

**Towers Watson
Monthly Regulatory Round-Up**

January 2010

- - Health and Group Benefits - -

The Monthly Regulatory Round-Up is a high-level summary of legal and regulatory developments that occurred during January 2010 that may be relevant to large employers. Developments are sorted according to

- federal legislative developments,
- federal regulatory guidance
- other developments (e.g., significant litigation, studies, select state law developments).

The Monthly Regulatory Round-Up is prepared by Towers Watson's Technical Services staff, located in Valhalla, NY. This material is not a substitute for legal, accounting, actuarial or other professional advice.

LEGISLATIVE

1. ***Obama Administration's budget proposal would extend federal COBRA subsidy...again.*** President Obama's proposed federal budget for fiscal year 2011 includes a provision calling for an additional extension of the 65% federal COBRA subsidy. Under the budget proposal, employees who are involuntarily terminated on or after March 1, 2010 through December 31, 2010 would be eligible for the federal COBRA subsidy for up to 12 months. Under current law, as amended by the 2010 Department of Defense Appropriations Act (see below), employees who are involuntarily terminated on or after September 1, 2008 through February 28, 2010 can receive the federal COBRA subsidy for up to 15 months.

REGULATORY

1. ***Mental Health Parity and Addiction Equity Act regulations finally arrive.*** The IRS, DOL and CMS jointly issued long-awaited interim final regulations implementing the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA amended and expanded the Mental Health Parity Act to require that a group health plan's financial requirements and treatment limitations applicable to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. The MHPAEA generally became effective, for calendar year plans, on January 1, 2010. However, employers are not required to be in compliance with the specific interpretations of the law as described in the new MHPAEA interim final regulations until the plan year beginning on or after July 1, 2010 (potentially later for certain collectively bargained plans). Consequently, calendar year group health plans must comply with the new rules beginning January 1, 2011.
2. ***DOL issues updated and new model COBRA subsidy notices.*** The DOL updated two of its existing model COBRA subsidy notices, and distributed a new model notice (i.e., the Premium Assistance Extension Notice), to assist group health plan administrators in complying with the new notice requirements included in the Department of Defense Appropriations Act. Enacted in December 2009, this new law extended the federal government's 65% COBRA subsidy from 9 to 15 months, and extended the deadline for qualifying for the subsidy from December 31, 2009 to February 28, 2010. The new Premium Assistance Extension Notice must be distributed to certain individuals who have already been provided a COBRA election notice that did not include information regarding the extension of the federal COBRA subsidy. For example, individuals who voluntarily or involuntarily terminated employment on or after October 31, 2009 and lost group health coverage must be provided a Premium Assistance Extension Notice by February 17, 2010, unless such individuals were already provided a timely, updated General COBRA Notice.
3. ***DOL launches Form 5500 EFAST2 electronic filing system.*** The DOL's all-electronic system for filing Form 5500 annual reports, EFAST2, "went live" on the DOL's website. The EFAST2 system is intended to facilitate the DOL regulatory requirement that all Form 5500s for plan years beginning on or after January 1, 2009 must be filed electronically. The DOL also issued guidance on how to file delinquent or amended Form 5500s for plan years prior to 2009, in light of the new electronic system that must be used. In addition, the DOL, IRS and PBGC jointly released informational copies of the Form 5500 and accompanying schedules and instructions, to be used for 2009 and 2010 plan year reporting.
4. ***CMS clarifies MSP reporting requirements for HRAs.*** CMS updated its Medicare Secondary Payer (MSP) Mandatory Reporting GHP User Guide to provide guidance to

“responsible reporting entities” (RREs) regarding reporting information on health reimbursement arrangements (HRAs). Under these “Section 111” reporting requirements, RREs must provide CMS with information to identify situations in which group health plans are, or should have been, the primary payer to Medicare. For this purpose, CMS considers an HRA to be a plan that is 100% funded by an employer, regardless of whether it has an end-of-year carry-over or roll-over feature. No retroactive reporting is required for HRA coverage; only HRA coverage with an effective date of October 1, 2010 and later must be reported. Specifically, RREs will be required to report “free-standing” HRA coverage for the first time beginning with MSP Input Files submitted in the 4th quarter of 2010 for HRA effective dates of October 1, 2010, and 1st quarter 2011 for HRA effective dates of January 1, 2011 and later. By “free-standing”, CMS means that the HRA should be reported in this manner only if it is not linked to other group health plan coverage. HRA coverage that is imbedded or part of a more comprehensive group health plan is not reported separately from that comprehensive group health plan. The guidance also states that an RRE should only submit termination dates when a covered individual loses or cancels HRA coverage, and not when the annual benefit value is reached. Finally, only HRA coverage that reflects an annual benefit value of \$1,000 or more must be reported. A copy of the most up-to-date MSP Mandatory Reporting GHP User Guide can be located at (see page 68 for further details on HRA reporting):

<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPUserGuideV3.pdf>

5. ***VEBA’s tax-exempt status not affected by plan’s survivorship benefits for non-tax dependent domestic partners.*** In Private Letter Ruling 200953029, the IRS ruled that a voluntary employee beneficiary association’s (VEBA’s) tax-exempt status under IRC §501(c)(9) is not adversely affected by a plan amendment permitting non-spousal, non-tax dependent domestic partner beneficiaries to be eligible to receive monthly survivorship payments. Under the plan amendment at issue in the ruling, a non-spousal domestic partner is eligible to receive a monthly benefit upon the death of a participant, whether or not the domestic partner qualifies as the participant’s tax dependent as defined in IRC §152.
6. ***IRS Q&A addresses federal COBRA subsidy cross-over year issue.*** The IRS issued a Q&A on its website addressing a timing issue around when an employer may claim a tax credit on its Form 941 related to the federal COBRA subsidy. Specifically, the Q&A provides that if an employer receives an “assistance eligible individual’s” (AEI’s) 35% share of the COBRA premium in 2010, for a 2009 period of COBRA coverage, the employer may claim the credit for the related 65% premium subsidy on Form 941 for either the quarter in 2010 in which it received the AEI’s premium payment, or a later quarter in 2010, but not for a quarter in 2009, regardless of the fact that the premium is for 2009 COBRA coverage.
7. ***CMS updates guidance on Medicare Part D creditable coverage issues.*** CMS revised Chapter 4 of its Medicare Prescription Drug Benefit Manual, which addresses the determinations of Part D creditable coverage, and the related late enrollment penalties. By way of background, an individual is subject to the Part D late enrollment penalty if, after the Part D initial enrollment period, such individual has a continuous period of 63 days or more during which he or she was eligible for but not enrolled in a Part D plan and was not covered under any creditable prescription drug coverage. The guidance in the updated chapter of the Manual is directed primarily to Part D plan sponsors, rather than to employer group health plan sponsors. Specifically, the guidance describes the procedures that Part D plan sponsors must utilize for making creditable coverage determinations, reporting those determinations to CMS, and collecting any late enrollment penalties from beneficiaries. Model forms and notices are included in the Manual. A copy of Chapter 4 of the Manual can be located at: <http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/ccLEPGuidance20070612.pdf>
8. ***IRS issues annual “no rulings” list.*** The IRS released Revenue Procedure 2010-3 listing those topics on which the IRS will not issue private letter rulings or determination letters. Among the health and group benefits topics that fall in this “no ruling” category are (i) whether a self-insured health plan satisfies the nondiscrimination requirements of IRC §105(h), (ii)

whether specific benefits offered through a §125 cafeteria plan are includible in participants' gross income and considered wages for withholding and employment tax purposes, and (iii) whether an action engaged in by a former employee constitutes "gross misconduct" for COBRA purposes.

9. ***DOL safe harbor for remitting employee contributions to small plans.*** The DOL published a final rule that provides a safe harbor for employers to remit employee contributions to small pension and welfare benefit plans (i.e., those with fewer than 100 participants). The safe harbor period is seven business days following receipt or withholding by employers. The DOL also considered expanding the safe harbor to cover large plans, but decided against it at this time. As a result, large plans must remit participant contributions in accordance with the general "plan asset" rule. Under the general rule, for example, the latest date for forwarding participant contributions to health plans is 90 days from the date on which such amounts are received or withheld by the employer.

OTHER

1. ***New York extends duration of health coverage continuation under insured plans.*** New York enacted a law that extends the duration of health coverage continuation under insured health plans in the state to 36 months. As a result, for example, an individual who is covered under a New York insured policy, and who terminates employment, is entitled to an additional 18 months of continuation coverage under state law after their 18-month federal COBRA period expires. The law also provides a 60-day special enrollment period to individuals whose federal COBRA or New York continuation coverage ended between July 1, 2009 and November 1, 2009. The 60-day period begins the date that notice of the new law is provided to the individual; if no notice is provided, the special enrollment period will end on May 19, 2010. Coverage issued during the special enrollment period is effective on a prospective basis, and any gap in coverage that results does not reduce the total 36 months of coverage to which the individual is entitled. The law applies to policies and contracts issued, renewed or amended between July 1, 2009 and October 31, 2009, and to all policies and contracts on or after November 1, 2009, regardless of the date of renewal or amendment. The law does not apply to dental-only plans or vision-only plans.