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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, which provides its core content, and is edited by Christopher Smith, employee benefits attorney and President of Flexible Benefits Systems, Inc., csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

House Committee Announces Hearing on Fiduciary Rule

The U.S. House of Representatives Education and the Workforce Committee will discuss the recent fiduciary rule re-proposal in a June 17 hearing, the committee recently announced. U.S. Secretary of Labor Thomas Perez is expected to testify before the panel.

As we have previously reported, the DOL's Employee Benefits Security Administration (EBSA) issued proposed regulations on April 14 that broadly update the definition of "investment advice" by extending fiduciary status to a wider array of advice relationships than the existing rules do. This regulatory project is a continuation of a similar effort from 2010 that was ultimately withdrawn in response to scrutiny from outside groups as well as members of Congress.

Comments are due on the proposal on July 20.

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.

Legislation Introduced to Ease Employers' PPACA Reporting Obligations

Lawmakers in the U.S. House of Representatives have introduced the bipartisan **Commonsense Reporting and Verification Act (H.R. 2712)**, a measure to give employers more flexibility with respect to their reporting obligations under the Patient Protection and Affordable Care Act (PPACA).

The measure is sponsored by representatives Diane Black (R-TN) and Mike Thompson (D-CA) – both members of the House Ways and Means Committee – and is the latest in a growing number of bipartisan measures designed to make PPACA more workable for employers.

The bill specifically addresses Internal Revenue Code sections 6055 and 6056, as added by PPACA. As we have previously reported, 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. Employers that provide self-insured coverage are also subject to the reporting requirements of Section 6055, which 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. (The Internal Revenue Service (IRS) recently revised its Questions and Answers on Reporting under Section 6056 to accompany its Questions and Answers on Reporting under Section 6055.)

Specifically, H.R. 2712 would:

- ***Create a prospective reporting system under Code Section 6056:*** Under prospective reporting, an employer could certify whether it was offering MEC to its full-time and part-time employees, as well as its employees' dependents and spouses. The employer would also certify whether the coverage was minimum value and met one of the affordability safe harbors relevant to Code Section 4980H. Finally, the certification would indicate the

months that the coverage was available (during the year) and any waiting periods that apply. An employer that took advantage of prospective reporting would not have to do any additional reporting to the IRS under Code Section 6056, unless the employer was notified by an Exchange that the employee (or the spouse or dependent of the employee) had been deemed eligible for an advance premium tax credit or cost sharing subsidy.

- ***Eliminate the requirement to collect dependent SSNs:*** H.R. 2712 provides that if the MEC provider did not collect or maintain information on the taxpayer identification numbers (TINs) of dependents of the primary insured/ employee prior to January 1, 2014, the issuer or employer could use the dependent's name and date of birth instead of the name and TIN. This rule would be effective for any returns due more than 60 days after the date of enactment of H.R. 2712.

- ***Expand employers' ability to use electronic statements:*** H.R. 2712 provides that an individual shall be deemed to have consented to receive a Section 6056 statement in electronic form if such individual has consented at any prior time to receive such statement in electronic form. It also provides that statements under Code Section 6055 may be provided electronically if the individual has previously consented to receive any private health information in electronic format.

- ***Require the Comptroller General to perform two studies:*** One study would be performed on the effectiveness of the process for Marketplaces to notify employers that one of their full-time employees has been deemed eligible for an advance premium tax credit or cost-sharing subsidy (and for employers to appeal that determination), and another on the prospective reporting system created by H.R. 2712.

- ***Creates eligibility process for subsidies:*** The bill would provide that a Marketplace can automatically reenroll an individual into a qualified health plan so long as the Marketplace re-determines the eligibility of the individual for an advanced premium tax credit or cost-sharing reduction.

Bipartisan Members of the Senate Finance Committee are working on a companion that is expected to be introduced before Congress' Independence Day recess.

House Committee Discusses Changes to PPACA, Health Care System

The U.S. House of Representatives Committee on Ways and Means discussed possible outcomes of the U.S. Supreme Court's *King v. Burwell* decision and areas of the Patient Protection and Affordable Care Act (PPACA) that need changes in a June 10 hearing on PPACA's implementation and the U.S. Department of Health and Human Services (HHS) Fiscal Year 2016 budget request.

The Supreme Court is soon expected to render its decision in *King v. Burwell*, the controversial case that challenges the legality of federal subsidies for individuals obtaining health coverage in federally facilitated insurance exchanges. A ruling for King to strike the legality of the subsidies would likely create pressure on the Obama Administration, Congress and states to address the decision in the form of regulatory or legislative "fixes," particularly for individuals who rely on subsidies to purchase health coverage.

In convening the hearing, committee Chairman Paul Ryan (R-WI) raised many of the issues often cited by opponents to PPACA, including increasing health insurance premiums and the issues some individuals faced when filing their taxes if they received a subsidy. Ryan also stated that the law could not be "fixed" with minor changes and tweaks but that the "answer is to repeal and replace this law with real, patient-centered reforms."

HHS Secretary Sylvia Burwell testified before the committee. In her testimony, Burwell stated that the budget "makes critical investments in health care, science, innovation and human services."

Committee members raised a number of concerns and areas of PPACA that need amending during the question-and-answer session.

Ryan asked Burwell whether President Obama would work with Congress on a solution to ensure the affordability of health insurance for Americans or whether he would "dictate" a solution if the Supreme Court strikes down the subsidies. Burwell stated that "if the court makes that decision [strikes the subsidies], we're going to do everything we can, and we're working to make sure we are ready to communicate, to work with states and do everything we can," but noted that the "critical decisions" in that situation will reside with Congress, the states and their governors to determine if the subsidies are available.

Rep. Kevin Brady (R-TX) asked Burwell if the president would sign legislation other than just extending the federal subsidies to states operating under federal exchanges. Burwell responded that the administration has always been open to legislation that expands access, affordability and quality. Brady specifically mentioned the measure recently introduced by Senator Ron Johnson (R-WI), the Preserving Freedom and Choice in Health Care Act (S. 1016), which would allow for individuals who receive subsidies through the federal exchange to keep their subsidies through August 2017 and also repeal both the individual and employer mandates. Burwell answered that they consider that measure a repeal of PPACA and that President Obama has indicated that he will not sign repeal.

Rep. Charles Boustany (R-LA) expressed concern that employees cannot use funds from a stand-alone Health Reimbursement Account (HRA) to purchase individual health insurance on a tax-favored basis. Boustany also raised this issue in a February 3 hearing to U.S. Treasury Secretary Jacob Lew. Burwell agreed that the administration should do more to allow flexibility for small employers providing assistance to their employees and also noted that they would like to expand the tax credit for small businesses who provide health insurance to their employees from businesses with fewer than 25 full-time employees to businesses with fewer than 50 full-time employees.

In 2014, Boustany introduced the Small Business Healthcare Relief Act, which would prevent small businesses from being penalized for providing monetary assistance to their employees to purchase insurance on the individual market on a pre-tax basis (such as in an HRA).

Rep. Bill Pascrell asked how PPACA has impacted employer-sponsored health insurance take-up rates. Burwell noted that studies have shown very slight, "basically the same" rates and added that there has not been a significant decrease.

Rep. Jim Renacci (R-OH) noted that fixes to PPACA are needed in defining seasonal employees as well as with implementation issues with the Hospital Readmission Reduction program. Other issues raised by committee members include: implementation dates of provisions of the recent

"doc fix" legislation, opioid addiction, electronic health records (EHRs) and allowing flexibility for physicians and end-of-life care.

Bill Introduced to Expand Electronic Disclosure of Retirement Information

Legislation has been introduced that would give employers the option to provide required retirement plan notices and statements in electronic format, while protecting plan participants' right to choose notices in hard copy.

The **Receiving Electronic statements To Improve Retiree Earnings (RETIRE) Act (H.R. 2656)**, introduced by Representative Jared Polis (D-CO), Phil Roe (R-TN), Mike Kelly (R-PA) and Ron Kind (D-WI), would amend ERISA and the Internal Revenue Code to allow for the electronic delivery of plan documents (*i.e.*, reports, statements, notices and notifications) to participants or beneficiaries if the document:

- is "designed to result in effective access to the document by the participant, beneficiary, or other specified individual through electronic means."
- permits the individual to select the specific electronic means of delivery (or allows the individual to select a preference for paper materials).
- protects the confidentiality of personal account information.

Under the legislation, electronic communication could include direct delivery by email or posting to a website or intranet with proper notice.

Roe and Polis are chairman and ranking member, respectively, of the Health, Employment, Labor and Pensions Subcommittee of the House of Representatives Education and the Workforce Committee. Kelly and Kind are members of the House Ways and Means Committee and Kelly is co-chair of the House Retirement Security Caucus.

While no action on the measure has yet been scheduled, given its bi-partisan support, another measure that might move through the legislative process could become a vehicle for consideration of this bill.

RECENT REGULATORY ACTIVITY

New IRS Guidance Indicates Changes to Determination Letter Program

Through the release of **Revenue Procedure 2015-36** on June 8, the Internal Revenue Service (IRS) has outlined changes to the determination letter program for pre-approved retirement plans – including Employee Stock Ownership Plans (ESOPs) and cash balance plans, in the pre-approved plan process for the first time. These changes, along with a reduction in the number of employers necessary to adopt a pre-approved plan in order to obtain a pre-approved plan determination letter, could make pre-approved plans available to more employers.

Very generally, when a retirement plan is established, the plan's sponsor may obtain a determination letter from the IRS affirming that the plan meets the requirements for qualification. A plan is then assigned to a group for cyclical remedial amendment periods, during which required and voluntary changes can be made and the plan is "determined" to still be qualified. Individually designed plans are on a staggered five-year remedial amendment period based on the last digit of their employer identification number. Determination letter filings for preapproved plans are on a set six-year cycle (all preapproved defined contribution plans are filed in one year of the cycle and all preapproved defined benefit plans are filed in another year). Plans can also seek a determination letter at the time a plan is being terminated.

This process is governed by a vast array of IRS revenue procedures including IRS Rev. Proc. 2011-49, which was revised by Rev. Proc. 2015-6 in January to reflect the shift in technical responsibility from the agency's Tax Exempt and Government Entities (TE/GE) Division to the Office of Associate Chief Counsel.

Rev. Proc. 2015-36 further modifies and supersedes Rev. Proc. 2011-49 while also extending (to October 30, 2015) the deadline for submitting on-cycle applications for opinion and advisory letters for pre-approved defined benefit plans for the plans' second six-year remedial amendment cycle. (This extension applies to pre-approved defined benefit mass submitter lead and specimen plans, word-for-word identical plans, master and prototype minor modifier placeholder applications, and defined benefit non-mass submitter plans.)

The changes to Rev. Proc. 2011-49, spelled out in detail in Section 3, relate largely to the treatment of employee stock ownership plans (ESOPs) and cash balance plans. Important changes include:

- Extending the application deadline for pre-approved defined benefit plans from June 30 to October 30, 2015.
- Opening the pre-approved plan program to cash balance plans for submission by October 30, 2015.
- Expanding the pre-approved plan program to ESOPs during the defined contribution application period beginning February 1, 2017.

Concurrent with Rev. Proc. 2015-36, the IRS has also released Listings of Required Modifications (LRMs), which function as sample language for pre-approved cash balance plans and ESOPs.

These changes could be particularly significant if the IRS eliminates most determination letters for individually designed plans (those that are *not* operating under a pre-approved vendor-sponsored master and prototype or volume submitter plan document), as the agency has informally indicated it is considering.

The agency is expected to solicit public comment on potential changes to the determination letter process in the coming months.

Final Regulations on PPACA Summary of Benefits and Coverage Issued

On June 12, the U.S. departments of Treasury, Labor and Health and Human Services issued final regulations on the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act (PPACA). A fact sheet is available as well.

The SBC is intended to provide consumers with consistent and comparable information regarding health plan benefits and coverage. The proposed regulations were issued in December 2014 and amended the final regulations released in February 2012 that implement the disclosure requirements under section 2715 of the Public Health Service Act to help individuals better understand their health coverage.

ERISA Advisory Council Hears Testimony on Lifetime Participation, Pension Plan De-Risking Disclosures

The ERISA Advisory Council (EAC) heard testimony on lifetime plan participation and pension plan “de-risking” disclosures in a series of meetings May 27 to 29.

The EAC is a group of benefits experts established by Congress and appointed by the U.S. Department of Labor (DOL) to identify emerging benefits issues and advise the Secretary of Labor.

The two topics the EAC is examining this year are: (1) pension plan "de-risking" (where plan sponsors partially or fully discharge their ERISA plan liabilities), which the EAC has dubbed "pension risk transfer," and the disclosures given to participants in these events, and (2) "lifetime plan participation" (relating to plan distributions and rollovers). The EAC has previously addressed both of these topics, examining pension fund de-risking in 2013 and lifetime plan participation in 2014, and stated that it plans to focus on notices and disclosure, providing administrative assistance to the DOL.

Lifetime Participation
On May 27, the EAC discussed model notices and plan sponsor education on lifetime plan participation, relating to encouraging employees to keep retirement plan assets within the employer-sponsored retirement system.

Witnesses from financial services companies, academic institutions and employer groups generally said that plan participants are most likely to have the best outcome if they maintain their assets within the employer-sponsored system, but participants often assume it is in their best interest or they are required to rollover their funds into an Individual Retirement Account (IRA) upon termination. Witnesses noted that model notices should be flexible for plan sponsors to use and short and easy for participants to understand. They also provided a number of recommendations for the model notices, including describing the long-term impact of "cashing out," or taking a lump sum, and clearly delineating participants' options and their likely outcomes upon termination.

Pension Plan De-Risking Disclosures
On May 28, the EAC examined model notices and disclosures for pension plan de-risking activities, in which companies transfer their ERISA pension plan liabilities by either offering participants a lump sum payout or providing an annuity through an insurer.

Witnesses from consumer groups, financial services companies and employer groups discussed the balance between providing participants with adequate information needed to make an informed decision and overwhelming participants with too much information. While some witnesses suggested that participants do not need additional disclosures in pension transfers, as the participants do not make a choice, other witnesses, along with EAC members, stated that participants need to be informed that they lose certain ERISA fiduciary protections, annual disclosures, access to federal courts and Pension Benefit Guaranty Corporation (PBGC) coverage in a pension transfer transaction. They also suggested that participants need to be informed they are losing important ERISA protections when they take a lump sum distribution and move pension funds to an IRA as well.

Cybersecurity/Cybertheft
The EAC heard testimony on May 29 from experts on cybersecurity and cybertheft issues, who discussed how those issues might relate to the EAC's work with regard to model notices. Witnesses from financial services companies discussed how new technology platforms and increasing complexity, coupled with more information being stored in clouds and accessed remotely, place employee data at risk both internally and externally. Witnesses also noted that with no single comprehensive federal law governing cybersecurity and without integrated statutory and regulatory rules at the state and federal level, there are gaps in security.

DOL Update
On May 29, the EAC received an update from officials from the DOL' s Employee Benefits Security Administration (EBSA), including testimony from Phyllis Borzi, assistant secretary; Judy Mares, deputy assistant secretary; and Tim Hauser, deputy assistant secretary for program operations.

Borzi discussed the proposed regulations defining the term "fiduciary" with respect to employee benefit plan investment advice. She stated that the DOL wants to hear from the public and that the DOL looks forward to an engaged conversation with interested parties. She indicated that DOL will shortly announce hearing dates during the week of August 10. She also said that there will be additional opportunity for comment after the hearing.

Borzi noted DOL will soon likely be submitting a "lifetime income" proposal to the Office of Management and Budget (OMB) for review and indicated that there will be considerable changes in the new proposal. The proposal will amend current pension benefit statements guidance and address Pension Protection Act (PPA) benefit statement requirements as well as determine whether and how the individual benefit statement should present a participant's accrued benefits in a defined contribution plan as a lifetime income stream of payments in addition to in the form of an individual account balance. The DOL is expected to address electronic disclosure later.

Secretary Borzi also stated that the Form 5500 project was a high priority for the DOL and discussed the recent report released by EBSA on the quality of plan audits, which she called disappointing given the amount of effort that has been put into improving audit quality. Along with the report results, the DOL announced that it will be proposing legislation, among other measures, to address audit quality.

Mares discussed the upcoming White House Conference on Aging, scheduled for July 13. She noted that the biggest issue identified by attendees in earlier forums was Social Security, followed by financial literacy and retirement security.

The EAC is expected to hold additional hearings on these topics August 18-20.

CMS Soliciting Feedback on HIPAA Health Plan Identifier Requirement

The Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) is seeking input on Health Plan Identifier (HPID) requirement under HIPAA, after having delayed enforcement of the requirement in October 2014.

An HPID is a standard, unique health plan identifier that must be obtained by health plans that are "controlling health plans", including self-insured health plans. (See also the dedicated CMS website with information on the application process and links to HPID frequently asked questions.)

Under September 2012 final regulations, these health plans were required to obtain an HPID by November 5, 2014, until HHS announced prior to that deadline that it would delay enforcement of the regulations until further notice. At that time, the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, had recommended that HHS rectify in rulemaking that all covered entities (health plans, healthcare providers and clearinghouses, and their business associates) not use the HPID in the HIPAA transactions.

The new **CMS request for information** was issued on May 29 "to collect perspectives from all segments of the industry on the current HPID policy in order to determine future policy directions." Specifically, the RFI seeks information from the health care industry about:

- The HPID enumeration structure outlined in the HPID final rule.
- The use of the HPID in HIPAA transactions in conjunction with the Payer ID.
- Whether changes to the nation's health care system, subsequent to the issuance of the final regulations, have altered stakeholder perspectives about the function of the HPID.

Comments are due July 28.

EBSA Report Finds Flaws In Employee Benefit Plan Audits

A **new report** released May 28 by the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) found that 39 percent of employee benefit plan audits "contained major deficiencies," prompting the agency to announce that it would soon propose legislation to change the way audits are conducted.

Originating with a DOL ERISA Advisory Council recommendation from 2011, EBSA has been engaged in a project to assess the quality of plan audits, particularly "limited scope audits," which allow plan administrators to instruct the auditor not to perform any auditing procedures with respect to certain investment information that has been otherwise prepared and certified by an outside institution.

The newly released study, conducted by EBSA's Office of the Chief Accountant (OCA) examined the quality of audit work performed by independent qualified public accountants with respect to financial statement audits of employee benefit plans covered under the ERISA 2011 filing year

(plan years beginning in 2011). It found that 61 percent of audits fully complied with professional auditing standards or had only minor deficiencies under professional standards, but the remaining 39 percent of audits "put $653 billion and 22.5 million plan participants and beneficiaries at risk."

The EBSA report also concludes:

- There is a clear link between the number of employee benefit plan audits performed by a Certified Public Accountant (CPA) and the quality of the audit work performed (more audits generally means higher quality).
- The accounting profession's peer review and practice monitoring efforts have not resulted in improved audit quality or improved identification of deficient audit engagements.
- CPA firms that were members of the American Institute of Certified Public Accountants' Employee Benefit Plan Audit Quality Center tended to produce audits that have fewer audit deficiencies.
- Training specifically targeted at audits of employee benefit plans may contribute to better audit work. As the level of employee benefit plan-specific training increased, the percentage of deficient audits decreased.
- Of the plan audit reports reviewed, 17 percent of the audit reports failed to comply with one or more of ERISA's reporting and disclosure requirements.

"The existing patchwork of regulations and rules needs to be overhauled and a meaningful enforcement mechanism needs to be created," Assistant Secretary of Labor for Employee Benefits Security Phyllis C. Borzi said in a news release. "The department is proposing, among other measures, legislation that will fix these problems."

These proposed legislative fixes include repealing the ERISA limited-scope audit exemption, and giving the Secretary of Labor the authority to define when a limited scope audit would be an acceptable substitute for a full audit.

The report also proposes (1) amending ERISA's definition of "qualified public accountant" to include additional requirements and qualifications necessary to ensure the quality of plan audits, and (2) giving the Secretary of Labor authority to "establish accounting principles and audit standards to protect the integrity of employee benefit plans and the benefit security of participants and beneficiaries."

These legislative proposals go well beyond the recommendations provided by the EAC in 2011.

RECENT JUDICIAL ACTIVITY

Ninth Circuit Amends Opinion, Denies Review in 'Stock Drop' Case, With Strong Dissent

In a May 26 decision, the U.S. Ninth Circuit Court of Appeals amended and replaced an earlier opinion but denied a more comprehensive re-hearing in the case of *Harris et al. v. Amgen et al.*

In this case, the plaintiffs (current and former employees of Amgen and AML), participated in two retirement plans that qualified as "eligible individual account plans" under ERISA. When the value of Amgen common stock fell, the plaintiffs alleged that the employers breached their fiduciary duties. The U.S. District Court for the Central District of California found that the plaintiffs' claim could not proceed because they had not alleged any misrepresentation made while defendants were performing a fiduciary function and because plaintiffs had not, in any event, alleged individual reliance on any misrepresentation.

The district court dismissed the complaint, finding that the plan fiduciaries did not violate their ERISA duties and were furthermore entitled to a presumption of prudence, as precedent had been established in other cases at the circuit court level. However, in June 2013, the U.S. Ninth Circuit Court of Appeals overturned the district court ruling, concluding that the presumption of prudence did not apply in this case, and sent the case back to the trial court for further proceedings. That decision was appealed to the U.S. Supreme Court, which vacated the ruling and sent the case back to the Ninth Circuit for further consideration in light of the Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*. The case is significant because it is applying securities law to a fiduciary breach case. The May 26, 2015, amended Ninth Circuit opinion again reversed the district court's decision and remanded the case for further proceedings.

In addition to denying an "*en banc*" review (in which the prior decision by a three-judge panel would be heard by the full court), the court's majority amended the opinion to address the Amgen argument that fiduciary action would have resulted in the stock drop that the court was trying to protect the participants against. The amended opinion indicated that if fiduciaries simply stopped allowing investment in the company stock once they were made aware of information that (under securities laws) should not have been withheld, they would have mitigated the effect of the eventual stock drop on plan participants.

The Ninth Circuit's amendment and denial drew a strong dissent from the minority judges, who argued that the majority ignored the new pleading standards outlined by the Supreme Court in the case of *Dudenhoeffer* and created "almost unbounded liability for ERISA fiduciaries."