2007 Compliance Dates For New and Recent Federal Regulations and Laws Applicable to Pension and Health and Welfare Plans

A number of compliance dates for qualified pension plans and ERISA-covered group health and welfare plans loom on the horizon in 2007. Some of these dates are recent but recurring in nature and should be of no surprise. Others are new this year, although plans were notified by published guidance of such dates in 2006.

This Client Bulletin will address the following compliance matters:

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Disclosure of Relative Values of Optional Forms of Benefit (1/1/07)
Code Section 417(a)(3) requires a plan to provide a written explanation to each participant that includes, among other information, the terms and conditions of a qualified joint and survivor annuity (QJSA). Final regulations under Section 417(a)(3) requiring disclosure of the relative value and financial effect of optional forms of benefit as part of QJSA explanations were published in late 2003. Those 2003 regulations were to be effective for QJSA explanations provided with annuities starting on or after October 1, 2004.

For a variety of reasons, the Internal Revenue Service (IRS) postponed the effective date of the 2003 relative value disclosure regulations until on or after February 1, 2006. In the Winter 2006 edition of the Employee Plan News, the IRS further postponed the effective date, indicating that it would only require a "good-faith effort that is in substantial compliance" with the 2003 relative value regulations for QJSA explanations provided before January 1, 2007. i.e. do the best you can in 2006, but be ready for full compliance by January 1, 2007.


Creditable Coverage Disclosure to CMS (60th day of Plan Year)
Health plans that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage."

This disclosure to CMS is required whether the entity's coverage is primary or secondary to Medicare. The Disclosure to CMS Form is due no later than 60 days following the beginning of the health plan’s plan year (renewal year, contract year, filing year, etc.). That would be March 1, 2007 for calendar year plans, etc.

Employers and unions that were accepted for the Retiree Drug Subsidy (RDS) are exempt from filing the Disclosure to CMS only for the individuals and plan options for which they are claiming the RDS. If the employer or union offers prescription drug coverage to any other Medicare Part D eligible individual (active, disabled, COBRA or any retirees or dependents who are covered by the employer or union but are not being claimed under the RDS), they must provide a disclosure to CMS for those plan options that cover those individuals and complete the requested information.
If a health plan does not offer prescription drug benefits to any Medicare Part D eligible individuals on the beginning date of their plan year (renewal year, contract year, etc.), the plan is not required to complete the disclosure to CMS form for that plan year.

Entities must use the online Creditable Coverage Disclosure Form to disclose its creditable coverage status to CMS. The Form can be found at: https://www.cms.hhs.gov/apps/ccdisclosure/default.asp

For more information on the Creditable Coverage Disclosure to CMS please refer to the following guidance on the CMS website:

- Creditable Coverage Disclosure to CMS Guidance
- Helpful Hints: Disclosure to CMS Form
- User Guide: Disclosure to CMS Form

**Information on Availability of HIPAA Privacy Rule Notice (4/13/07)**
The HIPAA Privacy Rule was effective for most covered entities (including health plans) on April 14, 2003 (April 14, 2004 for small health plans). The Privacy Rule requires health plans to provide a Notice of Privacy Practices (Privacy Notice) to individuals covered by the plan by the original effective date(s). Thereafter, plans are required to provide the Privacy Notice to individuals who are new enrollees at the time of enrollment and to individuals then covered by the plan within 60 days of a material revision to the Notice. Additionally, the health plan must notify all covered individuals of the availability of the Privacy Notice and how to obtain the Privacy Notice no less frequently than once every three years.

For small health plans, April 13, 2007 will be three years since the original Privacy Notice was distributed. Consequently, if they have not done so already, small health plans will need to notify all individuals covered by the plan of the availability of the Privacy Notice and how to obtain the Privacy Notice by April 13, 2007.

**NOTE: The plan is NOT required to resend the entire Privacy Notice.** There is no specific format or method for giving covered persons this information. A separate mailing is not required. However, in compliance with the spirit of the Privacy Rule, if the information on how to obtain a copy of the Privacy Notice is combined with other communications or placed in a newsletter, it would be advisable to use at least one of the following methods to make the information stand out: add the information in a text box, use a bolded or larger font, highlight or shade the text or somehow otherwise emphasize the information.
Defined Benefit Funding Notices (9/30/07)
The Pension Funding Equity Act of 2004 ("PFEA") added a funding notice ("Funding Notice") requirement to ERISA that is applicable to multiemployer defined benefit plans. The Funding Notice requirements DO NOT apply to multiemployer defined contribution plans. This law was discussed in detail in Client Bulletin 2004-57.

The Funding Notice must be furnished to participants, beneficiaries and other interested parties, including the Pension Benefit Guaranty Corporation (PBGC), within nine months after the close of the plan year for plan years beginning after December 31, 2004. For calendar year plans, the Funding Notice needs to be sent out before September 30, 2007, the same deadline for distributing the plan’s summary annual report (SAR). September 2007 is two months following the due date for calendar year plans to file their annual report (Form 5500). If the plan obtains an extension of time to file the annual report, then the Funding Notice must be furnished within two months after the close of the extension period.

As noted above, the PBGC must also receive copies of all multiemployer plan annual funding notices. See Benefit News Briefs 2006-37 for previous reporting on this matter. PBGC copies should be sent to:

PBGC
1200 K Street NW, Suite 930
Washington, DC 20005-4026
ATTN: Multiemployer Data Coordinator

The PBGC will also accept an electronic copy e-mailed to:
mailto:Multiemployerprogram@PBGC.gov

EGTRRA Determination Letter Program Open for Cycle B Individually Designed and Multiple Employer Plans (2/1/07 thru 1/31/08)
The IRS is now accepting applications for determination letters for Cycle B defined benefit and defined contribution individually designed plans. Cycle B includes applications for determination letters for multiple employer plans, such as District Council plans. Client Bulletin 2005-39 discussed the new determination letter cycles in detail.

The submission period for Cycle B plans begins on February 1, 2007, runs through January 31, 2008 and must be postmarked no later than this date to be submitted timely. The review of these applications will take into account the requirements of EGTRRA, as well as other changes in qualification requirements and guidance identified in the Cumulative List in Notice 2007-3, available at:
Under these new procedures, sponsors of individually designed plans will submit applications for determination letters once every five years, under a staggered system of five-year cycles. Not all individually designed plans have the same cycle, so fund professionals should be sure that the plan is submitted within the appropriate cycle. A chart showing the filing cycles is available at: http://www.irs.gov/retirement/article/0%2C%2Cid=146889%2C00.html

**Multiemployer pension plans are in Cycle D and have a filing period running from February 1, 2009 through January 31, 2010.**

User fees for submitting determination letters increased on July 1, 2006 and can be viewed at: http://www.irs.gov/charities/article/0%2C%2Cid=121515%2C00.html


**HIPAA National Provider Identifier (NPI) Final Rule (5/23/07)**

*Research Memo 2004-9* reported on the publication of the Final Rule concerning the National Provider Identifier (NPI) and *Benefit News Briefs 2006-12* provided an update on NPI compliance.

**HIPAA** covered entities such as providers completing electronic transactions, healthcare clearinghouses, and **group health plans must use only the NPI to identify covered healthcare providers in standard electronic transactions by May 23, 2007.**

**Small health plans must use only the NPI by May 23, 2008.**

The NPI is a ten-position numeric identifier consisting of the nine-digit employer identification number (EIN), with a check digit in the tenth position and no intelligence about the health care provider in the number.

**One issue confronting health plans is how to obtain providers’ NPIs.** Unfortunately, at the present, there is no national database of NPIs that health plans can access to obtain providers’ NPIs.
Based on industry reports, many health plans are following a proposal by the Workgroup for Electronic Data Interchange (WEDI) in its white paper entitled “Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers on X12 Transactions.” This paper advocates the transition to NPI compliance by following the dual use of the NPI and legacy identifiers strategy. A legacy identifier is the current identifier a provider uses. The white paper is available at: http://www.wedi.org/npoi/public/articles/index.cfm?fuseaction=link.

With Dual NPI-Legacy, the sender puts NPI in the Primary Identifier field, and it puts all Legacy Identifiers in one of the Secondary Identifier fields. Initially, the receiver’s logic ignores the NPI, finds the Legacy Identifier that it needs, and uses that Legacy Identifier as though it had come in as Primary. Later, the receiver changes its internal systems to use NPI as primary and ignores unnecessary legacy identifiers.

More information about the NPI is available from the CMS website at: http://www.cms.hhs.gov/NationalProvIdentStand/

**HIPAA Nondiscrimination Regulations (PYs after 7/1/07)**
On December 13, 2006, the IRS, Employee Benefits Security Administration (EBSA) and PBGC jointly published **Final Regulations** in the *Federal Register* (71 FR 75014) under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA).

These final regulations apply for plan years beginning on or after July 1, 2007.

The **Final Regulations** are available at: http://edocket.access.gpo.gov/2006/pdf/06-9557.pdf.

The regulations concern the HIPAA provisions prohibiting discrimination based on a health factor for group health plans and group health insurers.

In general, these Final Regulations do not change the 2001 interim “final” rules or the 2001 proposed rules on wellness programs, but do “finalize” those rules. See **Research Memo 2001-9** for an analysis of the *Interim Final Regulations Applicable To Group Health Care Plans Under HIPAA* and **Research Memo 2001-7** for an analysis of the *Proposed Regulations On Nondiscrimination In Wellness Programs*.

These regulations do clarify how the source-of-injury rules apply to the timing of a diagnosis of a medical condition. For wellness programs, the regulations clarify some ambiguities in the proposed rules, make some changes in terminology and organization and add a description of wellness programs not required to satisfy additional standards. These final regulations also clarify that benefits may not be denied for injuries resulting from a medical condition even if the medical condition was not diagnosed before the injury.
Part D Notice of Creditable Coverage to Participants (11/15/07)
Health plans that provide prescription drug benefits to Medicare-eligible individuals, whether retirees or active employees are required to determine whether the prescription drug coverage under the health plan is actuarially equivalent to Part D coverage, and to notify Medicare-eligible individuals covered under the plan before November 15 of each year. For more information, see Benefit News Briefs 2005-25 and 2006-23.

Group health plans, including multiemployer health plans, offering prescription drug coverage to Medicare-eligible individuals must also provide a notice of creditable coverage at other times as follows:

- Before the individual’s initial enrollment period for the Part D program;
- Before November 15th of each year, the start of the Part D open enrollment period;
- Before the effective date of the individual’s enrollment in the plan’s prescription drug coverage and at the time of any change that affects whether the prescription drug coverage is creditable coverage; and
- Upon request by the individual.

The CMS website at http://www.cms.hhs.gov/CreditableCoverage/ also contains guidance and model notices for relative to these creditable coverage notice requirements.

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