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August 2011 Employee Benefits Update

SELECT COMPLIANCE DEADLINES AND REMINDERS

Summary Annual Report Deadline for Health and Defined Contribution Calendar-Year Plans

Plan administrators of defined contribution and group health plans have nine months after the end of a plan year to provide participants and beneficiaries with a summary annual report (the SAR). The SAR summarizes the plan's latest annual report/return (Form 5500). For plan years ending December 31, 2010, the deadline for providing the SAR is September 30, 2011. However, if the filing deadline for a plan's Form 5500 is extended, the deadline for providing the SAR is extended by two months.

Administrators of defined benefit plans are not required to provide SARs for plan years beginning after December 31, 2007. Instead, some of the information on the SAR is included in the annual funding notice. The annual funding notice for defined benefit plans must be provided within 120 days following the end of the plan year.

Summary Plan Information Deadline for Calendar-Year Multiemployer Defined Benefit Plans

Multiemployer defined benefit plans are required to provide a summary report to each union and employer contributing to the plan within 30 days of the due date of Form 5500, including extensions. This report must include certain information that multiemployer pension plans are also now required to report on Form 5500, such as employers contributing more than 5% of total contributions; information on amortization extensions and the plan's funded status; the number of participants with no contributing employer; the number of contributing employers; and the number of employers that withdrew during the plan year and related withdrawal liability.

For plan years ending December 31, 2010, the deadline for providing the summary plan information is August 30, 2011. However, if the filing deadline for a plan's Form 5500 is extended, the deadline to provide the summary plan information is also extended by two months.

Medicare Part D Deadlines

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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 CMS 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.

Form 5500 Filing Deadline for Calendar-Year Plans With Extensions

If a plan administrator filed Form 5558 with the Internal Revenue Service (IRS) on or before July 31, 2011 for a calendar-year plan, the plan's Form 5500 filing deadline is extended to October 15, 2011. The plan sponsor does not need to attach a copy of Form 5558 to the annual return under EFAST2. However, the plan sponsor must keep a copy of the Form 5558 that was filed with the IRS in the plan's records.

ERRP Claims List Submission

Plans that participate in the Early Retiree Reinsurance Program (ERRP) that requested reimbursement before April 2011 and that have subsequently received reimbursement, must submit an error-free claims list with a reimbursement request before December 31, 2011, substantiating the amount that was reimbursed. If a plan fails to submit the claims list, the Department of Health and Human Services (HHS) will consider the previously reimbursed amount to be unsubstantiated and will initiate the process to recoup that money from the plan.

RETIREMENT PLAN DEVELOPMENTS

Department of Labor Finds that PTE 86-128 Applies to "Investment Advice" Fiduciaries

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In Advisory Opinion 2011-08A, the Department of Labor (DOL) concluded that the prohibited transaction exemption (PTE) under Class PTE 86-128 applies to "investment advice" fiduciaries. Class PTE 86-128 provides relief from the prohibited transaction restrictions of Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (Code) for fees paid to a plan fiduciary for executing securities transactions for the plan. Specifically, Class PTE 86-128 allows a plan fiduciary or an affiliate to engage in a securities transaction for a fee as an agent on behalf of the plan.

Class PTE 86-128 does not define "fiduciary" for purposes of the exemption. However, the DOL noted that the definition of "fiduciary" in ERISA section 3(21)(A) provides guidance on the scope of the term. Based on this definition of "fiduciary," the DOL concluded that Class PTE 86-128 is available to any fiduciary within the meaning of ERISA section 3(21)(A), including those fiduciaries who provide only investment advice.

DOL Extends Compliance Dates for Fee Disclosures

The DOL issued a final rule that delays the deadline for participant and service provider fee disclosures.

As background, the participant fee disclosure regulations apply for plan years beginning on or after November 1, 2011. The regulations include a "60-day transition rule" under which plan administrators can provide initial annual notices to participants no later than 60 days after the first plan year beginning on or after November 1, 2011.

The final rule modifies the 60-day transition rule by providing that the initial annual notices must be distributed to participants by the later of: (1) May 31, 2012; or (2) 60 days after the first day of the first plan year starting on or after November 1, 2011. Thus, a calendar-year plan must distribute the initial annual notice by May 31, 2012.

The final rule also expands the 60-day transition rule to the initial quarterly notices. Now, the initial quarterly notices must be distributed to participants within 45 days after the end of the quarter in which the initial annual notices were required. Thus, a calendar-year plan must provide the initial quarterly notice by August 14, 2012.

Finally, under the regulations, service providers are required to provide plans with information about the service provider's direct and indirect compensation. Under

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the final rule, service providers are not required to provide this information until April 1, 2012.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Departments Issue Amendment to Preventive Care Regulations and Updated Preventive Care Guidelines

The DOL, IRS and the HHS issued an amendment to the Patient Protection and Affordable Care Act (PPACA) Preventive Care regulations allowing an exemption from certain guidelines for religious employers. In addition, HHS also approved of the preventive care services guidelines recommended by the Health Resources and Services Administration (the task force mandated to determine which preventive care services should be covered for women).

Under PPACA, nongrandfathered plans must provide coverage for certain listed preventive care services without imposing any cost-sharing requirement. The regulations provide a list of which preventive care services a non-grandfathered plan must cover (the list can also be found here.) In addition, the regulations note that plans must cover newly issued recommendations and guidelines for the first plan year beginning on or after the date that is one year after the date the recommendation or guideline was issued.

The amendment to the regulations allows the Health Resources and Services Administration to exempt certain religious employers from the guidelines where contraceptive services are concerned. Under the amendment, a religious employer is one that "(1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization" that is a church, a church's integrated auxiliaries, conventions or associations of churches, or the exclusively religious activities of any religious order.

The amendment was in response to the following recommended guidelines for women's preventive care services that HHS adopted:

- well-woman visits (annual);
- screening for gestational diabetes (pregnant women in their 24th and 28th weeks and first prenatal visit for high-risk women);
- human papillomavirus (HPV) DNA testing for women age 30 years and older (no more frequently than every three years);
- sexually transmitted infection counseling (annual);

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- human immunodeficiency virus (HIV) screening and counseling (annual);
- FDA-approved contraception methods and contraceptive counseling (as prescribed);
- breastfeeding support, supplies, and counseling (in conjunction with each birth); and
- domestic violence screening and counseling (annual).

Non-grandfathered plans must cover these services without any cost sharing for the first plan year beginning on or after August 1, 2012. Grandfathered plans are not required to cover preventive care services without cost sharing until they lose their grandfathered status.

Sixth Circuit Court of Appeals Finds Health Care Reform's Individual Mandate Constitutional

In the first court of appeals decision on the PPACA, the Sixth Circuit Court of Appeals upheld the constitutionality of the individual mandate provisions of PPACA. These provisions require most individuals to have health coverage beginning January 1, 2014 or pay a penalty. *Thomas Moore Law Ctr. v. Obama*, 2011 WL 2556039 (6th Cir. 2011).

The district court had upheld the individual mandate on the following two independent grounds under the Commerce Clause of the Constitution: (1) that it regulates economic activity that substantially affects the interstate health care market; and (2) that it is essential to Congress' larger regulation of the interstate insurance market. The Sixth Circuit Court of Appeals affirmed the district court's decision on both grounds.

The Fourth Circuit Court of Appeals and the Eleventh Circuit Court of Appeals are also reviewing the constitutionality of PPACA's individual mandate. The constitutionality of the individual mandate is expected to be ultimately addressed by the U.S. Supreme Court.

HHS Issues Updated Guidance on the ERRP

HHS has recently issued new official and unofficial guidance on various aspects of the ERRP, including use of ERRP proceeds; documenting and reporting price adjustments; and notice requirements. In addition, HHS noted that as of June 10, 2011, ERRP has disbursed $2.7 billion from the appropriated $5 billion.

Use of ERRP Proceeds

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The PPACA and the corresponding ERRP guidance states that ERRP proceeds can be used only to reduce health benefit costs or health benefit premiums (collectively, "Health Benefit Costs") for the plan; to reduce premium contributions, co-payments, deductibles, coinsurance or other out-of-pocket costs for plan participants; or a combination of the two.

However, PPACA states that ERRP proceeds cannot be used as general revenues for the plan. The ERRP regulations also state that, to show that they were not using ERRP proceeds as general revenue, plans must maintain the same level of contribution to the plan as they did before participating in ERRP (the "Maintenance of Contribution" requirement).

Accordingly, provided that plans do not use the ERRP proceeds as general revenue, it appears that they can use ERRP proceeds in any way they see fit to reduce Health Benefit Costs for the plan or reduce premiums, co-pays, deductibles or other out-of-pocket costs for plan participants.

HHS has not described how plans are to document their use of ERRP proceeds. However, on July 20, 2011, HHS issued official guidance describing how plans will comply with the prohibition on using ERRP proceeds as general revenue.

Generally, plans must determine the amount they spent on Health Benefit Costs during a "Baseline Period" that occurred just before the plan began participating in ERRP. Plans must then compare the amount they spend on (or allocate for) Health Benefit Costs in each year in which the Maintenance of Contribution requirement applies with the amount spent in that Baseline Period. Plans must spend (or allocate) at least as much in each year the Maintenance of Contribution requirement applies as they did during the Baseline Period. The Maintenance of Contribution requirement applies to each year for which a plan received ERRP proceeds, each plan year in which a plan receives ERRP proceeds, and any plan year in which a plan still possesses ERRP proceeds.

Allocating Post-Point-of-Sale Negotiated Price Concessions

The PPACA requires all ERRP plans to take into account any post-point-of-sale negotiated price concessions obtained by the plan with respect to any health benefit. HHS recently issued guidance describing how plans are to allocate such post-point-of-sale negotiated price concessions among their early retirees.

Generally, plans must disclose the post-point-of-sale negotiated price concessions they have already received, those they expect to receive, and those they actually

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receive. When a plan knows the specific early retiree to which a price concession applies, the plan must apply the price concession to that early retiree. However, if the plan does not know which early retiree to apply the price concession to, the guidance allows plans to estimate the amount of price concessions the plan expects to receive, formulate a "Master Percentage," and then allocate the Master Percentage among all early retirees.

HHS also clarified that if a plan has early retirees who also qualify for reimbursement under Medicare's Retiree Drug Subsidy (RDS) program, the plan must treat any RDS received as a price concession. While the individual who qualifies as an "early retiree" will not qualify for RDS, the early retiree's spouse, surviving spouse or dependent may qualify. Also, HHS notes that plans are not obligated to adjust RDS data because of ERRP proceeds or to report ERRP proceeds to CMS for purposes of adjusting RDS reimbursement.

Unofficial Guidance

HHS also issued a number of new "Common Questions" on the ERRP Website. Among other things, the unofficial guidance address the following:

- Notices. Plans must deliver the ERRP notice within a reasonable amount of time after the plan receives its first reimbursement, but are not required to deliver the notice to the same participants after subsequent reimbursements. Plans must, however, deliver the ERRP notice to new participants within a reasonable amount of time after they enroll in the plan. ERRP notices must be addressed to each individual family member who is a plan participant (*i.e.*, to the participant by name; to each non-minor family member who is or may be eligible to enroll by name; "and family").
- Use of ERRP Proceeds.
  - "Reduce" means to directly subsidize; plans cannot use ERRP proceeds to implement cost savings or wellness programs, as these uses are not "reducing" Health Benefit Costs.
  - Plans can use ERRP proceeds received for one plan on permissible purposes for a second plan, provided both plans are ERRP-approved.
  - Plans can use ERRP proceeds to purchase stop-loss coverage.
  - Plans can deposit or allocate ERRP proceeds to an early retiree's HRA, provided the plans ensure the ERRP proceeds are used only to reduce the early retiree's Health Benefit Costs.
- Early Retirees. An individual does not have to be retired to be included as an early retiree, provided the individual meets the definition of "early retiree" (i.e.,

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over age 55, not eligible for Medicare, and not an active employee).
- Claims Lists. Plans must report only post-point-of-sale negotiated price concessions. Plans are not required to report any price concessions received at the point of sale.

IRS Requests Comments on Annual Fees Under Health Care Reform

In IRS Notice 2011-35, the IRS requested comments about the annual fees to be imposed on health insurers and employers who sponsor self-funded group health plans to fund the new Patient-Centered Outcomes Research Trust Fund (the Trust).

Under PPACA, the Trust was established to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. PPACA provides that the Trust will be funded in part by fees paid by issuers of health insurance policies and sponsors of self-insured health plans. These fees are imposed for plan and policy years ending on or after October 1, 2012.

In IRS Notice 2011-35, the IRS invited comments on how the fees should be determined and paid as well as possible rules and safe harbors. The IRS intends to publish proposed regulations to implement and provide guidance on the statutory requirements for issuers and plan sponsors that pay these fees.

Comments are due by September 6, 2011.

HHS Issues Proposed Regulations for State Exchanges and Reinsurance and Risk Standards

The Department of Health and Human Services (HHS) released proposed regulations, along with fact sheets and summaries, that set basic standards and provide information to assist states in setting up health insurance exchanges under PPACA.

As background, PPACA requires states to set up exchanges, which are state-based competitive health insurance marketplaces through which individuals and small businesses can purchase private health insurance. The deadline for states to establish exchanges is 2014.

Among other things, the proposed regulations address the following:

- Standards for Establishment of Exchanges. The proposed regulations allow a

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state to structure the exchange as either a nonprofit, an independent public agency, or as part of an existing state agency. In addition, a state can choose to operate a regional exchange in collaboration with other states or establish subsidiary exchanges within a state.

- Functions of Exchanges. Exchanges will perform various functions, such as certifying health plans as Qualified Health Plans (QHPs) to be offered in the exchange, operating a website to facilitate comparisons among QHPs for consumers, and facilitating enrollment of consumers in QHPs.
- HHS Approval Process. Under the proposed regulations, exchanges must be approved by HHS no later than January 1, 2013. If a state does not obtain HHS approval, a federally facilitated exchange would be implemented in 2014.
- Initial Enrollment Period. The initial open enrollment period would extend from October 1, 2013 through February 28, 2014. Only those who enroll before December 22, 2013 would be ensured coverage effective January 1, 2014.
- QHP Certification. To be certified as a QHP, a health plan would be required to meet minimum standards under the proposed regulations. Exchanges would be required to establish procedures for certification, recertification and decertification of QHPs.
- Small Business Health Options Program (SHOP). Each exchange must operate a SHOP beginning in 2014. A SHOP is a program that is intended to give small employers and their employees the same purchasing power that larger employers typically have and allow them to offer employees a choice of plans. The proposed regulations would provide a small business tax credit for up to 50% of contributions a small business made toward employees' premiums if certain conditions are met.
- Guidelines on Reinsurance and Risk. Separate proposed regulations provide standards for certain programs required by PPACA that are intended to mitigate the impact of adverse selection and stabilize premiums in the individual and small group markets. The proposed regulations would establish three programs, effective in 2014: a temporary reinsurance program and risk corridor program, and an ongoing risk adjustment program.

Court Holds Volvo Could Not Make Unilateral Changes to Retiree Health Care Benefits

The Fourth Circuit Court of Appeals affirmed a district court's decision to enjoin Volvo Group North America, Inc. (Volvo) from making unilateral changes to retiree health benefits after a collective bargaining agreement (CBA) expired unless it followed the CBA's requirements. The CBA prevented Volvo from changing retiree

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health benefits until a $3.9 million Voluntary Employees Beneficiary Association (VEBA) trust that was used to pay health benefit costs exceeding certain stated annual limits was projected to be exhausted within a one-year period. The CBA also required Volvo to negotiate with the retirees' union to bring down costs. If these negotiations were unsuccessful, then Volvo could make certain limited changes to benefits.

The court held that none of the CBA's conditions were satisfied when Volvo modified the retiree health benefits. The court also found that the CBA's cost provision contemplated that the requirement would remain in effect past the CBA's expiration. The court stated that the CBA's cost provision operates as a limit on Volvo's right to modify benefits beyond the term of the CBA, based in part on the fact that it did not contain any durational limiting language.

GENERAL DEVELOPMENTS

GASB Proposes Changes to Public Pension Plan Accounting

The Governmental Accounting Standards Board (GASB) proposed changes to how state and local governments report and account for the pension benefits provided to their employees.

The proposal would require public pension funds that are not adequately funded to lower their projected rate of return on investments to a more conservative 30-year municipal bond index rate, which is generally around 3 to 4%. However, adequately funded public pension funds could continue to project rates based on what they have historically received, which is around 8% for most funds.

In addition, when computing total pension liability, the proposal would require a public pension fund to immediately recognize more components of pension expenses. For example, a public pension fund would be required to include the effect on the pension liability of changes in benefit terms immediately. Currently, a public pension fund can defer and amortize actuarial gains and losses over as many as 30 years. The proposal would also require public pension funds to present more extensive note disclosures and required supplementary information.

Final rules are expected by July 2012.

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