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THE CICOTTE LAW FIRM, LLC

ERISA AND EMPLOYEE BENEFITS + CORPORATE

December 2011 Newsletter

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Treasury and IRS Seek to Define "Governmental Plan": The Treasury Department and IRS have issued two advance notices containing potential proposed regulations defining the term "governmental plan."

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Your Benefits Questions Answered: This month's question involves the relationship between health plans and wellness programs.

2012 Benefit and Contribution Limits: Review changes to benefit and contribution limits for the upcoming tax year.

Health Care Reform: Supreme Court to Review Constitutionality

Challenges to the constitutionality of the Patient Protection and Affordable Care Act ("PPACA") began almost immediately following its passage. As a result of those challenges, the United States Supreme Court recently agreed to review a decision by the Eleventh Circuit Court of Appeals that could potentially affect employers and the health plans they offer employees.

In *Florida v. U.S. Dept. Health and Human Services*, the Eleventh Circuit held the individual insurance mandate in PPACA unconstitutional.

Conversely, other federal appeals courts, including the D.C. Circuit and the Sixth Circuit, have upheld the individual insurance mandate. In two cases before the Fourth Circuit, the court held that neither case could continue. In *Virginia v. Sebelius*, the court explained that the State of Virginia did not have a legal right to challenge the law because it is not an individual. In *Liberty University v. Geithner*, the court held that individuals are unable to challenge the law until the individual mandate actually goes into effect in 2014 and they are required to purchase health insurance.

Consequently, there is now a split among the circuits, necessitating a resolution by the United States Supreme Court. Regardless of what the Court decides, health care reform and PPACA will continue to be hot topics for the foreseeable future.

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Pilot Phase is Underway for HIPAA Privacy and Security Audit Program

Under section 13411 of the HITECH Act, the U.S. Department of Health and Human Services ("HHS") is required to conduct periodic audits to ensure covered entities and business associates are complying with the HIPAA Privacy and Security Rules and Breach Notification standards. Accordingly, the HHS Office for Civil Rights ("OCR") is launching a pilot program to perform up to 150 audits of covered entities to assess privacy and security compliance.

The audit program was scheduled to begin in November 2011 and will run through December 2012. The program will serve as part of OCR's health information privacy and security compliance program to assess HIPAA compliance efforts by a range of covered entities and business associates. Consequently, covered entities and business associates should take appropriate steps to make sure all necessary procedures are in place and compliant with all applicable legal requirements.

Entities selected for audit will receive written notification from the OCR (i) introducing the audit contractor; (ii) explaining the audit process and expectations in detail; (iii) describing initial document and information requests; and (iv) specifying how and when to return the requested information to the auditor. Covered entities and business associates under audit generally must provide all requested information within 10 business days of OCR's request for information.

In addition, to help determine compliance, each audit will include an on-site visit that will consist of interviews with key personnel as well as observation of the entity's processes and operations, followed by an audit report. Selected entities will be notified between 30 and 90 days prior to the anticipated on-site visit, and the actual visit may take between 3 and 10 business days.

Following the site visit, the auditor will prepare a draft audit report and provide the entity with the opportunity to discuss any concerns and describe any corrective action it has implemented. Auditors will then submit a final report to OCR for review. OCR will use final reports to determine the types of technical assistance that should be developed, and the types of corrective action that is most effective.

Our office is available to assist covered entities and business associates in developing, revising, and/or implementing HIPAA privacy and security procedures and standards.

"Following the site visit, the auditor will prepare a draft audit report and provide the entity with the opportunity to discuss any concerns and describe any corrective action it has implemented."

Supreme Court to Review Health Care Reform

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The issues in the case center around whether Congress exceeded its power in passing PPACA. More specific arguments the Court agreed to hear include (i) whether Congress has authority to require individuals to purchase health insurance, otherwise known as the individual mandate; (ii) if the individual mandate is unconstitutional is the remainder of PPACA valid?; (iii) whether Congress can require states to expand and fund Medicaid; and (iv) whether a challenge to PPACA is prohibited until after the mandate goes into effect.

In the event the Supreme Court declares the entire law unconstitutional, health care laws will likely revert back to pre-PPACA. However, should the law or a portion of it be upheld, the debate and challenges will undoubtedly continue for some time.

Although many Supreme Court experts are predicting, with varying degrees of certainty, that the Court will find PPACA constitutional, not all share the same view. Because no one can be certain what the Court will decide, employers should move forward with PPACA compliance plans until any contrary guidance is provided.

The Supreme Court is expected to hear arguments in the case during March of next year, with a decision likely in June 2012, just in time for next year's presidential race.

No Remedy Under FMLA for Employee Whose Supervisor Gave Him Heartburn

The Seventh Circuit Court of Appeals has held that a former employee has no remedy under The Family and Medical Leave Act ("FMLA") for a medical condition exacerbated by a former employer because the employee had exhausted his FMLA leave. Here, one of the plaintiffs in the case, James Breneisen, a former Motorola employee claimed Motorola (i) failed to reinstate him to an equivalent position when he returned to work following FMLA leave; (ii) discriminated and retaliated against him following FMLA leave; and (iii) retaliated against him by way of harassment by a supervisor following a separate subsequent leave. Consequently, he sought recovery of back pay, payment for medical bills, lost employment benefits, and front pay.

Employers should review applicable FMLA requirements with management and supervisory personnel to ensure compliance and to help prevent retaliatory or discriminatory conduct against employees.

In January 2001, James Breneisen, took FMLA leave from his position at Motorola to receive treatment for gastroesophageal reflux. When he returned to work 12 weeks later, he was reassigned to a different position because his position had been eliminated during his leave. Although Breneisen received the same pay and benefits, he considered the change in position a demotion.

Shortly after returning to work, Breneisen took a second leave in April 2001 to receive esophageal surgery. He returned to work in September 2001, but took a third leave in February 2002, to undergo a total esophagectomy. Breneisen failed to return from this third leave and was terminated in June 2003. Breneisen alleged the total esophagectomy was necessary because a supervisor at Motorola caused him to suffer stress, high blood pressure, and stomach reflux, which exacerbated his pre-existing medical condition.

The FMLA generally entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered servicemember with a serious injury or illness.

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a "no fault" attendance policy. An employee generally has no greater right to restoration or to other benefits and conditions of employment than if the employee had been continuously employed.

"The crux of Breneisen's argument is that the alleged mistreatment he received from his supervisor at Motorola upon returning from his second leave in September 2001 exacerbated his pre-existing condition and caused him to take the third leave, from which he never returned." However, the Seventh Circuit found "the cause of an injury is irrelevant under the FMLA, although it would be relevant to a claim based in tort law." The court further suggests that "[e]ven if the cause of an employee's medical condition were relevant under the FMLA, it would not be relevant in Breneisen's case, since the exacerbating conduct he alleges occurred after a second, unprotected leave."

The Seventh Circuit adopted an approach from the Sixth Circuit and held that exacerbation is not a valid theory of liability under the FMLA. Furthermore, "[s]ince stress can adversely affect many common ailments from which physically infirm employees suffer, granting relief on this basis would contravene the straightforward premise of the FMLA—to protect employees from adverse actions by their employers during finite periods when short-term personal or family medical needs require it." Thus, regardless of the reason for sickness, when a medical condition prevents an individual from working "for longer than the twelve-week period contemplated under the statute, the FMLA no longer applies."

Although the court found no remedy existed here under FMLA, employers should be careful to avoid behavior that may lead to a remedy under a separate area of law, or potentially under the FMLA in the event an individual has not exhausted all FMLA leave.

"Employers should review applicable FMLA requirements with management and supervisory personnel to ensure compliance and to help prevent retaliatory or discriminatory conduct against employees."

Is Your Plan's SPD Missing One Key Sentence?

Often overlooked Labor Regulations require pension plans to adhere to non-English language notice requirements. When the number of participants who are literate only in the same non-English language exceeds the applicable threshold, assistance must be offered. Plan administrators should review the requirements and applicable threshold outlined below to determine whether they are in compliance.

The Employee Retirement Income Security Act ("ERISA") generally requires that a plan administrator must keep plan participants and beneficiaries informed of the terms and operation of the plan through the use of summary plan descriptions ("SPDs"). ERISA requires that an SPD must be written in a manner calculated to be understood by the average plan participant. In addition, an SPD must be sufficiently accurate and comprehensive to reasonably apprise participants and beneficiaries of their rights and obligations under the plan. To satisfy ERISA's requirements, the plan administrator must exercise considered judgment and discretion by taking into account factors such as the level of comprehension and education of typical plan participants and the complexity of the terms of the plan.

Plans subject to the non-English SPD notice requirements include plans covering: (i) fewer than 100 participants if 25% or more of all plan participants are literate only in the same non-English language; and (ii) 100 or more participants if the lesser of (a) 500 or more, or (b) 10% or more of all plan participants, are literate only in the same non-English language. If the threshold established in the regulations is satisfied, the plan administrator must include a prominently displayed notice, in the non-English language common to those participants. Additionally, the notice must offer them assistance, and clearly set forth the procedures participants must follow to obtain the assistance.

Foreign language assistance and notices are not required to be provided in every non-English language spoken by participants unless the applicable threshold is satisfied. The assistance does not have to involve written materials, but must be provided in the common non-English language and must be calculated to provide participants with a reasonable opportunity to become informed as to their rights and obligations.

Plans providing a foreign language notice for non-English-speaking participants under the SPD regulations must give participants an English language summary annual report that also includes a similar notice, in the non-English language common to the participants, offering assistance in understanding the financial status of the plan.

To minimize the risk of ERISA violations resulting from a deficient SPD, we recommend erring on the side of caution and including a foreign language offer of assistance in any situation where there is a possibility that the requirement might apply.

"Foreign language assistance . . . [is] not required to be provided in every non-English language spoken by a participant unless the applicable threshold is satisfied."

Treasury Department and IRS Seek to Define "Governmental Plan"

The U.S. Department of Treasury and the Internal Revenue Service ("IRS") recently issued two advance notices of proposed rulemaking relating to the definition of the term "governmental plan" under Code section 414(d). Because of increased questions from employers and lack of regulations defining the term "governmental plan," new rules will provide plan sponsors much needed guidance to help determine whether a retirement plan is a governmental plan.

Each advance notice contains drafts of potential proposed regulations. The first notice describes general guidance and approaches under consideration on how to determine whether a retirement plan is a governmental plan. The second notice is more specific and applies additional rules to the definition of a governmental plan sponsored by an Indian Tribal Government.

Comments on (i) the potential proposed regulations; (ii) other possible approaches; and (iii) other issues may be submitted to the IRS by February 6, 2012. For assistance filing comments relating to these advance notices please contact our office.

Selected 2011 Year-End and Early 2012 Compliance Deadlines

Plan sponsors should review their plans to ensure that they are in compliance with all applicable required amendments.

Selected amendments, disclosures, and legislative changes affecting retirement and health and welfare plans include:

Worker, Retiree, and Employer Recovery Act of 2008 ("WRERA")

- Required Minimum Distribution Waiver for 2009

Note: Governmental plans must amend plans to comply with WRERA by the end of the 2012 plan year.

Pension Protection Act of 2006

- Governmental plans must adopt all applicable PPA amendments by the end of the 2011 plan year.
- Other extended deadlines for nongovernmental defined contribution and defined benefit plans:
  - Three-year cliff vesting for cash balance plans.
  - Diversification requirements.
  - *Note: Funding benefit restrictions was originally required by the end of 2011, but has been extended to the end of the 2012 plan year.*

Cycle A Plans

- Must be submitted for determination letter no later than January 31, 2012.

Qualified Plan Required Notices:

Plan sponsors should make sure all required notices relating to their retirement plans are provided to participants in a timely manner. Some of the required notices may include:

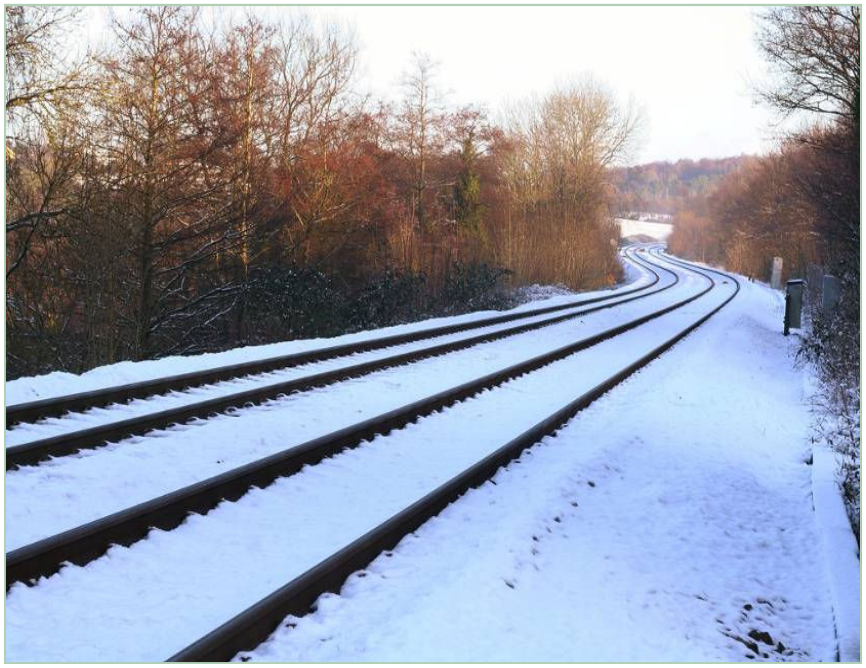
- 401(k) Plan Annual Automatic Enrollment Notice
- 401(k) Plan Safe-harbor Plan Notice
- Qualified Default Investment Alternative Notice
- Annual Funding Notice (applies to defined benefit plans)
- Benefit Statements

Health and Welfare Plan Year-end Compliance Issues

Plan sponsors should be aware of the following requirements under the Patient Protection and Affordable Care Act ("PPACA") that may affect their health and welfare plans:

- Internal Claims/Appeals and External Review
  - Applies to plan years beginning on or after January 1, 2012.
- W-2 Reporting of Health Care Coverage Costs
  - *This requirement is voluntary for 2011, and generally applicable for employers beginning with 2012 W-2 forms.*
- Summary of Benefits and Coverage
  - Generally effective March 23, 2012.
- General compliance with PPACA for all group health plans that will lose grandfathered status in 2012.

"Governmental plans must adopt all applicable PPA amendments by the end of the 2011 plan year."



Your Benefits Questions Answered

We welcome employee benefits related questions from our readers for possible inclusion in an upcoming issue of our newsletter. You may submit your employee benefits related questions at any time to: *questions@cicottelaw.com*.

Due to the volume of questions that may be submitted we cannot guarantee that all questions will be answered. We will select questions that are most applicable to a broad spectrum of employers and businesses.

Reader Question:

The claims administrator for our self-insured health plan recently asked us to sign a Hold Harmless and Indemnification Agreement ("HHIA") in response to our request for payments to be made to providers at our annual wellness fair. The claims administrator has never asked for this before. Should we sign it?

Response:

The claims administrator considers the payments to providers at the annual wellness fair to be "extra-contractual." In other words, the claims administrator has reviewed your health plan document and does not find the wellness services to be covered by your health plan.

Requesting the HHIA is the claims administrator's way of letting you know that it does not believe the requested payments are covered by your plan.

Because both ERISA and the tax code require health plans to be maintained pursuant to a written document, there are several potential types of liability that might arise if payments not authorized by the plan are made. The administrator wants to warn you of such liability in advance and wants to clarify that it will not be responsible for any liability.

The solution is to provide the claims administrator with a copy of your wellness program document. Because your wellness program and the annual wellness fair are parts of your health plan, payments permitted under the wellness program are permissible expenses under the health plan. The claims administrator is simply missing part of the documentation for your plan. For this reason, you should not sign the HHIA, but should help the administrator better understand your plan.

A wide variety of arrangements are commonly referred to as "wellness programs." Not all are part of an employer-sponsored health plan. If a wellness plan is a stand-alone arrangement, it may be inappropriate for wellness-related payments to be made from a health plan. Consequently, it is important for both plan sponsors and outside administrators to understand the scope of employer wellness programs and their relationship to any health plan(s) also sponsored by the employer.

"[T]here are several potential types of liability that might arise if payments not authorized by the plan are made."

2012 Retirement, Compensation, and Health Benefit Limits

Retirement Limits	Under Age 50	50 +
Maximum salary deferral to a 401(k), 403(b) or 457 plan	17,000	22,500
Maximum annual additions to a defined contribution plan	50,000	55,500
Maximum annual benefit in a defined benefit plan	200,000	200,000
SIMPLE account maximum deferral	11,500	14,000
Maximum IRA Contribution (Deductible or Roth)	5,000	6,000
ESOP distribution periods	5 years	6-10 years
account balances up to:	1,015,000	+200,000/year

Compensation Limits	2012	
Social Security Wage Base	110,100	
Highly compensated employee	115,000	
Maximum eligible compensation	250,000	
SEP minimum compensation	550	
Key employee	Officer	1% Owner
	165,000	150,000

Health Benefit Limits	2012	
HSA - Individual	3,100 (4,100 for age 55 +)	
HSA - Family	6,250 (7,250 for age 55 +)	
High Deductible Health Plan	Individual	Family
• minimum deductible	1,200	2,400
• maximum out-of-pocket	6,050	12,100
PPACA minimum annual limit on essential health benefits for 2011	1,250,000 (calendar year plan)	

Disclaimer: *Our firm issues this newsletter to provide legal updates in the areas of corporate and employee benefits law as a courtesy. This newsletter is for general information only and does not constitute legal advice. Additionally, this newsletter does not create an attorney-client relationship, nor does it create responsibility for The Cicotte Law Firm in regards to your corporate and employee benefit issues. Should you have any questions relating to matters discussed in this document, you should contact an attorney.*

About the Cicotte Law Firm

The Cicotte Law Firm is located in Kennewick, WA, and represents employers in several states in all aspects of benefits law, handling diverse employment, labor, tax and corporate matters.

The Firm's practice covers all areas relating to employee benefits, including designing "defined contribution-style" health plans (HRAs, HSAs, & FSAs), assistance with COBRA, HIPAA, ARRA, and PPACA issues, advising on fiduciary responsibilities, maintaining legal compliance with non-discrimination requirements, analyzing unusual benefit claims, representing employers in labor relations matters where pension or welfare benefits are involved, advising on the federal tax implications of complex benefits-related issues, and examining the ERISA status of compensatory arrangements.

Other practice areas vital to corporate function available at the Firm include corporate formation, corporate compliance, negotiations, mergers and acquisitions, SEC compliance, and HR liaison activities.

The Firm is also able to assist companies with licensing agreements, non-compete agreements, and nondisclosure agreements.

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