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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY 2

White House Details Deficit Reduction Proposal, Including PBGC Premium Increase 2
Senate Committee Discusses Retirement Tax Incentives 3
House Panel Holds Hearing on PPACA Grandfather Plan and Medical Loss Ratio Rules 5
House Subcommittee Discusses Health Industry Consolidation 7

RECENT REGULATORY ACTIVITY 8

DOL/EBSA to Re-propose Fiduciary Definition Regulations 8
PBGC Provides Penalty Relief for Late Premiums, Premium Funding Target Elections 8
IRS Corrects Proposed Regulations on Performance-Based Compensation under 162(m) 9
DOL Issues Guidance for Electronic Disclosure of 401(k) Fee Information 9
IRS, DOL Step-Up Worker Classification Efforts 10
IRS Request Additional Information on PPACA Affordability Safe Harbor for Employers 11
Treasury, IRS Issue Priority Guidance Plan for 2010-2011 12
EBSA Amends FAQ Regarding COBRA Premium Assistance Program 12

RECENT JUDICIAL ACTIVITY 13

Fourth Circuit Appeals Court Dismisses PPACA Challenge on Procedural Grounds 13

RECENT LEGISLATIVE ACTIVITY

White House Details Deficit Reduction Proposal, Including PBGC Premium Increase

Late on September 23, the White House released additional details on its submission to the 12-member Joint Committee on Deficit Reduction (known as the "supercommittee"). The president's plan includes a number of provisions related to employee benefit plans, most notably an increase in premiums paid by defined benefit pension plan sponsors to the Pension Benefit Guaranty Corporation (PBGC) and changes regarding Medicare premiums. In addition, the president's proposals to pay for his jobs initiative would dramatically change the tax treatment of employer-provided coverage for high earners.

PBGC Premiums

Under the new legislative language (Page 42), the PBGC single-employer flat-rate premium would rise to $70 per participant in 2021, indexed to wage inflation thereafter.

The PBGC board of directors would have discretion to increase the variable-rate premium beginning in 2014, based on "publically available measures of risk or exposure," including such factors as the plan's assets and liabilities (but, specifically, not the plan sponsor's credit rating). These increases would be capped at four times the amount paid in the 2012 plan year. (This is a change from the president's original summary, which set the cap at four times the amount paid for the 2010 plan year.)

In setting the variable-rate premiums, PBGC would be required to release the projected amount of the premium increase and the basis for this determination no later than 120 days before the effective date. The agency is also directed to minimize counter-cyclical premium increases, i.e., increases during times when the economy or markets are weak.

Under this proposal, the total flat- and variable-rate premium increases between 2014 and 2021 would generate revenue of $16 to $17 billion, regardless of overall funding levels. All of these changes apply to the single-employer program only; no changes are proposed to the multiemployer program.

The detailed proposal also includes additional information on various other issues related to employer-sponsored benefits:

Worker Classification

The Obama Administration appears to be ramping up efforts to address what they perceive as "worker misclassification" – the improper classification of employees as independent contractors. Page 279 of the detailed proposal explicitly permits the Internal Revenue Service (IRS) to issue guidance about the proper classification of workers and allows the IRS to require prospective (but not retroactive) reclassification of workers who are currently misclassified. Penalties would be waived or substantially reduced for employers under certain conditions.

This proposal would be effective upon enactment, but the ability to require prospective reclassification for those covered by the special provision would not be effective before the first calendar year beginning at least one year after the date of enactment and, in no event, earlier than with respect to services rendered on or after January 1, 2013.

Health Care Policy Provisions

Under the heading of "Health Savings," President Obama's plan would implement a pending legislative proposal to move up the availability date of federal "state innovation" waivers from the Patient Protection and Affordable Care Act (PPACA). Currently, these waivers would allow states to apply for five-year "State Innovation Waivers" from certain coverage requirements beginning in 2017, as long as the state program provides the same amount of coverage without increasing the federal deficit. The Empowering States to Innovate Act (S. 248), sponsored by Senators Ron Wyden (D-OR), Scott Brown (R-MA) and Mary Landrieu (D-LA), would accelerate the eligibility period to 2014. President Obama has already expressed support for this legislation.

The detailed proposal also outlines a number of cost savings with respect to the Medicare and Medicaid programs, including:

- Premium increases for beneficiaries in Medicare Parts B and D with "higher incomes." This threshold is newly defined on Page 215 of the detailed proposal. The freeze in income thresholds would be extended until 25 percent of beneficiaries pay the higher premium.
- A surcharge on Medicare Part B premiums equivalent to about 15 percent of the average Medigap premium for new beneficiaries that purchase Medigap policies with particularly low cost-sharing requirements, starting in 2017.

The president's deficit reduction plan also incorporates his American Jobs Act proposal, which calls for a reduction in the value of itemized deductions and other tax preferences for individuals with incomes over $200,000 or families with incomes over $250,000. This would require that these high-earner taxpayers include for the first time the value of employer-sponsored health insurance when reporting taxable income. Employees over these income thresholds would be allowed to take a deduction on the value of both the employer-and employee-paid portions of this coverage, but would only be able to do so at a rate of 28 percent even though these high earners are in a higher tax bracket.

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.

Senate Committee Discusses Retirement Tax Incentives

On September 15, the U.S. Senate Finance Committee hosted the hearing Tax Reform Options: Promoting Retirement Security, examining incentives in the current tax code for employer-sponsored retirement savings plans, and defined contribution arrangements (such as 401(k) plans) in particular.

Committee Chairman Max Baucus (D-MT) opened the hearing by raising the question, "the United States has the most successful private retirement system in the world, but for the amount our country spends on retirement savings, are we getting enough bang for our buck?" He also asserted that "In spite of the tremendous tax preferences for retirement savings, many Americans are left without sufficient resources to maintain a comfortable retirement."

Baucus specifically cited the Government Accountability Office (GAO) report Private Pensions: Some Key Features Lead to an Uneven Distribution of Benefits, which found that while "the existing system of tax preferences for pensions has played at least a supporting role in fostering current levels of pension plan coverage" and "recent initiatives, such as automatic enrollment, may increase participation," it appears that that "For [defined contribution] plans, a disproportionate share of these tax incentives accrues to higher income earners."

Ranking Republican Committee Member Orrin Hatch (R-UT), in his opening statement, suggested that "the private employer-based pension system has become the greatest wealth creator for the middle class in history, especially through 401(k) plans and Individual Retirement Accounts, or IRAs," and noted that a number of proposals to dramatically reform the system "are offered in the name of greater progressivity in the tax code, and helping lower wage workers. But this just doesn't make sense. Trying to help lower wage workers save for retirement by reducing the 401(k) and IRA contribution limits is like trying to cure a headache with a guillotine."

Testifying before the committee were the following witnesses:

- Jack VanDerhei, research director at the Employee Benefit Research Institute (EBRI), provided data on the 401(k) system based on EBRI's Retirement Security Projection Model and annual analysis of tens of millions of individual 401(k) participants. Addressing the aforementioned specific reform proposals, VanDerhei stated that the 20/20 proposal "would cause a significant reduction in retirement accumulations for the lowest-income workers" and suggested that the 18 percent match proposal would likely lead to reduced participation by employees.
- William G. Gale, senior fellow at the Brookings Institution and lead author of the 18 percent match proposal, argued that his proposal would make the defined contribution system more progressive – i.e., benefitting more low- and middle-income savers – while also raising substantial amounts of federal revenue.
- Judy A. Miller, chief of actuarial issues and director of retirement policy at the American Society of Pension Professionals and Actuaries, asserted that "the current tax incentives are working very well to promote retirement security for millions of working Americans," and voiced concerns with regard to the reform proposals. Miller also expressed opposition to the concept of consolidating all types of defined contribution plans into a single plan with a single safe harbor and contribution testing methodology, arguing that "less flexibility would reduce coverage, not enhance it."
- Karen Friedman, executive vice president and policy director at the Pension Rights Center, testified that 401(k) plans "do not work well as the primary retirement vehicle for most Americans" and espoused principles for "a new system on top of Social Security that covers everyone and that provides adequate and secure income." She also suggested a number of smaller reforms to enhance existing retirement saving programs, including: expansion of the Saver's Credit, incentives for establishment of defined benefit plans and reforms to prevent "leakage" from retirement funds.

During the question-and-answer period, Miller and Gale debated whether the tax incentive is "upside-down" – that is, whether lower income workers receive equitable benefit from the existing tax structure. While Gale insisted that the current system is not progressive enough, Miller emphasized that the existing non-discrimination rules help to distribute tax benefits to savers at all income levels. VanDerhei also presented data (Page 22, Figure 19) that demonstrated parity in the distribution of tax benefits.

Senator John Thune (R-SD) asked panelists if they would recommend raising plan limits, and by how much. Miller responded that higher limits would help increase retirement savings and also recommended simplifying existing rules and expanding the range of plan options for employers. VanDerhei specifically suggested raising the automatic-escalation limit – commonly used with automatic enrollment programs – from the current 10 percent cap. Conversely, Friedman suggested that Congress examine lowering limits to pre-2001 levels and using the federal revenue gained to invest in an alternative plan.

This is the third in a series of hearings held by the committee on federal tax expenditures.

House Panel Holds Hearing on PPACA Grandfather Plan and Medical Loss Ratio Rules

The House Energy and Commerce Committee's Subcommittee on Health held a September 15 hearing, Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations, focusing on the rules establishing minimum medical loss ratio (MLR) standards for insured health plans and the standards health plans must meet to retain "grandfathered" status.

The MLR standards call for health insurers to spend a minimum of 80 percent of premium revenue on clinical services and activities to improve health care quality for plans in the individual and small group markets, and 85 percent for plans in the large group market. The MLR Repeal Act (H.R. 2077), introduced in June by Representatives Tom Price (R-GA) and Kathy McMorris Rodgers (R-WA), would entirely repeal these regulations.

"Grandfathered" health plans that meet requirements of the interim final regulations (issued in June 2010) remain exempt from some, but not all, of the market reform provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA).

In his opening statement, Subcommittee chairman Joe Pitts (R-PA) cited findings from a May 2011 PricewaterhouseCoopers survey indicating that 51 percent of the employers surveyed did not expect to maintain grandfathered plan status. "Because grandfathered plans are subject to many of PPACA's requirements," Pitts said, "employers today are forced to pay more to keep their current grandfathered plans, shop for more expensive plans, or drop coverage for their employees altogether."

The subcommittee also released a discussion draft bill that would block the implementation of the June 2010 interim final regulations on grandfathered health plans and prevent federal agencies from imposing any other standards or requirements on grandfathered health plans. Pitts argued that the MLR rules for insured plans were overly restrictive by requiring plans to count fraud and waste prevention efforts as administrative activities rather than for the purposes of meeting the MLR thresholds. Pitts also pointed to several states which have sought waivers from the U.S. Department of Health and Human Services (HHS) to the MLR rules because of concern that they could destabilize their insurance markets.

Lead witness Steve Larsen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO) in the Centers for Medicare and Medicaid Services (CMS), defended both the MLR and grandfather rules and the regulatory process by which they were developed and modified. Larsen asserted that the MLR rules will "allow Americans to ensure they receive value for their premium dollars" and that the grandfather rules were designed to "preserve the ability of Americans to keep their current plan, while still allowing

employers flexibility in modifying existing plans to accommodate changing conditions, while ensuring Americans access to important consumer protections."

During the question-and-answer period, committee Democrats repeatedly suggested that the movement to repeal the grandfather plan and MLR regulations was simply an attempt to roll back PPACA and its patient protection reforms. Ranking Subcommittee Democrat Frank Pallone (D-NJ) suggested that most employer plans already meet the grandfather plan requirements and that the MLR rules lower premium rates by making them more transparent.

The committee discussed extensively the effect of the MLR requirements on insurance agents and brokers, whose income is being squeezed. Larsen indicated that this was not the intent of the rules, but CCIIO is concerned about the problem and is examining the matter. Pitts asked specifically if the cost of large employers' human resource functions – which mirror many agent and broker functions – are also applicable to the MLR rules, but Larsen indicated that they were not. In March, subcommittee member Mike Rogers (R-MI) introduced the Access to Professional Health Insurance Advisors Act (H.R. 1206), which would prevent the MLR regulation from reducing the commissions of agents and brokers.

Rep. Bill Cassidy (R-LA) asked Larsen a number of questions about the applicability of the MLR rules to consumer-directed health plans (CDHPs) such as HSAs, and whether PPACA exhibits a prejudice against health care consumers who are more cost-aware. Larsen admitted that he was not familiar with the law's impact on CDHPs. Cassidy also asked whether the MLR rules would effectively eliminate employer wellness programs, but Larsen indicated that such programs improve health care quality and represent permissible expenses under the law.

In response to a question by Rep. Leonard Lance (R-NJ), Larsen said he did not know when the interim final grandfather regulations would be replaced by a final rule.

A second panel of witnesses testified following Larsen, including:

- Edmund Haislmaier, senior research fellow for health policy studies at The Heritage Foundation, testified that the MLR rules "will produce negative effects for consumers – most notably, reduced insurer competition, higher premiums and more erroneous or fraudulent claim payments." He recommended Congress repeal the MLR rules and focus instead on insurance rate transparency.
- Grace-Marie Turner, president of the Galen Institute, criticized the grandfather plan regulations, arguing that they prevent employers from making changes to their health plans to keep costs down while increasing regulatory burdens. She noted that these cost increases are ultimately passed along to employees in the form of cost-sharing.
- Janet Trautwein, chief executive officer of the National Association of Health Underwriters, described the plight of insurance agents and brokers resulting from application of the MLR rules (as described above) and endorsed passage of H.R. 1206.
- Wendell Blaine Potter, senior analyst at The Center for Public Integrity, expressed support for PPACA and suggested that premium rate increases are the result of financial market pressure on for-profit insurers. He strongly opposed exempting all sales commissions, including agent and broker fees, from the MLR rules as outlined in H.R. 1206.
- Lynn Bates Quincy, senior policy analyst for Consumers Union (publishers of Consumer Reports magazine), asked the committee to take a "holistic" look at the draft grandfather rules repeal legislation and its potential impact on individuals, arguing that the measure

would undermine PPACA by expanding eligibility for grandfather status and allowing them to avoid key patient protection requirements.

During the second question-and-answer period, Pitts asked whether the grandfather plan regulations will force employers to move resources away from job creation and investment and toward health plans. Turner agreed, suggesting that the regulations will increase the cost of providing health care coverage.

In response to further questions from Subcommittee Vice Chair Michael Burgess (R-TX) about the effect of PPACA on CDHPs, Haislmaier observed that the law's focus on premium structure encourages plans that are "more comprehensive" and discourages consumer-directed designs.

House Subcommittee Discusses Health Industry Consolidation

On September 9, the U.S. House of Representatives Ways and Means Committee's Health Subcommittee held a hearing on the impact of health care industry consolidation on the cost of private health insurance, Medicare spending, and beneficiary costs. Consolidation is the process by which hospitals and physicians team up, ostensibly to provide greater efficiency and quality of care.

However, in his opening statement, Subcommittee Chairman Wally Herger (R-CA) argued that "consolidation allows providers to command higher private insurance payment rates," and noted that insurance companies ultimately pass along these increased prices to employers "by way of higher premiums, and employers pass it on to their workers by way of reduced wages, higher costs, and benefit cuts."

The subcommittee heard testimony from a panel of academic and professional experts who discussed the effects of consolidation on their constituencies and the health care system generally:

- Martin Gaynor, a professor at Carnegie Mellon University's H. John Heinz III School of Public Policy and Management, provided data showing that consolidation among providers and among insurers leads to some price increases while consolidation between providers and insurers yields little effect.
- Paul B. Ginsburg, president of the Center for Studying Health System Change, suggested that increased consolidation and opposition to managed care over the past two decades have reduced the bargaining power of insurance plans. He recommended that the federal government consider additional state-level rate regulation.
- Dianne Kiehl, executive director of the Business Health Care Group, described the experience of Wisconsin-based companies that have seen provider consolidation and increased emphasis on profitability impair their ability to control health care costs. She described a collaborative program between businesses, employees and providers that substantially decreased premium rates.
- Michael Guarino, member of the board of directors of the Ambulatory Surgery Center Association, described the interaction between hospital consolidation and increased payment rates, particularly with regard to the Medicare program. He strongly recommended vigorous oversight of Accountable Care Organizations (ACOs) and stressed the importance of improving transparency of quality and cost reporting.
- David Balto, senior fellow at the Center for American Progress Action Fund, suggested that highly concentrated healthcare markets, especially health insurance markets, can

result in escalating healthcare costs, greater numbers of uninsured and increased instances of fraud. He suggested a strong antitrust approach to consolidation and suggested that the Patient Protection and Affordable Care Act (PPACA) is already helping to moderate health markets.

RECENT REGULATORY ACTIVITY

DOL/EBSA to Re-propose Fiduciary Definition Regulations

In a September 19 News Release, the U.S. Department of Labor (DOL) announced that the Employee Benefits Security Administration (EBSA) will re-propose regulations revising the definition of the term "fiduciary" with respect to investment advice provided in conjunction with defined benefit pension plans or individual retirement accounts (including defined contribution plans).

DOL/EBSA issued proposed regulations that would have significantly expanded this definition. The proposal was originally designed to protect participants from conflicts of interest and self-dealing by giving a broader and clearer understanding of when persons providing such advice are subject to ERISA's fiduciary standards.

In Congress, the fiduciary definition project had been met with bipartisan criticism, not only with regard to the substance of the proposed regulation but also with the agency's rulemaking process, in part due to the conflicts with the proposed business conduct standards rules being promulgated by the Securities and Exchange Commission (SEC) and the Commodity Futures Trading Commission (CFTC) pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the Dodd-Frank Act).

According to the DOL news release announcing the re-proposal of the regulations, "the agency anticipates revising provisions of the rule including, but not restricted to, clarifying that fiduciary advice is limited to individualized advice directed to specific parties, responding to concerns about the application of the regulation to routine appraisals and clarifying the limits of the rule's application to arm's length commercial transactions, such as swap transactions. The new proposed rule is expected to be issued in early 2012.

PBGC Provides Penalty Relief for Late Premiums, Premium Funding Target Elections

On September 14, the Pension Benefit Guaranty Corporation (PBGC) issued a formal notice providing relief from certain premium penalties and in certain situations involving alternative premium funding target elections.

Specifically, the PBGC notice provides that:

- For 2011 and later plan years, PBGC will waive premium penalties assessed solely because payments are late by not more than seven calendar days.
- For 2010 and later plan years, PBGC is providing relief similar to, but more expansive than, the relief provided in Technical Update 10-2, in which relief was provided to certain "plans that intended to elect to use the alternative premium funding target to calculate the variable rate premium (VRP)" — i.e., those whose only error was not checking Box 5

for the 2008 plan year or for certain 2009 plan years — by treating them as "deemed to have made a valid election to use the APFT."
- For 2008 and 2009 plan years, PBGC will waive premium penalties for late premiums in connection with certain box 5 errors provided certain filing requirements are met.

Generally, the notice provides valuable relief for post-2009 plan years in that the focus is on which method is used by the actuary to determine the amount of variable rate premiums (alternative vs. standard method in line 7(d)(1) of Part III – Premium Information) rather than whether a particular box (5) was checked on the form (indicating selection of the alternative method). The seven-day "grace period" is also very helpful for post-2010 plan years.

IRS Corrects Proposed Regulations on Performance-Based Compensation under 162(m)

On September 7, the Internal Revenue Service (IRS) issued a brief correction to its 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 correction clarifies the regulations' proposed effective/applicability date, replacing language that previously stated:

These regulations under section 162(m) are proposed to apply to taxable years ending on or after the date of publication of the Treasury decision adopting these rules as final regulation [sic] *in the Federal Register.*

With the following language:

These proposed regulations will be effective upon publication in the Federal Register of a Treasury decision adopting these rules as final regulations.

DOL Issues Guidance for Electronic Disclosure of 401(k) Fee Information

During its September 13 webcast on 401(k) plan fee transparency, the U.S. Department of Labor issued Technical Release 2011-03, an interim policy on electronic disclosure of 401(k) fee information under the final regulations issued in October 2010.

In a media statement issued concurrently, Assistant Secretary of Labor for the Employee Benefits Security Administration Phyllis C. Borzi said that "this technical release responds to requests by some plan sponsors and service providers to expand the ability of ERISA plans to use modern electronic disclosure technologies to communicate with plan participants while ensuring that all workers will benefit from the increased transparency provided by our fee disclosure rule."

Technical Release 2011-03 follows this approach to some extent, while also imposing new notice requirements. Specifically, the guidance includes the following key elements for plan sponsors:

- The guidance allows plan sponsors to use FAB 2006-3 for the purposes of furnishing quarterly benefit statements to participants, including the newly required information (which must be included on quarterly benefit statements next year) under the final regulations. FAB 2006-03 permits electronic disclosure of quarterly benefit statements under certain conditions, such as sending notices of the availability of statement information through a secure, continuous access website.
- With regard to disclosures that are not included in participant statements, the guidance sets forth an alternative to the approach required under the current DOL electronic disclosure regulations. If the participant or beneficiary voluntarily provides an e-mail address, then the plan sponsor may be able to provide fee disclosures to participants electronically by providing an initial notice and annual notice electronically. The initial notice must meet five procedural and content criteria specified in the guidance, while the annual notice can be distributed electronically only if it meets certain criteria and there is evidence that the participant or beneficiary "interacted electronically" (e.g., updated certain online information or logged on to a secure website) with the plan after the last notice.
- The guidance provides a transition rule for which the plan sponsor may be eligible if it already possesses the e-mail address of a participant or beneficiary. In this case, the plan sponsor can use that e-mail address to disclose information electronically if the plan sponsor provides a "Transition Group Initial Notice" (meeting specified timing, procedural and content criteria) to the participant or beneficiary. This transition rule is not available for e-mail addresses established or assigned by the employer unless there is evidence that the company e-mail address has been used by the participant or beneficiary "for plan purposes," such as logging on to a secure, continuous access website.

This guidance is limited solely to the disclosures required under the defined contribution plan fee disclosure regulations. DOL recently issued a formal request for information (RFI) on electronic disclosure by employee benefit plans, seeking comments on the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by ERISA plans. In DOL's recently issued semi-annual agenda, this topic is listed as being in the "pre-rule" stage, with no action scheduled while the agency reviews public comments through October 2011.

IRS, DOL Step-Up Worker Classification Efforts

With two recent regulatory issuances, the Obama Administration appears to be ramping up efforts to address what they perceive as "worker misclassification" – the improper classification of employees as independent contractors.

On September 19, officials from the U.S. Department of Labor (DOL) and Internal Revenue Service (IRS) signed a memorandum of understanding (MOU) permitting the agencies to share information to "help reduce the incidence of misclassification of employees as independent contractors, help reduce the tax gap and improve compliance with federal labor laws." The MOU specifically indicates that DOL and IRS officials will meet on a regular basis and craft recommendations focused on "educating taxpayers/employers, promoting fairness and improved compliance, and creating a level playing field for law-abiding taxpayers and employers."

On September 21, the IRS issued Announcement 2011-64, unveiling a new Voluntary Classification Settlement Program (VCSP) "to permit taxpayers to voluntarily reclassify workers as employees for federal employment tax purposes." The announcement indicates that the

optional program will give employers the opportunity to “voluntarily reclassify their workers as employees for future tax periods with limited federal employment tax liability for the past nonemployee treatment.” To be eligible for the VCSP, employers must meet certain requirements, successfully apply to participate and enter into a closing agreement with the IRS.

The Obama Administration has previously demonstrated a strong interest in this issue. Fiscal 2012 budget proposal recommends a multi-pronged program to help eliminate worker misclassification, based on legislation Obama sponsored as a U.S. Senator. In the previous Congress, legislation was introduced in both the House and the Senate, the Fair Playing Field Act (S. 3786 and H.R. 6128), to prevent misclassification of certain workers. One significant change under the legislation would be to end the moratorium on Internal Revenue Service guidance addressing worker classification, which has been in place since the Revenue Act of 1978. It also would repeal the section 530 relief that protects companies against large penalties where they had a reasonable basis for treating the workers as contractors and meet certain other requirements.

More recently, Senator Thomas Carper (D-DE) introduced the Taxpayer Advocacy and Government Accountability Promotion (TAX GAP) Act (S. 1289), which includes a requirement for the U.S. Treasury Secretary to submit a report to Congress on worker misclassification. The measure has been referred to the Senate Finance Committee for further consideration.

Initiatives to address worker misclassification are likely to draw renewed attention because they typically raise federal revenue by increasing tax collections.

IRS Requests Additional Information on PPACA Affordability Safe Harbor for Employers

On September 13, the Internal Revenue Service (IRS) issued Notice 2011-73, a request for comments relating to the health care coverage affordability test for employers under the “shared responsibility” provisions of the Patient Protection and Affordable Care Act (PPACA). The notice seeks comment on a potential safe harbor that would permit employers that offer coverage to their employees to measure the affordability of that coverage by using wages that the employer paid to an employee (i.e., from Form W2 data) instead of the employee’s household income.

The "shared responsibility" provisions, also known as the "pay or play" mandate, require employers to offer health coverage for their "full-time employees" or pay a penalty if even one full-time employee receives a premium tax credit for health coverage obtained through a health insurance exchange, if the employer does not offer coverage or if the coverage does not satisfy affordability or minimum value requirements. PPACA defines a full-time employee as one who works at least 30 hours per week on average, and further IRS guidance is expected to clarify how that calculation is to be determined. This provision takes effect in 2014.

The IRS recently issued a notice of proposed rulemaking (NPRM) on the Health Insurance Premium Tax Credit, a refundable tax credit to help individuals and families afford health insurance coverage by reducing a taxpayer's out-of-pocket premium cost. The exchange will determine whether an individual meets the income and other requirements for the credit, based in part on the affordability of employer-sponsored coverage. The NPRM clarified that the "affordability test" for purposes of determining whether an employer-sponsored plan imposes a premium that is affordable or unaffordable could be based on an employee's Form W-2 rather than an employee's total household income.

Notice 2011-73 reiterates this interpretation in a discussion of the affordability test specifically with respect to employer penalties under the PPACA shared responsibility provisions.

Treasury, IRS Issue Priority Guidance Plan for 2010-2011

On September 2, the U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) released their 2011-2012 Priority Guidance Plan, listing those issues that will be the subject of formal guidance during the next year. The plan contains 317 regulatory projects to be completed through June 2010, including 37 items addressing retirement benefits (Pages 4-6 of the document) and 29 items addressing executive compensation, health care and other benefits – including items related to implementation of the Patient Protection and Affordable Care Act (PPACA) (Pages 6-8). A number of these items have already been completed, as indicated in the priority plan.

Other areas addressed in the plan include consolidated returns; corporations and their shareholders; excise taxes; exempt organizations; financial institutions and products; gifts, estates and trusts; insurance companies and products; international issues; partnerships; subchapter S corporations; tax accounting; tax administration; tax-exempt bonds and other general tax issues. An appendix also lists additional routine guidance that is published each year.

EBSA Amends FAQs Regarding COBRA Premium Assistance Program

The Department of Labor (DOL) Employee Benefits Security Administration (EBSA) has amended its Frequently Asked Questions clarifying eligibility and other issues as eligible individuals near the end of the COBRA continuation coverage premium assistance program (first enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA)).

Due to the statutory sunset, the COBRA premium reduction under ARRA is not available for individuals who experience involuntary terminations after May 31, 2010. The FAQs note, however, that individuals who qualified on or before May 31, 2010 may continue to pay reduced premiums for up to 15 months, as long as they are not eligible for another group health plan or Medicare even if their COBRA coverage did not start until a later date due to the terms of a severance arrangement, or the use of banked hours or other similar provision that delayed the start of their COBRA coverage. For example if an individual was involuntarily terminated on May 31, 2010 and due to the terms of a severance agreement their COBRA coverage did not start until December 1, 2010, they would still be eligible for the full 15 months of subsidy through February 29, 2012 as long as they are not eligible for another group health plan or Medicare.

The DOL/EBSA COBRA premium assistance website includes other resources for employers and employees, including a fact sheet that addresses several options that individuals may want to consider for obtaining coverage if their COBRA coverage is terminated or exhausted.

RECENT JUDICIAL ACTIVITY

Fourth Circuit Appeals Court Dismisses PPACA Challenge on Procedural Grounds

The U.S. Fourth Circuit Court of Appeals ruled on September 8 that the Commonwealth of Virginia lacks the standing to challenge the Patient Protection and Affordable Care Act (PPACA), effectively dismissing the case.

Virginia had maintained that it had standing to bring this action because the PPACA individual mandate conflicts with a state statute, the Virginia Health Care Freedom Act (VHCFA), which expressly prohibits an individual mandate. The Fourth Circuit ultimately determined that "the VHFCA does not confer on Virginia a sovereign interest in challenging the individual mandate." The Court further stated that "Virginia lacks standing to challenge the individual mandate because the mandate threatens no interest in the 'enforceability' of the VHCFA."

In separate cases the Eleventh Circuit Court of Appeals has found the PPACA individual mandate unconstitutional (while finding the remainder of the law "severable" and therefore valid) and the Sixth Circuit Court of Appeals has ruled that the PPACA individual mandate is a constitutional exercise of congressional authority under the Commerce Clause and therefore the entire law is valid.

These two prior rulings created a split among the circuits, making a review by the U.S. Supreme Court a near certainty. The Thomas More Law Center – the plaintiff in the Sixth Circuit case – filed a petition for review with the Supreme Court on July 26. The U.S. Circuit Court for the District of Columbia heard arguments on the challenge to the constitutionality of the individual mandate on September 23.