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WEB's ***Benefits Insider*** is a bi-monthly member exclusive publication providing the latest developments from Washington, DC, on matters of interest to employee benefits professionals. The content of this newsletter is being provided through a partnership with the American Benefits Council, a premier benefits advocacy organization. To inquire about membership with the Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Senate Committee Scrutinizes EEOC; Agency Aims to Publish GINA Rule in July

Lawmakers on the Senate Health, Education, Labor and Pensions (HELP) Committee raised strong concerns about the enforcement and litigation strategy of the Equal Employment Opportunity Commission (EEOC) in a May 19 hearing, touching on the agency's recent legal action against employer-sponsored wellness programs.

The hearing, Oversight of the Equal Employment Opportunity Commission: Examining EEOC's Enforcement and Litigation Programs, was held by the committee "to find out why such an important agency with such a critical task has gotten so far afield of its mission," said Chairman Lamar Alexander (R-TN).

In extensive opening remarks, Alexander asserted that the agency has "placed too much emphasis on litigating high-profile lawsuits at a time when there were more than 70,000 complaints of workplace discrimination that hadn't been investigated." Among his chief concerns with EEOC is the fact that, "after the agency initiated litigation against employee wellness programs – creating a conflict with the [Patient Protection and] Affordable Care Act [(PPACA)] and ignoring the clear intentions of Congress and the president to encourage these programs – the agency's proposed rule on the plans does not resolve all the issues it created."

The EEOC recently issued proposed rules that amend regulations and interpretive guidance under the Americans with Disabilities Act (ADA) relating to employer wellness programs. The proposed rules provide guidance on the extent to which employers may use incentives to encourage employees to participate in wellness programs that include disability-related inquiries and/or medical examinations.

The lack of clear guidance from the EEOC regarding the application of the ADA and the Genetic Information Nondiscrimination Act (GINA) to employer-sponsored wellness programs has contributed to the sense of legal and regulatory uncertainty for such programs, particularly as the EEOC began to pursue litigation against wellness plan sponsors in late 2014. Alexander has sponsored the Preserving Employee Wellness Programs Act (S. 620) designed to provide legal certainty to employers offering wellness programs.

The EEOC is soliciting comments on the proposed regulations through June 19.

Following Alexander's opening statement, the Committee's Ranking Democrat, Patty Murray (D-WA), focused her comments on the important role the EEOC plays in preventing workplace discrimination and the need to increase its budgetary funding.

The hearing featured testimony from Jenny R. Yang , Chair, Equal Employment Opportunity Commission, and P. David Lopez, General Counsel, Equal Employment Opportunity Commission, both of whom spoke very broadly about the EEOC's mission and caseload. Most relevant to benefit plan sponsors, Yang noted that the recent proposed rule addressing wellness programs was developed as part of an effort to "ensure coordination of our policy guidance and our enforcement efforts to provide a clear and consistent agency position." Because the proposal only addresses the application of the ADA to wellness programs, Yang said that the agency is targeting July 2015 for the issuance of a separate proposed rule on the application of GINA to wellness programs.

The bulk of the question-and-answer period was related to the criteria EEOC uses to prioritize its enforcement and litigation activities, in which the panelists cited age and gender discrimination as the predominant issues before the agency. At the end of the hearing, however, Alexander told Yang that he believes the EEOC's recent guidance does not resolve the regulatory conflict between PPACA and the ADA – and may even exceed the agency's jurisdiction. He asked Yang to review S. 620 as it develops its final rule.

House Subcommittee Examines PPACA Implementation, Executive Actions

In a May 20 hearing, the U.S. House of Representatives Ways and Means Subcommittee on Oversight heard testimony on the executive actions taken by the Obama Administration in implementing the Patient Protection and Affordable Care Act (PPACA) and discussed whether these actions were carried out in accordance with congressional intent.

The administration's actions in implementing a number of provisions of PPACA have been criticized by congressional Republicans, including the July 2013 delay of the mandatory employer and insurer reporting requirements under sections 6055 and 6056 of PPACA and the associated "employer shared responsibility" penalties.

In response, House leadership formally filed a lawsuit against the administration in November 2014, charging the president and other federal officials with failure "to act in a manner consistent with that official's duties under the Constitution and laws of the United States with respect to implementation of any provision of [PPACA]."

In his opening statement, subcommittee Chairman Peter Roskam (R-IL) said that though the hearing, "Examining the Use of Administrative Actions in the Implementation of the Affordable Care Act," focused on the executive actions relating to PPACA implementation, "don't lose sight of the critical importance of these issues at the core of our representative democracy." He said that the administration's use of unilateral actions erodes the balance of power through the system of checks and balances as established in the Constitution.

The subcommittee heard testimony from the following witnesses:

- Grace-Marie Turner, president of the Galen Institute, outlined the administrative actions taken that were contrary to the PPACA statute, including the employer mandate delay. She also noted that while many of the changes made to PPACA were supported by Congress and demonstrate that the law would have been nearly impossible to implement as it was written, "it is not the job of the administration to fix the law but to implement it as written. The U.S. Constitution requires the executive branch to seek new legislation ... if changes to the law are needed."

- Jonathan Adler, professor of law at the Case-Western Reserve University School of Law, testified that the administrative agencies have "repeatedly disregarded the plain text of [PPACA] and the limits on their statutory authority when implementing this law." He also listed examples of the actions he considers to be outside regulatory authority, including the issue at the heart of *King v. Burwell*, the controversial case that challenges the legality of federal subsidies for individuals obtaining health coverage in federally facilitated insurance exchanges.

- Elizabeth Papez, partner at Winston & Strawn LLP, testified that despite the administration's statements that its actions have past precedent, such precedents are not comparable to the actions taken in implementing PPACA. She also discussed the litigation challenging the legality of the federal subsidies for individuals in federal exchanges and stated that Congressional oversight is critical to ensuring implementation consistent with the Constitution.

- Robert Weiner, partner at Arnold and Porter LLC, testified on the benefits of PPACA and noted that, particularly with the employer mandate delay, there are numerous precedents for phased-in requirements past statutory deadlines. He said that such delays are "the prudent exercise of administrative discretion, based on a productive dialogue with the business community, to avoid disruption and achieve better long term compliance by phasing in new requirements instead of imposing them abruptly."

During the question-and-answer portion of the hearing, the subcommittee members discussed the executive actions and whether they established a precedent that could result in future executive overreach by other administrations. Representative Kristi Noem (R-SD) asked about the burden of cost on employers implementing PPACA. Papez responded that costs in addition to predictability are critical for businesses and stated that they are entitled to fair notice on how laws will be enforced without abrupt changes.

Bipartisan Lifetime Income Disclosure Legislation Introduced in Senate

Lawmakers in the U.S. Senate have introduced legislation that would require 401(k) plan sponsors to inform participating workers of the projected monthly income they could expect at retirement based on their current account balance.

The Lifetime Income Disclosure Act (S. 1317) was introduced on May 13 by Senators Johnny Isakson (R-GA) and Christopher Murphy (D-CT). The measure would require that sponsors of 401(k) and other defined contribution plans subject to ERISA inform participants of how their account balance would translate into guaranteed monthly payments based on age at retirement and other factors.

The legislation also directs the U.S. Department of Labor (DOL) to issue tables that employers could use in calculating an annuity equivalent, as well as a model disclosure. Employers and service providers using the model disclosure and following the prescribed assumptions and DOL rules would be insulated from liability.

This legislation has been introduced in each session of Congress dating back to 2009. In 2013, Isakson and Murphy were joined by Senators Elizabeth Warren (D-MA), Tim Scott (R-SC) and Bill Nelson (D-FL) as original cosponsors. Identical legislation was also introduced in the House in the prior Congress as H.R. 2171. A prior official summary of the measure is still available.

S. 1317 has been referred to the Senate Health, Education, Labor and Pensions (HELP) Committee. It is unlikely to receive attention as a stand-alone measure, although it is possible that the language could be added to broader retirement policy legislation in the future.

RECENT REGULATORY ACTIVITY

DOL Provides Additional 15 Days to Comment on Fiduciary Definition Proposal

In response to widespread calls for additional time to review and comment on proposed regulations defining the term "fiduciary" with respect to employee benefit plan investment advice, the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) announced on May 18 that they are adding 15 days to the previous comment deadline.

The proposed regulations, issued on April 14 along with a fact sheet, a series of Frequently Asked Questions and a series of proposed prohibited transaction exemptions, broadly updates the definition of fiduciary investment advice by extending fiduciary status to a wider array of advice relationships than existing rules.

The proposal initially established a comment period of 75 days (starting with the formal publication of the proposal on April 20), making the due date July 6. With the additional 15 days, the comment deadline will now be July 20.

On May 12, 36 Republican senators signed a letter asking DOL to extend the comment deadline to a total of 120 days.

EBSA also announced that a public hearing will be held the week of August 10, after which the comment period will be reopened for approximately 30 to 45 days.

IRS Provides New Guidance on PPACA Reporting

In one set of new and one set of revised Question-and-Answer documents released on May 19, the Internal Revenue Service provided additional detail on how to comply with the reporting requirements for employers under Internal Revenue Code sections 6055 and 6056, as added by the Patient Protection and Affordable Care Act (PPACA).

Code Section 6056 requires every applicable large employer (generally, an employer that employed on average at least 50 full-time employees or equivalents) to file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees during the year. Form 1095-C: Employer Provided Health Insurance Offer and Coverage is to be used to fulfill this requirement, while Form 1094-C is to be used for transmitting Form 1095-C.

Employers that provide self-insured coverage are subject to the reporting requirements of Section 6055 as well as Section 6056. (Section 6055 requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and other entities that provide minimum essential coverage to file annual returns reporting certain information for each individual for whom minimum essential coverage (MEC) is provided and to provide a copy of the return to the individual.) As discussed in previous IRS Questions and Answers on Information Reporting by Health Care Providers (Section 6055) (No. 27), applicable large employers will combine section 6055 and 6056 reporting on Form 1095-C.

The IRS has revised Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056), which provides the following guidance with respect to the reporting of health care coverage:

- Basics of Employer Reporting (Questions 1-4)
- Who is Required to Report (Questions 5-12)

- Methods of Reporting (Questions 13-17)
- How and When to Report the Required Information (Questions 18-31)

Notably, the new questions and answers in the revised document confirm that an "applicable large employer member" (generally, a member of the controlled group that constitutes an applicable large employer) that does not have full-time employees does not generally have to file under Code Section 6056, but will still have to file Form 1094-C and Form 1095-C if it sponsors a self-insured health plan in which any employer or employee's spouse or dependent was enrolled. There are also questions and answers that provide additional guidance on reporting under the "simplified" or "alternative" reporting methods that have been developed by the IRS. In addition, the IRS has confirmed what it previously had indicated informally- that a Form 1095-C may be delivered to employees in any manner permitted for Form W-2. However, the IRS also clarified that an employer is not required to furnish a Form 1095-C to an employee within 30 days of the employee's written request after the employee terminates employment (which is a requirement that applies to the Form W-2).

The IRS also released an entirely new guidance document, Questions and Answers about Employer Information Reporting on Form 1094-C and Form 1095-C. This document provides more specific guidance on how to complete the required forms, including:

- Basics of Employer Reporting (Questions 1-5)
- Reporting Offers of Coverage and other Enrollment Information (Questions 6-13)
- Reporting for Governmental Units (Questions 14-15)
- Reporting Offers of COBRA Coverage (Questions 16-18)

Among the issues addressed in this new document are:

- how an employer reports the offer of coverage for the month in which an employee is hired or terminates employment.

- how to report enrollment information for self-insured coverage that was provided to an individual who was not an employee on any day of the calendar year, such as a non-employee COBRA beneficiary.

- how to report an offer of COBRA continuation coverage to a full-time employee that terminates mid-year, and to an employee who receives an offer of COBRA continuation coverage due to a reduction in hours.

- how an employer that sponsors a self-insured plan reports MEC provided to spouses and dependents of an employee who separately elect to receive COBRA coverage.

New Guidance Further Clarifies Application of PPACA Maximum Out-of-Pocket Rules, Provider Nondiscrimination

In **an updated set of Frequently Asked Questions (FAQs) about Affordable Care Act Implementation** (Part XXVII),the U.S. departments of Labor (DOL), Health and Human Services (HHS) and the Treasury provided additional guidance on the application of the Patient Protection and Affordable Care Act's (PPACA) annual cost-sharing limits for other than self-only coverage. The FAQ also addressed issues related to provider nondiscrimination.

As we have previously reported, the 2016 maximum annual limitation on cost-sharing under PPACA for self-only coverage is $6,850, and for other than self-only coverage, the limit is $13,700. The preamble to the 2016 Notice of Benefit and Payment Parameters, published on February 27, stated that HHS is finalizing language clarifying (under Section 1302 of PPACA) that "the annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only."

In question-and-answer guidance released on May 8, HHS did not provide for any delay in the new requirement to offer an embedded MOOP limit for the 2016 policy year with respect to individual and small group insurance, as many had hoped for, and HHS did not clarify the applicability of the new requirement to large group and self-funded group health plans. The latest FAQ, however, provided that:

- The Public Health Service (PHS) Act Section 2707(b) applies the new requirement regarding the maximum annual limitation on cost sharing to *all* non-grandfathered group health plans.

- The clarification under PPACA Section 1302(c)(1) applies only for plan or policy years that begin in or after 2016.

- The clarification under PPACA Section 1302(c)(1) also applies to non-grandfathered HDHPs.

Employers will need to move quickly to implement this new requirement for the 2016 plan year.

The FAQs also address provider nondiscrimination under Section 2706(a) of the PHS Act, as added by PPACA. According to the statute, "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." The PHS Act does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in the PHS Act prevents "a group health plan, a health insurance issuer, or the Secretary [of Health and Human Services] from establishing varying reimbursement rates based on quality or performance measures."

In response to inquiries from lawmakers in Congress and public comments received in response to a March 2014 request for information, the departments are restating their "current enforcement approach." According to the FAQs,

- Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act Section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision.

- Question No. 2 in FAQs about Affordable Care Act Implementation Part XV, which previously provided guidance from the Departments on this subject, is superseded by this new FAQ (Question No. 4, FAQ XXVII).

This guidance is helpful in clarifying the Departments' current implementation of PHS Act Section 2706(a).

RECENT JUDICIAL ACTIVITY

Supreme Court Expands View of ERISA Statute of Limitations for 401(k) Plan Fee Litigation

In **a unanimous opinion** on May 18, the U.S. Supreme Court ruled that 401(k) participants can hold plan fiduciaries liable for including high-cost investments in the plan even when those investments were initially chosen outside ERISA's six-year statute of limitations. The opinion indicated that plan fiduciaries have "a continuing duty – separate and apart from the duty to exercise prudence in selecting investments at the outset – to monitor, and remove imprudent, trust investments." The court remanded the case, *Tibble v. Edison*, back to the Ninth Circuit U.S. Court of Appeals.

The claims had previously been dismissed by both the U.S. District Court for the Central District of California and the Ninth Circuit on the grounds that the statute of limitations had expired. The plaintiffs then appealed to the Supreme Court, arguing that the decision to offer the funds could have been reconsidered during the six-year window, making it a "continuing violation."

At that time, the U.S. Department of Labor (DOL) submitted an *amicus* brief in support of the plaintiffs, asserting that the ongoing duty to monitor includes a duty "to review plan investments and divest investments that are imprudent."

The Supreme Court's opinion, written by Justice Stephen G. Breyer, stated that "[a] plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones." The court ruled that "so long as the alleged breach of the continuing duty occurred within six years of suit, the claim is timely." However, the Supreme Court specifically said it was expressing no view on the scope of the fiduciary duty, e.g., whether and what kind of review of the contested funds is required.

Stock Drop Case Dismissed Under Post-Dudenhoffer Law

On May 13, the U.S. District Court for the Southern District of New York dismissed a class action lawsuit against Citigroup Inc., arguing that the defendant, as fiduciary of a defined contribution plan, acted imprudently by continuing to offer the corporation's common stock as an investment option for plan participants prior to a decline in the company stock price which caused losses to employee investors.

Such cases are commonly referred to as "stock drop" cases. In recent years, ERISA "stock drop" lawsuits have become commonplace and now often occur in tandem with securities fraud lawsuits and can follow even a modest decline in an employer's stock price.

The district court concluded that the case, *In Re: Citigroup ERISA Litigation*, was filed outside the three-year statute of limitations applicable to claims of fiduciary breach under ERISA, but also considered that the plaintiffs did not meet the new pleading standards outlined by the Supreme Court in the case of *Fifth Third Bancorp v. Dudenhoeffer*. The court ruled that the plaintiffs' claims didn't qualify as the "special circumstances" that would render the defendants

imprudent for relying on the stock's market value and also did not allege the existence of any material, nonpublic information affecting stock price.

This new case was filed shortly after the dismissal of a similar case against Citigroup was upheld in October 2011 by the U.S. Court of Appeals for the Second Circuit. In that earlier case, *In Re: Citigroup ERISA Litigation*, the Second Circuit ruled that Citigroup plan fiduciaries were protected by the now-defunct presumption of prudence, which previously protected fiduciaries of employer stock plans from liability for declining stock prices.

This presumption of prudence was invalidated by the U.S. Supreme Court's June 2014 decision in the *Dudenhoeffer* case. The Supreme Court ruled that (i) ESOP fiduciaries are not entitled to any special presumption of prudence and are subject to the same duty of prudence that applies to ERISA fiduciaries in general, except that they need not diversify the fund's assets and (ii) U.S. Court of Appeals for the Sixth Circuit, which had originally ruled in favor of the plan, should reconsider its criteria for whether a complaint meets the "pleading" standard for a breach of fiduciary duty.