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Employee Benefits & Executive Compensation Tips and Traps: Upcoming Deadlines - October 13, 2011

Welfare Plan Update

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Status of PPACA

- Several challenges to the Patient Protection and Affordable Care Act (“PPACA”) have been made
 - Primary challenge is that the law, or material portions thereof, is unconstitutional
- Split among Circuits as to outcome
 - 11th Circuit: *Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services*, Nos. 11–11021, 11–11067, 2011 WL 3519178 (11th Cir. Aug. 12, 2011); portions unconstitutional
 - 6th Circuit: *Thomas More Law Ctr. v. Obama*, No. 10-2388, 2011 WL 2556039 (6th Cir. June 29, 2011), *petition for cert. filed*, 2011 WL 3288255 (U.S. July 26, 2011) (No. 11-117); constitutional

Status of PPACA cont.

- *4th Circuit: Liberty Univ., Inc. v. Geithner*, --- F.3d ----, 2011 WL 3962915, C.A.4 (Va.), 2011; no jurisdiction to review; issue is tax issue and cannot be challenged until taxpayers have to pay tax
- Pressure from White House and others to have Supreme Court to grant certiorari in 11th Circuit case
- In the absence of definitive rulings from Supreme Court, companies should operate as though the law is constitutional and effective in accordance with its terms and applicable guidance

Brief Overview of Changes Effective for 2011

Change to Definition of Medical Expenses

- PPACA added new IRC Section 106(f) which revised the definition of “medical expenses” for purposes of employer-provided accident and health plans, including health flexible spending accounts (“FSA”) and health reimbursement arrangements (“HRA”)(and certain other types of arrangements such as health savings accounts)
- IRC Section 106(f) generally provides that expenses incurred for drugs or medicine will be treated as a medical expense only if the medicine or drug is insulin or if it is a prescribed drug (determined without regard to whether the drug is available without a prescription)

Brief Overview of Changes Effective for 2011

Change to Definition of Medical Expenses cont.

- There are also restrictions on the ability to use FSA and HRA debit cards to purchase over-the-counter drugs after 2010
- New rules generally effective for expenses incurred after December 31, 2010
 - Expenses incurred prior to December 31, 2010, even if reimbursed thereafter, are not subject to the new rules
- Effective date of December 31, 2010 applied without regard to plan year of employer's plan
- Cafeteria plan amendment deadline was June 30, 2011, retroactive to applicable effective date

Brief Overview of Changes Effective for 2011

Change to Definition of Dependent Children

- For non-grandfathered plans under PPACA that provide dependent coverage, dependent coverage to age 26 required (without regard to status of dependent as disabled, a student, etc.)
- Also applies to grandfathered plans but effective date is 2014 unless the dependent is not eligible to enroll in an employer-sponsored plan other than a grandfathered plan

Brief Overview of Changes Effective for 2011

Elimination of Lifetime Limits

- Elimination of lifetime limits for essential health benefits (all plans, including grandfathered plans)
- Regulations providing guidance for essential health benefits still pending

Brief Overview of Changes Effective for 2011

Prohibition on Pre-existing Conditions for Children Under 19

- Prohibition on pre-existing condition exclusion on children under age 19 (all plans, including grandfathered plans)

Brief Overview of Changes Effective for 2011

Grandfathered Plan Notice

- Grandfathered plan notice to be provided to plan participants in grandfathered plans
- Model language provided

Brief Overview of Changes Effective for 2011

Rescission

- Plans (including grandfathered plans) cannot rescind coverage except in cases of fraud or intentional misrepresentation of material fact
 - Generally prohibits retroactive termination of coverage but does not include a retroactive termination for failure to pay premiums in a timely manner
- Prospective termination is not a rescission for purposes of these rules
- Advance notice of cancellation required

Changes Effective in 2012

W-2 Reporting for Cost of Health Care Coverage

- Beginning for the 2012 year, employers will be required to report the “aggregate cost” of employer-sponsored group health coverage on employees’ Forms W-2
 - Reporting for 2011 was optional
 - Required amount is reported in Box 12 using code DD
- Employers may need to be ready prior to January 2013, when W-2s are generally required, with respect to employees who terminate prior to December 31, 2012 and who request a W-2 to be provided earlier

Changes Effective in 2012

W-2 Reporting for Cost of Health Care Coverage cont.

- The “aggregate cost” is to be determined under rules similar to those used to determine the applicable premium for COBRA purposes
- In the case of an FSA, reporting is only required for employer contributions; employee salary reductions not required to be included in the reporting
- Costs for dental and vision only required to be included if the benefits are incorporated into the group health plan
- Applies to all plans, including grandfathered plans

Changes Effective in 2012

Summary of Benefits and Uniform Glossary

- Plan administrators (or health insurance issuers in the case of insured arrangements) will be required to provide participants and beneficiaries in group health plans with a Summary of Benefits and Coverage (or SBC) and a uniform glossary of defined terms in accordance with guidance provided by HHS, the Department of Labor and the IRS
 - The SBCs are to be significantly more streamlined than an SPD (for example, the SBC can be no more than four double sided pages) and the SBC is to include specified information

Changes Effective in 2012

Summary of Benefits and Uniform Glossary cont.

- SBCs generally must be provided to participants and beneficiaries at the time of enrollment in the plan, at renewal (or open enrollment) and within 7 days after request
- In addition, material changes to the plan (other than changes made at renewal time) that would change the information contained in the SBC would be subject to a 60 day advance notice requirement (which is a departure from current DOL rules which require a 60 day post-adoption notice for adverse changes in benefits)

Changes Effective in 2012

Summary of Benefits and Uniform Glossary cont.

- The SBCs do NOT replace traditional SPDs, summaries of material modifications or other current existing disclosure materials or requirements
- Plan must also make a uniform glossary of defined terms available to participants and beneficiaries
 - The definitions in the glossary must be uniform for all plans
 - The SBC must disclose the right of a participant or beneficiary to receive the glossary and the glossary must be made available within 7 days following a request

Changes Effective in 2012

Summary of Benefits and Uniform Glossary cont.

- The penalty for failing to comply with the new requirements is \$1,000 per day (and a failure with respect to each participant and beneficiary is considered a separate failure)
- The new requirements become effective as of March 12, 2012
 - Guidance on the content of, and standards applicable to, the SBC was supposed to be issued by March 23, 2011 but proposed regulations and templates were not issued until August 22, 2011

Changes Effective in 2012

Summary of Benefits and Uniform Glossary cont.

- Comments on the proposed regulations are requested by October 21, 2011, including comments on whether meeting an effective date of March 12, 2012 is feasible
- It is important to note, however, that the March 12, 2012 deadline HAS NOT YET BEEN extended

Changes Effective in 2012

Changes to Claims and Appeals Procedures

- PPACA requires non-grandfathered plans to make changes to their claims appeal processes
- Generally, PPACA imposes new mandatory external claims review processes and makes changes to internal claims review processes
 - These requirements are in addition to the regular claims procedures under ERISA
 - If a plan does not “strictly adhere” to the claims procedures mandated by PPACA, the claimant will be deemed to have exhausted the claims and appeal process and may proceed to other available remedies, including judicial review

Changes Effective in 2012

Changes to Claims and Appeals Procedures cont.

- Substantial compliance is not sufficient to meet the strict adherence standard and de minimus errors are sufficient to violate the “strict adherence” standard
- Although these changes originally were to be effective beginning in 2011, there have been regulations issued in phases and there have also been several technical releases regarding the applicable requirements, resulting in enforcement grace periods (that is, periods for which enforcement and penalty actions will not be pursued if minimum requirements are met)
 - The current enforcement grace period generally expires for plan years beginning in 2012

Changes Effective in 2012

Preventive Services for Women

- PPACA generally requires non-grandfathered health plans to provide coverage for certain preventive services without cost sharing
 - Interim final rules were issued in July, 2010 and the rules generally became effective in 2011
- In August, 2011, the rules were amended to expand the preventive services that must be provided with respect to women's health issues

Changes Effective in 2012

Preventive Services for Women cont.

- The services that must be provided are determined by reference to guidelines developed by the Institute of Medicine and the guidelines may be updated from time to time and need to be monitored to ensure on-going compliance
- As the guidelines are modified, plans will need to comply within one year
- These changes go into effect for plan years beginning on and after August 1, 2012

Changes Effective in 2012

Lifetime Limits

- Annual limits under group health plans are currently permitted but will be phased out by 2014
 - The maximum annual limit that is permitted increases each year and the limit for 2012 is \$1.25M
 - This limit applies to plan years beginning on and after September 23, 2011 and before September 23, 2012

Changes Effective in 2012

Lifetime Limits cont.

- There is no specific definition of what benefits fall within the purview of “essential health benefits” but there is some guidance on the categories that are covered, including emergency services, lab services, hospitalization and prescription drugs
 - In the absence of definitive guidance, good faith compliance with a reasonable interpretation of the term is required

Nondiscrimination Rules

A Note of Caution

- PPACA provides that nondiscrimination rules similar to those applicable to self-insured health plans are to apply to insured health plans
- The deadline for application of these rules has been delayed and comments on application of the rules has been requested
- The penalty for failure to comply with the requirements can be quite serious

Nondiscrimination Rules

A Note of Caution cont.

- Accordingly, caution should be exercised when entering into any arrangement that may be subject to the nondiscrimination rules, such as an executive employment agreement or severance agreement, unless there is a provision that permits modification after guidance is issued in a manner that complies with the rules
- Although the guidance should only apply to insured arrangements, it may also inform interpretations of the rules applicable to self-insured arrangements which have been in place in for decades and may change some thinking on those rules also
- No current effective date is available

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