August 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

New Participant Fee Disclosures Due August 30, 2012

Plan administrators of defined contribution plans that permit participant direction of investments must provide a new fee disclosure to plan participants by August 30, 2012. These disclosures will provide participants with detailed plan expense and investment information. For more information on these disclosure requirements, see our articles on the final regulations and recent FAQs in the November 2010 and June 2012 Employee Benefits Updates.

New Summary of Benefits and Coverage Required for Open Enrollment

Beginning with a group health plan's first open enrollment period on or after September 23, 2012, plan sponsors are required to issue a new summary of benefits and coverage (SBC) to participants or beneficiaries covered under the plan. For more information on the FAQs issued by the Department of Labor (DOL), Health and Human Services (HHS) and the Internal Revenue Service (IRS) regarding SBC, see our article in the July 2012 Employee Benefits Update. Group health plan sponsors should also review open enrollment materials to confirm that they have been updated for any other legal or design changes.

DOL Issues Updated Self-Compliance Tool

Now that the Supreme Court has upheld the Patient Protection and Affordable Care Act (PPACA), plan sponsors who took the "wait and see" approach must now comply with PPACA. The Department of Labor (DOL) has updated its self-compliance tool for group health plans with pertinent provisions of PPACA, the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA) and Mental Parity and Addiction Equity Act (MHPAEA) to assist plan sponsors with the task of bringing their plans up-to-date.

RETIREMENT PLAN DEVELOPMENTS

IRS Issues FAQs on Notice Requirements for Benefit Restrictions for Single-Employer Defined Benefit Plans

The Internal Revenue Service (IRS) has issued new guidance regarding the notices required by Section 101(j) of the Employee Retirement Income Security Act of

1974 (ERISA) in FAQ format. ERISA Section 101(j) requires single-employer defined benefit plans subject to certain funding-based benefit restrictions to send notices to participants and beneficiaries.

ERISA Section 101(j) notices must be furnished after a plan becomes subject to the benefit restrictions relating to unpredictable contingent event benefits and prohibited payments (found in ERISA Sections 206(g)(1) and (3)) once the plan's adjusted funding target attainment percentage (AFTAP) drops below certain levels. The ERISA Section 101(j) notice must be furnished within 30 days after the plan's AFTAP has been certified or presumed to be below the prescribed level.

The guidance also elaborates on the interaction between the ERISA Section 101(j) notice rules and the Section 204(h) notice rules. If a plan is amended to cease future benefit accruals independent of the funding-based benefit restriction, the plan must furnish a 204(h) notice only; however, a 101(j) notice may be required if the plan also provides for and is unable to pay either unpredictable contingent event benefits or prohibited payments due to the funding-based benefit restriction. Section 101(j) notices must be provided to all participants who could have been eligible for unpredictable contingent event benefits or prohibited payments at the time the funding level dropped below the threshold. The notices must be in writing and furnished in paper or electronic form in accordance with IRS or DOL regulations.

IRS Notice 2012-46 becomes effective on November 1, 2012. In the meantime, plan administrators may rely on the provisions in Notice 2012-46, or apply a reasonable interpretation of ERISA Section 101(j).

IRS Issues FAQs Regarding Medicare Tax Increase Effective January 1, 2013

The IRS has issued a set of FAQs providing guidance on the Medicare tax increase, which was enacted as part of PPACA, for taxable years beginning after December 31, 2012. Effective January 1, 2013, the Medicare tax will increase by 0.9%. The increase applies to the same wages that are currently subject to the Medicare tax.

Employers are required to withhold Medicare Tax from an employee's wages that are in excess of the tax threshold ($200,000) even if the employee is married and his/her salary combined with his/her spouse's does not exceed the higher threshold for married couples filing jointly ($250,000). However, employers are not required to "match" the amount of the tax increase as they are with the regular Medicare tax. In addition, employers should continue to calculate wages for the purposes of withholding from nonqualified deferred compensation for the

Medicare tax increase in the same manner (see section 29 C.F.R. §31.3121(v)(2)-1(a)(2)).

DOL Issues Revised Guidance Regarding Participant-Level Fee Disclosures

The DOL has issued revised guidance clarifying certain aspects of the participant-level fee disclosures now required under ERISA sections 404(a) and 408(b)(2), and pertinent DOL regulations. The DOL released Field Assistance Bulletin (FAB) 2012-02R, on July 30, 2012, which supersedes and revises FAB 2012-02, released May 7, 2012. Both the old and the new guidance are in question-and-answer form. The only change made by the new guidance is a revised answer to the question pertaining to plans offering self-directed brokerage accounts, and whether these constitute "designated investment alternatives" subject to the Section 404(a) disclosure rules.

In the prior guidance, the DOL created an obligation on plan fiduciaries to determine whether an investment selected by a significant number of participants through the brokerage window constitutes a designated investment alternative for the purpose of disclosure. In the new FAB, the DOL changed its position on this issue, clarifying that a self-directed brokerage window does not constitute a designated investment alternative unless specifically designated as such by the plan. The new guidance also states that plans are not required to offer a certain number of designated investment alternatives, nor are they prohibited from using self-directed brokerage windows. However, the DOL continues to take the position that plans offering self-directed brokerage windows or other non-designated investment alternatives are bound by duties of prudence and loyalty required by Section 404(a) to their participants, and must take into account the nature and quality of services offered by the non-designated investment platform.

DOL Revises Mailing Address and Electronic Filing Method for Plan Fiduciaries to Report Disclosure Failures by Covered Service Providers

The DOL revised the mailing address and electronic filing method to be used by plan fiduciaries to file notices with the Employee Benefits Security Administration (EBSA) regarding disclosure failures by covered service providers. Covered service providers, as defined by ERISA section 408(b)(2) and related DOL regulations, must make certain disclosures to plan fiduciaries under ERISA section 408(b)(2). If they fail to do so, plan fiduciaries are obligated to make written requests to the service providers for the undisclosed information. If the covered service providers do not comply within 90 days of the date of the written request, the plan fiduciary

must notify EBSA.

These notices may be provided by mail to: *U.S. Department of Labor Employee Benefits Security Administration Office of Enforcement P.O. Box 75296 Washington, D.C. 20013*

Electronic filing of the notice can be made through a dedicated link on DOL's website. The link will contain instructions for making the filing and provide immediate confirmation to plan fiduciaries that the notice has been received by the DOL.

The DOL is soliciting comments on these rules until August 15, 2012. The rules can be found in the Federal Register.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Issues Audit Protocol for HIPAA Compliance as Mandated by HITECH Act

The Health Information Technology for Economy and Clinical Health (HITECH) Act requires the Department of Health and Human Services (HHS) to audit entities covered under HIPAA to ensure that they are in compliance with HIPAA's privacy, security and breach notification rules. HHS's Office of Civil Rights (OCR) has posted on its website a comprehensive audit protocol. In all, OCR will audit 115 covered entities. Its first round of 20 audits was completed in March 2012; OCR plans to complete the remaining 95 audits by December 2012. The audit protocol covers three aspects of HIPAA's requirements regarding the safeguarding of protected health information (PHI). First, the audit protocol covers the following seven requirements of HIPAA's Privacy Rule: (1) notice of privacy practices for PHI, (2) rights to request privacy protection for PHI, (3) access of individuals to PHI, (4) administrative requirements, (5) uses and disclosures of PHI, (6) amendment of PHI, and (7) accounting of disclosures. Second, the audit protocol requires investigation into the covered entity's compliance with HIPAA's Security Rule for administrative, physical and technical safeguards. Third, the audit protocol will examine compliance with HIPAA's Breach Notification Rules. The new audit protocol can be found on HHS's website.

REINHART COMMENT: The audit protocol may be useful for entities to self-assess compliance with HIPAA's privacy, security and breach notification requirements. Reviewing the protocol may also be beneficial in the event of a future audit.

HHS Releases Additional FAQs on Medical Loss Ratio Requirements

HHS has issued additional guidance in the form of questions and answers regarding medical loss ratio (MLR) reporting and rebate requirements, as last discussed in the May 2012 and June 2012 EB Updates. The Centers for Medicare and Medicaid Services (CMS) released guidance (CCIIO Technical Guidance 2012-0005) providing answers on three noteworthy topics: notices of MLR rebates, notices of MLR information and the definition of "plan document" under the pertinent regulations.

First, the FAQs provide that when members of a group health plan are entitled to an MLR rebate, the issuer must provide notice of the rebate to all subscribers enrolled in the group during the MLR reporting year, except those who are no longer enrolled at the time the notice is provided. The issuer may, but is not required to, include subscribers who are no longer enrolled in the group health plan but who were enrolled during the MLR reporting year. Second, the guidance also provides that an issuer whose MLR meets or exceeds the applicable standard may provide the one-time notice of MLR information under 45 C.F.R. Section 158.251 separately from other plan documents if it chooses to, as long as the MLR information is provided to enrollees prior to or concurrent with the first plan documents. Third, the guidance clarifies the definition of a "plan document" for purposes of 45 C.F.R. Section 158.251 as "a document pertaining to the plan or policy that is distributed to all policyholders in individual and group markets and all subscribers in group markets." Examples of plan documents, according to the guidance, include policies, summary plan descriptions, benefits summaries and group contracts.

The guidance can be found on CMS's website.

GENERAL DEVELOPMENTS

Federal Judge in Colorado Issues Temporary Injunction Against Birth Control Mandate

A judge in the U.S. District Court in Colorado has issued a temporary order barring enforcement of the provision in PPACA that requires group health plans to provide certain preventative care and screening services for women, including contraceptive services, at no cost. District Judge John L. Kane's order enjoins the government from enforcing the order against the plaintiffs for three months from the date of the order's issuance, July 27, 2012. The injunction was based on the ground that the mandate may violate the Religious Freedom Restoration Act of 1993 (RFRA). Because the RFRA was sufficient grounds for the injunction, Judge

Kane did not rule on the plaintiffs' challenges on First Amendment and other constitutional grounds.

It is important to note that the injunction applies only to the plaintiff, Hercules Industries Inc., (Hercules) a closely held Colorado corporation. Any other group health plan may be subject to enforcement action if it does not provide the applicable mandated coverage. Hercules, whose owners adhere to the Catholic faith, maintains a self-insured health plan. The owners of Hercules filed this suit because Hercules did not fulfill the criteria to obtain an exemption against the mandate on religious grounds. The mandate would have applied to Hercules on November 1, 2012. This is one of many challenges filed across the country against the contraception mandate.

REINHART COMMENT: We continue to monitor this and other cases around the country impacting the obligations to provide no-cost contraceptive coverage. In the absence of a binding court decision to the contrary, we caution employers to comply with this very high-profile mandate.

Federal Judge in Connecticut Strikes Down DOMA, Rules that Heightened Scrutiny Must Apply to Classifications Based on Sexual Orientation

District Judge Vanessa L. Bryant in the U.S. District Court in Connecticut has struck down Section 3 of the Defense of Marriage Act (DOMA) as unconstitutional under the Equal Protection Clause of the Fifth Amendment. Section 3 of DOMA defines marriage, for purposes of federal law, to be a legal union between one man and one woman, and defines spouse to be only a husband or wife of the opposite sex. The challenge to DOMA was filed by six same-sex couples legally married under the laws of three New England states who were denied federal benefits.

Judge Bryant also ruled that classifications based on sexual orientation should be subject to heightened scrutiny by courts, as homosexuals have historically faced the level of discrimination generally attributed to other classifications subject to heightened scrutiny, such as race and sex. However, Judge Bryant noted that DOMA is unconstitutional under even the lowest level of judicial scrutiny.

REINHART COMMENT: This is the second U.S. District Court within the Second Circuit to strike down Section 3 of DOMA, the first being the District Court in the Southern District of New York in early June. An appeal to the Second Circuit Court of Appeals is likely forthcoming. In all, the aforementioned two district courts within the Second Circuit, two California district courts, and the First Circuit Court of Appeals have struck down Section 3 of DOMA.