BENEFITS INSIDER
A Member Exclusive Publication

Volume 72, April 2011

WEB's ***Benefits Insider*** is a member exclusive publication providing the latest developments from the Nation's Capital on matters of interest to benefits professionals. The content of this newsletter is being provided as a result of a partnership with the American Benefits Council, a premier benefits advocacy organization, which provides its core content, and is edited by Christopher M. Smith, Employee Benefits attorney and Principal of Flexible Benefits Systems, Inc., csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Senate Committee Examines Impact of Tax Incentives

On March 30, the U.S. Senate Finance Committee held the hearing, How Do Complexity, Uncertainty and Other Factors Impact Responses to Tax Incentives?, examining the complexity of the Internal Revenue Code as it is currently written and the effectiveness of tax incentives designed to drive certain behavior.

The prominence in the federal budget of incentives to encourage sponsorship of, and participation in, health and retirement benefit plans means that the full range of these issues will be "in play" as Congress examines budget and tax reform. On March 15, Senators Michael Bennet (D-CO) and Mike Johanns (R-NE) led a bipartisan group of 64 Senators on a letter to President Obama urging him to engage in budget negotiations beyond FY2011 that include discretionary spending cuts, entitlement changes and tax reform, to create meaningful deficit reduction. The letter also notes that a bipartisan group of Senators is developing a comprehensive deficit reduction package based upon the recommendations of the president's bipartisan National Commission on Fiscal Responsibility and Reform.

In his opening statement, Committee Chairman Max Baucus (D-MT) noted that "In 2010, we used 109 billion dollars for more than a dozen different incentives to help Americans save for retirement," and said that "Studies have found that taxpayers save more of their money for retirement when they receive a contribution that matches their own rather than receiving a tax refund at the end of the year."

Each of the three witnesses before the committee referenced retirement savings in their testimony:

- Dr. Raj Chetty, professor of economics at Harvard University, argued that "the incentive effects of the Saver's Credit may be dulled because the rules associated with the credit are very complex, and it is hard for filers to predict their effective matching rate." He also noted that "the impacts of tax-deferred accounts are also relatively modest in comparison to other tools that aim to change savings behavior," such as automatic enrollment programs.
- Dr. Robert Carroll, principal in the field of quantitative economics and statistics at Ernst & Young LLP, suggested that an underlying consumption tax baseline (rather than a comprehensive income tax baseline system) would create a more tax-free saving and investment environment. "Provisions such as individual retirement accounts, section 401(k) accounts, education savings accounts, health saving accounts, accelerated depreciation, and expensing would all be excluded as tax expenditures under a consumption tax baseline," Carroll said.
- Dr. Eric Toder, institute fellow and co-director of the Urban Institute-Brookings Institution Tax Policy Center, echoed Chetty's argument that default rules (like automatic enrollment programs) significantly influence participation in retirement saving plans and choices among investments within plans. He also cited evidence that "matching grants increase contributions by low-income households to retirement plans more than refundable tax credits."

Senate Committees Discuss PPACA One Year After Enactment

On March 16 and 17, the two Senate committees with jurisdiction over health care reform held hearings to examine the nation's progress in implementing the Patient Protection and Affordable Care Act (PPACA) one year after enactment.

Senate Finance Committee

In a statement convening the hearing, Health Reform: Lessons Learned During the First Year, Senate Finance Committee Chairman Max Baucus (D-MT) focused on the strengthening of the Medicare program. "Because of the changes in the Affordable Care Act, Medicare is stronger than ever," Baucus said, citing improved wellness care, incentives to providers for high-quality care, increased use of health information technology, elimination of the prescription drug coverage "doughnut hole" and efforts to reduce fraud and waste.

Ranking Republican Member Orrin Hatch (R-UT), in his opening statement, emphasized the hidden costs of the bill and criticized "the heavy-handed intervention in their healthcare by Washington bureaucrats." He also decried a lack of transparency by HHS, asserting that the agency has failed to respond to nearly 67 percent of Republican requests for information.

The committee heard testimony from Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, whose written testimony summarized the successes of PPACA. She specifically noted the structural improvements to the Medicaid and Medicare programs, including quality improvement measures and delivery system reforms that she asserted would have an impact on private health insurance.

The committee also heard from the following policy experts:

- Douglas Holtz-Eakin, president of the American Action Forum, described PPACA as "a missed opportunity to reform Medicaid" and said that the law "damages budget and economic policy." In particular, Holtz-Eakin said that the presence of the exchanges in 2014 and the amount of money at stake would likely compel employers to drop coverage and force employees to pay for a greater share of their coverage.
- Paul Van de Water, senior fellow at the Center on Budget and Policy Priorities, focused his testimony on dispelling misconceptions that have arisen in two areas — health reform's effects on Medicare and on state budgets. He specifically sought to refute the notion that the Congressional Budget Office's cost estimate "double-counts" savings from Medicare.

Questions from the committee sought to address a number of topics, including whether PPACA is slowing the cost growth rate, provisions of waivers for limited benefit (or "mini-med") plans, the fiscal burdens placed on state budgets, and the use of waivers to give states greater flexibility under the law.

Senate Health, Education, Labor and Pensions (HELP) Committee

Senate HELP Committee Chairman Tom Harkin (D-IA) opened the hearing saying, "As usual, the states are already way ahead of the debate in Washington, working full steam ahead to lay the foundations for insurance exchanges. By providing funding and legal authority to establish exchanges, [PPACA] empowers States more than ever before to serve their citizens' unique

needs. Far from being a top-down approach, the law gives states flexibility to determine which plans will be offered in the exchange, to choose benefit rules that meet their citizens' needs, and to offer plan options particularly suited to small businesses, such as consumer-driven plans coupled with Health Savings Accounts."

Ranking Republican Member Michael Enzi (R-CA), in his opening statement, noted a string of disappointments resulting from the bill and promised to focus on ways to eliminate provisions in the new law that will increase choice in health care while decreasing health care costs.

The committee heard testimony from Steve Larsen, deputy administrator and director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the HHS Centers for Medicare & Medicaid Services (CMS), like Sebelius, touted the benefits of PPACA but focused his comments on the administration's initial efforts to establish of the state-based exchanges scheduled to take effect in 2014. With regard to employer plan sponsor challenges, he cited the popularity of the Early Retiree Reinsurance Program, which he said "provides much-needed financial relief for employers so early retirees and their families can continue to have quality, affordable insurance."

The committee also heard testimony from the following witnesses:

- Sandy Praeger, health insurance commissioner for the state of Kansas, chair of the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners (NAIC), and co-chair of NAIC's Health Insurance Exchanges Subgroup, identified a number of implementation challenges faced by states and expressed the hope for substantive new regulatory guidance.
- Joshua Sharfstein, secretary of the Maryland Department of Health and Mental Hygiene, provided background on Maryland's health care and health insurance system, described Maryland's implementation of PPACA to date and discussed the next steps for Maryland's Health Benefit Exchange.
- Utah State Representative David Clark described his state's health insurance exchange – one of only two currently operating state exchanges – and the optional program for small businesses to employ a defined contribution model for employer-provided health care insurance.

Congress is expected to continue its close oversight of PPACA implementation in the coming months.

Budget Committee Discusses Health & Retirement Policy

The House Budget Committee held a hearing on March 17 to discuss Fulfilling The Mission Of Health And Retirement Security, focusing primarily on the budgetary impact of health and retirement entitlement programs (Medicare, Medicaid and Social Security).

Convening the hearing, Committee Chairman Paul Ryan (R-WI), said, "If Congress wants to avoid defaulting on federal health and retirement programs, it must advance solutions that free the nation from the shadow of debt, strengthen its health and retirement safety net, and protect those in or near retirement from disruptions."

Ranking Democratic Member Chris Van Hollen (D-MD), in his opening statement, acknowledged these challenges but also suggested that budgetary relief might also be found in reforms to the discretionary budget and tax policy.

The committee heard testimony from the following witnesses:

- Alice M. Rivlin, senior fellow at the Brookings Institution (as well as founding director of the Congressional Budget Office and former director of the Office of Management and Budget), described the recommendations of the Bipartisan Policy Center's Debt Reduction Task Force with respect to Medicare, Medicaid and Social Security. Rivlin also said that it would be inappropriate, from a budgetary perspective, to repeal the Patient Protection and Affordable Care Act (PPACA).
- Charles Blahous, research fellow at the Hoover Institution and public trustee for Social Security, provided a technical overview illustrating the importance of action to reform Social Security as soon as possible.
- James C. Capretta, fellow at the Ethics and Public Policy Center and former associate director of the Office of Management and Budget, argued that passage of the PPACA has compounded the problem of rising federal health entitlement costs, rather than solved it. He also suggested shifting to a "defined contribution" approach, converting the current tax preferences for employer-paid premiums into a fixed, refundable tax credit that is available to all households.
- Paul Van de Water, senior fellow at the Center on Budget and Policy Priorities, discussed ways in which PPACA slows the growth of health care costs. "Slowing the growth of health care costs is one of our nation's most pressing economic challenges, and success will benefit employers, workers, and taxpayers," he said.

While large-scale entitlement reform is unlikely to be considered by Congress in the short term, the prominence of health and retirement benefits in the federal budget means that the full range of these issues will be "in play" as Congress examines budget and tax reform.

House Energy & Commerce Committee Examines CLASS Act

On March 17, the U.S. House of Representatives Energy and Commerce Committee held the hearing, The Implementation and Sustainability of the New, Government-Administered Community Living Assistance Services and Supports (CLASS) Program, to examine more closely this voluntary, federally administered long-term care insurance program established under the Patient Protection and Affordable Care Act (PPACA).

Under the program, individuals who enroll and meet benefit eligibility requirements will receive benefits to purchase long-term care services and support, including personal assistance, homemaker services, specialized transportation and assistive technology. CLASS Act requires that the benefit plan include a cash benefit averaging at least $50 per day. On March 9, the U.S. Health and Human Services Department's Administration on Aging (AOA) issued a frequently asked questions document indicating that HHS intends to designate a benefit plan by October 1, 2012.

Committee Chairman Fred Upton (R-MI) convened the hearing, saying that "the lack of clarity around the CLASS program has raised widespread concerns about the program's structure and long-term sustainability." He also noted the bipartisan concerns from the original health care debate that the CLASS program was actuarially unsound and fiscally irresponsible - creating a long-term financial risk for the federal government and potential beneficiaries.

Ranking Democratic Member Henry Waxman (D-CA), in his opening statement, said that "in creating the CLASS Program – a voluntary, self-sustaining, privately-financed, and beneficiary-driven effort – we set in motion a process that will allow the elderly and the disabled to be able

to stay in their homes and in their communities when they are no longer able to do so independently." However, he also admitted that "much work needs to be done before the program is ready to go 'live' in 2012."

The committee first heard testimony from Kathy Greenlee, assistant secretary of the AOA, who acknowledged that the CLASS program needs improvement but argued that it should not be repealed until every effort has been made to reform the program. She also outlined several areas within statutory flexibility to strengthen the CLASS program while ensuring its solvency, including "partnering with employers to disseminate outreach information and enroll their employees."

The committee also heard testimony from the following witnesses:

- Allen J. Schmitz, principal and consulting actuary at Milliman, on behalf of the American Academy of Actuaries (AAA);
- Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute;
- Mark J. Warshawsky, director of retirement research at Towers Watson and current member of the social security advisory board; Anthony J. Young, senior public policy strategist at NISH and representative of the AbilityOne program; and
- William Lawrence Minnix, Jr., president and CEO of LeadingAge and chair of Advance CLASS.

Representative Phil Gingrey (R-GA) announced that he and Rep. Charles Boustany (R-LA) will soon be introducing legislation to repeal the CLASS Act provisions of PPACA.

House Oversight Committee Hears Testimony on Mini-Med Waiver Program

On March 15, the U.S. House of Representatives Committee on Oversight Subcommittee on Health Care, District of Columbia, Census and the National Archives held the hearing Obamacare: Why the need for waivers? The panel sought testimony from policy experts on the provision of the Patient Protection and Affordable Care Act (PPACA) that permits waivers for sponsors of limited benefit (also known as "mini-med") health plans that feature low premiums and low annual limits.

To ensure that individuals with certain coverage – including coverage under "mini-med" plans – would not be denied access to needed services or experience more than a minimal impact on premiums, the interim final regulations (IFR) for patient protections under the Patient Protection and Affordable Care Act (PPACA) provides for the HHS Secretary to establish a program under which the requirements related to restricted annual limits may be waived if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums. HHS provided this waiver process in September 2010.

Steven Larsen, deputy administrator and director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS), said in his testimony that "the waiver process, which is grounded in our regulation and fleshed out in subsequent guidance, allows employers and insurers to continue offering limited coverage if they can show that complying with the regulation would cause their enrollees to experience a significant increase in premiums or decrease in access to benefits." The waiver procedure is

administered fairly based on each application's merits without regard to the type of applicant or size of business, with the goal of minimizing market disruption and maintaining coverage."

The committee also heard from the following witnesses:

- Edmund Haislmaier, senior research fellow at the Center for Health Policy Studies at The Heritage Foundation;
- Scott Wold, shareholder at Hitesman & Wold, P.A.; and
- Judith Feder, professor of public policy at Georgetown University and senior fellow at the Center for American Progress.

In a separate Senate Finance Committee hearing on March 16, Department of Health and Human Services Secretary Kathleen Sebelius was asked about these waivers and replied that "some coverage is better than no coverage at all."

Senate Aging Committee Discusses 401(k) Plans, GAO Issues New Report

The Senate Special Committee on Aging held a hearing on March 16, Securities Lending in Retirement Plans: Why the Banks Win, Even When You Lose, examining how securities lending affects 401(k) plan sponsors and investors. "Securities lending" is a means by which institutional clients who hold and plan to retain long securities positions can earn incremental income.

According to **a report prepared by committee staff**, based on a survey of the 30 largest 401(k) plans, more than one-third of surveyed employers indicated they had been restricted at the plan level from withdrawing from at least one investment option that participated in securities lending during the financial crisis. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") directs the SEC to propose rules by July 2012 to increase the transparency of information. The Financial Industry Regulatory Authority is considering rules that will ensure that broker-dealers disclose potential conflicts and any restrictions firms may have on liquidating securities.

The Committee heard testimony from the following witnesses:

- Charles Jeszeck, acting director for education, workforce and income security at the Government Accountability Office (GAO), submitted a new report on this issue (see below).
- Anthony Nazzaro, principal at A.A. Nazzaro Associates, offered a number of basic steps that can be taken to protect pension funds and limit the risk in securities lending transactions.
- Ed Blount, executive director for the Center for the Study of Financial Market Evolution, argued that the cash "lockups" of the financial crisis were not attributable to a failure of securities lending and noted that the restrictive actions of regulators affecting lendable securities could well impair the ability of pension plan sponsors to offer passive index funds and to hedge actively managed portfolios.
- Allison Klausner, assistant general counsel-benefits at Honeywell International, Inc., similarly urged the committee to recognize the importance of maintaining the flexibility currently available. "Fiduciaries should not be required to operate in a rigid environment which prohibits them from providing plan participants and retirees with valuable opportunities to achieve retirement security," Klausner said.

- Steven Meier, chief investment officer, global cash management at State Street Global Advisors, also asserted that the incremental income derived from securities lending activity directly benefits the millions of American workers that rely on their employee retirement plans.

The new GAO report, **401(k) Plans: Certain Investment Options and Practices That May Restrict Withdrawals Not Widely Understood**, sought to (1) identify some of the specific investments and practices that prevented plan sponsors and participants from accessing their 401(k) plan assets and (2) determine any changes the U.S. Department of Labor (DOL) could make to assist sponsors in understanding the challenges posed by the investments and practices that restricted withdrawals.

The report ultimately recommends (see Page 52 of the report) that DOL study stable value funds and the practice of securities lending with cash collateral reinvestment by 401(k) plans to identify situations or conditions where plan sponsors could be prevented from meeting their fiduciary obligations, revise one of its prohibited transaction exemptions, and provide better disclosures and guidance to plan sponsors and participants. DOL disagreed with three of GAO's recommendations (See Page 54) but stated that it will consider the remaining four.

In a closing statement, Committee Chairman Herbert Kohl (D-WI) suggested that employers provide plan participants with clearer disclosures about the benefits and risks of securities lending in their plan options and provide the Securities and Exchange Commission (SEC) and other bank regulators with information about securities lending practices. He also called on the U.S. Department of Labor to develop tools and guidance for employers on the benefits and risks of securities lending.

Legislation Introduced to Repeal FSA "Use-It-or-Lose-It" Provision

On March 11, Representatives Charles W. Boustany (R-LA) and John Larson (D-CT) introduced the Medical Flexible Spending Account Improvement Act (H.R. 1004) that would effectively repeal the "use-it-or-lose-it" provision of flexible spending accounts (FSAs). Specifically, the measure would allow participants to cash out any remaining FSA balances at the end of the year, and those funds would be treated as normal, taxable wages.

Prospects for passage of H.R. 1004 are unclear, though the bill does have the advantage of bipartisan sponsorship.

Employers Testify at House Hearing on Health Care Cost Pressures

The House Education and the Workforce Committee's Subcommittee on Health, Employment, Labor, and Pensions held a March 10 hearing on "The Pressures of Rising Costs on Employer Provided Health Care". The panel heard from four witnesses, including Thomas Miller, a resident fellow from the American Enterprise Institute (AEI); Brett Parker and James Houser, small business owners from New York City and Portland, Oregon; and J. Michael Brewer, president of Lockton Benefit Group. Brewer testified at the House hearing on behalf of Lockton and its mid-market clients.

AEI witness Miller told the House panel that the Patient Protection and Affordable Care Act (PPACA) is beginning to increase health cost for employers, but that it will have a more serious impact on health costs after 2014 when the employer mandate and other provisions of the act become effective and could lead to a "steady drip-by-drip political form of water torture" on

employer-sponsored health coverage by sending a signal to employers that they should either reduce or drop health coverage for employees. Miller also said that the loss of employer-sponsored coverage would be "explosively unaffordable" for the federal government if it had to replace the dollars now spent by employers who provide this benefit to employees.

The small business witnesses split over their views about the impact of the new health reform law on health care costs. Parker, who testified on behalf of the U.S. Chamber of Commerce, urged repeal of the employer mandate and said that the law will mean that fewer small businesses will add jobs if it takes them over the 50 employee threshold where they would be subject to the employer mandate starting in 2014. Houser, the Portland, Oregon small business owner, said that he has seen some benefits of the new law because his firm qualified for a small business premium tax credit and he was able to add his 22-year-old daughter to the company's health plan. Houser also testified that he believed that the establishment of state health insurance exchanges would help small firms to continue to offer health coverage to their workers.

Brewer, president of Lockton Benefit Group, shared results from a recent survey of their mid-market clients, which found an average 2.5 percent increase in health premiums related to the PPACA, due to the requirement to cover adult children up to age 26 and other provisions of the law that became effective starting with 2011 plan years. He also testified that the new law creates incentives for many employers to consider dropping coverage and that many clients have told Lockton, "We won't be the first to drop coverage, but we won't wait to be third, either." Brewer said that the cumulative burdens of the new law "give employers one more reason to surrender" their role as plan sponsors. He also agreed that the law could have a chilling impact on hiring decisions by many employers, including decisions about converting more workers to part-time schedules.

Subcomittee Chairman David P. Roe (R-TN), a physician before entering Congress, stated that "employers...understand better than most the tough choices workers and their families face as health care costs go up year after year." In his closing comments, Roe also echoed a point made by Mike Brewer that, in the future, the health reform law is likely to set up a tension between the perspecitves of chief financial officers and human resources executives over whether companies should continue to offer health coverage, and that such decisions are more likely to be decided in favor of the chief financial officer's perspective, especially if health coverage can be obtained by employees through sources other than the employer's plan.

The House subcommittee session is part of a series of hearings on the impact of the health reform law following the House of Representatives' vote to repeal PPACA. House committees with jurisdiction over health policy are now considering alternative approaches.

RECENT REGULATORY ACTIVITY

IRS Issues Guidance on Form W-2 Treatment Under PPACA

On March 29, the Internal Revenue Service (IRS) issued Notice 2011-28, providing interim guidance for employers reporting certain plan information to employees under the Patient Protection and Affordable Care Act (PPACA). Section 9002 of the new law, and Section 6051(a)(14) of the Internal Revenue Code, requires employer health plan sponsors to report the cost of coverage under an employer-sponsored group health plan on the Form W-2.

As the guidance states, this reporting requirement was intended " to provide useful and comparable consumer information to employees on the cost of their health care coverage." The guidance also emphasizes that this new reporting to employees is for their information only and does not cause excludable employer-provided health coverage to become taxable.

Using a question-and-answer format, Notice 2011-28 also provides guidance for employers that are subject to this requirement for the 2012 Forms W-2 and those that choose to voluntarily comply with it for either 2011 or 2012. The notice includes information on how to report, what coverage to include and how to determine the cost of the coverage.

In October 2010, the IRS released a new draft Form W-2 for 2011 along with Notice 2010-69, guidance indicating that the agency will defer the new requirement for employers making that reporting by employers optional for forms issued for the 2011 tax year (i.e., for 2011 Forms W-2 that generally would be furnished to employees in January 2012). Notice 2011-28 provides additional relief for smaller employers (those filing fewer than 250 W-2 forms) by making this requirement optional for them at least for 2012 and continuing this optional treatment for smaller employers until further guidance is issued.

HHS, CMS Propose Regulations for Accountable Care Organizations

On March 31, the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services(CMS) proposed regulations implementing the provisions of the Patient Protection and Affordable Care Act (PPACA) addressing Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs).

As defined by CMS in a preliminary fact sheet issued in 2010, an ACO is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program. They are used to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Under Section 3022 of PPACA, providers of services and suppliers can continue to receive traditional fee-for-service payments under Medicare Parts A and B, and be eligible for additional payments based on meeting specified quality and savings requirements. The statutory language requires the Secretary to establish this program no later than January 1, 2012.

HHS officials have estimated that the creation of ACOs will save the federal government up to $960 million over the first three years. In an op-ed published in the New England Journal of Medicine, CMS administrator Donald Berwick claimed that, with ACOs, "the era of fragmented care delivery should draw to a close. Too many Medicare beneficiaries — like many other patients — have suffered at the hands of wasteful, ineffective, and poorly coordinated systems of care, with consequent costs that are proving unsustainable."

Berwick's article goes on to describe the HHS/CMS proposal: "Under the proposed rule, institutions and health care providers interested in forming an ACO will have considerable flexibility in the structure they assume. ACOs may be led by physicians in group practices, networks of individual practices, hospitals employing physicians, or partnerships among these entities and other health care providers. … physicians and Medicare beneficiaries will have important seats at the table." The article included a list of proposed measures for ACO quality standards.

Berwick also described the two different models for an ACO to follow to achieve shared savings: "In the first model, ACOs earlier in their evolution can elect to assume a smaller share of upside gains but no risk of loss for two years and then transition in year three to accepting risk. In the second model, organizations that are willing to take on both upside gains and downside risk can qualify for a higher proportion of shared savings from the start. The newly chartered Center for Medicare and Medicaid Innovation will concurrently launch aggressive testing of innovative models for a nationwide technical support platform for ACOs, to complement the numerous ongoing efforts in which the private sector is already engaged. The Center for Medicare and Medicaid Innovation is also now exploring ways to test alternative models of ACOs that differ from the models specified in the proposed rule."

In addition to the HHS/CMS proposed rule itself, several other government agencies have issued additional guidance related to ACOs:

- The Federal Trade Commission and the Department of Justice jointly issued a Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. The statement addresses the application of the antitrust laws to health care collaborations among otherwise independent providers and provider groups, formed after March 23, 2010 (the date on which PPACA was enacted), that seek to participate, or have otherwise been approved to participate, as ACOs. This statement sends a positive signal that the agencies will establish different levels of antitrust scrutiny depending on the specific ACO arrangement.
- CMS and the HHS Office of Inspector General (OIG) issued a notice (with comment period) outlining proposals for waivers of certain federal laws, including the physician self-referral law, the anti-kickback statute and certain provisions of the civil monetary penalty law-in connection with the Shared Savings Program. CMS and OIG are also asking for comments on further waiver design considerations for the Shared Savings Program and for the separate waiver authority for the Center for Medicare and Medicaid Innovation under section 1115A of the Social Security Act.
- the Internal Revenue Service (IRS) issued Notice 2011-20 requesting comments regarding the need for guidance on participation by tax-exempt organizations in the Shared Savings Program through ACOs.

DOL Releases PPACA Study on Self-Insured Health Plans

On March 30, the U.S. Department of Labor today sent to Congress the first annual report on self-insured employee health benefit plans as required under the Patient Protection and Affordable Care Act (PPACA). The report contains general information on self-insured employee health benefit plans and financial information on the employers that sponsor them, while also documenting the limited scope of such data and the complexities involved in interpreting the data that are available.

The report estimates that 12,000 health plans filing a Form 5500 for 2008 were self-insured and 5,000 mixed self-insurance with insurance. These plans respectively covered 22 million and 25 million participants. Many self-insured health plans do not meet the filing requirements and therefore do not file the Form 5500. Therefore, it is likely that the report underestimates the total number of self-insured plans

The report includes two appendices: Appendix A provides aggregate information on self-insured and mixed health benefit plans that are required to file a Form 5500 Annual Return/Report of

Employee Benefit Plan (plans covering 100 or more participants or holding assets in trust). Appendix B presents a study that surveys the academic literature on self-insured health plans, explores statistical issues associated with Form 5500 data, and analyzes available financial data for the employers that sponsor group health plans filing the Form 5500.

DOL Issues Fact Sheet on Definition of Fiduciary

The U.S. Department of Labor (DOL) has released a fact sheet on the definition of the term "fiduciary," setting forth the regulatory issues and describing the proposed regulations issued in October 2010.

DOL Extends Grace Period for Internal Appeals Under PPACA

On March 18, the U.S. Department of Labor (DOL) issued Technical Release (TR) 2011-01, extending and modifying an enforcement grace period for certain new requirements related to internal appeals processes under the Patient Protection and Affordable Care Act (PPACA). These new requirements apply to non-grandfathered plans. The enforcement grace period, as established under Technical Release 2010-02 issued last fall, was due to end on July 1, 2011.

TR 2011-01 indicates that the extension and modifications are based on a review of the comments received on the Interim Final Rule on PPACA internal claims and appeals and external review processes (IFR), issued in July 2010, and other feedback from interested stakeholders.

The March 18 technical release document states that the DOL, as well as the departments of Health and Human Services and Treasury, "intend to issue an amendment to the 2010 interim final regulations in the near future that takes into account comments and other feedback received from stakeholders on the 2010 interim final regulations, and makes [sic] modifications to certain provisions of the 2010 interim final regulations." To avoid enforcing standards that the departments intend to modify in the near future, the relief contained in TR 2011-01 is intended to act as a bridge until an amendment to the 2010 interim final regulations is issued.

TR 2011-01 extends, with a few modifications, the enforcement grace period set forth in TR 2010-02 until plan years beginning on or after January 1, 2012. Specifically, TR 2011-01 extends the enforcement grace period with respect to requirements that:

- a plan or issuer notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer;
- notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and the IFR; and
- if a plan or issuer fails to strictly adhere to all the requirements of the IFR, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under state law.

TR 2011-01 modifies and extends the grace period with respect to requirements for broader content and specificity in notices to claimants. Specifically, with respect to the requirement to disclose diagnosis codes and treatment codes (and their corresponding meanings), TR 2011-01

extends the enforcement grace period until plan years beginning on or after January 1, 2012. The enforcement grace period will be extended with respect to the other disclosure requirements from July 1, 2011, until the first day of the first plan year beginning on or after July 1, 2011, (which is January 1, 2012, for calendar year plans). Therefore, enforcement with respect to the following provisions will take effect on a rolling plan year basis, starting on the first day of the first plan year beginning on or after July 1, 2011:

> (a) the disclosure of information sufficient to identify a claim (other than the diagnosis and treatment information),
>
> (b) the reasons for an adverse benefit determination,
>
> (c) the description of available internal appeals and external review processes, and
>
> (d) for plans and issuers in states in which an office of health consumer assistance program or ombudsman is operational, the disclosure of the availability of, and contact information for, such program.

TR 2011-01 also notes that a number of comments on the 2010 interim final regulations raised concerns about the scope of the federal external review process. It explains that TR 2011-01, TR 2010-02, and the model notices authorized by the federal departments do not address the scope of the federal external review process, which is still being reviewed by the departments and may be addressed in future guidance.

The extended grace period will avoid burdensome mid-year plan changes for group health plans and issuers.

Obama Administration Proposes Rules on State Waivers to Health Reform Law

The Department of Health and Human Services (HHS) and the Department of Treasury (Treasury) issued proposed regulations on March 10 to implement the application and approval process for states that seek waivers of certain provisions of the Patient Protection and Affordable Care Act (PPACA). As explained in an agency fact sheet, Section 1332 of PPACA authorizes the secretaries of HHS and Treasury to waive certain key provisions of the statute to give states greater flexibility to establish their own approaches to health reform, provided that the state's programs are at least as comprehensive and affordable as the coverage under the federal provisions. The state programs must also result in at least as many residents being covered with health insurance as they would under PPACA and may not result in an increase in the federal deficit.

Section 1332 of PPACA authorizes "waivers for state innovation" that may be granted for the following provisions of the statute:

- Subtitle D, Part 1 -- Qualified health plans (i.e., the health insurance plans which may be offered through a state health insurance exchange and the "essential benefits" they must offer)
- Subtitle D, Part 2 – Health insurance exchanges
- Section 1402 - Reduced cost-sharing for individuals enrolling in qualified health plans
- Section 36B – Refundable tax credits for coverage under a qualified health plan
- Section 4980H – Employer responsibilities regarding offering health coverage

- Section 5000A – Individual responsibilities regarding maintaining minimum essential coverage

The Secretary of HHS is authorized to approve state waivers for the provisions of PPACA related to qualified health plans and health insurance exchanges. The Secretary of Treasury is authorized to approve state waivers related to the individual and employer responsibility provisions and the subsidy provisions related to reduced cost sharing and refundable tax credits for individuals who qualify for this assistance on the basis of their household income. Importantly, PPACA does not authorize states to receive waivers of any other federal laws or regulations, including ERISA, which the proposed regulations further clarify by stating that "a state must comply with all applicable federal laws, regulations, interpretive policy statements and interpretive guidance unless expressly waived." In addition, the proposed rules would require the states to include in their waiver application "an explanation as to whether the waiver increases or decreases the administrative burden on individuals, insurers, and employers, and if so, how and why."

President Obama recently addressed the National Governors Association and expressed support for a bill cosponsored by senators Ron Wyden (D-Or) and Scott Brown (R-MA), the Empowering States to Innovate Act (S. 248), which would permit states to obtain PPACA waivers, starting in 2014.

HHS Administration on Aging Releases FAQ on CLASS

On March 9, "frequently asked questions" (FAQ) related to the Community Living Assistance Services and Support (CLASS) program were posted to a dedicated CLASS webpage on the U.S. Health and Human Services' Administration on Aging web site. CLASS is a voluntary federally administered insurance program established under the Patient Protection and Affordable Care Act (PPACA).

Under the program, eligible working adults will be able to voluntarily enroll in the program either directly or through their employers. Those who enroll and meet benefit eligibility requirements will receive benefits to purchase long-term services and support, including personal assistance, homemaker services, specialized transportation and assistive technology. According to the FAQ, HHS intends to designate a benefit plan by October 1, 2012, after taking into consideration the recommendations of the CLASS Independence Advisory Council. The CLASS Act requires that the benefit plan include a cash benefit averaging at least $50 per day. The FAQ describes how CLASS differs from long-term care insurance and addresses enrollment, benefits and premiums under the program. The FAQ indicates that enrollment will not begin until after HHS announces details about the CLASS benefit plan. The FAQ also states that employers will be able to decide whether to participate in the CLASS automatic enrollment for their employees. Employees of employers who participate in the automatic enrollment will be able to opt-out of enrollment. Employees of employers who do not participate in the automatic enrollment will have the option to enroll in CLASS individually, providing they satisfy eligibility requirements.

PBGC Releases Proposed Rule on Unpredictable Contingent Events

On March 10, the Pension Benefit Guaranty Corporation (PBGC) released a proposed rule interpreting the section of the Pension Protection Act of 2006 (PPA) that changed the phase-in period for the guarantee of benefits contingent upon the occurrence of an "unpredictable contingent event (UCE)," such as a plant shutdown. Previously, the five-year phase-in (20

percent per year) began when the amendment providing UCE benefits (UCEBs) was adopted or effective (whichever is later) but PPA added a third factor that the phase-in period starts no earlier than the date of the shutdown or other unpredictable event. The statutory change applies to benefits that become payable as a result of a UCE that occurs after July 26, 2005.

Notable comments and guidance in the proposed regulation includes:

- PPA did not alter the rule that UCEBs are not guaranteed at all unless the triggering event occurred prior to the plan termination date;
- The reference to "plant shutdown" in the statutory definition of UCEB includes a full or partial shutdown;
- When the UCEB is payable only upon the occurrence of more than one UCE, the guarantee is phased in from the latest date when all such UCEs have occurred;
- Based on plan provisions and other facts and circumstances, the PBGC would solely determine (a) which plan benefits are subject to the UCEB phase in and (b) the date(s) for which each such UCEB would be subject to the phase in;
- The proposed regulations includes eight examples that show how the UCEB phase-in rules would apply in the following situations:
    - Shutdown that occurs later than the announced shutdown date;
    - Sequential permanent layoffs;
    - Skeleton shutdown crews;
    - Permanent layoff benefits for which the participant qualifies shortly before the sponsor enters bankruptcy;
    - Employer declaration during a layoff that return to work is unlikely;
    - Shutdown benefit with age requirement that can be met after the shutdown;
    - Retroactive UCEB; and
    - Removal of Internal Revenue Code (Code) Section 436 restrictions (see discussion below).
- If a UCE occurs after a bankruptcy filing date, UCEBs arising from the UCE are not guaranteed at all because the benefits are not nonforfeitable as of the bankruptcy filing date; and
- If a UCE occurs before the bankruptcy filing date, the five-year phase-in period is measured from the date of the UCE to the bankruptcy filing date, rather than the plan termination date.

PPA also added a rule that prohibits UCEB payments with respect to a UCE if the plan is less than 60 percent funded for the plan year in which the UCE occurs (or would be less than 60 percent funded taking the UCEB into account). This Code Section 436 restriction is permanent unless additional contributions are made to the plan, or an actual certification meeting certain requirements is made, during the same plan year as the UCE. If a UCEB becomes payable because the funding restriction has been removed, the effective date of the UCEB for phase-in purposes is determined without regard to the restriction.

PBGC to Re-Propose Reportable Events Rule

The Pension Benefit Guaranty Corporation has decided to re-propose its regulations regarding "reportable events" – events that may be indicative of a need to terminate a plan – under ERISA Section 4043. The PBGC published the proposed regulations to reflect changes resulting from the Pension Protection Act of 2006 (PPA) and eliminate most automatic waivers and filing extensions provided under the prior reportable events regulations. In December 2010, PBGC also issued Technical Update 10-4, providing guidance on these matters.

The PBGC's 2011 Blue Book, recently distributed at a meeting of enrolled actuaries, says: "In light of Executive Order 13563 (Improving Regulation and Regulatory Review) and comments received on the proposed rule, PBGC plans to re-propose this rule with an emphasis toward reducing the burden on employers to the extent feasible." The text specifically mentions an examination of the extent to which (1) PBGC can take advantage of other reporting requirements to avoid burdening companies and plans with unnecessary reporting; and (2) if there should be different requirements for small plans.

New York Fed Developing Position on Derivatives Trades

The Federal Reserve Bank of New York (New York Fed) is currently working with a group of "swap" trade market participants (including the majority of the swap dealer community) on a "commitment letter" that will reflect commitments by the signatories with respect to the trading, confirmation, clearing and reporting of their future swap transactions.

As we have been reporting regularly, when used by defined benefit plans, swap trades are primarily used to mitigate risk. The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, which sets forth extensive rules for swaps, has required substantial rulemaking by the Commodity Futures Trading Commission (CFTC) and the Securities and Exchange Commission (SEC) affecting retirement plans.

The timeline for finalization of the commitment letter remains unclear at this time.

CMS/CCIOO Issue Report on ERRP

The Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) has issued a report on the Early Retiree Reinsurance Program (ERRP) during calendar year 2010.

The EERP, enacted under Section 1102 of the Patient Protection and Affordable Care Act (PPACA), allows employer health plan sponsors to apply and qualify for reimbursement of early retiree health care expenses. HHS' dedicated ERRP secure website includes resources related to the program.

The report includes a range of information related to application approvals and program reimbursements. As of December 31, 2010, the program provided $535 million in reimbursements to 253 approved sponsor applications (i.e., plans). The largest share of these reimbursements went to state government-sponsored entities, followed by non-profit, commercial, union, and religious organizations. In total, over 5,000 plan sponsors have been approved for participation in ERRP.

The temporary $5 billion program is scheduled to end the earlier of January 1, 2014, when the state-based health insurance exchanges are scheduled to be operational or when program funds are exhausted.

IRS Updates Form Replacing Schedule SSA Filing

On March 3, the Internal Revenue Service (IRS) issued Announcement 2011-21, indicating that the IRS (in coordination with the Social Security Administration) has developed, *Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits*, as the form to be used to satisfy the reporting requirements of Section 6057(a) of the Internal Revenue

Code for plan years beginning on or after January 1, 2009, and sets forth the due dates for filing the Form 8955-SSA for the 2009 plan year and subsequent plan years.

Code Section 6057(a) requires the plan administrator of a plan that is subject to the vesting standards of Section 203 of ERISA to report certain information relating to each plan participant with a deferred vested benefit (often called "terminated vested participants") in accordance with regulations prescribed by the Secretary of Treasury. In order to accommodate the DOL final regulations mandating electronic filing of the Form 5500 annual return/report, a number of changes were made to the Form 5500 Series and accompanying schedules and attachments. One of these changes was the removal of Schedule SSA from the Form 5500 annual return/report beginning with filings covering a plan year that begins on or after January 1, 2009.

Form 8955-SSA for the 2009 plan year is expected to be available for filing by plan administrators shortly. Form 8955-SSA for the 2010 plan year is being developed and is expected to be available for filing later this year. Plan administrators are permitted to report information that would otherwise be required to be reported on the 2010 Form 8955-SSA using a 2009 Form 8955-SSA. The IRS has also developed a voluntary electronic filing system for filing Form 8955-SSA for the 2009 plan year and subsequent plan years. This system is ready to accept filings of Form 8955-SSA when the form becomes available for filing. In general, as with Schedule SSA (Form 5500), if a Form 8955-SSA must be filed for a plan year, it must be filed by the last day of the seventh month following the last day of that plan year (plus extensions). For 2009 and 2010 plan years, Form 8955-SSA must be filed by the later of (1) the due date that generally applies, or (2) August 1, 2011.

RECENT JUDICIAL ACTIVITY – Nothing to Report this Month