

Benefits and Employment Briefing



“Wisdom consists of the anticipation of consequences.”

Norman Cousins

A quarterly newsletter about employee benefits and current issues

Third Quarter 2011

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HHS PROPOSES GUIDANCE ON ACA “EXCHANGES”

A cornerstone of last year’s Affordable Care Act (“ACA”) was the establishment of state-based “American Health Benefit Exchanges.” These Exchanges are to serve as health insurance clearinghouses, allowing health care consumers to connect with insurers. Each Exchange must also maintain a “Small Business Health Options Program” (or “SHOP”), through which small employers may obtain health insurance for their employees. In mid-July, the Department of Health and Human Services (“HHS”) proposed two sets of regulations concerning these new Exchanges.

One proposal outlines the requirements that each Exchange would be required to meet, along with similar requirements for the health insurers that would be allowed to offer “qualified health plans” through the Exchanges. Among other requirements, each “qualified health plan” must offer “essential health benefits,” a term that is yet to be defined.

The second proposal describes three different “transitional” programs. These are designed to minimize the negative consequences for insurers – and for the entire health insurance marketplace – as the Exchanges come online.

Requirements for Exchanges

Under the ACA, each state is to establish either a single Exchange covering the entire state or multiple exchanges covering discrete geographic areas. States may even enter into agreements with other states to create multi-state Exchanges. In no event, however, may Exchanges overlap; each individual is to have access to only a single Exchange.

The Exchanges are to become operational on January 1, 2014. If a state chooses not to establish an Exchange, HHS is to do so on its behalf. Moreover, each state wishing to establish an Exchange for 2014 must demonstrate to HHS by January 1, 2013, that its Exchange will be operational by January 1, 2014. This includes the ability to start enrolling individuals in qualified health plans by October 1, 2013.

In the first set of proposed regulations, HHS lists those functions that each Exchange must be able to perform. Consistent with their overall purposes of facilitating the purchase of health insurance coverage by qualified individuals and allowing small employers to offer their employees such coverage, each Exchange will be required to do the following:

- Establish a website through which individuals can obtain information about – and enroll in – qualified health plans.

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- Operate a toll-free telephone hotline through which individuals and small employers can obtain information about qualified health plans.
- Certify plans proposed by health insurers as “qualified health plans.”
- Gather and disseminate quality data concerning health plans.
- Grant exemptions from the ACA’s “individual coverage mandate.”
- Establish a “Navigator” program to assist individuals and small employers in selecting a health plan.

Many of these Exchange functions are designed to give individual consumers the same advantages they would enjoy as participants in a group health plan. These include assistance in selecting a qualified health plan and the benefit of group pricing.

SHOPs

The SHOPs are specifically designed to assist small employers in providing health coverage to their employees. For this purpose, “small” employers are generally defined as those with no more than 100 employees. Through 2016, however, states may limit SHOPs to employers with no more than 50 employees. Moreover, starting in 2017, states may open their SHOPs to employers with *more* than 100 employees.

The Navigator Program

The Navigator program is to be available in both the individual market and through the SHOPs (i.e., in the small-group market). A “Navigator” must be knowledgeable in the health care market and have (or be able to establish) relationships with health care consumers, employees, employers, or self-employed individuals. They must also meet any state licensing requirements, and they may not have any conflicts of interest. To satisfy this final requirement, “a Navigator must not receive any consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals.”

It will be interesting to see how this Navigator concept evolves. Many health insurance agents or brokers would seem to satisfy these requirements – assuming they do not rely solely on commissions paid by health insurers. The proposed regulations would not preclude a Navigator from receiving commissions when enrolling individuals or employers in health plans *outside* of an Exchange. Moreover, states may allow brokers or agents who do *not* choose to become Navigators to receive commissions for assisting consumers in obtaining coverage through an Exchange. Finally, Exchanges are free to list contact information for agents and brokers who are not serving as Navigators. As a result, the ACA’s negative effect on brokers and agents may be less significant than some had feared.

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Transitional Programs

A shorter set of proposed regulations provides guidance on three different transitional programs created by the ACA. Two of these would be effective only from 2014 through 2016, while the third program would be ongoing.

One of the short-term programs would be a reinsurance program designed to help stabilize premiums in the individual insurance market. This program would work by making payments directly to insurers that insure high-cost cases. These payments would be funded by fees imposed on all health insurers and third-party administrators during the period from 2014 through 2016.

The other temporary program would establish a “risk corridor” in both the individual and small-group markets. Under this program, insurers that experience larger-than-expected losses would receive subsidies from the federal government, while insurers that fare *better* than expected would be required to share a portion of their surplus with the government.

The third transitional program would be established only at each state’s option. If a state chooses to adopt this program, it would adjust risks for all *non-grandfathered plans* – in both the individual and small-group markets, and both inside and outside of the Exchanges.

In essence, an insurer that takes on more risk (such as more chronic cases) would receive a premium subsidy for doing so. HHS has proposed a risk adjustment methodology for this purpose, but states would be free to adopt their own alternatives.

Still to Come

Although the primary goal of these proposed regulations is to outline federal standards for Exchanges, HHS has taken pains to point out that states would retain broad discretion in many areas. HHS also promises to continue its ongoing consultations with the National Association of Insurance Commissioners, individual state representatives, and industry groups.

As noted above, both of these sets of regulations are only proposed. HHS has asked for public comments, with a comment deadline of September 28, 2011. The final regulations are to address those comments, as well as the numerous comments already received to date.

Moreover, there is much more Exchange-related guidance to come. According to HHS, future guidance will address the definition of “essential health benefits”; the quality-related standards to be met by Exchanges and insurers of qualified health plans; standards for determining whether an individual is eligible to participate in an Exchange and, if so, should receive either the premium tax credits or cost-sharing

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reductions called for by the ACA; and standards for granting exemptions from the ACA requirement that all individuals maintain some sort of health coverage. Given the ambitious timeline for states to demonstrate their ability to operate these Exchanges, we should expect to see some of this guidance soon. [Return to Top](#)

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SUPREME COURT DECISION REQUIRES NEW FOCUS ON PARTICIPANT COMMUNICATIONS

A long-awaited ruling issued by the United States Supreme Court this spring gives employers both reason to celebrate and cause for concern. The Court's decision in *CIGNA Corp. v. Amara* (May 16, 2011) reaffirms that courts will not enforce benefit rights that are described in a summary plan description ("SPD") as if those rights were actually set forth in the plan document. At the same time that it foreclosed this avenue of relief for plan participants, however, the Court apparently opened up another by concluding that participants who are actually harmed by inconsistent or misleading plan summaries may have an equitable right to be compensated for that harm. As a result, participant communications are likely to be a new source of ERISA litigation in the coming years.

The *Amara* case arose out of CIGNA's decision to convert its traditional defined benefit pension plan into a cash balance plan. A group of plan participants sued in 2001, contending, among other things, that CIGNA's description of the conversion did not comply with the notice requirements under ERISA Section 204(h) and that other communications led them to the mistaken belief that their benefits under the converted plan would always be greater than their benefits under the old formula.

The district court agreed that the communications were misleading and granted relief by essentially re-writing the plan so that it would provide benefits that were more consistent with those that CIGNA had described to participants. The court found support for this remedy in ERISA Section 502(a)(1)(B), which allows a participant to recover benefits "due to him under the terms of the plan."

The district court also considered another provision in ERISA – Section 502(a)(3), which authorizes any other "appropriate equitable relief" – as a basis for the remedy it afforded. Ultimately, however, the court opted not to apply that provision in light of several previous Supreme Court decisions that, in its view, had limited the equitable relief available under Section 502(a)(3). The Second Circuit Court of Appeals summarily affirmed the district court's decision.

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In a May 2011 ruling joined by all eight of the Justices who participated (Justice Sotomayor abstained), the Supreme Court rejected the rationale employed by the lower courts, finding that Section 502(a)(1)(B) does not authorize a court to re-write the terms of an ERISA plan. The Court concluded that this Section permits courts only to interpret or enforce *existing* plan provisions; it does not permit courts to *change* a plan's terms.

In addition, the Court held that the terms of the SPD – which described the enhanced benefits the participants sought – could not be enforced under Section 502(a)(1)(B) as if they were the terms of the plan itself. According to the Supreme Court, representations *about* a plan in the SPD cannot themselves be considered *part* of the plan. Thus, the Supreme Court rejected numerous lower court rulings that had found SPDs enforceable as “plan documents.”

But at the same time that the Supreme Court closed the door on recovery through Section 502(a)(1)(B), it apparently opened an even larger door through which the participants' claims might proceed – the “equitable relief” afforded under Section 502(a)(3). A majority of the Court found that the type of relief the district court granted could be considered “appropriate equitable relief” under that Section. Although ERISA litigators had long understood previous Supreme Court precedent to preclude awards of monetary relief – or “damages” – under Section

502(a)(3), six justices rejected that interpretation. (Justices Scalia and Thomas did not join this part of the opinion.)

The *Amara* Court carefully described a number of equitable remedies that might be available under Section 502(a)(3) to the plaintiffs in this case (and analogous cases), including monetary compensation. Those theories include:

- “Reformation” of a contract (i.e., re-writing a plan's terms);
- “Estoppel” (i.e., denying a plan sponsor the right to rely on the plan's terms when it has made contrary representations to participants); and
- “Surcharge” (a form of monetary compensation against a trustee or other fiduciary).

After *Amara*, the mere fact that the relief sought by plan participants is measured in dollars will not preclude them from filing suit under Section 502(a)(3).

Amara therefore presents a mixed bag for employers and plan fiduciaries. Although the Supreme Court's holding on the enforceability of SPD provisions is welcome news, its discussion of equitable relief is not. The ERISA plaintiffs' bar will undoubtedly use *Amara* to support claims for a broad range of equitable relief – including monetary compensation in the form of surcharge – that had previously been foreclosed by lower courts. Claims

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that would have been summarily dismissed for failure to plead an appropriate remedy under Section 502(a)(3) – for example, because they sought monetary damages – might now survive. This will increase both the likelihood and cost of ERISA litigation.

Litigation involving incomplete or misleading benefit descriptions is certain to increase. Such claims will include those involving an SPD or summary of material modifications that is inconsistent with the terms of the underlying plan, notices that do not adequately describe plan changes, erroneous benefit estimates, mistaken communications about eligibility for health plan coverage, incomplete or erroneous representations made by call center employees or human resource managers about 401(k) balances or distribution rights, and corporate communications describing the employer's benefit plans.

Plaintiffs' attorneys will look for inconsistencies between such communications and the underlying plan terms. It is therefore more important than ever that plan sponsors carefully vet all of their participant communications.

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REVISITING GRANDFATHERED STATUS FOR 2012

2011 has been a big year for grandfathered and non-grandfathered group health plans alike. A number of

significant changes mandated by the Affordable Care Act ("ACA") took effect for both types of plans. Now, 2014 looms as the next big milestone in health care reform. But losing track of the grandfathering rules is a trap for the unwary. While there are no major health care reform changes taking effect in 2012, sponsors of grandfathered plans should revisit the rules governing grandfathered status to ensure that they do not inadvertently lose that status in 2012.

As we explained in our [June 2010 article](#), there are several ways in which a plan can lose grandfathered status. A key point as we await the 2014 changes is that all of these criteria are measured against a static point in time: March 23, 2010 (the day that the ACA was enacted). Thus, *incremental* changes to a plan over time will accumulate, and each year it may be harder for a plan to preserve its grandfathered status.

For example, a plan will lose its grandfathered status if the rate of employer contributions to the plan (for any tier of coverage) decreases by more than five percentage points. Under this rule, the employer may *not* decrease the rate of its contributions by five percent each year.

Instead, if the *cumulative* decrease in employer contributions over two or more years results in a decrease of more than five percentage points below the rate in effect on March 23, 2010, the plan will lose its grandfathered status. Thus, if an employer has already reduced its contribution rate by three percentage

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points in 2011 (say, from 65% to 62% of the total premium), it may reduce its contribution rate by only two additional percentage points in 2012 if it wants to preserve the plan's grandfathered status.

Sponsors should also keep in mind that the regulations condition a plan's grandfathered status on the sponsor taking the following *affirmative* steps:

- Including "in any plan materials provided to a participant or beneficiary that describe the benefits provided under the plan" (such as a summary plan description) a statement that the plan believes it is a grandfathered health plan; and
- Maintaining records that document the terms of the plan as in effect on March 23, 2010, along with any other documents necessary to verify, explain, or clarify the plan's status as a grandfathered health plan. (Such records must then be made available for examination upon request by a participant, beneficiary, or government agency.)

Plan sponsors should carefully consider the *ongoing* nature of the grandfathering rules when setting contribution rates and making plan design decisions for 2012.

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AGENCIES ADOPT ADDITIONAL GUIDELINES FOR WOMEN'S PREVENTIVE SERVICES

As explained in our [August 2010 article](#), the Affordable Care Act ("ACA") requires group health plans (other than plans that are "grandfathered" under the rules described in our [June 2010 article](#)) to cover a list of preventive health services. Earlier this month, the three agencies charged with administering the ACA issued additional rules describing *women's* preventive services that must also be covered. Like the services listed in earlier agency guidance, these women's preventive services must be covered on a first-dollar basis, with no cost-sharing requirement, by "non-grandfathered" group health plans. This article briefly summarizes the new rules.

Covered benefits include well-woman visits, certain breastfeeding equipment, contraceptive methods and counseling, screening for gestational diabetes, and screening and counseling for domestic violence. Generally speaking, the new rules apply to all non-grandfathered plans and are effective for plan years beginning on or after August 1, 2012 (i.e., January 1, 2013, for calendar-year plans). However, the agencies have already amended the rules to allow religious employers to choose whether to cover contraceptive services.

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Guidelines for Women’s Preventive Services

The following chart summarizes the guidance issued this month by the Department of Health and Human Services (“HHS”) on the additional rules for women’s preventive services.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits	Annual visit for adult women to obtain age and developmentally appropriate preventive services, including preconception and prenatal care. Where appropriate, this visit include other preventive services listed in the HHS guidelines, as well as services described in previous guidance.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors.
Screening for gestational diabetes	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immunodeficiency virus	Counseling and screening for human immunodeficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling by a trained provider, during pregnancy and/or in the postpartum period, plus costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence.	Annual.

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Exemption for Religious Employers

Under the amended regulations, if a religious employer objects to contraception on religious grounds, its non-grandfathered group health plan (whether insured or self-funded) need not cover contraceptive services. Such plans must, however, offer all of the other women's preventive services listed in the chart, above.

The faith-based exemption is consistent with contraception coverage mandates under state laws, which typically exempt religious employers. To qualify for the exemption, a religious employer must satisfy three criteria:

- its purpose must be to instill religious values;
- it must primarily employ and serve persons who share its religious tenets; and
- it must satisfy the Internal Revenue Code filing exemptions for religious entities.

The exemption applies only to group health *plans* sponsored by certain religious employers and any group health *insurance* offered in connection with such plans. Accordingly, health insurance issuers in

the *individual* market are not covered under the exemption. [Return to Top](#)

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FORM 8955-SSA FILING DUE DATE EXTENDED

As we reported in our [May 2011 article](#), the Internal Revenue Service ("IRS") has replaced Schedule SSA to the Form 5500 with a new Form 8955-SSA ("Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits"), beginning with the 2009 plan year. The IRS has now released the 2009 Form 8955-SSA. It has also extended the August 1, 2011, deadline for the 2009 and 2010 filings.

The new due date for filing both the 2009 and 2010 Form 8955-SSA is the later of:

- I. the due date that would otherwise apply to the 2010 Form 8955-SSA; or
- II. January 17, 2012.

The January 17, 2012, deadline cannot be extended by filing Form 5558. Plan

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administrators may file a single Form 8955-SSA covering both the 2009 and 2010 reportable employees. In that case, the 2010 reportable employees will be treated as reported in 2009.

Form 8955-SSA can be submitted to the IRS on paper or filed electronically using third-party software and the IRS' Filing Information Returns Electronically ("FIRE") system. Plan administrators may obtain more information about the Form 8955-SSA on the [Form 8955-SSA Resources](#) page at www.IRS.gov. [Return to Top](#)

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