BENEFITS INSIDER
A Member Exclusive Publication

Volume 82, April 2012

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

Harkin Releases Wide-Ranging Legislation Including Retirement Provisions

Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Tom Harkin has introduced the Rebuild America Act, a wide-ranging domestic and economic policy bill. While immediate action is not expected on this measure, we believe it is important to alert you to a number of provisions related to employer-sponsored benefits.

Specifically relating to defined benefit plans, the bill would:

- Incorporate the defined benefit plan funding stabilization provision as included in the Moving Ahead for Progress in the 21st Century (MAP-21) Act (S. 1813).
- Increase Pension Benefit Guaranty Corporation (PBGC) premiums for single-employer defined benefit plan sponsors –
    - The flat-rate premium would increase from its current level of $35 per participant to (a) $42 for 2012, (b) $48 for 2013, and (c) $54 for 2014 and later years (indexed to inflation).
    - The variable-rate premium would be indexed to inflation beginning in 2012, thereby increasing from its current rate of $9 per $1,000 of unfunded vested benefits.
- Repeal a Pension Protection Act (PPA) provision that freezes PBGC guarantees as of the date a defined benefit plan sponsor enters bankruptcy.
- Establish a temporary Commission on Retirement Security, comprised of legislative and executive branch appointees, to "review relevant analyses of the private retirement system, identify problems that threaten retirement security and analyze potential solutions to such problems" and prepare a comprehensive report.
- Adds four members to the PBGC Board of Directors, to be appointed by the President.
- Establish a "Participant and Plan Sponsor Advocate" within the PBGC to act as a liaison between the agency, plan sponsors and participants. The advocate would be charged with identifying problems and proposing changes in the PBGC's procedures and administration.
- Increase the benefit guarantee and premiums for multiemployer plans.
- Require the Senate HELP Committee and the House Education and the Workforce Committee to issue a report by the end of 2012 that would include recommendations to (1) further stabilize pension funding, (2) provide more funding flexibility for employers enduring temporary hardships, (3) provide incentives for plan sponsors to establish or maintain active pension plans and to unfreeze frozen plans and (4) modify bankruptcy law and the PBGC guarantee rules.

In addition to these defined benefit plan provisions, the measure also includes Social Security reform; substantial tax reform (including a "Fair Share" tax on high-income individuals and imposition of the "Buffett Rule" for millionaires); workplace matters such as overtime, sick leave, minimum wages and salary thresholds; and measures for addressing the misclassification of workers as independent contractors. Other sections of the bill address topics such as infrastructure funding, promotion of manufacturing, education reform and job training.

Obviously, such a comprehensive measure will require a thorough review and various elements will have differing levels of support among the public and even in Congress. A number of these

provisions are simply issues that have been circulating on Capitol Hill and are being presented as a means of generating public discussion.

Ryan, House GOP Release Budget Proposal

On March 20, House Budget Committee Chairman Paul Ryan (R-WI) unveiled his Fiscal Year 2013 Path to Prosperity budget proposal. This proposal is designed as a response to President Obama's Fiscal Year 2013 budget proposal released earlier in the year, addressing broad-based entitlement and tax reform as well as both health and retirement benefits policy.

As with all federal budget proposals, in some respects it offers specific recommendations for policy changes and spending levels and in other respects it describes only broad parameters of policy, but would leave to the appropriate congressional committees the task of crafting the details. While it is expected that this budget blueprint will pass the U.S. House of Representatives, the Senate -- if it completes action on a budget at all -- would certainly develop a separate plan with different priorities. It seems very unlikely the Congress will agree on a budget for the fiscal year that begins October 1. Rather, as the new fiscal year approaches, Congress is more likely to agree to fund activities of the federal government at a certain level that corresponds roughly with the current spending levels. However, budget plans, such as the one released by President Obama and Chairman Ryan, do set forth priorities for each party and will be discussed extensively in the context of the current political debate.

Ryan's approach toward health care policy, as described in the second section of the proposal, "Restoring Economic Freedom," advocates repealing the Patient Protection and Affordable Care Act (PPACA), and replacing it with "common-sense solutions," including "enacting medical liability reform, ensuring Americans can purchase quality coverage across state lines, and expanding access to consumer-directed health care options."

The Ryan plan also suggests that "addressing distortions in the tax code could begin by giving employers the opportunity to offer their employees a free choice option, so that workers could be free to devote their employer's health coverage contribution to the purchase of a health insurance plan that works best for them." This provision is reminiscent of the "free choice voucher" program that was included in PPACA, as signed into law, but subsequently repealed. Under that provision, employers would have been required to offer a voucher to certain employees who were not offered what was deemed to be "affordable" employer-sponsored coverage. The employee could then request a voucher (equivalent to the value of the most generous plan in which the employee was eligible to participate) from the employer to purchase coverage through a health insurance exchange.

Under "Strengthening Health and Retirement Security", the budget proposal describes the challenges and possible approaches for shoring up Medicare (through premium support, competitive bidding, and more assistance for those with lower incomes or greater health care needs) and Social Security (through a legislative mechanism requiring action by the President and Congress to address the program's fiscal imbalance). The proposal makes no mention of employer-sponsored retirement or savings plans.

The section of Ryan's proposal entitled, "Pro-Growth Tax Reform" describes the current tax code as excessive and complex and notes that "Many of the deductions and preferences in the system … are mainly used by a relatively small group of mostly higher-income individuals." This is an argument that has been used by some to criticize the corporate and individual federal tax

incentives for the provision of employer-sponsored health and retirement benefits, although it is unclear how or whether the Ryan plan would affect existing tax preferences for employer-sponsored benefits.

Generally, the proposal advocates fundamental individual tax reform by lowering rates, simplifying the current tax brackets, broadening the base of taxpayers and "getting rid of distortions, loopholes and preferences that divert economic resources from their most efficient uses." The proposal does not directly address the proposed treatment of popular tax preferences such as the home mortgage interest rate deduction, the exclusion of employer contributions for health insurance premiums and the deferral on contributions to retirement plans. The proposal also recommends corporate tax reform through a reduction in the overall rate and a shift from a "worldwide" system of taxation to a "territorial" system.

CRS Report Shows Lack of Support for Elimination of Certain Tax Incentives

In its March 22 report, The Challenge of Individual Income Tax Reform, the Congressional Research Service (CRS, a nonpartisan congressional think tank) examines some of the challenges underlying broad-based tax reform.

Numerous budget proposals, such as those developed by President Obama and House of Representatives Budget Committee Chairman Paul Ryan — as well as various bipartisan deficit commissions — have generally advocated fundamental tax reform under which income tax rates might be lowered and the tax base broadened by reducing or eliminating certain exclusions and deductions in the Internal Revenue Code. Such tax preferences include the home mortgage interest payment deduction, the deduction on charitable donations, the exclusion of employer contributions for health insurance premiums and the deferral on contributions to retirement plans.

For example, Page 261 of the Analytical Perspectives document of Obama's Fiscal Year 2013 budget, lists federal income tax expenditures ranked by total Fiscal Year 2013-2017 projected revenue effect. According to this table, the largest expenditure is the "exclusion of employer contributions for medical insurance premiums and medical care," accounting for more than $1 trillion of foregone tax revenue over the next five years. If we combine the tax deferrals for 401(k) plans and the tax exclusion for employer-provided pension contributions and earnings, the total foregone tax revenue is $728.8 billion over the next five years, which would be No. 2 on the list.

The CRS report notes that "repealing the 20 largest tax expenditures — including the tax exclusion for employer-provided health insurance and the mortgage interest deduction — would allow the top individual income tax rate to be cut from 39.6 percent to about 23 percent, but surveys show there are relatively few Americans who would be willing to accept the necessary trade-offs."

Specifically, only 39 percent of surveyed taxpayers would be willing to sacrifice their tax exclusion for 401(k) plan contributions in return for a lower tax rate. Similarly, only 40 percent would be willing to sacrifice the exclusion for employer-provided health insurance in return for a lower tax rate. The only tax preference reduction that received significant support was a change to the tax treatment of capital gains, which 54 percent of respondents were willing to sacrifice in exchange for a lower overall rate.

For each significant exclusion or deduction, the CRS report describes the underlying policy justification as well as criticisms and proposed modifications. The latter section of the report specifically outlines the administrative and technical challenges presented in each instance.

Senate Banking Subcommittee Examines Retirement Security

The U.S. Senate Banking, Housing and Urban Affairs Committee's Economic Policy Subcommittee held a hearing on March 28, Retirement (In)security: Examining the Retirement Savings Deficit – the difference between what Americans have and what they will need to save for retirement. While this committee has no jurisdiction over retirement policy issues, it signals broad interest in these matters, particularly as it affects the Baby Boomer generation.

In his opening statement, Subcommittee Chairman Jon Tester (D-MT) decried the impact of the economic downturn on retirement savings, including market volatility, the housing crisis and participation in qualified plans.

Ranking Republican Member David Vitter (R-LA), in his opening statement, expressed concern about the Federal Reserve Board's monetary and interest rate policy as well as the long-term stability of the Social Security system.

The committee heard testimony from a number of academic and policy experts:

- Michael Calabrese, senior research fellow at the New America Foundation, described the challenge of the "savings deficit" in economic terms. He expressed concerns about the lack and decline of employer-sponsored retirement plan coverage and the effect that might have on the Social Security program. He recommended continued promotion of automatic enrollment, escalation and annuitization systems in qualified plans.
- Jack VanDerhei, director of research at the Employee Benefit Research Institute, presented his own research on the broader economic impact of the retirement savings gap – including its effect on the capital and labor markets and on individuals – and the extent to which this deficit has been impacted by the recent economic conditions.
- James G. Rickards, senior managing director at Tangent Capital Partners, LLC, discussed the Federal Reserve's policies on retirement income security. Like Vitter, he cited the Federal Reserve's "zero" interest rate policy's deleterious effect on retirement savings. Rickards also pointed to the recent collapses of the stock market, the housing market and the banking industry and the important need for the right government policies to repair the damage.

During the question and answer period, when asked by Tester how to improve individual awareness of retirement savings, Calabrese recommended a broad educational financial literacy campaign targeting secondary education students. VanDerhei suggested improved interactive technology for people to use to calculate their retirement needs, while Rickards stated that more attention needs to be focused on investment returns and the need for a broader set of investment options beyond stocks and bonds.

Vitter also asked what the "next step" would be to build on the successes of automatic enrollment. VanDerhei cautioned that many employers may still be evaluating whether to implement automatic enrollment, particularly given the cost of matching contributions. Rickards suggested additional attention to the default investments into which participants are

automatically enrolled, noting that alternative investments to stocks and bonds may be advisable in some circumstances.

The lawmakers also briefly discussed the Automatic IRA Act (H.R. 4049), legislation introduced in the U.S. House of Representatives to provide for automatic enrollment of employees in payroll-deduction savings plans. Companion legislation has not been introduced in the Senate, although Senators Jeff Bingaman (D-NM) and John Kerry (D-MA) introduced the Automatic IRA Act (S. 1557), in September 2011.

Senate Committee Hears Testimony on Disability Insurance

On March 22, the U.S. Senate Health, Education, Labor and Pensions Committee (HELP) held a hearing, Stay-at-Work and Back-to-Work Strategies: Lessons from the Private Sector, to discuss the private income protection industry and the need for more individuals to have income protection insurance policies. In an opening statement, Committee Chairman Tom Harkin (D-IA) said that the purpose of the hearing was to learn what strategies private sector experts use to help disabled workers return to work or keep people at work.

The committee heard testimony from business owners, service providers and academic experts, including Thomas R. Watjen, president & CEO of Unum Group. Watjen's testimony discussed the value of income protection insurance to individuals, employers and the government; the approach the private sector takes in assisting someone when they become disabled; and the opportunities the private and public sector have to work together to expand these protections. His testimony also emphasized the role private income protection insurers serve in "maximizing the potential for someone in the workforce who experiences a work-limiting illness to return to their job."

Also appearing before the committee:

- Karen A. Amato, director of Wellwithin and corporate responsibility programs at SRA International, Inc. (testifying on behalf of the Society for Human Resource Management), discussed the challenges and successes large employers have had bringing employees with disabilities back to work.
- Eric Buehlmann, an attorney, described his physical and occupational therapy experience after suffering a traumatic brain injury, and the policies and factors that enabled him to successfully return to work.
- Kenneth Mitchell, managing partner at WorkRx Group, Ltd (a company that helps employers reduce the impact of injury, illness and chronic disease in the workplace), suggested moving away from the current compensation claims model in favor of a health and productivity "return-to-work" model or more of an integrated disability care model.
- Christine V. Walters, sole proprietor of FiveL Company (also appearing on behalf of SHRM), discussed return-to-work strategies and other disability management practices in the current workplace, with a focus on the experiences and challenges from the small business perspective.

During the question-and-answer period, committee members discussed strategies to raise awareness of the need for, and the importance of, purchasing disability income protection policies and issues related to employer sponsorship of this type of insurance. The committee also explored ways to improve the Social Security Disability Insurance Program (SSDI).

RECENT REGULATORY ACTIVITY

Regulatory Guidance Issued on SBC Rules, Offers 'Good Faith' Compliance Standard But No Delay

On March 19, the U.S. departments of Labor (DOL), Health and Human Services (HHS) and Treasury issued DOL FAQs About Affordable Care Act Implementation Part VIII, guidance specifically addressing issues related to the final regulations on Summary of Benefits and Coverage (SBC) and uniform glossary requirements recently issued under the Patient Protection and Affordable Care Act (PPACA).

The "frequently asked questions" document provides guidance on a number of technical and formatting matters related to the provision of the SBC disclosure. Most notably, however, the document describes the regulatory departments' approach to implementation and enforcement of the requirements, particularly with respect to the applicability date for these new plan option disclosures which must be provided to all current and newly eligible plan participants.

Importantly, the first FAQ reaffirms that for disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures to plans, and to individuals and dependents in the individual market, these requirements are applicable to health insurance issuers beginning on September 23, 2012.)

The second FAQ in the new guidance states that "during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community."

CMS Updates "Culturally and Linguistically Appropriate" County List for PPACA Disclosures

The U.S. Department of Health and Human Services' Center for Consumer Information & Insurance Oversight (CCIIO) of the Centers for Medicaid and Medicare Services (CMS) has updated its Culturally and Linguistically Appropriate Services (CLAS) county data for purposes of complying with certain disclosure requirements under the Patient Protection and Affordable Care Act (PPACA).

The CLAS establishes the counties in which group health plans and health insurance issuers offering non-grandfathered health coverage are required to provide notices related to a consumer's right to external review as well as the summary of benefits and coverage "in a culturally and linguistically appropriate manner" as required under Section 2719 of the Public Health Services Act (as added by PPACA).

The regulations implementing Section 2719 require these plans and issuers to make certain accommodations for notices sent to an address in a county meeting a threshold percentage of people who are literate only in the same non-English language. This threshold percentage is set at 10 percent or more of the population residing in the claimant's county, as determined based

on American Community Survey (ACS) data published by the United States Census Bureau. PHSA Section 2715 similarly requires that the Summary of Benefits and Coverage (SBC) be provided "in a culturally and linguistically appropriate manner." Recent final regulations implementing Section 2715 provide that a plan or health insurance issuer may meet this requirement by following the Section 2719 rules for providing claims and appeals procedures in this manner.

The chart is applicable for 2012 and will be updated annually. A June 2011 HHS technical guidance document provides instructions for calculating these county-level estimates, but affirms that plans and issuers are not obligated to perform calculations on their own and can rely on the chart as a safe harbor.

HHS Finalizes Regulations for State Health Exchanges

On March 12, the U.S. Department of Health and Human Services (HHS) issued final regulations governing the establishment of "Affordable Insurance Exchanges" under the Patient Protection and Affordable Care Act (PPACA). An HHS fact sheet on the regulations is also available. The earlier proposed regulations on this matter were issued in July 2011.

These state-based, competitive marketplace-style exchanges are envisioned to be the site where individuals and small employers will obtain coverage from a health plan. The exchanges will be the venue where subsidized health coverage for individuals with household incomes below 400 percent of the federal poverty level (FPL) will be available. Subsidized health coverage will also be available through the insurance exchanges for qualified individuals (also on the basis of household income below 400 percent of FPL) who are full-time employees and do not have the opportunity to elect "affordable" health coverage from their employer.

Under the PPACA, the exchanges are scheduled to be operational beginning January 1, 2014. The exchanges will initially be open only to those in the individual and small group insurance markets through operation of a Small Business Heath Options Program (SHOP). States can set the size of the small group market at either "1 to 50" or "1 to 100" employees until 2016. In 2016, exchanges must allow employers with up to 100 employees to participate. Beginning in 2017, states are authorized (but not required) to make health coverage under the insurance exchanges available to employer groups larger than 100. (The definition of "large" employer groups for this purpose will be based on separate state standards.)

Generally, the final regulations are designed to offer states substantial discretion in the design and operation of an exchange, including standards for:

- the establishment and operation of an exchange;
- qualification and accreditation of health insurance plans that participate in an exchange;
- determinations of an individual's eligibility to enroll in exchange health plans and in insurance affordability programs;
- enrollment in health plans through exchanges; and
- employer eligibility for, and participation in, a SHOP.

Under the final regulations, exchanges must verify whether an applicant who requested an eligibility determination for subsidized insurance affordability programs is enrolled in an eligible employer-sponsored plan. The preamble to the final regulation indicates that HHS intends to consult with the Departments of Labor and Treasury regarding the optimal solution for gathering

information for the purposes of verification of eligibility for qualifying coverage in an eligible employer-sponsored plan and will issue guidance on this topic. Both the template and database options described in the proposed rule are being considered as operational solutions.

HHS is also considering ways in which an individual could gather information from his or her employer for the purposes of this verification. HHS indicates that a combination of methods could provide the most accurate and reliable results, while gathering information from both employees and employers. HHS is also considering additional options in which employees seeking coverage could provide other sources of documentation from his or her employer that could verify eligibility. HHS plans to issue future guidance outlining one or more possible methods for comment that will help guide the collection of information necessary to verify eligibility for qualifying coverage in an eligible employer sponsored plan.

DOL Secretary Solis Testifies Before House Committee on 2013 Budget Request, Including Fiduciary Definition

In a March 21 hearing to discuss the U.S. Department of Labor's Fiscal Year 2013 budget request, members of the House of Representatives Education and the Workforce Committee pressed Labor Secretary Hilda Solis on a number of employee benefits-related issues, most notably the status of the fiduciary definition project.

DOL/EBSA originally issued proposed regulations in October 2010 designed to protect participants from conflicts of interest and self-dealing by giving a broader and clearer understanding of when individuals providing such advice are subject to ERISA's fiduciary standards. However, in the face of bipartisan congressional criticism, DOL announced in September 2011 that EBSA would withdraw and re-propose the regulations. At that time, DOL announced that "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."

Phyllis Borzi, assistant secretary for the Employee Benefits Security Administration at DOL, indicated that the agency intends to re-propose regulations revising the definition of a fiduciary sometime in 2012, including a more vigorous cost analysis, amendments to existing prohibited transaction exemptions (PTEs), one new PTE and an update of DOL Interpretive Bulletin 96-1 (which distinguishes investment education from investment advice).

Members of the committee expressed continued concerns about the project during the March 21 hearing and asked about the progress being made on re-proposal. Representative Judy Biggert (R-IL) asked Solis to verify recent comments by Borzi that the regulations would be re-proposed in May and "would seek to greatly expand liability for the companies that provide services to IRAs and pension plans." Solis could not confirm these statements but asserted that the agency was seeking "a balance" and was still in the process of collecting data from stakeholders. Solis also assured Biggert that DOL would be working with the Securities and Exchange Commission and Commodity Futures Trading Commission in the development of a new proposed rule.

Representative Rush Holt (D-NJ) expressed concern that, "in requesting more data, you won't get the data that will actually get to the issue of how employees make decisions … and what

you can do, what we can do, to help employees make decisions that will leave them better prepared for retirement [and] how we can increase access to investment advice." Rep. Carolyn McCarthy (D-NY) voiced the same concerns. Solis responded that "We're not finished. That's why [the comment period] is open, and we definitely want to hear from stakeholders and your comments and obviously hear from the public overall. So, we're not in a hurry."

Solis' testimony did not discuss any of these proposed measures, focusing instead on job training programs and enforcement efforts, nor did these matters come up during the hearing's question-and-answer session. However, Solis did cite the fiduciary definition project and the recently finalized retirement plan fee disclosure rules under the heading of "Securing Americans' Incomes and Benefits."

Committee Chairman John Kline (R-MN), in his statement convening the hearing, said that "The department's use of taxpayer dollars sends a strong message to employers that they have an adversary in the federal government, not an ally. For example, in policies governing workplace safety and wage and hour standards, punitive enforcement actions take precedent over efforts to help employers understand and comply with the law."

GAO Reports on Defined Benefit Plans and Hedge Fund/Private Equity Investments

On February 16, the Government Accountability Office (GAO) issued a report, Defined Benefit Pension Plans: Recent Developments Highlight Challenges of Hedge Fund and Private Equity Investing, examining plan sponsors' experiences with these alternative investments.

The report was requested by Representative Rob Andrews (D-NJ), ranking Democratic member of the House of Representatives Education and the Workforce Committee's Health, Employment, Labor, and Pensions Subcommittee. Specifically, he asked GAO to ascertain the lessons learned by plan sponsors with regard to their alternative investments following the economic downturn in 2008 and what steps have been (or should be) taken to help plan sponsors make and manage investments in such alternative assets. In the past, members of Congress have expressed concern about the growing investment in hedge funds and private equity by private and public defined benefit plans and supported the call for regulatory guidance from the U.S. Department of Labor (DOL). This report follows three previous GAO examinations of this topic:

- Plans Face Challenges When Investing in Hedge Funds and Private Equity (August 2011);
- Plans Face Valuation and Other Challenges When Investing in Hedge Funds and Private Equity (July 2010); and
- Defined Benefit Pension Plans: Guidance Needed to Better Inform Plans of the Challenges and Risks of Investing in Hedge Funds and Private Equity (August 2008)

The most recent GAO report found that most plans included in the review "have taken actions to address challenges related to their hedge fund and private equity investments, including allocation reductions, modifications of investment terms, and improvements to the fund selection and monitoring process." In addition, "most plans have adjusted investment strategies as a result of recent years' experiences. For example, three plans have reduced their allocations to hedge funds or private equity. Other plan representatives also took steps to improve investment terms, including more favorable fee structures and enhanced liquidity."

Despite the evidence that plan sponsors are adapting to meet these challenges, the GAO's report reemphasizes a general recommendation from the August 2008 report that DOL provide guidance to help plans investing in hedge funds and private equity. The DOL's ERISA Advisory Council recently issued a report on hedge funds and private equity investments, recommending the development of a "tip sheet" to assist plan sponsors in evaluating the appropriateness of hedge fund and/or private equity fund investments, and in selecting and monitoring these investments in defined benefit plans.

CMS Establishes Timeframe for ERRP Expenditures

In a March 13 notice, the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS) reiterates and formalizes the timeframe under which plan sponsors participating in the Early Retiree Reinsurance Program (ERRP) are expected to use ERRP reimbursement funds. Plan sponsors are expected to use such funds "as soon as possible," but not later than December 31, 2014.

The ERRP, which allows employer health plan sponsors to apply and qualify for reimbursement of early retiree health care expenses, was enacted under Section 1102 of the Patient Protection and Affordable Care Act (PPACA). 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 were exhausted. In late 2011, CMS announced that the agency would deny any reimbursement requests under the Early Retiree Reinsurance Program (ERRP) that include claims incurred after December 31, 2011.

According to the most recent ERRP status report, released on February 17, "requests for reimbursement have exceeded the $5 billion in funding appropriated." Requests in excess of the program's $5 billion budget will now be held in the order of receipt, pending the availability of funds that may become available as a result of overpayment recoupment activities. CMS will continue to report the status of payments to plan sponsors periodically.

CBO and JCT Release Estimated Effect of PPACA on Employer-Based Health Plan Participation

On March 15, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued a report, Effects of the ACA on Employment-Based Health Insurance, estimating that, as a result of the Patient Protection and Affordable Care Act (PPACA) "about 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law." However, the report does not conclude that all of those people will be uninsured. Rather, it acknowledges that most will be covered either by public programs or in the state insurance exchanges.

Specifically, the report estimates:

- About 11 million people who would have had an offer of employment-based coverage under prior law will not have an offer under the ACA, with the businesses that choose not to offer coverage as a result of PPACA tending to be employers whose workers are more likely to be eligible for Medicaid, CHIP, or subsidies through the health insurance exchanges.
- Another 3 million people who would have had employment-based insurance under prior law and will still have an offer of such coverage under PPACA will instead choose to

obtain coverage from another source. Included in this calculation is the assumption that, while workers with an offer of employment-based coverage will generally be ineligible for exchange subsidies, that "firewall" will presumably be enforced imperfectly and an explicit exception to it will be made for workers whose offer of employment-based coverage is deemed unaffordable.
- About 9 million people who would not have been covered by an employment- based plan under prior law will have that coverage under the ACA. That change reflects the combined impact of the insurance mandate, the penalties that will be imposed on employers who do not offer insurance, and the tax credits for certain small employers who provide insurance for their workers.

Addressing the prevailing expectations that employer-sponsored coverage would decrease more steeply in light of the expanded availability of subsidized health insurance coverage, the report asserts that "the legislation leaves in place some financial incentives and also creates new financial incentives for firms to offer and for many people to obtain health insurance coverage through their employers," citing:

- Employment-based health insurance will continue to receive a significant subsidy through the tax exclusion for employer-paid premiums and tax provisions that allow a large portion of employees' shares of premiums to be paid out of pretax income, which will in turn provide an ongoing incentive for employers to offer coverage, even after certain high-premium plans face an excise tax beginning in 2018.
- The administrative costs involved in operating and managing health insurance plans will be higher in the exchanges than they will be for large employers, principally because administering plans (including handling enrollment and collecting premiums) for many individual policyholders is more expensive than administering them for a single employer.
- The requirement that individuals obtain health insurance coverage and the penalties that will apply to many individuals if they do not obtain it will lead more workers to seek health insurance coverage. Greater demand for health insurance will increase the incentive for employers to offer insurance as well as for employees to take up insurance offered by employers.
- Starting in 2014, firms with more than 50 employees that do not offer insurance and have at least one employee who receives an exchange subsidy will be subject to a penalty; that penalty will initially be as much as $2,000 per full-time worker (beyond the first 30 such workers) and in subsequent years is set to increase at the rate of growth in per capita health insurance premiums.
- Firms with up to 25 full-time-equivalent employees and with average annual wages of less than $50,000 may be eligible for a tax subsidy that covers a percentage of their contributions to health insurance premiums.
- Employers who drop coverage, leaving their employees to purchase insurance on their own, will generally have to raise the cash compensation of their employees to compete with employers who continue to offer health insurance.

The report also asserts "the fact that many firms currently offer health insurance coverage to their workers despite the high cost of premiums and rapid growth in those premiums for many years shows that many firms continue to find health insurance coverage to be a worthwhile element of their compensation packages."

The report also asserts "the fact that many firms currently offer health insurance coverage to their workers despite the high cost of premiums and rapid growth in those premiums for many years shows that many firms continue to find health insurance coverage to be a worthwhile element of their compensation packages." Another reason that employers continue to sponsor health coverage according to CBO and JCT is because of current flaws in the individual insurance and "the possibility of coverage exclusions or premium surcharges due to specific health conditions of a family member." Of course, since PPACA makes insurance market reforms, including disallowing coverage exclusions for pre-existing conditions as well as premium surcharges resulting from health status, it is unclear what impact that may have on some employers' motivation to continue sponsoring plans, when their employees and family members may have viable alternative sources of coverage.

CBO and JCT largely dismiss the notion that large numbers of employers will choose not to offer coverage based on the availability of the exchanges and the low cost of the penalty relative to the cost and burden of providing insurance, suggesting that these incentives to exit the system will be mitigated by a desire not to disturb employee expectations or increase cash compensation. CBO and JCT also downplayed the significance of recent surveys of employers' expected responses to health reform after 2014 – including surveys which have reported that significant numbers of employers might stop offering health coverage entirely – asserting that "such surveys have no consequences for responders, do not require careful analysis or deliberations, and are necessarily based on limited information about the various ways the ACA will affect the market for health insurance."

The report also goes into substantial detail about how characteristics of the workforce will affect incentives for firms to offer health insurance under PPACA (including eligibility for subsidies). It also examines a number of alternative calculations based on different assumptions about employers' behavior, including the extent to which employers might restructure their workforces so that low-income workers and their families can take advantage of the exchange subsidies and expanded Medicaid and CHIP eligibility.

The March 15 report follows a March 13 estimate by CBO that the estimated net costs of expanding health care coverage under PPACA have been reduced by $48 billion through 2021 and the number of nonelderly people without health insurance coverage will be reduced by 30 million to 33 million in 2016 and subsequent years, but that nonetheless millions of Americans will remain uninsured. These reports, while generally complimentary of the PPACA's aims and effects, are likely to give ammunition to both the law's proponents and detractors, particularly in the current highly charged political environment..

ERISA Advisory Council Announces 2012 Discussion Topics

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 released its working group topics for 2012. These topics are:

- Managing disability risks in a world of individual responsibility
- Beneficiary designation and estate implications — best practices for retirement plans and individuals

- Income replacement options, education, and the role of the employer

The 2012 EAC includes employer representatives Karen Kay Barnes, managing counsel for McDonald's Corporation (EAC vice chair); Jack Towarnicky, employee benefits attorney for Willis North America; and Neal S. Schelberg, senior partner at Proskauer Rose LLP.

Hearings generally take place during the summer. The EAC's official reports to DOL, stemming from its 2011 working groups, were released in November 2011:

- Hedge funds and private equity investments
- Privacy and security issues affecting employee benefit plans
- current challenges and best practices for ERISA compliance for 403(b) plan sponsors

Hearings will begin on June 13 and continue on days to be determined throughout the summer.

IRS to Examine Safe Harbor 401(k) Plans

In an Internal Revenue Service (IRS) phone forum on March 6, Employee Plans Team Audit Manager Janice Gore revealed that the agency will undertake a project to examine safe harbor 401(k) plans.

Safe harbor 401(k) plans are not subject to the annual benefits testing required with traditional 401(k) plans but instead must provide employees with a certain level of employer contributions. Often, these mandatory employer contributions must be fully vested when made. These plans also impose additional content and timing requirements for notification of participants.

According to a Tax Notes report, the new IRS project will take a closer look at plans that suspended their safe harbor 401(k) contributions to ensure that they complied with the proper procedural requirements, including required notice and nondiscrimination testing. Plan sponsor members who discontinued nonelective contributions to a safe harbor 401(k) plan for any period of time may want to review their documentation to ensure they met the requirements.

The project is based on feedback obtained through the 401(k) Compliance Check Questionnaire Project begun in 2010. The IRS issued an interim report on the questionnaire's findings on February 3.

RECENT JUDICIAL ACTIVITY

PPACA Supreme Court Arguments

On March 26, the U.S. Supreme Court began its hearing of oral arguments in the case to determine the constitutionality of the Patient Protection and Affordable Care Act (PPACA). On the first day, the court devoted 90 minutes to a discussion of the applicability of the Anti-Injunction Act.

The Anti-Injunction Act (AIA), a federal law enacted in 1867, says that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any

person." Therefore, if the health care law's individual mandate penalty is determined to be a "tax," the Anti-Injunction Act may prohibit the court from ruling on the matter until the tax is actually owed in 2015. The U.S. Court of Appeals for the Fourth Circuit previously ruled that it was not yet able to rule on the law's constitutionality, based in part on the AIA.

Both the challengers of the law in the two principal cases before the court (The National Federation of Independent Business and a collection of 26 states) and the Obama Administration have argued that the case should be decided on its merits now, but the court asked a separate, independent counsel to present the case under which the AIA would apply.

Jim Napoli of Proskauer offered first-hand analysis on the day's proceedings, reporting that "on first impression, it appears that the Justices are unlikely to hold that the AIA bars its review of the constitutionality of the individual mandate and its related penalty under PPACA," while noting that "first impressions can be wrong when it comes to reading the tea leaves set forth by the Supreme Court."

On March 27, the U.S. Supreme Court entered its second day of oral arguments. The court devoted two hours to a discussion of the central question in this case: whether the law's "minimum coverage provision" (or "individual mandate") – the requirement to purchase health insurance – is within the scope of Congress' authority to regulate interstate economic activity under the Commerce Clause of the Constitution.

The court will seek to resolve a split in decisions at the circuit court level. In The National Federation of Independent Business (NFIB) v. Sebelius, et al., the Sixth Circuit Court of Appeals upheld PPACA's individual mandate as a constitutional exercise of congressional authority under the Commerce Clause. However, in Florida, et al. v. the Department of Health and Human Services, et al., the Eleventh Circuit Court of Appeals found the PPACA individual mandate unconstitutional (while finding the remainder of the law "severable" and therefore valid).

Jim Napoli reported on the second day of oral arguments that:

- The Justices appeared to come into the courtroom divided along ideological lines: Chief Justice Roberts and Justices Scalia and Alito posed many critical questions to Solicitor General Donald Verilli, who defended the constitutionality of the individual mandate, while Justices Breyer, Ginsburg, Sotomayor and Kagan directed many difficult questions to the attorneys representing the 26 states and the NFIB, who challenged the individual mandate's constitutionality. As many suspected, Justice Kennedy appears to be the swing vote, though it is possible that Roberts may also be swayed by a majority argument.

- In asking his questions, Kennedy clarified that there are actually two distinct markets that are significant to understanding the issues discussed during the arguments: the individual insurance market and the health care market. PPACA regulates the individual insurance market. The key issue raised by Kennedy is whether the government can regulate the individual insurance market because, as the government argues, all citizens will one day find themselves within the healthcare market and the individual insurance market is a primary funding mechanism for the healthcare market. Kennedy acknowledged that this type of derivative regulation causes some concern.

- One potentially important line of questions posed to Verilli, also initiated by Kennedy, was whether any limits on Congress's Commerce Clause power would remain if the Court were to uphold the constitutionality of the individual mandate. The Solicitor General answered in the affirmative but was unable to provide good examples of how that power would be limited.

- As part of his argument for the constitutionality of the mandate, Verilli asserted that the individual mandate penalty is a tax, which Congress has the power to levy. This argument is in contrast to Verilli's March 26 remarks in which he argued that the penalty is not a tax and that, therefore, the Anti-Injunction Act does not apply. It is unclear how whether the government's seemingly conflicting view of the mandate can be reconciled by the Court. Ginsburg, in particular, seemed to focus on this issue during the second-day arguments.

- Notably, during the second-day arguments, the litigants and the justices referred to PPACA as a "comprehensive regulatory scheme."

On March 28, the U.S. Supreme Court concluded its three day hearing of oral arguments in the case to determine the constitutionality of the Patient Protection and Affordable Care Act (PPACA). The court is expected to issue its final decision in June.

On March 28 the court concluded its three day hearing of oral argument devoting 90 minutes to a discussion of the individual mandate's "severability" – whether, if the mandate is determined to be unconstitutional, other parts of the law (such as the individual insurance market reforms and the employer responsibility provisions) must also be invalidated. In Florida, et al. v. the Department of Health and Human Services, et al., the Eleventh Circuit Court of Appeals found the PPACA individual mandate unconstitutional but ruled that the entire remainder of the law was "severable" and therefore valid. The law's challengers assert that if the individual mandate is unconstitutional, the entire law should be nullified. The Obama Administration asserts that if the individual mandate is struck down, only certain health care insurance market reforms (such as such as "guarantee issue" requirements and prohibitions on preexisting conditions) should be voided while the rest of the law should be left to stand. The court is empowered to divide the law however it sees fit.

Jim Napoli reported on the third day of oral arguments that:

- Unlike the previous discussion of the individual mandate's constitutionality, in which the justices appeared to be divided along ideological lines, the justices seemed to have a common goal of defining the standard by which the Supreme Court should analyze the severability arguments presented by the parties. Many of the justices seemed uneasy determining whether and to what extent legislative intent and detailed economic analysis should play in their determination of severability.
- Most of the justices, notably the ideologically divergent Justices Breyer and Scalia, expressed an extreme reluctance to scour the entire 2,700-page bill to determine which provisions should be severed and which provisions should remain. Breyer asked Paul Clement, attorney for the 26 states, whether the court should "appoint a special master" or whether the court should "spend one year going through this" in an attempt to highlight the enormous difficulty that analyzing the entire bill would entail.
- Scalia was clear that, if the individual mandate were held unconstitutional, the remaining law would be a distortion of the one passed by Congress. On that same note, Chief

Justice Roberts , as well as Justices Kennedy and Alito, seemed particularly concerned with the negative consequences that would occur absent the individual mandate and how those negative consequences would be redressed. Roberts repeatedly asked questions on this point and seemed unconvinced that parties, whether individuals or companies, would have an adequate forum within which to redress a negative consequence suffered under the judicially altered law.

- There appeared to be apprehension on the part of Roberts, as well as Scalia, Kennedy and Alito, in leaving it to Congress to fill the gaping hole that would be left in the law absent the individual mandate and to otherwise curb any negative consequences that would flow from application of the law in the absence of the individual mandate. With that in mind, both Scalia and Kennedy indicated that "judicial restraint" in this case may call for the court to strike the entire law – implying that it would be more of an offense on congressional intent to strike the individual mandate and leave the law to operate in a manner unrecognized by Congress than to strike the entire law and provide Congress with a clean slate. "There is no way that this Court's decision is not going to distort the congressional process. Whether we strike it all down or leave some of it in place, the congressional process will never be the same," Scalia said.
- Scalia made it clear that he would strike the entire "body" of the law to the extent it was deemed that the individual mandate and related market reforms constituted the "heart" of the law. This raises the question whether such a formulation works to the extent the law covers multiple "bodies" of law. For example, while the individual mandate and certain market reforms may be the "heart" of the law with respect to the body of law under the law addressing coverage issues (e.g., individual mandate, employer mandate, market reforms, exchanges), there are other "bodies" of law addressed under the law that would appear to stand on their own (e.g., black lung provisions, workplace relief for breast feeding mothers, etc.). This is a point Breyer raised numerous times during the arguments.
- Justice Sotomayor seemed comfortable to leave the issue entirely with Congress as to what to do with the law absent the individual mandate. Justice Kagan appeared to agree with the government's argument that certain market reforms need to be struck should the individual mandate be found unconstitutional.
- Ultimately, it is clear that the justices are struggling with the standard that should be used in determining what provisions of PPACA must be stricken should the individual mandate be found unconstitutional. Current precedent does not provide a satisfactory answer to this question. We may see new law developed or at least current precedent better harmonized as the court navigates its way through the thicket of issues raised under severability analysis.

Of note, the parties made passing reference to the employer mandate on several occasions:

- Clement, in making the point that the entire law is inextricably entwined with the individual mandate and should be nullified, noted that "those provisions that have the constitutional difficulty are the very heart of this Act. And … they are textually interconnected to the exchanges, which are then connected to the tax credits, which are also connected to the employer mandates, which is also connected to some of the revenue offsets, which is also connected to Medicaid […]" (Page 15 of the transcript, beginning Line 22). Later, Clement similarly notes that "the exchanges are also key to the employer mandate, because the employer mandate becomes imposed on an employer if one of the employees gets insurance on the exchanges" (Page 24 of the transcript, beginning Line 16.)

- Deputy U.S. Solicitor General Edwin Kneedler, arguing for the Obama Administration that certain sections of the law should be severed, asserted that because so many Americans receive insurance coverage through their employers, Congress sought to expand the availability of affordable care through a provision requiring employers to purchase insurance. Upon an inquiry from Kennedy on how the cost assumptions behind the imposition of the individual mandate would affect the employer mandate, Kneedler replied that "there is no indication that Congress made any cost assumptions, but there is no reason to think that the individual – that the individual market, which is where the minimum coverage provision is directed, would affect that" (Page 52 of the transcript, beginning Line 3.)

Following the severability arguments, the court heard another one hour of discussion on the applicability of the Constitution's spending clause to the law's Medicaid expansion, under which eligibility would be granted to all residents earning less than 133 percent of the federal poverty level. A collection of 26 states has asserted that the federal funding provided for this expansion coerces compliance by the states, while the Obama Administration claims that that the funding merely encourages compliance. During the severability argument, Kneedler affirmed the government's position that if the Medicaid expansion is struck down, the rest of the PPACA can operate and needs not be invalidated.

Generally, during this session, the justices were somewhat receptive to the challengers' argument that the law's Medicaid provisions unconstitutionally coerces states to expand the program. Both Kneedler and Clement faced extensive inquiry on the fundamental question of whether such heavy reliance on federal funding is implicitly coercive.

The court is expected to issue its final decision in June.