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September 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Medicare Part D Deadlines

All group health plans that offer prescription drug coverage to Medicare-eligible employees (under either an active plan or retiree plan) must provide an annual creditable coverage disclosure notice to Medicare-eligible participants and dependents no later than October 15, 2012. Group health plans must also provide notices to each new participant who may be Medicare eligible.

Centers for Medicare and Medicaid Services (CMS) provides a model notice that can be accessed through the CMS website. Plan sponsors should review the model notice to ensure that it accurately reflects the nature of the coverage and the rights that individuals have if they lose coverage.

Cycle B Determination Letter Filings

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 multiple employer plans.

Reminder: 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 summary of benefits and coverage (SBC) to participants and beneficiaries covered under the plan. Group health plans without open enrollment must issue the SBC starting the first plan year beginning on or after September 23, 2012.

RETIREMENT PLAN DEVELOPMENTS

Pension Plan Funding Stabilization Rates Under MAP-21

The IRS recently issued guidance on the funding stabilization rates added to the Employee Retirement Income Security Act (ERISA) by the Moving Ahead for Progress in the 21st Century Act (MAP-21). MAP-21 is intended to provide short-term relief for single-employer defined benefit pension plan sponsors that may otherwise be subject to higher pension contributions because of the historically low interest rates. Under MAP-21, the segment rates used to determine the future

value of future pension benefits to be paid by a plan are limited to a minimum of 90% and a maximum of 110% of a 25-year average of the segment rates as of September 30 of the preceding year. This range will gradually increase to a minimum of 70% and a maximum of 130% for plan years beginning after 2015.

In IRS Notice 2012-55, the IRS announced that the 25-year average of the rates for the period ending September 30, 2011 will be not less than 5.54% for the first period, 6.85% for the second period and 7.52% for the third period. Additionally, the Pension Benefits Guaranty Corporation has issued Technical Update 12-1 clarifying that the 25-year average rates do not apply to the interest rates used to determine the variable rate premium.

IRS Updates Form 8955-SSA Electronic Filing Specifications

The IRS has announced updated electronic filing specifications for filing the Form 8955-SSA, Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits, through the IRS's Filing Information Returns Electronically (FIRE) System. Plan sponsors must follow the procedures set forth in Revenue Procedure 2012-34 when preparing current and prior years' information returns that will be filed beginning January 1, 2013 and received by FIRE through December 31, 2013. Highlights of the new procedures include submitting the Form 4419, Application for FIRE, at least 45 days prior to the due date for the Form 8955-SSA and holding Form 8955-SSAs with a "Good, Not Released" status for ten calendar days before it is automatically released.

IRS Discontinues Letter-Forwarding Service

The IRS, in Revenue Procedure 2012-35, has announced that it will no longer forward letters on behalf of plan sponsors or administrators of qualified retirement plans. The IRS noted that there are now numerous alternative missing person locator resources, such as the internet, that plan sponsors can use. Additionally, the IRS noted that it intends to provide an extended Employee Plans Compliance Resolution System correction period for plan sponsors affected by this change. Revenue Procedure 2012-35 applies to letter forwarding requests postmarked on or after August 31, 2012.

Update: Seventh Circuit Upholds Arbitrator's Determination on Withdrawal Liability

The Seventh Circuit Court of Appeals recently affirmed the District Court for the Northern District of Illinois' decision in Chicago Truck Drivers, Helpers et al v. CPC Logistics, Inc. As reported in the September 2011 EB Update, the district court

upheld the arbitrator's decision that the withdrawal liability a multiemployer plan sponsor calculated did not represent the actuary's "best estimate" of anticipated experience under the plan.

Generally, under ERISA, withdrawal liability calculations must be based on the plan actuary's best estimate. The plan sponsor used two methods that utilized different assumptions to determine the unfunded vested benefit liabilities (UVBs): a "modified" method for the funding report and the Segal "Blend" method for the withdrawal liability report, which both parties agreed was the best estimate of withdrawal liability. The Court held that by not using the Segal Blend to calculate the plan's overall UVB, the plan sponsor violated ERISA. Accordingly, the Court upheld the decision of the District Court.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Issues Temporary Guidance on the 90-Day Waiting Period Limitation

The IRS recently issued Notice 2012-59 (the Notice) providing temporary guidance on the 90-day waiting period limit established by the Patient Protection and Affordable Care Act (PPACA). PPACA added section 2708 to the Public Health Services Act, which prohibits plan sponsors from imposing waiting periods exceeding 90 days on individuals otherwise eligible for coverage beginning in 2014. Plan sponsors can rely on the guidance provided by the Notice at least through the end of 2014.

The Notice clarifies that “otherwise eligible for coverage” means an individual has met the eligibility conditions under the group health plan. Eligibility conditions that are based solely on the lapse of time are prohibited, but other types of eligibility conditions are acceptable provided their purpose is not to avoid compliance with the 90-day waiting period limit.

The Notice also provides guidance regarding variable hour employees for group health plans that condition eligibility on regularly working a specified number of hours (or full time). If, at the time an employer hires an employee, the plan sponsor cannot determine whether the employee is reasonably expected to regularly work that specified number of hours (or full time), the group health plan may take a reasonable period of time to determine whether the employee satisfies the plan's eligibility conditions. This measurement period must be consistent with the timeframes allowed under Internal Revenue Code (Code) section 4980H (regarding the employer responsibility provision of PPACA discussed further below). The time period the plan sponsor uses to determine

whether the employee satisfies the plan's eligibility conditions will not be considered to avoid compliance with the 90-day waiting period limitation if the employee's coverage is effective no later than 13 months from the employee's start date. The Notice also clarifies that if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month can be added to the 13 month limit.

Finally, the Notice clarifies that an individual is not eligible for minimum essential coverage under the plan during the waiting period or any measurement period. Accordingly, that individual may be eligible for a premium tax credit through the Exchanges.

IRS Issues Guidance Expanding Safe Harbor Methods for Determining Full-Time Employees for Purposes of the Employer Shared Responsibility Provisions

The IRS has issued guidance expanding the safe harbor methods by which to determine which employees are treated as full-time employees for purposes of PPACA's shared responsibility provisions. PPACA added section 4980H to the Code, generally requiring employers to offer affordable minimum essential coverage to all full-time employees or pay a penalty. The IRS had previously issued guidance describing the safe harbor methods. Notice 2012-58 clarifies that employers can rely on this guidance as well as the previously issued guidance through at least the end of 2014.

In Notice 2012-58, the IRS expands the safe harbor described in the previous guidance. Generally, employers with variable hour and seasonal employees now have an option to take up to a 12-month look-back measurement period to determine whether such employees are full-time employees. The employer may also take an up to 90-day administrative period but, for employers choosing to do so, the measurement period plus administrative period cannot exceed 13 months (plus the rest of the calendar month remaining until the first day of the next calendar month if the employee did not start work on the first day of a calendar month). During this time, the employer will not be subject to a penalty for failing to offer minimum essential coverage.

HHS Issues Final Regulations on Health Care Electronic Funds Transfers and Unique Plan Identifiers

The Department of Health and Human Services (HHS) has adopted two additional standards related to health care related transactions under HIPAA. These regulations are the third and fourth in the series of regulations mandated by

PPACA to streamline health care administrative transactions.

HHS issued final regulations adopting operating rules for health care electronic funds transfers (EFT) under HIPAA. The operating rules require health plans to offer providers standardized, online enrollment for EFT and to send the EFT to providers within a specified time of the electronic remittance advice so that providers can quickly reconcile their accounts. The EFT regulations also include the initial set-up requirements for electronic communication between plans and providers. Covered entities must be in compliance with the EFT regulations by January 1, 2014.

HHS has also issued final regulations concerning unique health plan identifiers (HPID). These final regulations are substantially similar to the proposed regulations issued in April 2012. Group health plans that meet the definition of a controlling health plan must obtain an HPID, which is a ten-digit code to be used by group health plans in HIPAA's standard electronic transactions. Large group health plans must obtain an HPID by November 5, 2014, small group health plans must obtain an HPID by November 5, 2015, but the full implementation date for all plans to use HPIDs in standard transactions is November 7, 2016.

CCIIO Updates Technical Guidance on the Temporary Safe Harbor for Coverage of Contraceptive Services by Employers with Religious Objections

The Center for Consumer Information and Insurance Oversight (CCIIO) has updated the technical guidance on the temporary safe harbor for coverage of contraceptive services by certain employers. Under PPACA, nongrandfathered health plans are required to offer contraceptive services to women free of charge. Religious employers meeting the definition set forth in the interim final regulations are exempted. Pursuant to technical guidance issued by CCIIO in February, nonexempted group health plans maintained by nonprofit organizations whose plans have consistently not covered contraceptive services for religious reasons at any point from February 10, 2012 on are eligible for a one-year enforcement safe harbor.

The updated guidance does not change the policy but clarifies that the safe harbor is available to nonprofit organizations with religious objections to some but not all contraceptive coverage. Additionally, the safe harbor is available to nonprofit organizations that attempted but failed to exclude or limit coverage for contraceptive services before the February 10, 2012 deadline. Finally, the updated guidance clarifies that nonprofit organizations can invoke the safe harbor, without prejudice, even if they are uncertain whether they qualify for the religious

employer exemption.

Departments Issue New FAQ on Summary of Benefits and Coverage

The Department of Labor, HHS and the IRS have issued a new frequently asked question (FAQ) concerning the SBC. The FAQ generally states that plan sponsors that offer Medicare Advantage plans are not required to issue an SBC for the Medicare Advantage plan. Medicare Advantage plans are not health insurance coverage within the meaning of the SBC regulations because they are Medicare benefits. Accordingly, the FAQ states that no SBC is required.

HHS Issues Final Blueprint for Exchanges

HHS has issued the final Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges. The Exchanges, established by PPACA, will facilitate the purchase of health insurance by individuals and small businesses beginning in 2014. The Blueprint describes the functions of state and federal government in the Exchanges. The Blueprint also describes the various options available to states to operate all, none or some functions of the Exchanges. Additionally, the Blueprint provides a checklist of the activities the Exchange will perform.

HHS Issues Informal Guidance on PPACA Nondiscrimination Rules

HHS has issued guidance on the nondiscrimination rules established by PPACA in the form of questions and answers. PPACA section 1557 generally prohibits health programs that receive federal financial assistance (including credits, subsidies or insurance contracts) from excluding individuals from coverage based on age, disability, national origin, race or sex. HHS clarifies that the prohibition of discrimination based on sex means that health programs cannot discriminate based on gender identity or sex stereotyping. HHS also reiterated that it intends to issue further guidance on PPACA section 1557.

HHS Issues Enforcement Safe Harbor for Non-Federal Governmental Plans Adverse Benefit Determination Notices

HHS has issued an enforcement safe harbor with regard to the content of adverse benefit determination notices issued by nonfederal governmental plans. PPACA requires plans to include a notice of the ERISA private right of action in all notices of adverse benefit determination. However, such right of action is not available to participants of non-federal governmental plans. Accordingly, HHS will not enforce the requirement that nonfederal governmental plans provide notice of the ERISA private right of action. To qualify for the safe harbor, nonfederal governmental plans must instead provide contact information for member assistance provided

by any third-party administrator or insurance issuer contracted with or hired by the plan, and, if available, consumer assistance offered directly by the plan. Additionally, in states with no consumer assistance program, the notice must include contact information for the HHS Health Insurance Assistance Team.

Eleventh Circuit Holds Wellness Program Not in Violation of ADA

The Eleventh Circuit Court of Appeals has upheld a district court decision holding an employer-sponsored wellness program as not violating the Americans with Disabilities Act of 1990 (ADA). Seff v. Broward County. Broward County sponsored an insured group health plan, through which employees could participate in a wellness program. While participation was not required, employees who failed to participate were charged a $20 fee each pay period. The ADA generally prohibits covered entities from requiring a medical examination or making inquiries of an employee regarding potential disabilities. However, the ADA contains an exception for administering the terms of a bona fide benefit plan that are based on underwriting, classifying or administering risks. Dismissing the argument that the wellness program was not actually written in the insurance plan, the Court stated that wellness programs do not need to be explicitly identified in a plan's written documents to be considered a "term" of the benefit plan. Because the wellness program was sponsored as part of the Broward County insurance contract, was available only to enrolled employees and was described in at least two employee handouts, the Court held that the district court did not err in holding that the wellness program was a term of the insurance plan and therefore fell within the safe harbor.

District Court Holds Michigan Surcharge Not Preempted by ERISA

The District Court for the Eastern District of Michigan has held that the Michigan Health Insurance Claims Assessment Act (the Act) is not preempted by ERISA. Self-Insurance Institute of America, Inc. v. Rick Snyder et al. Generally, the Act requires all carriers, which includes self-funded group health plans under ERISA, and third-party administrators to pay a 1% surcharge on the value of all claims paid for medical services rendered in Michigan to Michigan residents.

The District Court found that the Act does not exclusively impact ERISA plans nor is it aimed at ERISA plans. Rather, the Act is imposed on all carriers and all carriers are treated the same. Additionally, the District Court determined that the Act does not mandate any benefit structure or bind administrators to any benefit choices and that the effect of the Act was not related to ERISA's concern of establishing uniform procedures for processing claims and disbursing benefits. Rather, the surcharge is assessed only after the coverage decision has been made and the

claim paid. Accordingly, the District Court held that the Act "does not refer to an ERISA plan within the meaning of the preemption doctrine" and does not have an impermissible connection to an ERISA plan. The District Court therefore held that the Act was not preempted.