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March 2013 Employee Benefits Update

SELECT COMPLIANCE DEADLINES AND REMINDERS

Deadline for 2012 Employer and Employee HSA Contributions is April 15, 2013

The deadline for employers and employees to make 2012 contributions to a health savings account (HSA) is April 15, 2013. Although the dollar limit on HSA contributions is determined monthly, HSA contributions for a taxable year may be made in one or more payments as long as the payments are not made before the beginning of the applicable tax year and not later than the original filing deadline (without extensions) for the individual's federal income tax return for that year.

Annual Funding Notice Deadline is April 30, 2013

All defined benefit plans must provide an annual funding notice to participants, beneficiaries, the Pension Benefit Guaranty Corporation (PBGC), labor organizations representing participants and beneficiaries and, for multiemployer plans, contributing employers. The annual funding notice must be provided within 120 days following the end of the plan year (for example, April 30, 2013, for calendar-year plans). Small plans (plans with 100 or fewer participants) generally have until the Form 5500 filing deadline to provide the annual funding notice.

RETIREMENT PLAN DEVELOPMENTS

Changes to Instructions for Completing the 2012 Form 8955-SSA

The Internal Revenue Service (IRS) has released the 2012 Form 8955-SSA and instructions. The 2012 Form 8955-SSA has not changed from the 2011 Form 8955-SSA. The instructions, however, have a few minor changes. First, the instructions note that the Social Security Administration (SSA) will not process any non-standard version of page 2. Rather, plan sponsors must use an additional copy (or copies) of page 2 if more space is needed. Additionally, instructions clarify that lines 6 and 7 on the Form 8955-SSA concern only those participants not previously reported. Thus, the total in line 7 does not need to equal the total number of participants in Part III of the Form 8955-SSA.

REMINDER: In conjunction with filing the Form 8955-SSA, plan sponsors must send an individual statement to all participants listed in the Form 8955-SSA. The

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individual statements must contain the name of the plan, the name and address of the plan administrator, the name of the participant and the nature, amount and form of the deferred vested benefit to which such participant is entitled. The individual statement does not need to be a separate statement if the information is timely provided in other documents, such as benefit statements or distribution forms.

DOL Issues Advisory Opinion on Clearing Swaps

The Department of Labor (DOL) has issued an advisory opinion clarifying whether certain parties involved in the clearing of swaps are ERISA fiduciaries, whether a margin held by a clearing member is a plan asset and whether a clearing member or clearing organization is a party in interest. The Securities Industry and Financial Markets Association requested the advisory opinion to clarify how ERISA would apply to cleared swap transactions required by the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank). Dodd- Frank imposes clearing and trade execution requirements on standardized derivative products, which generally requires swap transactions to go through a clearing process.

Pension plan sponsors had been hesitant to execute swaps contracts because of the lack of guidance on these issues. The DOL opinion now clarifies that clearing members and clearing counterparties involved in the swap process are not fiduciaries under ERISA. However, if the clearing member provides investment advice or recommendations to the plan in conjunction with the swap, the clearing member would be an ERISA fiduciary to the plan.

The DOL opinion further clarifies that while the clearing organization is not a party in interest, the clearing member is a party in interest when it represents the plan in the swap. The DOL notes that prohibited transaction exemptions may, however, be available to cover the arrangement between the clearing member and the plan. Finally, the DOL states that its position is that the margin deposited by the swap is not a plan asset.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Departments Issue Regulations on Multiple PPACA Provisions

The DOL, the Department of Health and Human Services (HHS) and the IRS (collectively, the Departments) have issued multiple sets of proposed and final regulations as well as a new set of frequently asked questions (FAQ) and other sub-regulatory guidance on a number of provisions of the Patient Protection and

Affordable Care Act (PPACA). This guidance addresses various items such as essential health benefits, contraceptive coverage, shared responsibility payments and individual mandate exemptions. A brief summary of this new guidance follows.

HHS Clarifies that Annual Limits on Out-of-Pocket Maximums Apply to Group Health Plans; Issues Minimum Value Calculator. HHS issued final regulations on determining essential health benefits and the actuarial and minimum value requirements under PPACA. These final regulations largely track the proposed regulations issued in November, which were discussed in the December 2012 EB Update, but also include some additional guidance on the annual cost-sharing limits. Beginning in 2014, PPACA limits non-grandfathered plans' deductibles to $2,000 per person and $4,000 per family, and out-of-pocket maximums to that of high deductible health plans ($6,250 per person and $12,500 per family for 2013). The final regulations clarify that the deductible limit applies only to insured plans in the small group market but the limit on out-of-pocket maximums apply generally to all group health plans and insured plans. Additionally, the final regulations note that these limits apply only to in-network benefits; benefits provided out of network will not accumulate toward the annual limits on cost-sharing. The final regulations also include the list of essential health benefit benchmark plans.

REINHART COMMENT: "Cost-sharing" for purposes of the limits on cost-sharing rules includes deductibles, coinsurance and copayments but does not include balance billing, premiums or services not covered by the plan. Currently, copayments do not accumulate toward out-of-pocket maximums in most plans. Plan sponsors will need to review their plans and determine whether changes to the definition of out-of-pocket maximums need to be made for 2014.

In conjunction with these regulations, HHS issued the minimum value calculator that group health plans will use to determine whether the plans satisfy the minimum value requirement. Generally, group health plans must cover 60% of the cost of coverage to satisfy this requirement. Employers whose group health plans fail to satisfy the minimum value requirement could be subject to penalties under PPACA's shared responsibility provisions if an employee enrolls in coverage through the Exchanges and receives a premium tax credit.

HHS Issues Proposed Regulations on Eligibility for Exemptions From the Individual Responsibility Requirement. Beginning in 2014, generally all individuals will be required to maintain minimum essential coverage or pay a penalty (the Individual

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Responsibility Requirement, commonly referred to as the Individual Mandate). PPACA contains a limited number of categories of exemptions whereby an individual will not be subject to penalties for failing to maintain health coverage. For example, exemptions are available for religious conscience, members of a health care sharing ministry, individuals in jail, members of Native American tribes and hardship. In the proposed regulations, HHS proposes to have the Exchanges issue exemptions in five categories and have the IRS review the remaining categories of exemptions as part of the tax filing process. Additionally, HHS proposes to designate self-funded student health coverage, foreign health coverage, refugee medical assistance, Medicare advantage plans, state high-risk pool coverage and coverage for AmeriCorps volunteers as minimum essential coverage.

IRS Issues Proposed Regulations on Individual Responsibility Exemptions, Clarifies Self-Funded Plans Qualify as Minimum Essential Coverage. In conjunction with the proposed regulations issued by HHS on exemptions from the Individual Responsibility Requirements, the IRS issued proposed regulations addressing the exemptions from the requirement to maintain minimum essential coverage for which it will be responsible. Importantly, the proposed regulations also clarify that self-insured group health plans, coverage provided under COBRA and retiree health coverage are eligible employer-sponsored plans and therefore qualify as minimum essential coverage. While only in proposed form, these regulations provide much needed clarification that self-insured plans qualify as eligible employer-sponsored plans.

IRS Confirms Premium Tax Credit Eligibility Is Based on Self-Only Coverage. The IRS has issued final regulations confirming that, for purposes of eligibility for the premium tax credit, an eligible employer-sponsored plan is affordable for an employee's family members if the portion of the annual premium the employee must pay for self-only coverage does not exceed 9.5% of the employee's household income.

HHS Issues Final Regulations on Health Insurance Market Rules and Rate Review; Refuses to Extend Exemption to Bona Fide Associations. HHS has issued final regulations on a number of health insurance market rules, including guaranteed availability of coverage, guaranteed renewability, and fair health insurance premiums and updating the rate review rules. Under PPACA, beginning in 2014, health insurance issuers will be prohibited from denying coverage because of pre-existing condition exclusions or any other health factors, will be prohibited from varying premiums for any reasons other than age, tobacco use, family size and

geography, and will be required to renew coverage at the employer's or individual's option, except in limited instances such as failure to pay premiums.

Additionally, the final regulations also confirm that bona fide associations will not be exempted from the guaranteed availability requirement. The preamble to the final regulations notes that although bona fide associations are exempted from the guaranteed renewability provision, PPACA does not similarly exempt bona fide associations from the guaranteed availability provisions. HHS declined to extend the exception to guaranteed availability. Accordingly, because bona fide associations will not be exempted from the guaranteed availability rule, they will no longer be able to provide coverage exclusively to members of the association.

The Departments Issue FAQs Addressing the Annual Cost-Sharing Limits and Preventive Care Services. The Departments issued a twelfth set of FAQs providing a transition rule for the annual cost-sharing limits for non-grandfathered group health plans and addressing a number of questions on preventive care services. Many of the FAQs clarify what plans must cover as part of the preventive care recommended services.

- Plan sponsors that use more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums (for example, major medical and prescription drug) will have to coordinate the benefits under each. However, for the first plan year beginning on or after January 1, 2014, the plan will satisfy the requirement if both the major medical and the other coverage each satisfy the limit.
- If a non-grandfathered health plan does not provide a certain preventive care service in network, the plan must cover that service from an out-of-network provider at 100% with no cost-sharing.
- Aspirin and other over-the-counter drugs (including over-the-counter contraceptive coverage) must be covered at 100% with no cost-sharing only when prescribed by a doctor.
- ***REINHART COMMENT***: The FAQs do not specify whether this rule would also apply to emergency contraception, which is available without a prescription.
- Plans must cover removal of polyps during a colonoscopy at 100% with no cost sharing. The FAQ notes that polyp removal is an integral part of a colonoscopy and is therefore covered under the preventive care guideline as part of the screening procedure. However, the FAQ also reiterates that plans may continue

to impose cost-sharing on other treatments that are not a recommended preventive care service, even if the treatment results from a recommended preventive care service.

- The BRCA counseling and evaluation recommendation includes the BRCA testing, if appropriate, as determined by a doctor. Thus, the BRCA test, if appropriate, must be covered at 100% with no cost-sharing.
- A patient's doctor is responsible for identifying who is "high risk" to determine whether certain of the preventive care services may apply (for example, screening for certain STDs or screening for osteoporosis at an early age). If the doctor determines that a person is high risk and a recommended preventive care service applies to that high-risk population, the service must be covered at 100% with no cost-sharing. Similarly, for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), if a recommendation applies for certain individuals rather than an entire population, the doctor will determine whether the vaccine should be administered. If the vaccine is prescribed by the doctor consistent with the ACIP recommendation, the plan must cover the vaccine at 100% with no cost-sharing.
- The guidelines for women's preventive care do not promote multiple visits for separate services. Rather, the FAQ notes that many of the required women's preventive care services can be accomplished during one visit. Nevertheless, if the doctor determines that a woman requires additional well-woman visits to obtain all the necessary recommended preventive care services, then the additional visits must be covered at 100% with no cost-sharing.
- ***REINHART COMMENT***: The FAQ does not directly address the question of whether all prenatal care visits must be covered. However, this FAQ implies that if a doctor recommends prenatal care for the duration of the pregnancy, the plan will have to cover all the prenatal care visits.
- Plans must cover the HIV test at 100% with no cost-sharing as part of the HIV screening recommendation.
- Plans may limit contraceptive coverage to generic and impose cost-sharing on brand drugs, but cannot limit contraceptive coverage to oral contraceptives only. Plans that limit contraceptive coverage to generic must accommodate any individual for whom the generic drug would be medically inappropriate, as determined by the doctor, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version. If a

generic version does not exist, or would not be medically appropriate (as determined by the doctor), then the plan must cover the brand drug at 100% with no cost-sharing. The FAQs clarify that plans must also cover the services related to follow up and management of side effects, counseling for continued adherence and device removal at 100% with no cost-sharing.

- The FAQs state that plans must cover comprehensive lactation support and counseling and the cost of rental or purchase of breastfeeding equipment for the duration of breastfeeding, but may use reasonable medical management.
- ***REINHART COMMENT***: This FAQ seems to confirm that plans can cover the purchase of a breast pump in lieu of covering the rental costs. However, this FAQ does not address the additional questions that could result from covering the purchase price in lieu of rental, such as whether the plan must pay for a new pump in conjunction with each birth. This FAQ also implies that a plan may use reasonable medical management to limit the duration of the coverage.

Departments Jointly Issue Proposed Rules on Religious Employer Contraceptive Coverage Accommodation. The Departments have issued proposed regulations providing the promised accommodation to non-exempted religious employers with objections to contraceptive coverage. Generally, non-grandfathered health plans must provide coverage for contraceptive methods without imposing any cost-sharing in network as part of PPACA's preventive care services rule. Certain religious employers were exempted from this requirement and the Departments provided a temporary enforcement safe harbor for certain non-exempted, non-profit employers with religious objections to contraceptive coverage. The proposed regulations provide an accommodation for certain non-exempted employers with religious objections to contraceptive coverage by requiring a third party, generally an insurer or third-party administrator, to provide the coverage at no cost to the employee with no direct role for the employer. The proposed regulations also clarify which employers qualify for the exemption for religious employers. The previous guidance on the exemption had stated that a religious employer was one that served or hired only people of the same faith. The proposed regulations now clarify that religious employers that hire or serve people of different faiths, for example through soup kitchens, are exempt from the contraceptive coverage requirement.

OSHA Issues Interim Final Regulations On Whistleblower Retaliation. The Occupational Safety and Health Administration (OSHA) issued interim final regulations prohibiting employers from discharging, retaliating against or taking

unfavorable employment action against an employee who reported PPACA violations or received a premium tax credit. If an employer is found to have retaliated against an employee, OSHA may require the employer to reinstate the employee, pay back wages or restore benefits, among other possible relief options, to make the employee whole.

CMS Issues Clarification on ERRP Maintenance of Contribution Requirement and Posts New "Common Questions" on the ERRP Website

The Centers for Medicare and Medicaid Services (CMS) issued revised guidance on complying with the maintenance of contribution requirement under the Early Retiree Reinsurance Program (ERRP). Generally, participants in the ERRP are prohibited from using ERRP proceeds as general revenue. Additionally, ERRP participants must satisfy a maintenance of contribution requirement to demonstrate that the employer contributions to the plan have not decreased as a result of the ERRP proceeds. CMS has issued revised guidance on the maintenance of contribution requirement to clarify that satisfying the maintenance of contribution requirement does not, however, conclusively establish compliance with the prohibition on using ERRP proceeds as general revenue. CMS states that its position is that an ERRP participant may satisfy the maintenance of contribution requirement but may still be found to have violated the prohibition on using ERRP proceeds as general revenue.

REINHART COMMENT: Plan sponsors that participate in the ERRP and still have ERRP proceeds in their possession must ensure that they continue to satisfy the maintenance of contribution and prohibition on using ERRP proceeds as a general revenue requirement.

Common Questions Update. Most of the new guidance is applicable only to those plans that still have ERRP proceeds to use or are on the waiting list for additional reimbursement. However, the common questions provide new guidance on the ERRP notice, which is generally applicable to any plan that has received ERRP reimbursement. Additionally, the common questions provide an important reminder to plan sponsors to continue updating any data inaccuracies.

- *Using ERRP Proceeds, Generally*. Plan sponsors may use the ERRP funds it receives during a plan year to retroactively offset health benefit or health benefit premium cost increases it already experienced during that same plan year. Plan sponsors may do this by either actually applying the ERRP funds during that same plan year or retroactively applying the ERRP funds during the

subsequent plan year. The guidance notes that the latter approach may be particularly suitable for self-funded plans because by waiting until a future year to apply the funds, the plan sponsor might know with more certainty what its actual costs were for the previous year, which could reduce or eliminate the burden of reconciling its estimate with actual costs.

- In the alternative, plan sponsors may estimate the expected amount of health benefit costs for a given plan year and apply ERRP funds received during that same plan year to offset expected cost increases. However, if the plan sponsor determines that the estimate exceeded the actual amount of health benefit costs increases, the plan sponsor must reconcile the estimate with the actual costs and return the excess ERRP funds to its "ERRP account." The plan sponsor could then use those ERRP funds in a future year.

- *Using ERRP Proceeds When Baseline Costs Decreased*. A plan sponsor may offset per capita increases to its health benefit costs and/or health benefit premiums even if the aggregate plan-wide health benefit costs and/or health benefit premiums decreased when compared to the plan sponsor's baseline costs. However, the plan sponsor must then satisfy the maintenance of contribution requirement solely through the per capita spending trend, total dollars methodology.

- A plan sponsor may offset percentage increases to its health benefit costs and/or health benefit premiums even if the aggregate plan-wide health benefit costs and/or health benefit premiums decreased when compared to the plan sponsor's baseline costs. However, the plan sponsor must then satisfy the maintenance of contribution requirement solely through the aggregate spending trend, percentage methodology.

- *ERRP Notice*. Plan sponsors can stop sending the ERRP notice to new participants when it no longer possesses any ERRP funds. If the plan sponsor subsequently receives additional ERRP funds, the plan sponsor must resume sending the ERRP notice and send to all participants that joined the plan after the plan sponsor ceased sending the notice.

- *Reporting Data Inaccuracies*. Plan sponsors that have never received ERRP reimbursement and are currently in the list of reimbursement requests on hold will have to make corrections of the data inaccuracies to their reimbursement request only when they become the first plan in line and funds become available to pay the request. When that happens, the plan sponsor will be

notified by the ERRP Center to make any corrections.

REMINDER: Plan sponsors that have received ERRP reimbursement requests must continue to report any data inaccuracies in the early retiree and/or claims data associated with the paid reimbursement request. CMS will require plan sponsors to return the amount paid if plan sponsors fails to timely report data inaccuracies. It is unclear whether the "amount paid" refers to the entire reimbursement or the overpayment amount.

DOL Issues Final Regulations on MEWA Reporting and Enforcement

The DOL has issued the final regulations on Multiple Employer Welfare Arrangements (MEWA) reporting obligations and DOL enforcement of MEWAs. The DOL also released a revise 2012 Form M-1 in conjunction with these new regulations to reflect the changes.

The final regulations generally track the proposed regulations issued in December 2011. The final regulations expand the existing reporting requirements by requiring non-group health plan MEWAs to register with the DOL before operating in a state, and all plans that are MEWAs or entities claiming exemption to file a Form 5500 Annual Return/Report. Additionally, the final regulations permit the DOL to issue cease and desist orders, without notice, when it appears that the MEWA's conduct is fraudulent, creates an immediate danger to public safety or welfare, or is causing significant, imminent and irreparable public injury. The DOL may also issue a summary seizure order to preserve plan assets when the DOL has probable cause that the MEWA is in a financially hazardous condition.

The reporting changes under the final regulations are effective to all M-1 filing events on or after July 1, 2013 (except that the deadline for filing the 2012 Form M-1 is May 1, 2013 with an available extension to July 1, 2013) and to all Form 5500 filings beginning with the 2013 Form 5500.

GENERAL DEVELOPMENTS

DOL Extends FMLA Protection to Military Family Members, Clarifies Intermittent Leave Calculation

The DOL has issued additional final regulations extending FMLA protections for military family members and airline flight crews. The final regulations expand eligibility for qualifying exigency leave, increase the maximum number of days an individual may take when a military family member is home for temporary rest

and recuperation, and expand military care-giver leave. The final regulations also clarify the instances in which airline flight crews are eligible for FMLA leave. Additionally, the final regulations clarify the calculation of intermittent leave. Generally, the final regulations require an employer to account for FMLA leave based on the lesser of the shortest increment of time the employer uses to account for other forms of leave or one hour. For example, if an employer accounts for leave in 15-minute increments, then FMLA leave can also be used in 15-minute increments. If an employer accounts for leave in one-day increments, then FMLA leave can be used in one-hour increments.