements (the Regulations). In addition, the Departments issued a template for the SBC and instructions. The Departments are requesting comments on the regulations, template and instructions.

SBC Form and Content

The SBC is a stand-alone summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan. The SBC must be in the form authorized by the Departments, which will be no longer than four double-sided pages with no smaller than 12-point font. The SBC may be in either paper or electronic form and can be either the color or grayscale version of the template.

The SBC must be presented in a culturally and linguistically appropriate manner and must be understandable by the average participant. The Regulations clarify that the same rules governing culturally and linguistically appropriate notices of adverse benefit determinations will apply to the SBC. Accordingly, if a plan sponsor sends an SBC to a participant who lives in a county in which 10% or more of the population is literate in the same non-English language, the SBC must include a statement informing the participant of language services. In addition, the plan sponsor must also provide oral language services (such as a telephone customer assistance hotline) and SBCs in the non-English language upon request.

Providing the SBC

Plan sponsors must provide participants and beneficiaries with a written SBC, free of charge, for each benefit package for which they are eligible. Generally, an SBC must be provided at enrollment, at renewal (if applicable), and upon request. In addition, plan sponsors must give all Health Insurance Portability and Accountability Act (HIPAA) special

enrollees an SBC. Plan sponsors may send a single SBC to a family if all participants and beneficiaries in the family live at the same address. If a beneficiary's last known address is different than the participant's, plan sponsors must send that beneficiary a separate SBC.

The Coverage Facts Labels

The coverage facts labels are intended to illustrate common benefits scenarios. The coverage facts labels will be hypothetical situations, including a treatment plan for a specialized condition during a specified time. Plan sponsors will then simulate how claims would be processed in that hypothetical situation to generate an estimate of cost-sharing. The coverage facts labels will include any cost-sharing, excluded benefits, and other limits on coverage.

Currently, the Departments require three coverage facts labels (for pregnancy, breast cancer treatment and managing diabetes), but the Regulations authorize the Departments to require up to six coverage examples. However, the Regulations clarify that any additional coverage facts labels will be prospective only.

The Departments issued instructions on completing the coverage facts label contemporaneously with the Regulations. Plan sponsors should review these instructions to determine how to simulate the claims processing. In addition, the information needed to complete the coverage examples will be available on the [HHS website](#). This information will be updated annually. Within 90 days of the update, plan sponsors must include the updated information in any SBC required to be provided. The Departments do not consider these updates to be "material modifications," which would require a Notice of Modifications (discussed below).

The Notice of Modifications

If a plan sponsor makes any material modification to the terms of the plan that would affect the content of the SBC and is not reflected in the most recent SBC, the plan sponsor must provide a Notice of Modifications to participants. The plan sponsor must provide the Notice of Modifications no later than 60 days prior to the modification's effective date. The Notice of Modifications must be in a form consistent with the Regulations. If a complete Notice of Modifications is provided timely, plan sponsors will also satisfy the summary of material modifications requirement under ERISA Part I.

The Uniform Glossary

The Uniform Glossary contains uniform definitions for medical- and health coverage-related terms. Plan sponsors must make the Uniform Glossary available to participants and beneficiaries. As noted above, the SBC will include a website where participants can obtain the Uniform Glossary. In addition, plan sponsors must provide the Uniform Glossary upon request, in either paper or electronic form (as requested) within seven days of the request. The Regulations are unclear regarding whether the request can be written or oral. The Uniform Glossary must be in an appearance authorized by the Regulations and plan sponsors are not permitted to make any modifications to it.

Health Reimbursement Arrangements Receive Annual Limits Waiver Exemption

HHS has issued supplemental guidance establishing a class exemption for Health Reimbursement Arrangements (HRAs) that are subject to PPACA's restricted annual limits and that were in effect on September 23, 2010 from having to apply individually for waivers or waiver extensions from the restricted annual limits. Generally, plan sponsors are permitted to have only restricted annual limits on essential health benefits for plan years beginning before January 2014 (after January 2014, plan sponsors are not permitted to

have any annual limit on essential health benefits). Plan sponsors could apply for a waiver of the restricted annual limits or an extension of their waiver and could then retain their lower annual limits if they showed that applying the restricted annual limits would result in a significant decrease in the access to benefits or increase in costs.

The class exemption states that HHS believes all HRAs have annual limits lower than PPACA's restricted annual limits and that applying the restricted annual limit to HRAs would result in a decrease in access to benefits. Accordingly, all HRAs subject to PPACA's restricted annual limits are exempt from having to apply individually for a waiver for plan years beginning before January 2014. However, the exempt HRAs must still comply with the record retention and annual notice requirements.

The guidance notes that HRAs integrated with other health coverage that complies with restricted annual limits would not need a waiver, as the preamble to the restricted annual limit regulations states that such HRAs would not need to independently satisfy the restricted annual limits requirements.

Proposed Health Insurance Premium Tax Credit Regulations Preview Anticipated Guidance for Employer Pay-or-Play Requirement

The IRS recently issued proposed regulations on PPACA's Health Insurance Premium Tax Credit. Generally, the Health Insurance Premium Tax Credit is designed to enable low-income individuals to purchase insurance in the state-run insurance exchanges that are scheduled to be effective in 2014. The regulations clarify eligibility for the tax credit, how to compute the tax credit, and how to reconcile the credit with any advance credit payments. In addition, the preamble to the regulations previews anticipated guidance that will impact the employer pay-or-play requirements:

- Regulations under Code section 4980H (the employer pay-or-play rule) are expected to provide an "affordability safe harbor" for employers. Under the anticipated safe harbor, an employer that meets certain requirements (such as offering its full-time employees and dependents the opportunity to enroll in eligible employer-sponsored coverage) will not be subject to penalties for employees that receive a premium tax credit or cost-sharing reduction for a taxable year if the employees' portion of the self-only premium for the employer's lowest-cost plan does not exceed 9.5% of the employees' current W-2 wages from the employer. Currently, PPACA's employer pay-or-play rule imposes penalties on an employer if the employee's contribution exceeds 9.5% of the employee's household income.
- Regulations are expected under Code section 5000A (the individual mandate, which includes the definition of "minimum essential coverage") to clarify the definition of minimum essential coverage to include self-funded plans. Currently, Code section 5000A defines minimum essential coverage to include coverage under an "eligible employer-sponsored plan," among other types of coverage. An "eligible employer-sponsored plan" is defined as a governmental plan or any other plan offered in a state's small- or large-group market (*i.e.*, an insured plan). As the regulations currently stand, self-funded plans are not considered minimum essential coverage and employers offering coverage under a self-funded plan could be subject to penalties for not offering minimum essential coverage.

HHS Issues Regulations on Eligibility for Health Insurance Exchanges and Exchange Standards for Employers

HHS has issued proposed regulations describing the eligibility standards for PPACA's state-run health insurance exchanges and the exchange standards for employers. Generally, the regulations propose the standards and processes for enrolling in a qualified health plan

through the exchange and provide that the exchanges will determine an individual's eligibility for the exchange. The regulations also create the standards for small-employer participation in a Small Business Health Options Program (SHOP), which include following the SHOP processes to offer employees qualified health plans and providing information to employees about selecting and enrolling in a qualified health plan.

Patient-Centered Outcomes Research Trust Fees Will Become Effective With Little Guidance

PPACA established the Patient-Centered Outcomes Research Trust, which will be funded through fees payable by sponsors of group health plans. Generally, the fee equals \$1 (\$2 in future years) multiplied by the average number of lives covered under the plan and is effective plan years ending after September 30, 2012 (*i.e.*, plan years beginning on and after October 1, 2011). However, the IRS has yet to issue guidance describing how plan sponsors will determine the average number of lives covered under the plan. The IRS has requested comments on how to determine the average number of lives, as well as whether any transitional period should apply and whether a plan administrator could pay the fee on behalf of the plan sponsor.

Reinhart Comment: The comment period closed September 6, 2011. The IRS is expected to issue proposed regulations thereafter.

PPACA Constitutional Challenges Update

Various cases challenging the constitutionality of PPACA allege that the individual mandate exceeds Congress's authority under the Commerce Clause of the Constitution. Generally, the individual mandate would require most individuals to have health coverage beginning January 1, 2014 or pay a penalty.

- *The Fourth Circuit.* The Fourth Circuit Court of Appeals has dismissed two cases challenging PPACA. In the first, *Virginia v. Sebelius*, the court ruled that the state of Virginia does not have the right to sue because it is individuals and not the state of Virginia that could suffer an injury as a result of the individual mandate. In the second, *Liberty University v. Geithner*, the court ruled that the suit sought to strike down the individual mandate before it took effect, which would usurp the government's right to collect a tax. Accordingly, the suit was in violation of the Anti-Injunction Act, which prohibits cases seeking to restrain collection or assessment of taxes, and must be dismissed.
- *The Eleventh Circuit.* The Eleventh Circuit Court of Appeals has ruled that the individual mandate is unconstitutional, but left the remainder of PPACA intact. *Florida v. HHS*. The court held that Congress had exceeded its enumerated powers under the Commerce Clause when enacting the individual mandate and, accordingly, the individual mandate was unconstitutional. In doing so, the court upheld the decision of the district court, discussed in the [February 2011 Employee Benefits Update](#). However, the court ruled that the individual mandate could be severed from the remainder of PPACA, thereby overturning the portion of the district court's decision that had held PPACA, as a whole, void because the provision could not be severed.
- *The Sixth Circuit.* As discussed in the [August 2011 Employee Benefits Update](#), the Sixth Circuit Court of Appeals upheld the constitutionality of the individual mandate provisions of PPACA. *Thomas More Law Ctr. v. Obama*. The petitioners, the Thomas More Law Center and some private citizens, have appealed the decision to the Supreme Court.

Reinhart Comment: There is now a split in the circuits as a result of these decisions. The Supreme Court is expected to accept review and it is generally believed that if the Supreme Court accepts review, it will issue a decision in 2012.

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.