***BENEFITS INSIDER***
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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

### Bill Introduced to Increase Retiree Health Program Funding

Senator John Kerry (D-MA), introduced **the Retiree Health Coverage Protection Act (S. 1088)** which would provide an additional $5 billion to the Early Retiree Reinsurance Program (ERRP) that was enacted under Section 1102 of the Patient Protection and Affordable Care Act (PPACA). Kerry, who originally sponsored the ERRP amendment added to the health care reform measure, is joined on S. 1088 by original cosponsors Debbie Stabenow (D-MI) and Richard Blumenthal (D-CT)

Under PPACA, employers who participate in the ERRP can receive a reinsurance reimbursement of up to 80 percent of catastrophic medical claims between $15,000 and $90,000 for their early retiree enrollees. The reimbursement is used to reduce the employer's health care costs and to lower premiums to retirees and their families.

The U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) issued an updated progress report on the Early Retiree Reimbursement Program (ERRP) and announced that the program would stop accepting applications on May 5, 2011, due to a projected lack of available funds. The temporary $5 billion program was designed to end on the earlier of January 1, 2014 (when the state-based health insurance exchanges are scheduled to be operational) or when program funds are exhausted.

The additional $5 billion provided by S. 1088 would allow more employers to participate in the ERRP and could help reduce the cost of retiree coverage. The bill's obvious federal revenue cost is not offset, meaning that it would likely need to be paired with a revenue-raising measure in the current federal deficit environment.

### Senate Finance Ranking Member Introduces HSA, FSA Expansion Measure

Senator Orrin Hatch (R-UT), ranking Republican member on the Senate Finance Committee, introduced the Family and Retirement Health Investment Act (S. 1098), legislation to expand the use of Health Savings Accounts (HSAs) and Flexible Spending Arrangements (FSAs). An identical companion bill has been introduced in the House of Representatives (H.R. 2010) by Representative Erik Paulsen (R-MN).

HSAs (when paired with a high-deductible health plan) and FSAs permit individuals with opportunities to make pre-tax contributions to an account that can be used to pay for qualified medical expenses. Specifically, S. 1098/H.R. 2010 includes provisions that would:

- allow a husband and wife to make catch-up contributions to the same HSA, up to double the amount currently permitted;
- remove the new restrictions on the use of HSA and FSA dollars for the purchase of over-the-counter drugs (note: this provision would also apply to health reimbursement arrangements);
- allow individuals to carry forward up to $500 from their FSA accounts to the following year;
- clarify the use of prescription drugs as preventive care that will not be subject to an HSA-eligible plan deductible;
- allow for the purchase of a high-deductible health plan, COBRA continuation coverage and qualified long-term care insurance with HSA dollars;

- allow seniors enrolled in Medicare Part A to continue contributing to their HSAs; and

## House Subcommittee Hearing Examines PPACA Regulatory Burden

On March 15, the U.S. House of Representatives Energy and Commerce Committee's Health Subcommittee held the hearing PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden. The panel sought testimony from employers, insurers and other health care policy experts on the real-world effects of the implementation of Patient Protection and Affordable Care Act (PPACA).

The Subcommittee also intended to hear testimony from Steven Larsen, deputy administrator and director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS), but his appearance had to be postponed due to scheduling problems.

In his opening statement, Subcommittee Chairman Joe Pitts (R-PA) focused on two elements of the Obama Administration's rulemaking process: the interim final regulations for "grandfathered" health plans (group health plans or insurance coverage existing as of March 23, 2010) and interim final regulations on a plan's Medical Loss Ratio (MLR, the percentage of a plan's premium revenues that pay for medical services). "According to the administration's own estimates … its regulations will force half of all employers – and as many as 80 percent of small businesses – to give up their coverage in the next two years," Pitts said. He also noted that "more regulations are due out in the near future, including the establishment of the essential minimum benefits package, which will increase premiums and put people's coverage at risk."

The committee heard testimony from the following witnesses:

- Edward Fensholt, senior vice president of Lockton Benefit Group;
- Randi Reichel, counsel at Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C., on behalf of America's Health Insurance Plans, a Policy Board of Directors organization;
- Scott Harrington, professor of health care management & insurance & risk management at the Wharton School at the University of Pennsylvania;
- Janet Trautwein, CEO of the National Association of Health Underwriters;
- Katherine Hayes, associate research professor at the Department of Health Policy of the George Washington University School of Public Health and Health Services;
- Terry Gardiner, vice president, policy and strategy for the Small Business Majority; and
- Ethan Rome, executive director of Health Care for America Now, a grassroots health care advocacy organization.

The Republican majority in the House is expected to continue to advance legislation that would repeal and/or de-fund significant portions of PPACA, though attempts thus far have been opposed by the White House and the Democrat-controlled Senate.

## GAO Issues Report on QSERPs

On June 13, the Government Accountability Office (GAO) released a report on Private Pensions: Little Information Available on Qualified Supplemental Executive Retirement Plans. The report formally conveys information that the GAO previously presented to the staff of Representatives Sander Levin (D-MI) ranking Democrat on the House of Representatives Ways and Means Committee, Richard Neal (D-MA), ranking Democrat on the Ways and Means

Subcommittee on Select Revenue Measures, and Lloyd Doggett (D-TX), Ways and Means Committee member, who collectively requested the report.

Specifically, the report studies the use and implications of Qualified Supplemental Executive Retirement Plans (QSERPs) to transfer certain nonqualified executive benefits into existing defined benefit pension plans under the existing nondiscrimination rules. "Since QSERPs are provided to [highly-compensated employees (HCEs)], but are funded by the assets used to pay qualified plan benefits for all employees, some observers have questioned whether these arrangements affect the benefits promised to [non-highly-compensated employees (NHCEs)]. To the extent that the share of benefits to HCEs was maximized, NHCEs' benefits would represent a smaller proportion of the accrued benefits under the company's qualified plan. However, a few experts maintain that increasing some HCEs' tax-qualified benefits could give HCEs and plan decision makers a larger stake in continuing the [defined benefit] plan and in keeping it adequately funded," the report reads.

Ultimately, GAO found that quantitative and qualitative information on the prevalence of QSERPS remains largely unknown, and notes that while "it is possible that plan sponsors could introduce new QSERPs in the future as the ratio of plan assets to plan liabilities improves, … the current pension plan funding requirements of the Pension Protection Act of 2006 (PPA) place limits on the addition of new liabilities to a tax-qualified plan." Most notably, as lawmakers discuss the budget and tax implications of benefit plans, the report states that "potential QSERP implications may in some instances include a reduced federal income tax liability for plan sponsors and a higher and more secure qualified benefit amount for HCEs. Any effect on the benefit security of NHCEs is uncertain."

In the previous congress, Doggett introduced the Retirement Fairness Act (H.R. 4126) (and later circulated a draft revision of the bill) Doggett introduced in November 2009. The measure would have directed the Secretary of the Treasury to review the current nondiscrimination regulations under Section 401(a)(4) of the Internal Revenue Code of 1986 and modify such regulations to address "abusive practices and plan designs that may comply with such current regulations but that have the effect of significantly discriminating in favor of highly compensated employees." Doggett has not yet announced plans to re-introduce the measure. It is possible that a review of the nondiscrimination rules could be part of a larger review of retirement related tax code provisions in the tax reform debate.

## Kohl, Enzi Introduce Legislation Addressing Defined Contribution Plan Loans

Senate Special Aging Committee Chairman Herb Kohl (D-WI) and Senate Health, Education, Labor and Pensions (HELP) Committee Ranking Republican Member Mike Enzi (R-WY) introduced the Savings Enhancement by Alleviating Leakage in 401(k) Savings (SEAL) Act, a measure to address "leakage" of retirement assets occurring through hardship withdrawals and defined contribution plan loans to participants. A news release and summary of the bill are available on the Aging Committee website.

Specifically, the SEAL Act would:

- Extend the right of participants to make a rollover contribution for plan loan offset amounts, allowing employees to contribute the amount outstanding on their loan to an IRA by the time they file their taxes for that year;

- direct the U.S. Treasury Department to adjust its regulations to allow 401(k) participants to continue to make elective contributions during the six months following a hardship withdrawal;
- reduce the overall number of loans that participants can take at one time to three (limits are currently at the discretion of the employer); and
- prohibit plans from making loans available through the use of credit cards. In 2008, Kohl and Senator Charles Schumer (D-NY) introduced a bill barring companies from offering 401(k) debit cards.

The SEAL Act is the culmination of Kohl's longtime interest in this subject. In July 2008, the Aging Committee held the hearing Saving Smart for Retirement: Are Americans Being Encouraged to Break Open the Piggy Bank? and in August 2009 he requested the Government Accountability Office (GAO) report, 401(k) PLANS: Policy Changes Could Reduce the Long-term Effects of Leakage on Workers' Retirement Savings.

The legislation has been referred to the Senate Finance Committee, where the timetable for consideration of the measure is uncertain.

**HHS Secretary Sebelius Testifies Before House Committee**

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius testified before the House of Representatives Education and the Workforce Committee in the May 5 hearing, Policies and Priorities of the U.S. Department of Health and Human Services.

In his opening statement, Committee Chairman John Kline (R-MN) framed the hearing as a discussion of HHS funding under President Obama's federal budget proposal. "These proposals fail to rise to the challenges we face. If we adopt the president's plan, the Congressional Budget Office reports the federal government will spend $46.2 trillion dollars, impose $1.5 trillion dollars in new taxes and add roughly $9 trillion to the national debt over the next decade." Kline was also critical of the Patient Protection and Affordable Care Act (PPACA), saying that "already the price tag for the new law has increased by more than 50 percent. A plan that supporters promised would reduce costs will instead charge taxpayers more than $2.6 trillion dollars when fully implemented and add more than $700 billion to the national debt."

President Obama's budget message stated that the administration "is committed to implementing the [PPACA] swiftly and efficiently since rising health care costs are the single biggest driver of our long-term fiscal problems."

Sebelius' testimony outlined the reductions in HHS' operating budget in the administration's proposal while describing investments in ongoing programs. Her testimony included a specific section on "transforming health care," including the following policy efforts related to PPACA:

- Expanding access to coverage and making coverage more secure, referring to the patient protection (or so-called "Patients' Bill of Rights") provisions;
- ensuring access to care for "vulnerable populations" through funding for PPACA's Community Health Center Fund;
- improving health care quality through the formation of Accountable Care Organizations, value-based purchasing programs, the CMS Innovation Center and efforts to combat health care associated infections;

- reducing health care costs by providing rate adjustments for Medicare providers and enforcing new rules for private insurers, such as medical loss ratio standards and enhanced review of premium increases; and
- stabilizing Medicare physician payments by setting forth short- and long-term plans to alleviate payment decreases due to the Medicare Sustainable Growth Rate (SGR) formula.

Sebelius also advocated for advancing Patient-Centered Health Research and Health Information Technology and improving public services through such measures as the reauthorization of the Older Americans Act, which provides community-based support for seniors.

During the question-and-answer period, Sebelius touted the Partnership for Patients program, an initiative aimed at addressing preventable injuries and complications in patient care over the next three years.

Generally, committee Republicans challenged Sebelius on the sustainability of PPACA and the disruptions it could cause to the health care system. In particular, Representative Phil Roe (R-TX) outlined the fundamental choice for employers to either comply with the law, absorbing substantial new costs, or pay the penalty and allow their employees to purchase insurance through the exchange. Committee Democrats defended the health care reform law while also criticizing cuts to the "Head Start" program under the House Republicans' Fiscal Year 2012 budget proposal.

## House Subcommittee Examines Public Pensions

On May 5, the House of Representatives Ways and Means Subcommittee on Oversight held a hearing on the transparency and funding of state and local pension plans, featuring testimony from economic and academic experts. Discussion focused largely on the Public Employee Pension Transparency Act (H.R. 567), a measure sponsored by Ways and Means Committee member Devin Nunes (R-CA) that would expand transparency requirements from state and local public pension plans and prohibit the federal government from providing any financial assistance or bailouts to public pension funds in the future.

In a news advisory announcing the hearing, Subcommittee Chairman Charles Boustany (R-LA) said, "whether the underfunding of state and local pension plans is $700 billion or over $3 trillion, it is a serious concern for workers and retirees, for state and local governments, and for taxpayers in general. The Subcommittee needs to understand how public plans are currently calculating their assets and liabilities, not just so we can get a clearer picture of how underfunded those plans really are, but also to determine whether there is adequate transparency in how these plans are reporting their shortfalls. Given that some have raised the specter of a federal taxpayer bailout to cover the unfunded liabilities of these state and local plans, it is important for the Subcommittee to review this issue and to consider possible approaches to ensure that no such federal taxpayer bailout is ever needed."

The subcommittee heard testimony from the following witnesses:

- Walker Stapleton, treasurer for the state of Colorado, expressed support for H.R. 567 given the challenges facing the state's Public Employee's Retirement Association (PERA). He also argued that "public pension plans like PERA need to start adopting rates of return in line with Treasury Yields and stop the pervasive underfunding of plans.

Overestimating a pension system's expected return is essentially gambling with the financial welfare of the next generation of Americans."

- Josh Barro, Walter B. Wriston Fellow at the Manhattan Institute for Policy Research, argued that Congress can play a valuable role by requiring greater financial transparency by state and local pension funds. He identified a few key areas in which the federal government should encourage better reporting, including a plan's discount rate, smoothing, projections and normal cost.
- Jeremy Gold, of Jeremy Gold Pensions (an independent pension actuary firm), also supported H.R. 567 but suggested a number of technical changes to the measure.
- Robert Kurtter, managing director of U.S. Public Finance at Moody's Investors Service, acknowledged that H.R. 567 would increase access to, and comparability of, state and local government pension plan data, but also noted that the bill could increase the amount and complexity of the information disclosed. Moody's supports H.R. 567 as well as the Governmental Accounting Standards Board (GASB) process to set new standards.
- Iris J. Lav, senior advisor at the Center on Budget and Policy Priorities, suggested that proposed federal requirements would undercut the GASB initiative and is unnecessary because market discipline will enforce the new GASB standards. "A combination of the recovery of market losses sustained during the recession, modest increases in employer (and in some cases) employee contributions, and moderate restructuring of benefits should be able to restore the vast majority of state and local pension plans to full solvency," she said.

## House Approves PPACA De-Funding Legislation

On May 3, the U.S. House of Representatives approved H.R. 1213, a bill introduced by House Energy and Commerce Committee Chairman Fred Upton (R-MI) to repeal mandatory funding provided to states to establish benefit exchanges that must be operational by 2014. The bill generally passed along party lines, with minimal Democratic support.

During debate of H.R. 1213, the House defeated a motion to "recommit" the bill, sending it back to committee for further review, as well as a number of amendments that would have (1) required HHS to post the amount of money rescinded on the HHS website; (2) required an HHS report on state difficulty in establishing the exchanges without the funding; (3) require an HHS report on possible delays and enrollment reductions to the exchanges and (4) required a GAO report on the benefits of exchange funding for states versus a federal exchange. The House also rejected an amendment in the nature of a substitute that would have preserved exchange funding for states that apply for early innovator grants before 2012.

H.R. 1213 – along with a number of other PPACA de-funding measures – was recently approved by the House Energy and Commerce Committee. The measure is highly unlikely to receive consideration in the Senate, however, where Democrats still hold the majority. Additional pieces of PPACA repeal and replacement legislation are expected to be introduced in the coming weeks and months.

## Senate Hears Testimony on Tax Incentives

On May 3, the U.S. Senate Finance Committee hosted the hearing, Is the Distribution of Tax Burdens and Tax Benefits Equitable?, examining whether the Internal Revenue Code has contributed to real or perceived disparities in income growth.

In his opening statement, Committee Chairman Max Baucus (D-MT) noted that "two prime examples of [income tax] inequality are deductions and exclusions. Many of these incentives only benefit people who earn higher incomes, and the size of the benefit they receive is also often dependent on income. … We should consider whether our tax system should take these disparities into account in some way, and we must question whether our tax code can better promote economic mobility and opportunity."

Some of the four witnesses appearing before the committee referenced employee benefit expenditures in their testimony:

- Daniel Shaviro, Wayne Perry Professor of Taxation at the New York University School of Law, provided a technical outlook on tax reform, focusing on the challenges of eliminating deductions and exclusions (such as the exclusions of contributions to defined contribution savings plans and employer contributions for health insurance) while expanding the taxpayer base.
- Scott Hodge, president of the Tax Foundation, said that "the U.S. tax system is in desperate need of simplification and reform," criticizing the use of the tax code to direct social and economic objectives such as retirement savings and health care coverage.
- Aviva Aron-Dine, Ph.D. candidate at the Massachusetts Institute of Technology Department of Economics, offered evidence of tax inequality – particularly as it affects lower-income individuals. She strongly recommended changes to high-income marginal tax rates and continued support of the Earned Income Tax Credit and Refundable Child Tax Credit.
- Alan Reynolds, senior fellow at the Cato Institute, argued that increasing marginal tax rates for high-income individuals will yield limited results because it would only reduce the amount of reported income. He suggested that the perceived income inequality is most attributable to capital gains and dividends.

Senate Finance Committee staff have indicated that an upcoming hearing will focus specifically on retirement plan tax incentives.

## RECENT REGULATORY ACTIVITY

### IRS Extends Deadline for Reporting Separated Participants' Retirement Benefits

According to Issue 2011-5 of the Internal Revenue Service (IRS) Employee Plans News, dated June 22, 2011, the IRS will extend the deadline for filing Form 8955-SSA for both the 2009 and 2010 plan years, under which employers must report the deferred vested retirement benefits of separated participants. The new deadline will be the later of (1) January 17, 2012 or (2) the due date that generally applies for filing the Form 8955-SSA for 2010. The IRS, in Announcement 2011-21, had previously extended the filing deadline for form 8955-SSA to August 1, 2011. The January 17, 2012, date will not be eligible for further extensions by filing Form 5558.

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.

Updated filing instructions for Form 8955-SSA and guidance in the form of Frequently Asked Questions are available on the IRS website.

## PPACA Claims and Appeals/External Review Rules Amended, New Guidance Issued

On June 22, the U.S. Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) collectively released **an amendment** to the original interim final regulations (IFR) (first issued July 23, 2010) relating to internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act (PPACA). The regulatory agencies reexamined and amended the rules after numerous commenters argued that the original rules included unworkable requirements and inadequate timelines for compliance by plan sponsors.

The amended IFR supersedes DOL Technical Release 2010-02 which expanded the safe harbor standard and set forth an enforcement grace period through July 1, 2011 for employers and health plans to comply with the original IFR. In addition to the amended IFR, the agencies also issued separate guidance addressing individual issues under the new rules (see the second subheadline below).

### *Amendment to the Interim Final Regulations*

The amended regulations include a number of important changes including:

- *Notices provided in a culturally and linguistically appropriate manner:* The amended IFR establishes a "single threshold" with respect to the percentage of people who are literate only in the same non-English language. This threshold is set at 10 percent or more of the population residing in the claimant's county being literate only in the same non-English language, and is tied to a U.S. Census Bureau list of such counties that is included in the guidance and will be updated annually by the Departments. As of the date of this rule, 255 counties in the United States (78 of which are in Puerto Rico) were identified as meeting this threshold amount; in addition, the primary non-English language for these counties is also identified in this list. In those identified "threshold" counties, plans and health insurers would be required to include a simple one-sentence statement on future notices in the appropriate language which informs these non-English speaking individuals how to obtain language assistance services, which may include oral language translation services over a telephone provided that the plan also makes a written translation of the oral discussion with the translator available upon request.
- *Inclusion of diagnostic codes in notices of internal claims and appeals determinations*: The original IFR had required that notices of an adverse benefit determination at either the initial claims stage or on appeal include any diagnosis and treatment codes and a description of the meaning of such codes. The revised rule eliminates this requirement and instead includes a requirement that such adverse determination notices must include notice of the opportunity to request the diagnosis and treatment codes and their meanings, along with a requirement that such codes and their meanings be provided when they are so requested. In addition, the amended IFR states that a plan or an issuer may not consider a request for diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review.
- *Urgent claims review period:* The original IFR required a benefit determination to be made on an urgent claim within 24 hours, taking into account medical exigencies. The amended IFR maintains the current rule pertaining to the timeline for the review of urgent claims, which requires that a decision on pre-service urgent claims be made as soon as possible, taking medical exigencies into consideration, but not later than 72 hours. The amended IFR adds that the plan must defer to the attending health care provider with respect to whether a claim involves a matter of "urgent care."

- *Scope of claims eligible for external review:* The new standard for health claims eligible for external review by an independent review organization (IRO) is generally narrowed from "any" adverse benefit determination to those that involve medical judgment and rescissions of coverage. For example, a denial of a claim based on a judgment that it was not a medically necessary procedure would be eligible for external review, but not one that was made solely on a legal or contractual interpretation of plan terms. For example, a denial of a claim based on a judgment that a particular procedure was not medically necessary or that a health condition was pre-existing would be eligible for external review, but not one that was made solely on a legal or contractual interpretation of plan terms. However, the new guidance also includes a category of decisions that would eligible for external review for the first time. Specifically, the guidance states that determinations concerning whether a plan participant is entitled to participate in a "reasonable alternative" program or activity in order to obtain a reward under the plan's wellness program will also be eligible for external review. This would apply to wellness programs which require individuals to satisfy a standard related to a health factor in order to obtain a reward and where it would be unreasonably difficult or medically inadvisable for the individual to attempt to satisfy the applicable health standard.
- *Deemed exhaustion standard:* Earlier guidance included a requirement that a claim could immediately move to external review if the plan failed in any manner to adhere to all of the regulatory requirements for internal review. The amended IFR adds exceptions to this "strict adherence" exhaustion rule for de minimis violations of regulatory procedures as well as actions that are non-prejudicial, attributable to good cause or matters beyond the plan or issuer's control, made in the context of an ongoing good faith exchange of information or that are not reflective of a pattern or practice of non-compliance.
- *Clarification of binding decisions by external reviewers:* The original IFR stated that determinations by independent external reviewers would be binding on the plan, health insurer and plan participant. The modified rule clarifies that the plan may still make payment on a claim or otherwise provide benefits at any time including after a final external review decision which upholds the plan or issuer's initial determination that the claim should be denied.
- *Minimum number of independent review organizations (IROs):* Earlier non-regulatory guidance issued by the regulatory agencies on September 20, 2010 in the form of "frequently asked questions" temporarily withdrew a safe harbor standard which would have required a self-insured health plan (or its third party administrator) to contract with at least three independent review organizations — and rotate the assignment of claims to them for external review — to assure unbiased independent review determinations. The amended IFR is supplemented with Technical Release 2011-02, which restores that safe harbor but phases it in. Specifically, self-insured plans (or third party administrators for these plans) will be eligible for an enforcement safe harbor from the DOL and the Internal Revenue Service (IRS) if they have contracted with at least two IROs by January 1, 2012 and with at least three by July 1, 2012 and rotate claims assignments among them. Insured plans will be required to comply with applicable state standards for external review and will have to meet a federal fallback standard in states without such a requirement or where the state's standards for insured coverage do not meet the minimum federal requirements.

The IRS is also publishing a notice of proposed rulemaking with text identical to the IFR amendment.

***Additional guidance***

The various regulatory agencies have also provided a number of technical guidance documents to assist with various aspects of the amended IFR:

- DOL and HHS have issued **Technical Release 2011-02**, guidance on external review for group health plans and health insurance issuers offering group and individual health coverage, and guidance for states on state external review processes. This guidance establishes a transition period until January 1, 2012, for state external review process implementation and provides a set of 16 temporary standards for National Association of Insurance Commissioners (NAIC)-similar processes that will apply until January 1, 2014.
- HHS has issued **a technical guidance document** with instructions for self-insured, non-federal governmental health plans and health insurance issuers offering group and individual health coverage on how to elect a federal external review process. According to this guidance, all such plans and insurance issuers using a federally-administered external review process must submit certain information regarding their election of a federal external review process to HHS via e-mail by the earlier of January 1, 2012 or the date by which such plans and issuers use the federal external review process.
- HHS has also issued **another technical guidance document** with instructions for obtaining and following the "culturally and linguistically appropriate standards" set forth in the interim final regulations for internal claims and appeals and external review processes. As noted in the amended IFR, HHS provides information on calculating county-level estimates to determine the 10 percent threshold for purposes of obtaining a safe harbor (see the first bullet under Amendment to the Interim Final Regulations, above). Plans and issuers are not obligated to perform calculations on their own and can rely on the chart in the amended IFR as a safe harbor.

## IRS Proposes Regulations Clarifying Definition of Performance-Based Compensation under 162(m)

On June 24, the Internal Revenue Service (IRS) issued proposed regulations clarifying the definition of performance-based compensation as it relates to stock options and stock appreciation rights under Internal Revenue Code Section 162(m). This part of the tax code generally places a $1 million cap on the amount of annual compensation that may be deducted by a public company for the chief executive officer and certain top-paid executives. Certain types of performance-based compensation are not subject to the limit.

The proposed regulations clarify that qualified performance-based compensation in the form of stock options and stock appreciation rights must specify the maximum number of shares with respect to which options or rights may be granted to each individual employee. The preamble to the proposed regulations states that the rule is necessary to be consistent with the broader requirement that a performance goal include an objective formula for determining the maximum amount of compensation that an individual employee could receive if the performance goal is satisfied.

The proposed regulations also clarify the application of the existing transition rule for taxpayers that are not publicly held corporations and then become publicly held corporations by not permitting its application to compensation paid under a restricted stock unit or a phantom stock arrangement. The transition rule allows an exception to the $1 million deduction limit for certain remuneration paid, pursuant to a compensation plan or agreement that existed during the period when the company was not a public company.

IRS is soliciting comments on the proposed regulations until September 22, 2011.

## HHS Revises PPACA Annual Limits Waiver Policy; Guidance Available

The U.S. Department of Health and Human Services unveiled guidance establishing a new process for plans receiving waivers from the annual dollar limits on health insurance benefits (for non-grandfathered plans) under the Patient Protection and Affordable Care Act (PPACA).

The official guidance has now been released, in addition to the fact sheet and news release issued on June 17.

## IASB Revises Accounting Standards for Pensions, Post-Employment Benefits

On June 16, the International Accounting Standards Board (IASB) unveiled amendments to IAS 19 Employee Benefits, the accounting rules for pensions and other post-employment benefits such as post-employment health care. The project summary is not yet available, but according to an IASB news release, the amendments will:

- enhance the disclosure requirements for defined benefit plans, expanding the necessary reporting on the characteristics of defined benefit plans and the risks that entities are exposed to through participation in those plans;
- eliminate an option to defer the recognition of gains and losses, known as the 'corridor method'; and
- streamline the presentation of changes in assets and liabilities arising from defined benefit plans, including requiring re-measurements to be presented in "other comprehensive income" (OCI), thereby separating those changes from changes that many perceive to be the result of an entity's day-to-day operations.

The European Paritarian Institutions of Social Protection (AEIP) and the National Coordinating Committee on Multiemployer Plans (NCCMP) – filed written comments with the International Accounting Standards Board (IASB) in September 2010 regarding the amendments, originally proposed in Exposure Draft 2010/3, Defined Benefit Plans. Our comment letter urged the IASB to proactively reconsider the fundamental assumptions and methodology used for measuring defined benefit plan obligations. In addition to the formal comment letter, the three groups were joined by the European Federation for Retirement Provision (EFRP) on a separate letter to IASB Chairman Sir David Tweedie highlighting the group's common concerns with the proposed changes to IAS 19.

The amendments to IAS 19 constitute a part of the "Memorandum of Understanding" between the IASB and the Financial Accounting Standards Board (FASB), the national accounting standard-setter in the United States. The elimination of the corridor method further aligns IFRSs and US generally accepted accounting principles. In light of these new developments, it is likely that IASB and FASB will ultimately move to address accounting standards for private, single-employer plans.

## IRS Extends Deadline for FBAR Filing

The Internal Revenue Service (IRS) has issued Notice 2011-54, extending the deadline for certain filers of Form TD F 90-22.1 (Report of Foreign Bank and Financial Accounts, or FBAR).

The IRS Financial Crimes Enforcement Network ("FinCEN") published final FBAR regulations providing relief for many plan sponsors and their employees who might otherwise have been required to make FBAR filings or adjustments to their individual Form 1040s due to the plan's foreign investments. Groom Law Group has prepared a summary of the final regulations. These regulations became effective on March 28, 2011, and apply to FBARs required to be filed by June 30, 2011, with respect to foreign financial accounts maintained in calendar year 2010, as well as to FBARs for subsequent calendar years.

The filing relief provided in Notice 2011-54 applies to persons having signature authority over, but no financial interest in, a foreign financial account in 2009 or earlier calendar years, and who received prior relief under Notice 2009-62 . For these individuals, the filing deadline is now November 1, 2011. The notice also indicates that the deadline for reporting signature authority over, or a financial interest in, foreign financial accounts for the 2010 calendar year remains June 30, 2011.

## ERISA Advisory Council Announces Topics for Consideration in 2011

The ERISA Advisory Council (EAC), a group of benefits experts established by the U.S. Department of Labor (DOL) to identify emerging benefits issues and advise the Secretary of Labor on health and retirement policy, has announced the three working group topics to be discussed this year:

- Privacy and Security Issues Affecting Employee Benefit Plans: The EAC will examine how the changes in technology – in particular, electronic methods of plan disclosure – affect participants and sponsors, how ERISA requirements protect participants in the current environment, and what guidance is offered in related matters.
- Current Challenges and Best Practices for ERISA Compliance for 403(b) Plan Sponsors: The EAC plans to study the current issues facing plan sponsors in administering 403(b) plans so that it can determine (1) whether to make recommendations on guidance to plan sponsors regarding best practices for complying with the new rules and regulations regarding 403(b) plans; and (2) whether there is further need for the DOL to address additional 403(b) issues through regulation or other guidance to facilitate effective and efficient administration of these plans.
- Hedge Funds and Private Equity Investments: Industry research and survey data has shown that on average, plan fiduciaries have been increasing their allocations to hedge funds and private equity funds as they seek to mitigate volatility in market performance. The EAC will study these potential investments for retirement plans with the goal of providing recommendations for guidance, such as suggested best practices for evaluating and monitoring investment strategies.

The 2011 EAC includes: Theresa Atanasio, vice president/lead group counsel for Ameriprise Financial, Inc. (representing investment management), Karen Kay Barnes, managing counsel for McDonald's Corporation (representing employers), Jack Towarnicky, employee benefits attorney for Willis North America (representing employers) and Richard A. Turner, vice president and deputy general counsel for The Variable Annuity Life Insurance Company (VALIC) (representing the insurance industry).

## IRS Releases Notice on Health Coverage Fee to Fund Comparative Effectiveness Program

On June 9, the Internal Revenue Service (IRS) released Notice 2011-35M requesting comments on the implementation of a new fee included in the Patient Protection and Accountable Care Act of 2010 (PPACA) to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute was established to conduct research to evaluate and compare the clinical effectiveness, risks and benefits of medical treatments, services, procedures, drugs or other items or strategies that treat, manage, diagnose or prevent illness or injury.

The notice requests comments regarding how the fees to fund the institute should be calculated and to what the fees will apply. The guidance also requests information in reply to various rules and safe harbors, including a safe harbor for determining the number of dependents covered by a plan. Comments on Notice 2011-53 are due by September 6, 2011.

The fee to fund the comparative effectiveness research program was included under section 6301 of PPACA, which added three new sections to the Internal Revenue Code (sections 4375, 4376 and 4377). These refer to "specified health insurance policies" and "applicable self-insured health plans" that will be assessed an annual fee based on the average number of lives covered under the policy or plan. The fees are effective for policy or plan years ending after September 30, 2012. No fee would be assessed for policy or plan years ending after September 30, 2019. For calendar year plans, this means that the fees would apply for plan years 2012 through 2018. For the first assessment year, the fee would be $1.00 for each covered life. In the second year, the fee increases to $2.00 for each covered life and it is indexed thereafter according to the increase in per capita national health expenditures as determined by the Department of Health and Human Services.

For a self-insured employer, the fee must be paid by the plan sponsor. The IRS, though, is specifically seeking comments in Notice 2011-35 on whether guidance is needed concerning the ability of a third-party administrator to act on behalf of the plan sponsor to comply with the assessment.

The IRS is also seeking comments several other topics related to the new fee, such as:

- "Reasonable methods" to determine the average number of covered lives and the need for guidance establishing safe harbor rule for determinations based on the use of a formula.
- Whether there may be certain health Flexible Spending Arrangements (FSAs) providing coverage that should be subject to the fee. (In general, a health FSA would not be subject to the fee, along with all other HIPAA "excepted benefits" under Code section 9832(c)).
- Whether certain types of Health Reimbursement Arrangements (HRAs) would be excluded from the definition of "applicable self-insured health plan" for purposes of the fee.
- Whether transition rules may be needed for the first policy or plan year in which the fee is effective.
- The need for further guidance on the definition of a policy year or plan year.
- Circumstances in which the insurer or plan sponsor may not know whether a covered individual resides in the United States and the application of the fee to plans covering expatriates.

- The timing of reporting of covered lives and payment of the fee; e.g., quarterly or annually.

The notice states that the IRS expects to take public comments in response to these issues into consideration as it prepares guidance on the implementation of the new fee.

## CMS Issues Proposed Rule Releasing Medicare Claims Data

On June 3, the Centers for Medicare & Medicaid Services (CMS) released proposed regulations directing increased access to Medicare claims data.

The proposed rules issued by CMS include important safeguards intended to assure that the information released to evaluate provider performance is accurate and used appropriately, while also safeguarding patient privacy. Claims data from Medicare and private health purchasers would be made available to qualified entities that would aggregate the information and develop profiles of provider performance. CMS also posted a news release summarizing the proposed regulation.

Performance information should be easily accessible so employers and consumers can quickly locate health care providers who have a proven record of delivering high quality care. A more transparent system also gives health care providers the tools they need to compare their performance with other professionals in their field and encourages continuous quality improvement. Done right, increased health care transparency promises to be one of the most important building blocks in transforming our health care system to one that rewards the value, not simply the volume, of health care services.

Full public disclosure of performance results is one of the most important tools Medicare can implement. This information will help Medicare and employers and other consumers identify health providers on the basis of reliable information on their performance in the delivery of care, thereby helping to improve quality outcomes and reduce costs across the entire spectrum.

## PBGC Approves Change to Investment Strategy

The Pension Benefit Guaranty Corporation's (PBGC) Board of Directors – comprised of the U.S. Secretaries of Labor, Commerce, and the Treasury – announced the unanimous adoption of a new investment strategy for the agency's nearly $80 billion in trust fund assets. The PBGC bylaws require the board to review the investment policy at least every two years and approve an investment policy at least every four years.

The new investment policy establishes a 30 percent target asset allocation for equities and other non-fixed income assets, and a 70 percent asset allocation for fixed income, with a permitted range of plus- or minus-5 percent. The prior change to the PBGC's investment strategy, undertaken in 2008, placed 45 percent of the PBGC's portfolio in equity holdings and a matching 45 in fixed-income vehicles, with the remainder allocated to alternative investment classes, such as private equity. The 2008 strategy had been a substantial change from the PBGC's historical strategy, which generally set an equity investment target of 15 to 25 percent in equities.

## IRS Releases 2012 Indexed Amounts for HSAs, HDHPs

The U.S. Treasury Department and Internal Revenue Service (IRS) released Revenue Procedure 2011-32, which lists the 2012 indexed amounts, adjusted for inflation, for health

savings accounts and high-deductible health plans (HDHPs). (In some cases, this resulted in no change from the prior year.) The following table lists the 2011 amounts and the new 2012 amounts:

| | Calendar Year 2011 | | Calendar Year 2012 | |
|---|---|---|---|---|
| | **Self-only** | **Family** | **Self-only** | **Family** |
| **Annual Contribution Limit** | $3,050 | $6,150 | $3,100 | $6,250 |
| **HDHP Minimum Deductible** | $1,200 | $2,400 | $1,200 | $2,400 |
| **HDHP Out-of-Pocket Limit (includes deductibles, co-payments and other amounts but not premiums)** | $5,950 | $11,900 | $6,050 | $12,100 |

The Revenue Procedure is effective for calendar year 2012.

## RECENT JUDICIAL ACTIVITY

### Supreme Court Rules In ERISA Cash Balance Conversion Case

On May 16, the U.S. Supreme Court rendered a decision in the case of CIGNA v. Amara, ruling that ERISA does not authorize relief for alleged misrepresentations made in a summary plan description document (SPD). However, the Supreme Court essentially remanded the case to the lower courts to fashion a new remedy under ERISA Section 502(a)(3), which allows a plan beneficiary "to obtain other appropriate equitable relief". The Court then proceeds to discuss possible remedies under that section (remedies that many in the employee benefits industry believed precluded by other Supreme Court decisions).

The case arose out of a 1998 change to the structure of CIGNA's pension plan, in which the employer converted from a traditional defined benefit model to a cash-balance model but did not specifically describe some of the various changes (including a wearaway period, in which benefits payable at certain ages or in certain forms may not increase for some employees) in its summary plan description. A district court decision ruled for the plaintiffs in a class-action suit brought on behalf of 25,000 beneficiaries of the pension plan, stating that CIGNA's descriptions of the new plan violated various disclosure requirements imposed by ERISA, and granted relief by "reforming" CIGNA's plan and requiring the company to provide benefits in accord with the plan as "reformed". On appeal, the Second Circuit summarily affirmed the district court's decision.

The U.S. Supreme Court, which agreed to hear the case last year, vacated the lower court decision and remanded the case on the ground that the ERISA provision on which the district court relied (Section 502(a)(1)(B)) did not authorize the court to "reform" CIGNA's pension plan. The Court's majority opinion, authored by Justice Steven Breyer, argues that this provision of the statute only authorizes relief to enforce the terms of an existing plan and does not permit a court to rewrite a plan to conform to the representations made in an SPD. In doing so, the Court rejected the argument by the U.S. Solicitor General and the U.S. Department of Labor that the

terms of the SPD are themselves part of the plan which the SPD is intended to summarize, concluding that statements in an SPD are merely communications "about the plan" and do not "constitute the terms of the plan for purposes of ERISA Section 502(a)(1)(B).

The majority opinion does not detail what plaintiffs must prove to be entitled to equitable remedies but states that, at a minimum, "a plan participant or beneficiary must show that the violation injured him or her" and that "other prerequisites to relief" may exist that the Court does not discuss. Breyer's opinion affirms that that "actual harm must be shown."

In a minority opinion, Justices Antonin Scalia and Clarence Thomas agreed with the majority that Section 502(a)(1)(B) did not authorize the remedy fashioned by the district court, but argued that this holding was sufficient to dispose of the case.

This ruling is very significant in that the Supreme Court appears to reject the theory that an SPD that is inconsistent with the plan document can, in effect, change the terms of the plan. However, the case also opens up the possibility of significant "equitable" relief possibilities under 502(a)(3). The legal and administrative complexity of defined benefit plans generally – and hybrid plan conversions in particular – continue to pose challenges for employer sponsors of pension plans.

## Appeals Court Decision Upholds PPACA Individual Mandate

On June 29, a panel of judges for the Sixth Circuit Court of Appeals ruled that the Patient Protection and Affordable Care Act's (PPACA) individual mandate – which requires that all individuals have health insurance – is "a valid exercise of Congress's authority under the Commerce Clause" and therefore legal.

This decision stems from a lawsuit filed against PPACA and the Obama Administration by the Thomas More Law Center in the U.S. District Court for the Eastern District of Michigan. In October 2010, District Court Judge George Caram Steeh dismissed two out of six claims under the same reasoning as the appeals court. This appeals court ruling reflects the disposition of those two dismissed claims.

The Sixth Circuit Court of Appeals is the highest court yet to rule on the constitutionality of PPACA. As we have previously reported, the U.S. District Court for the Northern District of Florida (Pensacola Division) handed down a judgment ruling the individual mandate unconstitutional and further invalidated the entire PPACA based on the inseverability of the mandate from the rest of the law's provisions. The U.S. District Court for the Eastern District of Virginia handed down a similar December 2010 ruling declaring that the law's individual mandate exceeds the authority granted to Congress under the Commerce Clause of the Constitution. Unlike the Florida case, however, the Virginia judge found that the law is severable and therefore did not invalidate the entire law.

The resolution of this matter will ultimately be determined by the U.S. Supreme Court and, of course, the more expeditiously it is resolved, the better for all stakeholders.