February 2013 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Cycle C Submission Period Opened February 1, 2013

Effective February 1, 2013, the Internal Revenue Service (IRS) began accepting determination letter applications from remedial amendment period Cycle C individually designed plans. In general, Cycle C plans must be submitted for a determination letter no later than January 31, 2014 to rely on the extended period during which qualification amendments may be retroactively adopted. Cycle C plans include those sponsored by employers with EINs ending in a "3" or an "8".

Annual Funding Notice Due April 30, 2013

All defined benefit plans must provide the 2012 Annual Funding Notice to plan participants, beneficiaries, labor organizations representing participants and beneficiaries (if applicable), contributing employers and the Pension Benefit Guarantee Corporation (PBGC) (if the plan has more than 100 participants) no later than April 30, 2013.

New Business Associate Agreements Must Comply with New HIPAA Regulations by September 23, 2013

All business associate agreements entered into after January 25, 2013 must comply with newly issued Health Insurance Portability and Accountability Act (HIPAA) regulations by September 23, 2013. For more information regarding changes required to business associate agreements, please see our expanded HIPAA guidance section below.

RETIREMENT PLAN DEVELOPMENTS

PBGC Releases Update Addressing Waivers and Missed Contributions

On January 30, 2013, the PBGC issued Technical Update 13-1 (the Update.) The Update addresses interim guidance regarding funding-related determinations for purposes of waivers, extensions and the advanced threshold test as well as the small-plan waiver for missed quarterly contributions. In general, the Update provides that, for plan years beginning after 2012, a plan's unfunded vested benefits and the value of its assets and vested benefits are determined in the same manner as for variable-rate premiums for the preceding plan year.

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Additionally, the Update provides that for plan years beginning after 2012, the section 4043.25 reporting requirement for missed quarterly contributions is waived if the contribution was missed for reasons other than financial inability to make the contribution and either (1) the plan had fewer than 25 participants for the preceding plan year, or (2) the plan had between 25 and 100 participants during the preceding plan year and a simplified notice is filed with PBGC by the time the first missed quarterly reportable event report not timely made for the current year would otherwise be due.

IRS Releases New Rules for Correcting Plan Errors Through EPCRS

The IRS has released Revenue Procedure 2013-12 updating the Employee Plans Compliance Resolution System (EPCRS). Changes to the EPCRS program clarify and streamline the correction for many operational and plan document errors. Additionally, the IRS has released standardized forms for use in submitting plan corrections. The changes to EPCRS take effect on April 1, 2013. However, plan sponsors are able to begin using the new forms immediately, if desired.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Issues Updated Regulations Under HIPAA and HITECH

On January 25, 2013, the Department of Health and Human Services (HHS) released final regulations implementing provisions of the Health Insurance Technology for Economic and Clinical Health Act (HITECH) under HIPAA. Covered entities generally must comply with the new rules by September 23, 2013. As discussed in more detail below, covered entities should begin the process of making changes to comply with the new rules, including:

- Updating their HIPAA policies and procedures;
- Updating their existing Notice of Privacy Practices;
- Updating existing business associate agreements. There is a transition rule extending the deadline to update existing business associate agreements (meaning executed before January 23, 2013) to September 23, 2014;
- Reviewing whether a business associate agreement is now required with entities not previously considered business associates; and
- Revising notice requirements in privacy, security and breach notification procedures.

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Business Associates. The final regulations expand the definition of "business associate" to include any entity that creates, receives, maintains or transmits protected health information (PHI) on behalf of a covered entity or an organized health care arrangement. Specifically, the new definition includes health information organizations, e-prescription gateways, entities that provide data transmission services and require routine access to the PHI, and persons offering personal health records to individuals on behalf of covered entities. Importantly, the new rule maintains the proposed rule's extension of "business associate" to downstream subcontractors of any business associate. As with the earlier proposed rule, the final rule maintains the "conduit" exception for entities that merely transport PHI, but do not have access to PHI on a regular basis.

The final regulations also finalize rules for making business associates directly liable for HIPAA compliance and incorporate the increased and tiered civil penalty structure adopted by HITECH. However, the rule also clarifies that a covered entity will be liable for a business associate's breach if the business associate was acting as agent for the covered entity.

Notification of Breach. The new rules expand the definition of "breach" to clarify that an impermissible use or disclosure of PHI is assumed to be a breach unless the disclosing entity demonstrates that there is a low probability that PHI has been compromised or that an exception applies. Additionally, the new rules remove the actual harm standard, focusing instead on the mere risk that PHI has been compromised. Finally, the new rules remove the exception for limited data sets that do not include dates of birth and ZIP codes; the use or disclosure of any limited data set could trigger notification. The impact of these changes means that covered entities may encounter more situations for which a notice is required. Factors to consider when making a determination whether to provide notification include:

- The nature and extent of the PHI involved, including the types of identifiers and the possibility that an individual could be re-identified;
- The identity of the person or entity who made the unauthorized disclosure or to whom the disclosure was made;
- Whether PHI was actually acquired or viewed;
- The extent to which the risk to PHI has been mitigated; and
- Other appropriate factors, where necessary.

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Access to PHI. The new regulations grant individuals new rights relating to PHI. Individuals have a greater ability to restrict uses and disclosure of PHI. For example, covered entities may not disclose information to health insurers if the patient pays for the treatment and requests that the information not be disclosed to insurers. Additionally, a covered entity that maintains PHI in electronic format must make that PHI available to a requesting individual in the electronic format and form requested by the individual. If individuals request their PHI be sent to another person, the covered entity must comply if the request is in writing, signed by the individual and identifies the designate person and where to send the PHI. Finally, a covered entity must produce the requested PHI, or give reason why it cannot produce the PHI, within 30 days of the request, even if the PHI is not maintained on-site.

The new rules also make it easier for family members to obtain information about decedents. The rule also clarifies that HIPAA ceases to apply to information 50 years after the decedent's death.

Notice of Privacy Practices. The final regulations amend the content requirements for a Notice of Privacy Practices. Specifically, the Notice must now include:

- A statement that most uses and disclosures of: (1) psychotherapy notes (if the covered entity records or maintains psychotherapy notes); (2) PHI for marketing purposes; and (3) PHI for reasons other than those described in the Notice, require an individual's authorization and that such authorization may be revoked.
- A statement that PHI disclosed for underwriting purposes will not include PHI that is genetic information about an individual for such purposes.
- A statement describing an individual's right to be notified following a breach of unsecured PHI.

Covered entities are required to inform individuals of these changes because HHS specifically identified the changes as material. If the covered entity is a health plan that posts its notice on its website, the covered entity must prominently post notice of the change to, or a copy of, the notice on its website by the effective date of the change. The covered entity must also provide a copy of the revised notice, or information about the change and instructions on how to receive a copy of the revised notice, in the annual mailing following the effective date of the change. If the covered entity does not post its notice to its website, the covered

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entity must provide a copy of the revised notice, or information about the change and instructions on how to request a copy of the revised notice, to individuals within 60 days of the change.

Finally, the new rules include privacy protections implementing the provisions of the Genetic Information Nondiscrimination Act (GINA). The HIPAA definition of "health information" now includes "genetic information, whether oral or recorded in any form or medium" to the extent that such information is individually identifiable and held by an entity covered under HIPAA. The result of this expansion is the prohibition of the use or disclosure of genetic information for underwriting purposes. Importantly, the rules contain a temporary exception for long-term care insurance coverage allowing such entities to use genetic information for underwriting purposes.

HHS Issues Proposed Regulations Regarding Verification of Employee Eligibility for Advance Tax Credit and Employers' Limited Appeal Rights

On January 14, 2013, HHS issued proposed regulations clarifying the process by which exchanges will verify an employee's eligibility for advance payment of the premium tax credit and the process through which employers will be able to dispute an exchange's determination. This process means that employers will generally not learn of an employee's eligibility until after the exchange approves the credit. Because employee qualification for the advance credit may trigger an employer penalty under the Patient Protection and Affordable Care Act's (PPACA) shared responsibility provisions, employers should work with legal counsel to develop a procedure for reviewing notifications and, where appropriate, appealing eligibility determinations.

Under PPACA, some employees will be eligible for an advance tax credit when purchasing health care coverage through an exchange if they are not eligible for or enrolled in employer-sponsored coverage. Upon applying to the exchange for the advance payment of the credit, employees will be required to provide certain information regarding their access to and the affordability of employer-sponsored coverage. The exchange will then attempt to verify the eligibility information; importantly, the exchange is not required to contact the employer to confirm the employee's eligibility. The employer will then receive notification from the exchange of the final eligibility determination.

Under the proposed regulations, an employer can dispute an exchange's determination that the applying employee is eligible for the payment of the

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advance credit. The employer may request an appeal from the exchange within 90 days from the date of notice of an employee's eligibility of advance payment of the premium tax credit or cost-sharing reduction. Additionally, employers would be able to submit relevant evidence to the exchange to support their appeal request. Notably, however, employers may not appeal directly to HHS.

Departments Release Additional PPACA Frequently Asked Questions

On January 24, 2013, the Department of Labor (DOL), HHS and the IRS jointly released a new list of frequently asked questions (FAQs) in the series FAQs About Affordable Care Act Implementation. The following answers are of note:

- *Exchange Notice*. Employers were required to give employees written notice regarding health care exchanges by March 1, 2013. The due date of this notice has now been delayed. Although no specific alternative date has been given, the DOL expects that the distribution date will be sometime in late summer or fall of 2013.
- *Integrated HRAs Exempt From Limits*. Only integrated Health Reimbursement Arrangements (HRA) are exempt from the prohibition on annual and lifetime limits. An integrated HRA is one that requires employees to enroll in primary group health coverage to be eligible for the HRA. The FAQ clarifies that:
    - An HRA that is used to purchase coverage on an exchange or to purchase employer-provided individual coverage is not considered an integrated HRA.
    - An HRA that is offered to employees who refuse coverage that would result in the HRA being an integrated HRA will not be considered an integrated HRA.
    - Unused amounts in an HRA credited prior to January 1, 2014 may be used after December 31, 2013 to reimburse medical expenses without causing the HRA to fail to comply.
- *Employer Group Waiver Plans*. Pending further guidance, the FAQ clarifies that the Departments will not take enforcement action against Employer Group Waiver Plans (EGWP) providing non-Medicare prescription drug coverage to employees as well as retirees. Non-Medicare prescription drug coverage provided only to retirees in connection with an EGWP is exempt from the requirements of many of the provisions of the Public Health Services Act, ERISA and the PPACA requirements of the Internal Revenue Code. Additionally, supplemental benefits provided only to retirees through an EGWP are excepted

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benefits (and therefore exempt from the PPACA requirements) if insured under a separate policy, certificate or contract of insurance. Although EGWP rules do not extend these same benefits to EGWPs providing coverage to Medicare-eligible employees, the FAQ clarifies that the Departments will not seek enforcement action against EGWPs that also provide coverage to employees.

- *Fixed Indemnity Insurance*. The FAQ clarifies that hospital, or other fixed indemnity insurance, will be considered excepted benefits under a group health plan if: (a) the benefits are provided under a separate policy, certificate or contract of insurance; (b) there is no coordination between the indemnity benefits and any other benefits provided under the same group health plan; and (c) the benefits are paid without regard to whether other benefits are provided for the same event under any group health plan maintained by the employer.
- *PCORI Fees*. In the FAQs, the DOL clarified that fees payable to the Patient Centered Outcomes and Research Institute (PCORI) by a self-insured multiemployer plan may generally be paid from plan assets unless the plan document provides otherwise.

GENERAL DEVELOPMENTS

DOL Clarifies Meaning of "Son or Daughter" Under FMLA

Under the Family Medical Leave Act (FMLA), employees are entitled to up to 12 work weeks of unpaid, job-protected leave during a 12-month period to care for an adult son or daughter who is incapable of self-care because of a mental or physical disability. The DOL's Wage and Hour Division issued Administrator's Interpretation No. 2013-1 on January 14, 2013, clarifying the definition of "son or daughter." The Interpretation provides that FMLA leave to care for an adult son or daughter must be available without regard to whether the adult son or daughter became disabled before or after attaining the age of 18.

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