

THE CICOTTE LAW FIRM, LLC

ERISA AND EMPLOYEE BENEFITS + CORPORATE



March 2011 Newsletter

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Fee Disclosure Regulations:

The DOL has extended the applicability date for the new fee disclosure regulations to January 1, 2012; however early compliance efforts should continue.

Is Your Health Plan Grandfathered? PPACA recognizes certain health plans as grandfathered; however, plan sponsors must be aware of certain changes will cause a plan to lose grandfathered status.

Debit Cards and the Purchase of Over-the-Counter Medicines: The IRS has issued modified guidance permitting the use of debit cards to purchase over-the-counter medicines and drugs under certain circumstances.

Cycle A Submissions Underway: The new submission

period for determination letters for individually designed single employer plans in Cycle A began on February 1, 2011.

Challenges to Healthcare Reform: Many judicial and legislative challenges regarding the constitutionality of PPACA continue to intensify the debate over healthcare reform as we approach one year since the passage of PPACA.

Red Flags Rule Clarification: The Red Flag Program Clarification Act of 2010 has clarified the definition of creditor for purposes of who is required to comply with the Red Flags Rule.

VCP Fee Discount Ending: Plan sponsors using pre-approved 401(k), profit-sharing, money purchase, or

other defined contribution plans who failed to timely adopt a pre-approved EG-TRRA plan have until April 30, 2011 to take advantage of a discounted Voluntary Correction Program fee.



Applicability Date for New Fee Disclosure Regulations Extended

The Employee Benefits Security Administration ("EBSA") has extended the applicability date for the new disclosure regulations under ERISA section 408(b)(2) to January 1, 2012. Plan sponsors and service providers to pension plans, however, should continue implementing compliance rather than delay such efforts because of the extension.

According to the EBSA the decision to extend the effective date was based in part on comments and suggestions received on the interim final rule and the need for careful review of such input. The EBSA also indicated that the

extension will (i) afford the agency with the time it needs to get the final rule correct; and (ii) provide plans and their service providers the time they need to orderly and efficiently implement compliance efforts.

The interim final regulations require certain service providers to disclose information to assist plan fiduciaries in understanding the reasonableness of the fees charged for plan services and assess potential conflicts of interest that may affect the quality of services. Under the interim rule the affected service providers include those that expect to receive at least \$1,000 in

compensation in connection with their services and that provide: (i) certain fiduciary or registered investment advisory services; (ii) recordkeeping or brokerage services to a participant-directed individual account plan in connection with the investment options made available under the plan; or (iii) certain other services for which indirect compensation is received.

Although no major change to the interim rule is expected, early compliance efforts will allow plan sponsors and service providers to easily adapt should any modification to the final rule arise.

Is Your Health Plan Grandfathered?

When the Patient Protection and Affordable Care Act (“PPACA”) was enacted, one of the President’s stated goals was to allow Americans who already have healthcare coverage the ability to maintain that healthcare coverage. In an effort to meet this goal, PPACA recognizes certain plans as being “grandfathered.” Among other requirements, a grandfathered plan must have been in place the day PPACA was enacted, March 23, 2010. Grandfathered status exempts plans from some, but not all, of the healthcare reform requirements.

While it is a simple process to *determine* whether a plan is grandfathered, the process of *maintaining* grandfathered status is more difficult. To *maintain* status as a grandfathered plan, a health plan must refrain from making certain changes. Changes that will cause a health plan to lose grandfathered status include:

- Eliminating all or substantially all of the benefits to diagnose or treat a particular condition;
- Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual’s coinsurance requirement);
- Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase;¹
- Any increase in a fixed-amount copayment, determined as of the effective date of the increase if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:
 - An amount equal to \$5 increased by medical inflation, or
 - The maximum percentage increase, determined by expressing the total increase in the copayment as a percentage;
- Decreases in contribution rates by an employer or employee

organization based on cost of coverage or based on a formula, towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010;

- Addition of an annual or lifetime limit if a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits;
- Decrease in limit for a plan or coverage with only a lifetime limit if a group health plan, or group or individual health insurance coverage that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits;
- Decrease in limit for a plan or coverage with an annual limit if a group health plan, or group or individual health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits.

One of the most potentially problematic limits on grandfathered plans is the provision which limits an employer’s ability to increase employee contributions by an amount greater than 5%. This provision comes up most often when an employer seeks to increase the portion of premium paid by employees.

For example, assume that as of March 23, 2010, the total premium cost was \$100 and the employer contributed \$80 (or 80%) and the employee contributed \$20 (or 20%). In 2011, the premium amount increases to \$200 and the employer wishes to increase the employee contribution amount. To maintain grandfathered status, the employer may only increase the employees’ contribution rate by 5% (to 25% of the total premium), resulting in the employer contributing \$50 and the employee contributing \$150.

All plans, including grandfathered plans, commencing with plans years beginning after September 23, 2010, must comply with PPACA’s prohibitions on (i) denying coverage based on pre-existing conditions for children under the age of 19; (ii) the requirement to extend coverage to dependents until the age of 26; (iii) limits on annual and lifetime limits; and (iv) new rules regarding when a rescission of coverage is appropriate.

If a health plan was not in existence on March 23, 2010, or was in existence on March 23, 2010 but is unable to comply with the limits on grandfathered plans, then the health plan must comply with new requirements for health plans contained in PPACA. These new requirements include a series of new patient protections, increased external and internal appeals processes, and non-discrimination rules.

Plan sponsors need to assess the pros and cons of maintaining grandfathered status. If a decision is made for a plan to remain grandfathered, procedures should be put in place to protect that status.

¹ The term maximum percentage increase means medical inflation (the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) published by the Department of Labor) plus 15 percentage points.



“To maintain status as a grandfathered plan, a health plan must refrain from making certain changes to the plan.”



IRS Issues Revised Guidance on Use of Debit Cards to Purchase Over-the-Counter Medicines

Many health FSA and HRA sponsors prefer to provide participants with debit cards to pay for covered services rather than be concerned with reimbursement claims. Prior IRS guidance issued in 2010 would have severely limited use of debit cards after January 15, 2011; however, the IRS modified such guidance earlier this year to permit additional exceptions to the previous restrictions.

IRS Notice 2011-5 provides that health FSA and HRA debit cards may continue to be used after January 15, 2011 to purchase OTC medicines or drugs from drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs if:

- (1) Prior to the purchase, the prescription for the medicine or drug is presented to the pharmacist, the medicine or drug is dispensed in accordance with applicable law and regulations pertaining to the practice of pharmacy, and a prescription number is assigned;
- (2) the pharmacy or other vendor retains a record of the prescription number, the name of the purchaser, and the date and amount of the purchase according to IRS requirements;
- (3) all of these records are available to the employer or its agent upon request;
- (4) the debit card system will not accept a

charge for an OTC medicine or drug unless a prescription number has been assigned; and

- (5) the requirements of IRS Notice 2011-5 are satisfied.

Health FSA and HRA debit cards may also continue to be used after January 15, 2011, to purchase OTC medicines and drugs from vendors having health care related Merchant Codes if the requirements above are satisfied, with the exception of the requirements in items (1) and (4) above, and the requirement in item (2) that a record of the prescription number be retained.

Furthermore, health FSA and HRA debit cards may continue to be used to purchase OTC medicines and drugs at a pharmacy if it is a store for which ninety percent (90%) of gross receipts during the prior taxable year consist of items that qualify as medical care expenses under the Internal Revenue Code ("90 percent pharmacies"), but only as provided by guidance in IRS Notice 2010-59.

With respect to all other providers and merchants not described in IRS Notice 2011-5, health FSA and HRA debit cards may not be used to purchase OTC medicines or drugs after January 15, 2011.



"Prior IRS guidance issued in 2010 would have severely limited use of debit cards after January 15, 2011"

Cycle A Submission Period Underway

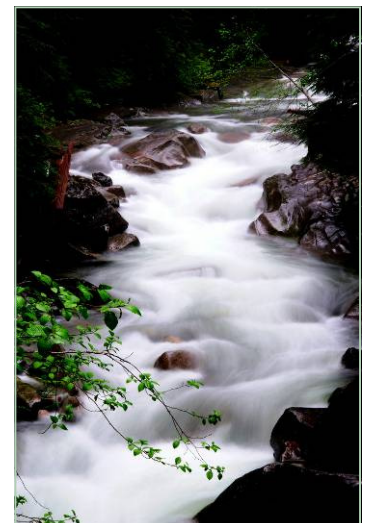
Sponsors with Cycle A plans should begin preparing for submission by making certain their plans are amended in accordance with the 2010 Cumulative List and any other relevant qualification requirements.

The Cycle A submission period opened on February 1, 2011 and runs through January 31, 2012 for individually designed single employer plans to file determination letter applications. Cycle A plans generally include plan sponsors with an EIN ending in 1 or 6.

This submission period begins the second 5-year remedial amendment cycle for individually designed plans. As in previous cycles, the IRS will review all plans for compliance according to the most recent Cumulative List. Plans submitting applications in Cycle A must comply with the 2010 Cumulative List which was issued in IRS Notice 2010-90.

In accordance with provisions in the 2010 Cumulative List, the IRS will not consider in its review of any Cycle A determination letter application any: (i) guidance issued after October 1, 2010; (ii) statutes enacted after October 1, 2010; (iii) qualification requirements first effective in 2012 or later; or (iv) statutory provisions that are first effective in 2011, for which there is no guidance identified in the 2010 Cumulative List.

While the 2010 list does not include any of the items described in (i)-(iv) above, a plan must comply with all relevant qualification requirements, not only those on the cumulative list. Failure to comply with all requirements may result in plan disqualification. In addition, terminating plans must include all statutory changes in effect at the time of termination.



Challenges to Healthcare Reform: What Does It All Mean?

On January 31, 2011, a federal district court in Florida ruled that the federal healthcare reform law, the Patient Protection and Affordable Care Act ("PPACA"), is unconstitutional. The Florida court's ruling came less than two weeks after the House voted to repeal the controversial law and many Americans are left wondering if the healthcare reform laws are really here to stay.

Although these challenges to PPACA are serious and could result in the law eventually being overturned, it remains unclear whether these challenges will actually have any immediate effect on the law. The ultimate success of the myriad of judicial challenges to the law will likely depend on the opinion of the U.S. Supreme Court. It is difficult to estimate how long the appellate process will take. In the meantime, the House's vote to repeal the law will likely remain a symbolic gesture, unless the Democrats lose their majority in the Senate or lose the presidency in 2012.

Judicial Challenges

The federal court in Florida held that the individual mandate, requiring all Americans to obtain health insurance was an unconstitutional exercise of authority by the federal government. The court reasoned that the federal government's powers under the Commerce Clause of the United States Constitution, which allows the federal government to "regulate commerce with foreign nations, and among the several states, and with the Indian tribes," were not so great that the federal government could actually require Americans to obtain health insurance. The court went on to find that the individual mandate was an essential part of the healthcare reform legislation and could not be severed from the rest of the law. As a result, the judge found the entire law unconstitutional. As expected, the federal government immediately appealed this decision.

A federal court in Virginia has also held the portion of the law relating to the individual mandate, rather than the entire law, unconstitutional. Conversely, two additional challenges to healthcare reform were decided in favor of the law.

Each of these challenges to healthcare reform has been appealed; however, before a case may be heard by the U.S. Supreme Court it must generally be heard first by the appropriate federal court of appeals. Once the appeals process is complete, the Supreme Court must issue a writ of certiorari agreeing to take the

case. The appeals process can take months, if not years, before the Supreme Court issues a final decision.

In rare circumstances the Supreme Court will hear a case before a court of appeals issues a decision. Cases not yet decided by a court of appeals may be heard by the Supreme Court if the Court decides the case is of such imperative public importance that deviation from normal appellate practice and immediate determination by the Supreme Court is justified. Virginia Governor Bob McDonnell, a plaintiff in the recent Virginia challenge, has sought this type of expedited review; however, it has not been decided whether the Court will agree to hear the case on an accelerated basis.

At this time it is uncertain how long it will take the Supreme Court to issue a final decision on the constitutionality of PPACA. Even if the Court allows the Virginia case to circumvent the appeals court, it may be months before a decision is issued. Furthermore, there is no guarantee the Supreme Court will decide the healthcare reform debate once and for all, as it is possible the Court could find the individual mandate unconstitutional but uphold the remainder of the law.

Legislative Challenges

On January 19, 2011, the House voted to repeal PPACA, but the immediate practical effect of this vote is primarily symbolic. In order for the law to be repealed, the Senate would also need to vote to repeal the law; however, because the Senate has a Democratic majority, it has refused to allow such a vote. Moreover, even if a change of heart occurs in the Senate, the law's champion, President Obama, would likely veto any repeal. Consequently, it is unlikely that any legislative challenges to healthcare reform will be successful until after the next presidential election in 2012.



"The court went on to find that the individual mandate was an essential part of the healthcare reform legislation and could not be severed from the rest of the law."



Recent Legislation Limits the Type of Creditors Subject to the Red Flags Rule

Many businesses such as doctor's offices, law firms, and veterinary clinics were inadvertently subjected to the Red Flags Rule promulgated by the Federal Trade Commission ("FTC") under the Fair and Accurate Credit Transactions Act of 2003. The Red Flags Rule, if enforced, would have required a small business that extends credit incidental to the delivery of its service, such as a doctor providing medical care in exchange for future payment, to comply with identity theft prevention guidelines, resulting in a potentially unnecessary cost burden. The FTC repeatedly delayed the final rule to allow Congress to legislatively clarify which entities should be covered as "creditors."

The Red Flag Program Clarification Act of 2010 amended the Fair Credit Reporting Act ("FCRA"), with respect to federal agency guidelines regarding identity theft and the users of consumer reports, to define creditor to mean one that regularly and in the ordinary course of business: (i) obtains or uses consumer reports, directly or indirectly, in connection with a credit transaction;

(ii) furnishes information to certain consumer reporting agencies in connection with a credit transaction; or (iii) advances funds to or on behalf of a person, based on the person's obligation to repay the funds or on repayment from specific property pledged by or on the person's behalf.

The clarification includes in the definition any other type of creditor as the federal agency (e.g. banking agency, National Credit Union Administration, or the FTC) having authority over that creditor may determine appropriate, if the creditor offers or maintains accounts subject to a reasonably foreseeable risk of identity theft. Excluded from the definition of creditor, however, is any creditor that advances funds on behalf of a person for expenses incidental to a service the creditor provides to that person.

The FTC is in the process of updating and revising materials on the Red Flags Rule website to reflect the change in the law. Additional information may be found at: www.ftc.gov/redflagrule.

VCP Fee Discount Ending for Sponsors Who Failed to Timely Adopt EGTRRA-Approved Plan

Plan sponsors using pre-approved 401(k), profit-sharing, money purchase, or other defined contribution plans were required to adopt a plan approved by the IRS for EGTRRA by April 30, 2010.

Plan sponsors that failed to adopt an EGTRRA-approved plan by the deadline may correct such failure through the IRS' Employee Plans Compliance Resolution

System ("EPCRS") Voluntary Compliance Program ("VCP") for a discounted fee of \$375 through April 30, 2011.

Because April 30, 2011 falls on a Saturday, the IRS will accept submissions postmarked on or before May 2, 2011. Submissions postmarked after May 2, 2011 will not qualify for the discounted fee.

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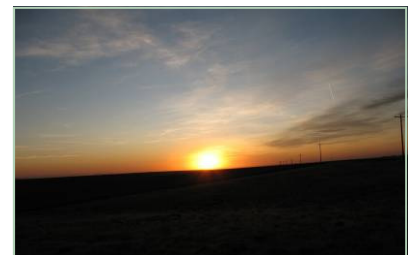
About the Cicotte Law Firm

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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