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May 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Service Provider Fee Disclosure Deadline

As reported in Reinhart's February 2012 Employee Benefits Update, the Department of Labor (DOL) issued final regulations under Employee Retirement Income Security Act of 1974 (ERISA) section 408(b)(2) for service provider fee disclosures. All covered service providers must provide their initial fee disclosures to plan fiduciaries by July 1, 2012.

REINHART COMMENT: Plan fiduciaries may want to contact their service providers at this time to determine whether they are covered service providers who must comply with this requirement.

Summary of Description of Material Modifications for Calendar-Year Plans

Plan administrators of employee pension and welfare benefit plans must provide to each participant covered under the plan and each beneficiary receiving benefits under the plan a summary description of any material modifications to the plan and changes to the summary plan description. Administrators must provide this summary no later than 210 days after the close of the plan year in which the modification or change was adopted, unless otherwise described in a timely summary plan description. For calendar-year plans, this deadline is July 28, 2012.

FBAR Filing for Certain Foreign Investments

U.S. persons who have a financial interest in, or signature or other authority over, foreign financial accounts are generally required to report on the Treasury Department Form TD F 90 22.1 (the FBAR) by June 30 of each year. While foreign hedge funds and private equity funds are not required to be reported on the FBAR, many other accounts in foreign jurisdictions might. Plan sponsors should consult with tax and legal counsel to determine possible FBAR filings required by June 30, 2012.

RETIREMENT PLAN DEVELOPMENTS

IRS to Propose Rules Applying Normal Retirement Age to Government Plans

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The Internal Revenue Service (IRS) issued Notice 2012-29, describing the IRS's anticipated guidance on the applicability of the normal retirement age regulations to government plans. The IRS published final regulations in 2007 pertaining to distributions from a pension plan upon attainment of normal retirement age. In part, the final regulations provided that a pension plan's normal retirement age be an age that is not earlier than the earliest age that is reasonably representative of the typical retirement age for the industry in which the covered workforce is employed, with certain safe harbors. The IRS has previously extended the effective date of these regulations for government plans while it determines how the normal retirement age requirements should apply to them.

Notice 2012-29 provides that the IRS anticipates issuing guidance to clarify that government plans do not need to have a definition of normal retirement age that satisfies the requirements of the regulations if: (1) the plan is not subject to Internal Revenue Code section 411(a) through (d); and (2) the plan does not provide for in-service distributions before age 62. Also, the IRS intends to modify the regulations to provide that the rule deeming age 50 or later to be a normal retirement age that satisfies the regulations will apply to a group of employees substantially all of whom are qualified public safety employees, regardless of whether the qualified public safety employees are covered by a separate plan.

The IRS intends to amend the regulations to change the effective date of the regulations for government plans to plan years beginning on or after the later of January 1, 2015 or the close of the first regular legislative session of the legislative body with the authority to amend the plan that begins on or after three months after the final regulations are published in the Federal Register. The IRS further noted that governmental plan sponsors may rely on this notice of extension until the regulations are amended.

PBGC Issues Final Rule Making Penalty Assessments Subject to Administrative Review Rules

The Pension Benefit Guarantee Corporation (PBGC) issued a final rule that makes its administrative review regulation applicable to assessments of penalties for failure to timely provide certain notices or other material information. The PBGC's regulations for administrative review govern the PBGC's issuance of initial determinations and the procedure for requesting and obtaining review of those determinations. A failure to exhaust administrative remedies may result in a person's inability to raise certain legal defenses in court.

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ERISA section 4071 authorizes the PBGC to assess a penalty for a plan's failure to timely provide a required notice or other material information. This final rule makes determinations under ERISA section 4071 after May 16, 2012 subject to the above noted administrative review requirements.

Court Finds a Breach of Fiduciary Duty in Failure to Monitor Recordkeeping Fees and Revenue Sharing

The U.S. District Court for the Western District of Missouri recently held that a company breached its fiduciary duties to its 401(k) plan participants due to a failure to comply with its investment policy statement (IPS). Tussey v. ABB, Inc., 2012 WL 1113291 (W.D. Mo. 2012). In Tussey, plan participants argued that the plan fiduciaries did not abide by the terms of the IPS with regard to numerous investment decisions. The court held that the plan sponsor failed to monitor the recordkeeper's revenue sharing income and determine whether the revenue sharing mechanism actually reduced costs. The court noted that, while it is not necessarily imprudent to use revenue sharing to pay recordkeeping costs, the IPS stated as such in this case, and plan sponsors must follow the plan's governing documents. The court also held that the plan fiduciaries failed to follow the IPS in two other regards. The fiduciaries failed to follow the IPS's selection process when they replaced a lower-cost fund with a higher-cost lifestyle fund affiliated with the recordkeeper. In addition, fiduciaries failed to follow the IPS when they selected fund share classes with higher expense ratios to increase revenue sharing.

REINHART COMMENT: While the outcome of Tussey is based primarily in the terms of that IPS, plan fiduciaries should be cognizant of their fiduciary duties in operating in accordance with all governing documents, including investment policies. In addition, fiduciaries should be aware of the fees service providers receive, especially in comparison to market rates.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Announces Proposed Regulations to Establish Health Plan Identifiers for Health Plans

The Department of Health and Human Services (HHS) recently announced proposed regulations that would establish a unique health plan identifier (HPID) program for health plans. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act (PPACA) require HHS to adopt standards for electronic health care transactions to more efficiently exchange health information between entities. To date, HHS issued

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guidance regarding identifier standards for employers and health care providers, but it had not yet addressed the issue for health plans. Currently, health plans are identified in HIPAA standard transactions using multiple identifiers in inconsistent formats, causing health care providers difficulty when processing transactions. Under this guidance, each health plan would need to obtain its own HPID. Each health plan will be assigned a ten-digit code to use in all HIPAA standard transactions. Health plans would receive their HPIDs through an online application process under HHS's enumeration system, which currently assigns identifiers to health care providers. Health plans would assume the cost and obligation to obtain an HPID and implement its use in all HIPAA standard transactions, even though health providers will experience the most benefit through efficiency in processing transactions.

The proposed regulations include self-insured group health plans in the definition of health plans that must obtain an HPID. HHS recognized that self-insured plans often use third party administrators (TPA) such that the plan is not identified in the HIPAA standard transaction. However, based on the potential need for identification, HHS determined that self-insured plans should be subject to the requirement. The regulations also propose allowing other administrators, like TPAs, to voluntarily obtain an other entity identifier (OEID) for use in HIPAA standard transactions in which they are involved. However, even if the TPA chooses to obtain an OEID, the health plan still needs to obtain an HPID. The OEID and/or HPID would then be used in the transaction. The proposed regulations also differentiate between "controlling health plans" and "subhealth plans." A subhealth plan is a plan whose business activities, actions or policies are directed by another, controlling health plan. In that case, the subhealth plan can choose to use the controlling health plan's HPID or obtain a unique HPID.

If finalized, health plans would need to comply with the regulations by October 1, 2014, with a compliance extension for small health plans until October 1, 2015.

IRS Publishes Proposed Regulations Imposing Fees to Fund Patient-Centered Outcomes Research

On April 17, 2012, the IRS published proposed regulations addressing the fees issuers of certain health insurance policies and plan sponsors of self-insured health plans will be charged to fund comparative effectiveness research. As noted in the September 2011 Employee Benefits Update, PPACA established the Patient-Centered Outcomes Research Trust, which will be funded through fees payable by sponsors of group health plans. Under the proposed regulations, the fee will be

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calculated using the applicable dollar amount in effect for the plan year and one of the permitted methods for determining the average number of lives covered under the plan during the plan year.

The fees apply to policy or plan years ending after October 1, 2012 and before October 1, 2019 (i.e., for seven full plan years). The applicable dollar amount for plan years beginning on or after October 1, 2012 and before October 1, 2013 is $1. The proposed regulations provide four alternative methods a health plan issuer can use for determining the average number of lives covered: the actual count method; the snapshot method; the member month method; and the state form method. Plan sponsors of self-insured health plans can choose any of three alternative methods, including the actual count method; the snapshot method; and the Form 5500 method.

The proposed regulations also provide guidance on what plans are subject to the fee requirements. Only accident and health insurance policies that are issued with respect to an individual residing in the U.S., including specified U.S. territories and possessions, are subject to the fee. Group policies issued to an employer designed and issued specifically to cover primarily employees who are working and residing outside of the U.S. are not subject to the fee requirements. Prepaid health coverage arrangements are included within the requirements, but stop loss and reinsurance policies are not.

With regard to self-insured health plans, the fees apply to a plan that is established or maintained by a plan sponsor for the benefit of employees, former employees, members, former members or other eligible individuals to provide accident and health coverage, any part of which is provided other than through an insurance policy and meets other conditions. The following types of self-funded health plans are specifically covered within the proposed regulations:

- Plans established or maintained solely for the benefit of former employees, including retiree-only plans, are classified as self-insured health plans subject to the fee.
- Flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) are included within the definition of a self-insured health plan. However, multiple self-insured arrangements established and maintained by the same plan sponsor and with the same plan year are subject to a single fee. Thus, an HRA that is integrated with another applicable self-insured health plan is not separately subject to the fee as long as the HRA and other plan are established or maintained by the same plan sponsor and have the same plan year.

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- An HRA that is integrated with an insured group health plan is treated as an applicable self-insured health plan subject to the fee, even though the insurer of the insured group health plan is also separately subject to the fee.
- An FSA that satisfies the requirements of an excepted benefit is excluded from the fee.
- An employee assistance program, disease management program or wellness program that does not provide significant benefits in the nature of medical care or treatment are not applicable self-insured plans subject to the fee.

Under the proposed regulations, the fees will be reported and paid once a year on Form 720, due by July 31 of each year. Comments on the proposed regulations can be submitted to the IRS by July 17, 2012.

IRS Provides 2013 Inflation Adjusted Amounts for HSAs

The IRS recently published the 2013 inflation adjusted amounts for health savings accounts (HSAs) in Revenue Procedure 2012-26. For calendar year 2013, the annual limitations are as follows:

- $3,250 annual limit for an individual with self-only coverage under a high deductible health plan.
- $6,450 annual limit for an individual with family coverage under a high deductible health plan.

High deductible health plans are defined as health plans with an annual deductible that is not less than $1,250 for self-only coverage or $2,500 for family coverage with annual out-of-pocket expenses not exceeding $6,250 for self-only coverage or $12,500 for family coverage.

CMS Releases Guidance on Medical Loss Ratio Regulations

The Centers for Medicare & Medicaid Services (CMS) recently published guidance in the format of questions and answers on the medical loss ratio (MLR) regulations. As discussed in the January 2012 Employee Benefits Update, HHS issued final regulations on PPACA's MLR requirements implementing the requirement that insurers provide rebates to enrollees if less than 85% of premium dollars (80% in the small group and individual markets) are spent on clinical services and health care quality improvements. Topics addressed in the guidance include: applicability of the MLR to certain types of plans; employer groups of one; counting employees to determine market size; individual association policies; offering policyholders a "premium holiday"; reinsurance and

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reporting; insurance exchange user fees; states with a higher medical loss ratio standard; application of the adjustment to "mini-med" plans; and the form of the rebate to be provided.

Of note, the guidance clarifies that a self-funded plan is not subject to the MLR requirements because it is not a health insurance issuer, regardless of whether the self-funded plan is subject to ERISA. With regard to counting employees to determine market size, issuers should make every attempt to accurately count the number of employees employed by the policyholder. However, in certain circumstances, such as when a policyholder does not make the policy available in all states in which it does business, the issuer may determine the group size for MLR purposes based on the information available to the issuer. In addition, the guidance provides conditions that must be met before an issuer may provide MLR rebates in the form of a prepaid debit card.

HHS Releases List of Counties for Which Culturally and Linguistically Appropriate Notices are Required in 2012

HHS released the list of counties for which non-grandfathered group health plans and issuers of non-grandfathered health insurance coverage will be required to provide notices in a "culturally and linguistically appropriate manner" in 2012. The counties include those in which 10% or more of the population is literate only in one of four non-English languages, including Spanish, Chinese, Tagalog and Navajo. The full list can be accessed on the CMS website.

In order to comply with the "culturally and linguistically appropriate" requirements, a plan must provide oral language services in the non-English language, and the notices that are sent to addresses within the listed counties must include a statement in the applicable non-English language clearly indicating how to access the plan's language services. A plan must also provide the notice in the non-English language upon request.

IRS Issues Notices Requesting Comments on Regulations Implementing Minimum Essential Coverage Requirements

The IRS published three notices requesting comments on issues pertaining to regulations implementing the minimum essential coverage requirements as required by PPACA. Under PPACA, beginning in 2014, eligible individuals who purchase coverage through an insurance exchange may receive a premium tax credit unless they are eligible for other minimum essential coverage, including coverage under an employer-sponsored plan that is affordable to the employee

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and provides minimum value. Accordingly, the IRS is requesting comments on how to implement this requirement.

The notices request comments on methods for determining whether employer-sponsored health coverage provides minimum value, as well as methods for health plan sponsors and employers to report information about their coverage. Individuals may submit comments on the proposals to the IRS on or before June 11, 2012.

Departments Issue New FAQs on SBC Requirements

On March 19, 2012, the DOL, IRS and HHS (the Departments) issued a new set of FAQs (FAQ VIII) that address the Summary of Benefits and Coverage (SBC) requirements. Many of the FAQs concern the content and format of the SBC (e.g., including a foreign language statement, deleting headers and footers) or simply reiterate the rules found in the final regulations. The FAQs provide model language that plans can use if they choose to provide the SBC electronically. The full version of the FAQs is available on the DOL website, but the following are highlights of the guidance:

- The Departments reiterated their position that compliance assistance is a high priority, and that their emphasis is on assisting plan sponsors to comply and not on imposing penalties. Accordingly, the Departments stated that during the first year the SBC requirement is applicable, the Departments will not impose penalties on plans that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations.
- If a plan has entered into a contractual arrangement whereby another party (e.g., a pharmacy benefit manager or managed behavioral health organization) will be responsible for completing the SBC, providing information necessary to complete a portion of the SBC, or to deliver the SBC, until further guidance is issued, the plan will not be subject to an enforcement action, provided:
  - The plan monitors performance under the agreement;
  - If the plan learns of a violation and has the information to correct it, the plan corrects the violation; and
  - If the plan learns of a violation and does not have the information to correct it, the plan communicates with participants and beneficiaries under the plan regarding the violation and takes significant steps as soon as practicable to avoid future violations.
  - ***REINHART COMMENT***: The FAQs do not clarify what type of communication is

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necessary nor what a "significant" step would entail.

- Where the regulations require an SBC to be "provided" within seven business days, the FAQs clarify that the SBC must be sent within seven business days, not necessarily received within that timeframe.
- The FAQs clarify that COBRA beneficiaries must receive an SBC during open enrollment. However, a qualifying event does not trigger the requirement to send an SBC.
- Grandfathered plans are not required to include the notice of grandfathered status in the SBC, but may choose to include it if they want.

GENERAL DEVELOPMENTS

Ninth Circuit Rejects Claim for Equitable Relief Following SPD and Plan Document Discrepancies

The Ninth Circuit Court of Appeals recently issued a decision holding that employees who received a summary plan description (SPD) that did not accurately explain their retirement plan benefits were not entitled to equitable relief under ERISA. Skinner v. Northrop Grumman Ret. Plan B (9th Cir. Cal. 2012). The Skinner decision was based on the Supreme Court's decision in Cigna Corp. v. Amara, 131 S.Ct. 1866 (2011). In the Cigna decision, discussed in the June 2011 Employee Benefits Update, the U.S. Supreme Court held that the terms of an SPD cannot be enforced as the terms of the plan and that recovery in connection with an inaccurate SPD can only be based on equitable remedies.

In *Skinner*, Northrop Grumman Corp. consolidated a number of pension plans following acquisitions into a single cash balance plan. The plaintiffs in the case argued that the terms of an SPD pertaining to an annuity equivalent offset were misleading. Based on Cigna, the plaintiffs sought to obtain equitable relief under ERISA section 502(a)(3). Three possible equitable remedies exist under ERISA section 502(a)(3): estoppel, reformation and surcharge. The plaintiffs did not present evidence of reliance on the inaccurate SPD so were prohibited from making an estoppel claim. With regard to reformation, the Court determined that under both trust and contract law, reformation is proper only in cases of mistake and fraud. In this case, the Court determined that neither a mistake in drafting the plan provision in question nor fraud in providing the incorrect SPD occurred. Under the surcharge claim, the Court initially held that the plan sponsor did not have a fiduciary duty to enforce the terms of the SPD rather than the plan document. The Court then held that the plan sponsor may have breached its fiduciary duty to provide participants with an accurate SPD, but even so, no

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remedy was available to the plaintiffs. The plan sponsor was not unjustly enriched by the mistaken SPD, and the plaintiffs did not experience any damage due to the SPD because the harm of being deprived of a statutory right to an accurate SPD was not compensable harm.

REINHART COMMENT: The Skinner decision appears to be the first appellate court decision exploring the elements necessary in an equitable claim with regard to an inaccurate SPD following the Supreme Court's decision in Cigna. This decision and others will aid plans and plan sponsors in determining the long-term effects of the Cigna decision."

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