December 2012 Employee Benefits Update

POSTED:

Dec 16, 2012

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Cycle B Determination Letter Filings Due January 31, 2013

As noted in last month's Employee Benefits Update, the Remedial Amendment Period Cycle B individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2013. Cycle B plans include those sponsored by employers with tax identification numbers (EINs) ending in a two or a seven, as well as any multiple employer plans.

Year End Plan Amendments

In order to comply with IRS deadlines, discretionary plan amendments must be adopted by the last day of the plan year in which the change is effective (subject to anti-cutback rules that may require earlier adoption). Thus, plan sponsors of calendar year qualified benefit plans must amend their plans prior to the end of 2012 to reflect any discretionary plan amendments that took effect during the current calendar year. As further discussed later in this Update, the IRS has again extended the deadline for adopting an interim amendment with respect to Code section 436, and thus no amendment is required prior to the end of this calendar year.

RETIREMENT PLAN DEVELOPMENTS

PBGC Announces Section 4062(e) Enforcement Pilot Programs

On November 2, the Pension Benefit Guaranty Corporation (PBGC) announced that it is implementing a pilot program changing its enforcement approach with regard to ERISA section 4062(e). ERISA section 4062(e) requires employers with pension plans to report to the PBGC when they stop operations at a facility and employees lose their jobs. In such a case, 4062(e) requires the employer to provide financial security to protect the plan. As a result, the PBGC generally had required that employers make additional contributions or provide a financial guarantee. Under the new enforcement policy, the PBGC will not enforce section 4062(e) against small plans with 100 participants or less or against "creditworthy" employers. Instead, the PBGC will target its enforcement efforts at employers where the risk remains substantial. The PBGC stated that it will make this

determination based on common financial measures of financial soundness, such as credit ratings, credit scores, indebtedness, liquidity and profitability. As a result of this change in the PBGC enforcement policy, the PBGC estimates that 92% of companies that sponsor pension plans will not face enforcement efforts. Employers still must report 4062(e) events to the PBGC (using PBGC Form 4062-E).

IRS Permits Governmental Plans to Elect Cycle E

Under recently released Revenue Procedure 2012-50, the IRS announced it will allow individually-designed governmental plans to elect Cycle E (instead of Cycle C) as the plan's second remedial amendment cycle. The election is made by filing a determination letter application for the plan during the one-year submission period for the second Cycle E (February 1, 2015 through January 31, 2016). No election form or notice to the IRS is required. If the sponsor of an individually-designed governmental plan elects to file a determination letter application for the plan during the Cycle E submission period, all requirements for an individually-designed plan submitted for a determination letter during the Cycle E submission period are applicable to the sponsor's plan, including the requirement to amend the plan for all applicable items on the Cycle E Cumulative List and the requirement to timely adopt any interim amendments that are required for a governmental plan during Cycle C and Cycle D. For any subsequent remedial amendment cycle, the plan's cycle will revert to Cycle C. Sponsors of a governmental plan filing during the second Cycle E submission period will have their plan's second cycle determination letter expire at the end of the third Cycle C submission period (January 31, 2019).

IRS Again Extends Code Section 436 Amendment Deadline to December 31, 2013 (for Calendar Plan Years)

On November 21, 2012, the IRS issued Notice 2012-79 extending both the deadline to amend a plan to satisfy Internal Revenue Code (Code) section 436 and the period during which such an amendment is eligible for relief from the anti-cutback requirements of Code section 411(d)(6). Code section 436, as added by the Pension Protection Act of 2006, sets limits on benefit payments and pension accruals for defined benefit plans that are "underfunded." As discussed in the December 2011 Employee Benefits Update, the IRS previously issued Notice 2011-96 extending both the deadline to amend a plan to satisfy Code section 436 and the period during which such an amendment is eligible for relief from the anti-cutback requirements of Code section 411(d)(6).

The new Notice 2012-79 provides an additional extension on the amendment deadline. Pursuant to this Notice, the deadline for adopting an interim amendment with respect to Code section 436 has been extended to the latest of: (1) the last day of the first plan year that begins on or after January 1, 2013, (2) the last day of the plan year for which Code section 436 is first effective for the plan, or (3) the due date (including extensions) of the employer's tax return for the tax year that contains the first day of the plan year for which Code section 436 is first effective for the plan. However, in the case of an application for a determination letter for an individually designed plan that is filed on or after February 1, 2013, the restated plan that is submitted with the application must incorporate an interim amendment with respect to Code section 436. Individually-designed and pre-approved single employer defined benefit plans may adopt the sample amendment provided in Notice 2011-96. The notice also provides that a plan amendment adopted with respect to Code section 436 that eliminates or reduces a Code section 411(d)(6) protected benefit does not cause the plan to fail to meet the anti-cutback requirements of Code section 411(d)(6) if the amendment is adopted by the deadline described above and the elimination or reduction is made only to the extent necessary to enable the plan to meet the requirements of Code section 436.

Furthermore, like the previous guidance extending the amendment deadline, the new extension also provides that a plan amendment adopted with respect to Code section 436 that eliminates or reduces a Code section 411(d)(6) protected benefit does not cause a plan to fail to meet the anti-cutback requirements of Code section 411(d)(6) if the amendment is adopted by the extended deadline and the elimination or reduction is made only to the extent necessary to enable the plan to meet the requirements of Code section 436.

IRS Issues Final Regulations Amending the Prohibited Payment Option Under Single-

Employer Defined Benefit Plan of Plan Sponsor in Bankruptcy The IRS issued final regulations providing a limited exception to the anti-cutback rules under Code section 411(d)(6) for a plan sponsor that is a debtor in a bankruptcy proceeding. The anti-cutback rules generally prohibit amendments to qualified retirement plans that reduce or eliminate accrued benefits, early retirement benefits, retirement-type subsidies or optional forms of benefits. The final regulations would allow a plan sponsor who is a debtor in bankruptcy to amend its plan to eliminate a lump sum distribution option or other optional form of benefit providing for accelerated payments if certain requirements are satisfied.

The final regulations permit amendments to eliminate an optional form of benefit that includes a prohibited payment described under Code section 436(d)(5) if the following four conditions are satisfied on the later of the date the amendment is adopted or effective: (1) the plan's enrolled actuary certifies that the plan's adjusted funding target attainment percentage is less than 100%, (2) the plan is not permitted to make prohibited payments because the plan sponsor is a debtor in a bankruptcy case, (3) the bankruptcy court (after a notice to each affected party and hearing) issues an order that the amendment is necessary to avoid a distress or involuntary plan termination, and (4) the PBGC has issued a determination that the amendment is necessary to avoid a distress or involuntary plan termination and that the plan is not sufficient to guaranty benefits. The final regulations apply to plan amendments that are adopted and effective after November 8, 2012.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Supreme Court Ruling Allows New Challenge to Affordable Care Act to Proceed

The Supreme Court granted a petition for rehearing in Liberty University v. Geithner, requiring the Fourth Circuit Court of Appeals to consider the plaintiff's challenge of certain aspects of the Patient Protection and Affordable Care Act (PPACA). The Fourth Circuit had originally ruled that the plaintiff's suit sought to strike down the individual mandate before it took effect was in violation of the Anti-Injunction Act, which prohibits cases seeking to restrain the collection or assessment of taxes, and must be dismissed. As a result of the remand by the Supreme Court, the Fourth Circuit will have to consider Liberty University's argument, among other claims, that PPACA's minimum coverage requirements violate the free exercise of religion clause in the First Amendment and the Religious Freedom Restoration Act.

Obama Administration Extends Deadline for State Exchanges

States intending to run their own exchanges for 2014 are required to submit an "exchange blueprint" to the Secretary of Health and Human Services. On November 9, 2012, the Department of Health and Human Services (HHS) issued an FAQ extending the deadline for the state-based exchange blueprint applications to Friday, December 14, 2012. States planning on partnering with the federal government to build exchanges (state partnership exchanges) have until Friday, February 15, 2013, to submit a declaration letter and blueprint application.

New Guidance Released on Wellness Programs

The Department of Health and Human Services, Department of Labor and the IRS jointly released proposed amendments to regulations, consistent with PPACA, regarding nondiscriminatory wellness programs in group health coverage. Generally, group health plans and group health insurance issuers are prohibited from discriminating against individual participants and beneficiaries in eligibility, benefits or premiums based on a health factor. An exception to the general rule allows premium discounts or rebates or modification to otherwise applicable cost sharing (including copayments, deductibles or coinsurance) in return for adherence to certain programs of health promotion and disease prevention, subject to compliance with a number of conditions and limitations.

These regulations generally propose standards for group health plans and health insurance issuers offering group health insurance coverage with respect to wellness programs. Consistent with the wellness program provisions of prior regulations issued in 2006, these proposed regulations generally would maintain the five requirements for health-contingent wellness programs with one significant modification relating to the size of the reward. In addition, the proposed regulations provide several clarifications of the prior 2006 regulations and changes intending to be consistent with the amendments made by PPACA. Specifically, these proposed regulations would increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20% to 30% of the cost of coverage. The proposed regulations would further increase the maximum permissible reward to 50% for wellness programs designed to prevent or reduce tobacco use. These regulations also include other proposed clarifications regarding the reasonable design of health-contingent wellness programs and the reasonable alternatives they must offer in order to avoid prohibited discrimination.

These proposed regulations would replace the wellness program provisions of prior regulations issued in 2006 and would apply to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after January 1, 2014.

Center for Medicare and Medicaid Services (CMS) Release Health Insurance Market Reform Rules

CMS has released a proposed rule to implement several health market reform

rules of PPACA. The proposed health insurance market reform regulations provide new rating parameters for health insurance premiums, extend guaranteed availability (also known as guaranteed issue) protections to the individual market, continue current guaranteed renewability protections, prohibit issuers from dividing up their insurance pools, and clarify the approach used to enforce the applicable requirements of the Affordable Care Act with respect to issuers and group health plans that are non-federal governmental plans. In addition, the new health insurance market reform rules provide coverage and enrollment guidelines for catastrophic plans. More specifically, some of the major provisions of the proposed rules are:

- Health Insurance Premiums. The proposed regulations require issuers offering nongrandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Affordable Insurance Exchange (Exchange) starting in 2017, to limit any variation in premiums based on a limited set of specific factors. The factors relate to, with respect to a particular plan or coverage, age and tobacco use within limits, family size and geography. The proposed rule prohibits the use of other rating factors such as health status, medical history, gender and industry of employment to set premium rates. Other factors that might be considered for rating purposes, such as eligibility for tax credits, prior source of coverage and credit worthiness, also are prohibited.

- Guaranteed Availability of Coverage. The proposed regulations provide that issuers offering non-grandfathered health insurance coverage must accept every individual or employer who applies for coverage in the individual or group market, as applicable, subject to certain exceptions (for example, limits on network capacity). These exceptions allow issuers to limit enrollment: (1) to certain open and special enrollment periods, (2) to an employer's eligible individuals who live, work or reside in the service area of a network plan, and (3) in certain situations involving network capacity and financial capacity. In addition, individuals would have new special enrollment rights in the individual market when they experience certain losses of other coverage.

- Guaranteed Renewability of Coverage. The proposed regulations direct that any health insurance issuer offering health insurance coverage in the individual or group market must renew all coverage at the option of the plan sponsor or individual, subject to certain exceptions (for example, nonpayment of premiums or fraud).

- Single Risk Pool. The proposed regulations generally would require health insurance issuers to treat all of their non-grandfathered business in the individual market and small group market, respectively, as a single risk pool. This requirement applies to health plans both inside and outside of an Exchange for both markets. A state would have the authority to choose to direct issuers to merge their nongrandfathered individual and small group pools into a combined pool.

These provisions would generally apply to non-grandfathered health insurance coverage in the individual and small group markets for plan years (group market) and policy years (individual market) starting on or after January 1, 2014, and the large group market, if such coverage is available through the Exchange, for plan years and policy years starting on or after January 1, 2017. The proposed rule can be found at the CMS website.

HHS Releases Proposed Rule Relating to Essential Health Benefits Actuarial Value and Accreditation Standards

On November 20, 2012, the HHS published a proposed rule outlining health insurance issuer standards related to the coverage of essential health benefits (EHB) and the determination of actuarial value (AV). Additionally, the rule proposes a timeline for when issuers offering coverage in a federally-facilitated Exchange or State Partnership Exchange must become accredited. The rule also proposes an application process for accrediting entities seeking to be recognized to fulfill the accreditation requirements for issuers offering coverage in any Exchange.

- Essential Health Benefits - Benchmark Plan Options. PPACA requires that health plans offered in the individual and small group markets cover a core package of items and services (referred to as EHB.) EHB include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs and maternity and newborn care, and are equal in scope to a typical employer health plan. To meet the requirement in PPACA that EHB be equal in scope to benefits offered by a "typical employer plan," the proposed rule defines EHB based on a state-specific benchmark plan, including the largest small group health plan in the state. The rule proposes that states select a benchmark plan from among several options identified in the proposed rule, and that all plans that cover EHB must offer benefits that are substantially equal to the benefits offered by the benchmark plan. The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products in the state's

small group market, (2) any of the three largest state employee health benefit plans options by enrollment, (3) any of the three largest national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment, or (4) the largest insured commercial Health Maintenance Organization in the state. The proposed rule also clarifies that in the event a state does not make a selection, HHS will select as the default benchmark the largest small group product in the state, as described in option (1).

- Actuarial Value. PPACA provides that non-grandfathered individual and small group plans, both inside and outside of the Exchanges, will be offered at certain specific AV targets (or metal levels): 60% for a bronze plan, 70% for a silver plan, 80% for a gold plan and 90% for a platinum plan. AVs are calculated based on the provision of EHB to a standard population. Under the proposed regulations, HHS has proposed the use of an AV calculator to determine levels of coverage for non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside the Exchanges. The proposed rule includes standards and considerations for plans with benefit designs that the AV calculator cannot easily accommodate. Consumer-driven health plans, such as high-deductible health plans and health savings accounts, are compatible with the AV calculator. The proposed AV calculator is posted on the CMS website.

- Accreditation Standards. PPACA requires that qualified health plans (QHPs) must secure accreditation on the basis of local performance from recognized accrediting entities, on a timeline established by each Exchange that certifies the QHP. The new rule proposes a timeline for the accreditation requirement for issuers offering qualified health plans in a federally-facilitated Exchange or state partnership Exchange, and provides an application process for additional accrediting entities to be recognized for the purposes of providing accreditation to fulfill the requirements for QHP certification.