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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

House Committee Examines Tax Incentives for Workplace Retirement Plans

Members of the House of Representatives Ways and Means Committee discussed a wide variety of issues related to employer-sponsored retirement savings plans at an April 17 hearing on Tax Reform and Tax-Favored Retirement Accounts.

As Committee Chairman Dave Camp (R-MI) stated in the original hearing announcement, the hearing was designed to "consider the current menu of options for retirement savings – both with respect to employer-based defined contribution plans and with respect to IRAs" in the context of comprehensive tax reform. In his opening statement on April 17, Camp cited three principles for reforming the current retirement system: simplification, increasing participation and the improving the efficiency of tax incentives.

In conjunction with the hearing, the Joint Committee on Taxation released a report, Present Law and Background Relating to the Tax Treatment of Retirement Savings, which provides a summary of the present law tax rules applicable to retirement savings arrangements and describes selected reform proposals and economic issues relating to retirement savings. The report does not draw any conclusions about reforming the current system, but notes concerns about the regressive nature of the tax benefit for participants while acknowledging that complexity and liability concerns pose significant challenges for plan sponsors. "In evaluating proposals related to vehicles for retirement savings arrangements (both employer-sponsored and individual arrangements), including the tax treatment of contributions and distributions, an initial question is whether the proposal serves to better achieve the goals that justify the tax subsidy than present law."

The committee also heard from the following witnesses:

- Randy Hardock, managing partner at Davis & Harman LLP, asserted that "the first, and most important, principle to consider in the context of tax reform and the retirement system is: do no harm." He emphasized the success of the existing defined contribution plan system and urged the committee to avoid dramatic changes in the rules and incentives governing retirement plans while offering a number of suggestions for improving retirement savings, especially for those with lower incomes.

- Jack VanDerhei, research director at the Employee Benefit Research Institute, described research showing that the current retirement system can be effective. He noted in his testimony that "defined contribution plans are the component of retirement security that appears to be generating the most non-Social Security retirement wealth for 'Baby Boomers' and 'Gen Xers' " but cautioned that substantial modifications to existing programs could increase the number of individuals at risk of an insecure retirement.

- Judy A. Miller, chief of actuarial issues and director of retirement policy at the American Society of Pension Professionals and Actuaries, observed that "the current tax incentives are working very efficiently to promote retirement security for millions of working Americans," and asserted that increasing the availability of workplace savings is the key to increasing retirement and financial security. Miller disputed the notion that the large number of different kinds of savings vehicles leads to confusion, suggesting that

consolidating all types of defined contribution plans into one type of plan would disrupt savings.

- William Sweetnam, principal at Groom Law Group, called upon his experience as former Benefits Tax Counsel in the Office of Tax Policy at the U.S. Treasury Department to describe the retirement savings simplification proposals offered by the Bush Administration in 2004. At that time, the administration outlined a system of tax-favored savings with only three types of vehicles: Lifetime Savings Accounts (LSAs), Retirement Savings Accounts (RSAs) and Employer Retirement Savings Accounts (ERSAs). Sweetnam's testimony described these vehicles in more detail and discussed their potential simplicity as a replacement for existing retirement savings programs.

- David John, senior research fellow in Retirement Security and Financial Institutions at The Heritage Foundation, also expressed support for simplification and consolidation of existing retirement savings vehicles, while also promoting the Auto-IRA concept, in which employees are automatically enrolled in payroll-deduction savings plans. John, along with current senior adviser to the U.S. Secretary of the Treasury and deputy assistant secretary for retirement and health policy Mark Iwry, are the original authors of the proposal, which has received the support of President Obama and is embodied by the Automatic IRA Act (H.R. 4049), introduced by committee members Richard Neal (D-MA) and Earl Blumenauer (D-OR).

During the question-and-answer period, committee members raised a wide variety of issues, including financial literacy education, inclusion of annuity and lifetime income options, disclosure requirements, small business plan sponsorship challenges, employee stock ownership plans, and increasing participation among low- and middle-income workers.

While the witnesses shared differing views on the extent of reform needed – particularly with respect to consolidation of existing savings vehicles – the witnesses were generally in agreement that the existing tax incentives are essential for continued plan sponsorship and participation. Responding to a question from Rep. Kenny Marchant (R-TX) about the so-called "20/20 " proposal (under which the cap on annual employer and employee retirement plan contributions would be lowered to the lesser of 20 percent of the employee's compensation or $20,000), VanDerhei explained that such a proposal would reduce aggregate retirement savings, particularly for lower-income individuals. Miller added that such an impact is actually understated, since many employers would be unlikely to sponsor a plan in such circumstances.

Members and witnesses were also generally supportive of automatic enrollment and escalation programs – though they did not explicitly endorse H.R. 4049 – as the first step in expanding coverage up and down the income spectrum.

While lawmakers are unlikely to pursue comprehensive tax reform in earnest this year, the April 17 hearing sets the stage and establishes the parameters of policy discussions to take place in the coming months and years. Given the prominence of retirement tax incentives in the federal budget, such programs may remain a target as lawmakers seek additional revenue from the process.

New Worker Classification Legislation Introduced in Senate, House

Worker misclassification issues continue to be a topic of discussion on Capitol Hill, as Senator John Kerry (D-MA) and Representative Jim McDermott (D-WA) have each introduced versions of the Fair Playing Field Act (S. 2145 in the Senate, H.R. 4123 in the House of Representatives), legislation to prevent certain workers from being classified as independent contractors. Such legislation would dramatically impact employment practices and benefit plans, and raise significant federal revenue. Kerry and McDermott introduced identical legislation in the previous Congress in September 2010.

Under current law, a "safe harbor" permits employers to treat a worker as not being an "employee" for employment tax purposes unless the employer has no reasonable basis for such treatment or fails to meet certain requirements. Specifically, S. 2145/H.R. 4123 will:

- end the moratorium on Internal Revenue Service (IRS) guidance addressing worker classification;
- require the Treasury Department to issue prospective guidance clarifying the employment status of individuals for federal employment tax purposes;
- increase penalties on employers for failure to deduct and withhold income taxes and the employee's share of FICA taxes in certain circumstances;
- require those who employ independent contractors on a regular and ongoing basis to provide a written statement to each independent contractor of the federal tax obligations of independent contractors, the labor and employment law protections that do not apply to independent contractors, and the right of the independent contractor to seek a status determination from the IRS; and
- require the Treasury Department to issue annual reports on worker classification.

S. 2145 has been referred to the Senate Finance Committee and H.R. 4123 has been referred to the House Ways and Means Committee, the committees with jurisdiction over Internal Revenue Code issues.

Senator Sherrod Brown (D-OH) and Representative Lynn Woolsey (D-CA) have introduced legislation to address worker classification issues by compelling new regulations through ERISA. The Payroll Fraud Prevention Act (S. 770), introduced by Brown, and the Employee Misclassification Prevention Act (H.R. 3178), introduced by Woolsey, seek to reduce misclassification violations by imposing more stringent penalties with regard to overtime and minimum wage rights. H.R. 3178, in particular, goes even farther by creating a system of mandatory state audits and encouraging coordination between the U.S. Department of Labor and IRS.

Congress is not expected to take action on worker classification measures before the end of the year, but the introduction of new legislation – as well as the inclusion of similar initiatives in the budget proposals offered by President Obama and House Budget Committee Chairman Paul Ryan (R-WI) – suggests increased attention on this issue in future months

House Committees Continue Scrutiny of PPACA: Approve De-Funding Measures, Hear HHS Testimony

In a series of committee actions this week, Republicans in the House of Representatives continued to push back against the Patient Protection and Affordable Care Act (PPACA), frequently citing the threats that rising health care costs pose for businesses.

Energy and Commerce Committee Markup

On April 25, the House Energy and Commerce Committee approved three separate draft reconciliation measures that would fulfill a portion of the House budget resolution's directive to reduce the federal deficit by $3.8 billion this year, by $28.4 billion over a five-year period and $96.8 billion through 2022. These measures specifically target spending programs in PPACA:

- The first measure would eliminate PPACA's Prevention and Public Health Fund. Originally intended to promote preventive health care, though the bulk of that money has been used to fund the creation of state insurance exchanges.
- The second measure would repeal the "maintenance of effort" provisions that require states to freeze current eligibility standards for Medicaid and the Children's Health Insurance Program (CHIP). This measure would also cut the federal Medicaid match rate for U.S. territories from 55 percent to 50 percent and cut the health care provider tax from the current 6 percent threshold to a maximum of 5.5 percent.
- The third measure would overhaul the medical malpractice system, capping liability damages at $250,000, limiting attorney fees and establishing a statute of limitations on lawsuits.

The House of Representatives Ways and Means Committee recently approved its own health-related budgetary reconciliation measure in the form of legislation to recapture overpayments resulting from certain federally-subsidized health insurance. When committee action is complete, these individual measures will be combined and, likely, approved by the full House of Representatives. The budget measure will not receive consideration in the Senate, however, making this committee action largely symbolic. However, considering the amount of federal revenue it is calculated to raise, it can be expected to be considered again in future deficit reduction or revenue offset purposes.

Earlier this month, the Energy and Commerce Committee Republicans released a staff report, Higher Costs, More Confusion, Less Coverage: How the Health Care Law Affects Employer-Provided Health Care Coverage. The report, based on discussions with employer members of the President's Council on Jobs and Competitiveness, concludes that "the law will increase costs, make future planning for hiring and expansions difficult due to the uncertainty created by the law, and could ultimately lead to employers dropping health insurance coverage for their employees."

Education and the Workforce Committee Hearing

Republicans on the House Education and the Workforce Committee reiterated these themes in an April 26 hearing, Reviewing the President's Fiscal Year 2013 Budget Proposal for the U.S. Department of Health and Human Services. The committee heard testimony from U.S. Health and Human Services Department Secretary Kathleen Sebelius to discuss PPACA and

specifically the $932 billion funding request in President Obama's Fiscal Year 2013 budget proposal.

Committee Chairman John Kline (R-MN), in his opening statement, criticized PPACA for failing to lower costs while exacerbating the federal deficit and blamed the law for slowing job creation as employers grapple with rising costs, government regulations and mandates. "Toward that end, we will continue to conduct aggressive oversight of the law and the related regulatory actions taken by the administration," Kline said.

Representative George Miller (D-CA), the committee's ranking Democrat, touted the importance of PPACA's and its successes in his opening statement. "We never said [the health care law] would change everything that was wrong with our health care system, or fix everything that people would like or as fast as they would like. But we know [PPACA] is moving in the right direction."

Sebelius' testimony touched on the progress regulators are making with PPACA implementation, but focused primarily on funding for the Head Start health and education program for low-income children and their families.

During the question and answer period, Kline referenced an April 25 Government Accountability Office (GAO) report recommending that HHS cancel the Medicare Advantage (MA) Quality Bonus Payment Demonstration — because the design shortcomings of the demonstration may undermine its ability to achieve its stated research goal — and allow the MA quality bonus payment system established by PPACA to take effect. Sebelius responded that HHS has no intention of canceling the program and that the MA program is improving in cost and quality effectiveness.

Representative Phil Roe (R-TN) confronted Sebelius with the facts of soaring health care costs and insurance premiums, suggesting that these costs were threatening small- and medium-sized businesses and job growth. Representative Rush Holt (D-NJ) cited evidence that the rate of premium increases have slowed somewhat, which Sebelius attributed to federal rate review and preventive care efforts.

Representatives Scott DesJarlais (R-TN) and Larry Bouchon (R-IN) asked Sebelius about the potential of employers to pay a penalty and sending employees to the state insurance exchanges, shifting costs to the federal government. Sebelius noted that businesses in Massachusetts have maintained plan sponsorship despite a structure and incentives similar to PPACA.

House Committee Examines Taxation of OTC Medications

On April 25, the U.S. House of Representatives Ways and Means Committee Oversight Subcommittee held a hearing on limitations on the purchase of over-the-counter (OTC) medication with tax-advantaged accounts such as Flexible Spending Arrangements (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

Individuals are currently permitted to use the funds in these accounts to pay for qualified unreimbursed medical expenses such as deductibles and copayments. Until 2011, individuals were also able to use these funds for OTC medication without a prescription. However, in 2010, Section 9003 of the Patient Protection and Affordable Care Act (PPACA) instituted a change in

the tax code that modified the definition of a "qualified medical expense" to exclude OTC medication without a prescription.

Employer, consumer and provider groups have expressed concern that these changes have resulted in unintended, harmful consequences. Under current law, the only way to purchase these drugs with these account funds is to have a physician write a prescription for the item, thereby triggering additional but unnecessary health care costs to the consumer.

Lawmakers have already introduced legislation to address this matter. The Restoring Access to Medication Act, bipartisan legislation sponsored in the House (H.R. 2529) by Ways and Means committee members Lynn Jenkins (R-KS) and Shelley Berkley (D-NV), would simply repeal Section 9003 of PPACA and restore individuals' ability to use tax-advantaged account funds to pay for OTC medications without a prescription. Identical bipartisan legislation has also been introduced in the Senate (S. 1368) by Finance Committee member Pat Roberts (R-KS) and Senator Ben Nelson (D-NE).

Similarly, the Patients' Freedom to Choose Act has been introduced in the House (H.R. 605) by Representative Erik Paulsen (R-MN) and in the Senate (S. 312) by Senator Kay Bailey Hutchison (R-TX). This measure also repeals the prescription requirement while also repealing the $2,500 cap on FSA contributions.

In his statement opening the hearing, Subcommittee Chairman Charles Boustany (R-LA) — a practicing physician — asserted that the hearing was not intended to be a broad debate of the health care law, but rather to examine this one specific provision, though he noted that "too often in Washington, officials make decisions about health care policy based on abstract theories and budgetary scores."

Speaking for the subcommittee Democrats, Representative Xavier Becerra (D-CA) noted that the PPACA policy was originally proposed by the Joint Committee on Taxation in 2005 as a means of improving tax compliance and added that many Republican and Democratic policymakers have suggested deleting all targeted tax preferences — like the FSA preference — as part of comprehensive tax reform.

The committee heard testimony from health care providers, retailers and policy experts on this topic:

- Scott M. Melville, president and CEO of the Consumer Healthcare Products Association, spoke from the perspective of manufacturers and distributors of OTC drugs, arguing that OTC medications are an essential element of personal health care and effectively reduce aggregate health care costs. He expressed support for H.R. 2529 and H.R. 605 as a means of repealing the current restriction.
- Dr. Joel M. Feder, representing the American Osteopathic Association, shared his personal experience of how the current tax policy has affected his practice. He described the restriction as "counterintuitive to the concepts of enhancing access to health care and promoting patient-centered care" and discussed how it places a burden on physicians and patients and subjects physicians to new liability concerns.
- Steven Taylor, CEO of Sjogren's Syndrome Foundation (an advocacy group for sufferers of a common auto-immune disease), explained how OTC medications can help alleviate some of the secondary symptoms associated with Sjogren's Syndrome. He said that the current policy harms Sjogren's patients and pointed out that patients with diabetes are

able to include medically-necessary OTC products for their disease in their Health Savings Plans without having to first obtain a prescription.

- Jennifer Hatcher, senior vice president of government and public affairs at the Food Marketing Institute (an advocacy group representing represents supermarket retailers and wholesalers), argued that the restrictions on FSA OTC purchases create a real burden for consumers and the retail community, and they will significantly diminish retailers' investments in the eligible product database required under prior IRS regulations.
- Paul N. Van de Water, senior fellow at the Center on Budget and Policy Priorities, defended the current policy as an essential funding mechanism for PPACA. He cited research indicating that the prior system was inefficient and unfairly benefitted higher-income individuals — a charge later echoed by Becerra and the subcommittee's ranking Democrat, John Lewis (D-GA).

H.R. 2529 and S. 1368, though they both enjoy bipartisan support, and H.R. 605 and S. 312 come at a significant federal revenue cost and therefore are unlikely to receive serious consideration in the House and Senate — particularly in the current budget deficit environment — unless paired with a revenue source.

Aging Committee Examines Long-Term Care

On April 18, the Senate Special Aging Committee held a hearing, The Future of Long-Term Care: Saving Money by Serving Seniors, to discuss the need, risks and costs of long-term care insurance.

In a news release announcing the hearing, Committee Chairman Herb Kohl (D-WI) cited the growing cost of long-term care, citing data indicating that more than 14 percent of personal health care service expenditures in 2009 was spent on long-term care, the bulk of which was subsidized by taxpayers through the Medicare and Medicaid programs. “The cost of long-term [care] services … are already massive for both taxpayers and families. Left unchecked, this burden will continue to grow as our rapidly aging population requires more long-term care,” Kohl said. “

In his opening statement, Kohl also noted the challenge of coordinating private and public coverage. “While our two largest publicly-financed health care programs, Medicaid and Medicare, currently pay for the bulk of long-term care, they are limited in scope. And, private long-term care insurance has the potential to play a larger role, but the market is facing challenges, and some consumers have been skeptical that purchasing a policy is both worth the cost and represents a secure and sound investment.”

The committee heard from a panel of experts with differing perspectives on the long-term care challenge:

- John O'Brien, director of healthcare and insurance at the U.S. Office of Personnel Management, recounted the 10-year history of the Federal Long-Term Care Insurance Program, the largest private long-term care insurance program in the nation. While he described progress in improving enrollment and benefits levels, he cautioned that “the long-term care insurance market is still relatively young and uncertain.”
- Loren Colman, assistant commissioner for the Minnesota Department of Human Services, which has established a model long-term care program, credited the state’s

success to the consolidation and coordination of services and of the state agencies that oversee them. In particular, he noted that the effort to move seniors from institutional and nursing home care to home and community based care has demonstrated lower costs and improved quality. He also mentioned that the state has been engaged in targeted outreach to the employer community in Minnesota.

- Judy Feder, professor of public policy and former dean of the Georgetown University Public Policy Institute, focused on the challenges of rising costs, particularly as they affect the Medicare program. She described research indicating that "it is the high cost associated with [Medicare] enrollees with the combination of chronic illness and functional limitations – and not the cost of those with multiple chronic conditions alone – that drives the disproportionate share of Medicare spending associated with enrollees with multiple chronic conditions" and suggested that programs should target at this population.
- Bruce Chernof, president and CEO of SCAN Foundation (an independent foundation focused on developing innovative health care solutions for California seniors), described Medicaid's role as the nation's long-term care safety net and discussed existing delivery system and financing opportunities that could improve the efficiency of care. "Current laws and federal regulations already exist that allow for states to upgrade their operations and administrative structures to create more integrated, beneficiary-protected, and efficient care," he said, but "policy options are needed to ensure that there is not a growing disparity among states to absorb these costs through already constrained resources, those same resources that face potential cuts as part of a larger entitlement reform discussion."
- Douglas Holtz-Eakin, president of the American Action Forum (and former chief economist for the Council of Economic Advisors and director of the Congressional Budget Office), suggested that "an enormous effort should be placed on enhancing the private sector financing of these services," since doing so would both reduce pressure on Medicare and the federal budget and encourage individuals to save or "pre-fund" for long-term care needs.

During the question-and-answer portion of the hearing, the committee's ranking Republican Senator Bob Corker (R-TN) asked how private long-term care insurers were managing the cost challenge. Holtz-Eakin described the landscape as a mixed bag, with some successes and some failures, but suggested that increasing sponsorship and participation would lower costs by pooling risk.

Holtz-Eakin went on to suggest other possible innovative strategies that could be deployed, such as products that combine annuities with long-term care insurance or "automatic" programs in which workers would be enrolled in long-term insurance programs unless they formally opt out.

Feder countered that the private long-term insurance market is small and unpredictable (particularly with regard to premium increases) and emphasized an approach that shores up Medicare and Medicaid.

The hearing was designed to be informational and no legislative action is imminent.

Tax Committee Approves PPACA Subsidy Recapture Measure

In an April 18 "mark-up" session, the House of Representatives Ways and Means Committee approved legislation to recapture overpayments resulting from certain federally-subsidized health insurance. The measure, which is estimated to raise $43.9 billion in federal revenue over ten years, would fulfill a portion of the House budget resolution's directive to the committee to reduce the deficit by $1.2 billion for fiscal years 2012 and 2013, by $23 billion for fiscal years 2012 through 2017 and by $53 billion for fiscal years 2012 through 2022.

Under Section 1401(36B) of the Patient Protection and Affordable Care Act (PPACA) a refundable tax credit is available to eligible individuals and families who purchase health insurance through a state health insurance exchange. Eligibility for the credit is extended to individuals (single or joint filers) with household incomes between 100 and 400 percent of the federal poverty level (with phase-outs as income increases) and who do not receive "affordable" health insurance through an employer or a spouse's employer.

Currently, if an individual receives the tax credit but experiences an increase in income or becomes eligible for affordable employer-sponsored insurance coverage, they can still keep a portion of the credit. (The amount of the subsidy that is subject to recapture was previously modified through enactment of the Small Business Paperwork Mandate Elimination Act (H.R. 4), which related to certain information reporting requirements under PPACA.) The committee-approved measure would repeal the present-law provision under which, in the case of an individual with household income below 400 percent of the federal poverty level, liability for an overpayment resulting from excess advance payments is limited to the applicable dollar amount. Thus, under the proposal, an individual would be liable for the full amount of the overpayment. A Joint Committee on Taxation summary of the measure is available.

Given that the House budget resolution was not approved in the Senate, the measure is unlikely to be enacted this year. However, considering the amount of federal revenue it is calculated to raise, it can be expected to be considered again in future deficit reduction or revenue offset purposes.

RECENT REGULATORY ACTIVITY

IRS Issues PPACA Guidance Seeking Comments on Minimum Value for Employer Plans, Reporting Requirements

On April 26, the Internal Revenue Service (IRS) issued several notices providing guidance on various elements of the Patient Protection and Affordable Care Act (PPACA).

Notice 2012-31 describes three possible approaches to determining whether health coverage under an eligible employer-sponsored plan provides the necessary "minimum value" as defined under PPACA. Beginning in 2014, eligible individuals who purchase coverage under a qualified health plan through a state Affordable Insurance Exchange may receive a premium tax credit *unless* they are eligible for other minimum essential coverage, including coverage under an employer-sponsored plan that is affordable to the employee and provides "minimum value." Under the Internal Revenue Code, as amended by PPACA, a plan fails to provide minimum value if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs." An applicable large employer may be liable for an assessable payment under PPACA Section 4980H if any full-time employee receives a premium tax credit.

The U.S. Treasury Department and IRS intend to issue proposed regulations on determining "minimum value" and are considering incorporating the approach described in this notice. The anticipated guidance would permit employer-sponsored plan to use one of the following alternative approaches for determining whether it provides "minimum value":

- an actuarial value calculator (AV calculator) or a minimum value calculator (MV calculator), to be made available by the U.S. Departments of Health and Human Services (HHS) and Treasury (The calculator would permit an employer-sponsored plan to enter information about the plan's benefits, covered services, and cost sharing information to determine whether the plan provides minimum value. The data underlying the MV calculator are expected to be claims data reflecting typical self-insured employer plans);
- an array of design-based safe harbors in the form of checklists; or
- (for plans with nonstandard features that preclude the use of the AV calculator or the MV calculator,) an appropriate certification by a certified actuary (for plans with nonstandard features), in accordance with prescribed continuance tables, recognized actuarial standards, and other conditions that may be prescribed in administrative guidance, that the plan provides minimum value.

Notice 2012-31 requests comments related to these approaches by June 11, with specific feedback requested on four specific questions listed on pages 15-16 of the notice.

IRS also issued guidance on related reporting requirements under PPACA.

Notice 2012-32 requests comments on reporting requirements under tax code Section 6055 for health insurance issuers, government agencies, employers that sponsor self-insured plans, and other persons who provide minimum essential coverage to an individual. Notice 2012-32 states that Treasury and IRS plan to propose regulations implementing the reporting requirements and to include guidance that is "intended to minimize administrative burden and duplicative reporting."

Tax code Section 6055(a), as amended by PPACA, requires every entity that provides minimum essential coverage (including health insurance issuers and sponsors of a self-insured health plan) to file annual returns reporting specific information for each individual for whom minimum essential coverage is provided. If health insurance coverage is provided by a health insurance issuer and consists of coverage provided through a group health plan of an employer, it is anticipated that the regulations would make the health insurance issuer responsible for the reporting. The reporting requirements apply to coverage provided on or after January 1, 2014. The first information returns will be filed in 2015.

In addition, tax code Section 6056, as amended by PPACA, directs every applicable large employer that is required to meet the shared employer responsibility requirements of PPACA Section 4980H during a calendar year to file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees during the year. The return is also required to include and certify detailed and specific information on the employer's full-time employees, including those who received the coverage and when they received it. Section 6056(d) permits the Secretary to provide, to the maximum extent feasible, that any return or statement required under Section 6056 may be provided as part of a return or statement under Section 6055 or Section 6051 (relating to reporting by employers on the Form W-2) and that an applicable large employer offering coverage of an issuer may agree with the

issuer to include information under section 6056 with the return and statement provided by the issuer under Section 6055.

To assist in the development of regulations, Notice 2012-32 requests comments, due by June 11, on issues arising under Section 6055, including seven specific topics listed on pages 3-5 of the notice.

Notice 2012-33 requests comments, also due by June 11, on issues arising under section 6056 that would be helpful for the regulations to cover, including how to coordinate and minimize duplication between the data employers must report under Section 6056 and the data they must report under Section 6055 or other applicable tax code or PPACA provisions.

HHS Issues Bulletin Requesting Comment on Proposed Guidance for Verification of Access to Employer Coverage

On April 26, the U.S. Department of Health and Human Services (HHS) issued the bulletin **Verification of Access to Employer-Sponsored Coverage**, which requests public comment on a proposed interim strategy and regulatory approach for verification of access to qualifying coverage under PPACA with respect to an individual's eligibility for advance payments of the premium tax credit through an state Affordable Insurance Exchange. The bulletin provides background information and an overview of the relevant legal provisions as well as a discussion of stakeholder considerations.

HHS is seeking comment on a proposed interim strategy for verification related to coverage during the first two years of exchange operations (the 2014 and 2015 plan years). First, HHS proposes to provide a standardized way for employees and employers to voluntarily collect and communicate employer-sponsored coverage information needed to complete an exchange application. Second, HHS proposes to allow exchanges to verify employer-sponsored coverage for this interim period through use of limited pre-enrollment verification based on data sources available to an exchange and a post-enrollment verification screening process where data sources are not available during the eligibility determination process. When pre-enrollment verification is possible, this is the preferred approach. For this reason, the interim strategy is subject to change as exchanges gain access to data sources that might allow more pre-enrollment verification.

The bulletin also describes considerations and requests comment on long-term strategies for verification related to coverage during plan year 2016 and beyond. The bulletin notes that HHS is looking for ways to foster the identification and/or development of data sources that would facilitate real-time verification of access to employer-sponsored coverage information during the enrollment process. HHS seeks comment from employers and other stakeholders on data sources so as to minimize the need for employers to respond to requests from employees or exchanges for information. There is particular interest in leveraging any data accumulated through other reporting requirements. HHS and the U.S. departments of Labor and Treasury are collectively considering a number of existing reporting mechanisms to identify opportunities for streamlining, with the goal of minimizing the burden on employers. The bulletin does not include a comment deadline.

IRS Proposes Regulations For PCORI Fee

On April 12, the Internal Revenue Service (IRS) published proposed regulations to implement and provide guidance on fees to fund the Patient-Centered Outcomes Research Institute (PCORI). As established under the Patient Protection and Accountable Care Act of 2010 (PPACA), the PCORI will conduct research to evaluate and compare the clinical effectiveness, risks and benefits of medical treatments, services, procedures, drugs or other items or strategies that treat, manage, diagnose or prevent illness or injury.

The PCORI will be funded through fees paid by issuers of certain health insurance policies and plan sponsors of certain self-insured health plans. The fee is imposed on issuers of health insurance policies for each policy year ending on or after October 1, 2012, and before October 1, 2019 and plan sponsors of applicable self-insured health plans for each plan year ending on or after October 1, 2012, and before October 1, 2019. The fee is two dollars (one dollar in the case of policy years ending before October 1, 2013) multiplied by "the average number of lives covered under the policy." For policy years ending on or after October 1, 2014, the fee is increased based on increases in the projected per capita amount of National Health Expenditures.

On June 8, 2011, the IRS issued Notice 2011-35 requesting comments on how the fee should be calculated and paid, including possible rules and safe harbors.. The preamble to the April 12 proposed regulations discusses those and other comments submitted to the IRS.

Generally, the proposed regulations provide guidance on which policies, plans and plan sponsors are subject to the fee; how the fee is to be calculated; rules for depositing, paying, and return filing certain excise taxes, including electronic filing of returns; and third-party reporting and payments. The proposed regulations specifically clarify that:

- Plan sponsors are provided three alternative methods for determining "the average number of lives covered under the plan for the plan year", including an actual count method, a "snapshot" method; and a Form 5500 method (examples of each method are provided in the guidance);
- Plan sponsors are not required to use the same calculation method from one plan year to the next;
- A "special rule" is provided for the first year the fee is in effect that permits plan sponsors to use any reasonable method for determining "average number of covered lives;"
- An Employee Assistance Plan (EAP), disease management program or wellness program is not subject to the fee if the program "does not provide significant benefits in the nature of medical care or treatment";
- Expatriate plans are not subject to the fee;
- Retiree-only plans are subject to the fee;
- HSAs are not subject to the fee, however under certain circumstances, HRAs and FSAs may be subject to the fee (a group health plan used with such arrangements is subject to the fee);
- Issuers and plan sponsors are required to report and pay the fees only once a year on Form 720, which may be filed electronically and is due by July 31 of each year; and
- The IRS will not be a third-party reporting and payment regime because the costs of establishing such a program would outweigh the benefits given the limited period over which the fee will apply.

According to the preamble, the regulations are proposed to apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019. The preamble further states that issuers and plan sponsors may rely on these proposed regulations for guidance pending the issuance of final regulations. Final regulations are effective as of April 17, 2012, the proposed regulations' publication date. The preamble also states that "if and to the extent future guidance is more restrictive than the guidance in these proposed regulations, the future guidance will be applied without retroactive effect."

Recent PPACA Final Regulations Address Reinsurance Assessment

Final regulations regarding reinsurance, risk corridor and risk adjustment standards under the Patient Protection and Affordable Care Act (PPACA), issued by the U.S. Department of Health and Human Services (HHS) on March 23, provides guidance on the implementation of a new assessment to fund a transitional reinsurance program and its impact on insured and self-insured group health plans.

Section 1341 of PPACA provides that each state must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years the state health insurance exchanges are operational (2014 through 2016). Under the statute, the program is to be funded through "contribution funds from contributing entities," meaning a reinsurance assessment (RA) on health insurance issuers and third party administrators on behalf of self-insured group health plans. The final regulations address the timing, method and other aspects of the RA as it applies to these plans.

- *Timing*: The final regulations clarify that the RA is determined on a national basis, rather than a state-level basis, and announced by HHS for each given "benefit year". While the statute and the proposed regulations were unclear as to whether the RA would be measured and paid on a calendar or plan year basis, the final regulations appear to resolve this issue by defining a "benefit year" to be a calendar year.

- *Method of collection*: The proposed regulations were also unclear as to whether the RA payable by a health insurance issuer or third-party administrator (TPA) would be measured as a percent of premium (or deemed premium, in the case of self-funded plans) or on a per-covered-life basis. The final regulations clarify that the RA applies on a per-covered-life basis, which HHS believes will allow for easier administration of the RA and enable compliance by covered entities. The final rule also makes clear that the RA is to be collected on a quarterly basis beginning on January 15, 2014. For self-insured plans, the RA will be collected by HHS. HHS will also collect the RA from insured plans unless individual states indicate that they want to collect the RA with respect to the insured coverage.

- *Liability for the RA*: With respect to whether the TPA or the plan is financially liable for the RA, the final rule does not appear to address the question. The regulations merely set forth those plans that do not give rise to an RA in the first instance, such as a plan providing only HIPAA-excepted benefits. The preamble to the final regulations restates the language of the statute: PPACA "requires that health insurance issuers and third-party administrators on behalf of group health plans make contributions." Although unclear in the regulations, it appears that the third party administrator is responsible for payment of the RA, but that the RA can nonetheless be passed on to the plan in the form of additional fees.

EEOC Final Regulations on Disparate Impact May Affect Retirement Plans

On March 30, the Equal Employment Opportunity Commission (EEOC) amended existing regulations under the Age Discrimination in Employment Act (ADEA) to address "disparate-impact" legal claims and the reasonable factors other than age (RFOA) defense. "Disparate impact" is a methodology for establishing that an employer has engaged in discrimination against a specific group of employees or job applicants of the same race, ethnicity, religion or sex that does not require evidence that the employer intended to discriminate. The revised EEOC regulations took effect on April 30, 2012.

The U.S. Supreme Court, in its 2008 decision in Smith v. City of Jackson, ruled that disparate-impact claims are susceptible to the jurisdiction of a court under ADEA but that liability is precluded when the impact is attributable to a "reasonable factor other than age." EEOC subsequently proposed regulations codifying this ruling, stating that an employment practice that has an adverse impact on individuals within the protected age group on the basis of older age is discriminatory unless the practice is justified by a "reasonable factor other than age" and that the individual challenging the allegedly unlawful employment practice bears the burden of isolating and identifying the specific employment practice responsible for the adverse impact.

The final regulations retain this substantive language, though the viability of the RFOA defense will depend on the employer's ability to show that the challenged practice was objectively reasonable when viewed from the position of a "prudent employer" mindful of its responsibilities under the ADEA under like circumstances. Close analysis of the final regulations suggests that they effectively impose a more rigorous standard for application of the defense, or at the very least, create more opportunity for factual disputes and litigation.

The final regulations also provide a non-exhaustive list of considerations that may be used to help determine whether an employment practice is based on a reasonable factor other than age. Along with the final regulations, the EEOC also published the document, Questions and Answers on EEOC Final Rule on Disparate Impact and "Reasonable Factors Other Than Age" Under the Age Discrimination in Employment Act of 1967, which provides some additional guidance for interpreting the five factors listed as relevant considerations to the reasonableness of the practice.

A detailed analysis of the EEOC regulations and guidance is attached.

Tips for Fiduciaries, Fee Disclosure FAQs

On April 4, the Securities and Exchange Commission (SEC) announced that it is re-opening the comment period for proposed regulations addressing disclosure requirements for target retirement date funds (TDFs). When the regulations were first issued, the proposed rules would require that:

- Marketing materials for a target date fund that includes the target date in its name need to disclose, together with the first use of the fund's name, the asset allocation of the fund at the target date;
- Marketing materials that are in print or delivered through an electronic medium need to include a table, chart, or graph depicting the fund's glide path, together with a statement that, among other things, would highlight the fund's asset allocation at the landing point (when the fund becomes most conservative);

- Radio and television advertisements need to disclose the fund's asset allocation at the landing point;
- Marketing materials need to state that a TDF should not be selected based solely on age or retirement date, that a TDF is not a guaranteed investment, and that a TDF's stated asset allocation may be subject to change;

(The last three items above apply regardless of whether the TDF includes a target date in its name.)

The reopened comment period ends 45 days after publication in the Federal Register (expected in the next day or so), putting the deadline on or around May 21. The stated reason for re-opening the comment period is "to allow interested persons to submit comments on the results of investor testing regarding target date retirement funds." On February 15, the Siegel+Gale research firm released a report sponsored by the SEC, Investor Testing of Target Date Retirement Fund (TDF) Comprehension and Communications. The report found, among other things, that:

- Many respondents believed that the target date is the point at which the fund is at its most conservative allocation and that the allocation stops changing thereafter.
- Respondents who viewed a glide path illustration were more likely to understand that asset allocation continues after the target date
- Only 36 percent of respondents correctly indicated a target date fund does not provide guaranteed income in retirement. (This percentage was higher among those who actually own a target date fund, though still under 50 percent).

These findings are being used to support the argument that participants can be confused and even misled about TDFs as well as the recommendation that final regulations include a glide path.

The SEC proposed regulations are related to, but separate from, the U.S. Department of Labor (DOL) target date fund proposal. DOL previously issued proposed regulations regarding TDFs as qualified default investment alternatives (QDIAs). These regulations would amend the final QDIA regulations of October 2007 as well as the October 2010 final regulations addressing fee disclosure to participants in participant-directed individual account plans (such as 401(k) plans). Under the DOL proposed regulations, plans would be required to provide enhanced disclosures, including a narrative explanation and graphical illustration of how asset allocation changes over time, as well as explanation of the relevance of any date in the TDF's name. (A DOL fact sheet on the proposal is available.)

It is unclear how, if at all, the SEC's action will affect DOL's timing. While the target date disclosure project has remained on DOL's official regulatory agenda, final regulations have not yet been remitted to the Office of Management and Budget and it does not appear as though DOL is moving to finalize the regulation soon. However, Assistant Labor Secretary for the Employee Benefit Security Administration Phyllis Borzi indicated at a recent Senate Special Committee on Aging hearing that informal "tips for ERISA plan fiduciaries" on TDFs will be released soon. The DOL has also indicated that it will soon issue a Frequently Asked Questions (FAQ) document on the final participant-level and fiduciary-level fee disclosure rules.

GAO Identifies International Models for Regulating Defined Contribution Plans

The Government Accountability Office (GAO) recently released a new research paper, Defined Contribution Plans: Approaches in Other Countries Offer Beneficial Strategies in Several Areas, analyzing efforts in Australia, Chile, Sweden and the United Kingdom to address practices that could harm defined contribution plan participants. The report generally recommends that the U.S. Department of Labor consider other countries' experiences as it continues to improve its supervision and requirements related to fee disclosures.

At the request of Representative George Miller (D-CA), ranking Democrat on the U.S. House of Representatives Committee on Education and the Workforce, and Representative Rob Andrews (D-NJ), ranking Democrat on that committee's Health, Employment, Labor and Pensions Subcommittee, GAO was asked to examine other countries' defined contribution systems to determine how service providers are overseen by regulatory agencies; what key strategies are used to improve fee disclosure to participants; and what key strategies are used to reduce fees.

GAO determined that plans and service providers in the four model countries are overseen by multiple agencies — primarily a pensions regulator and a securities regulator. Among the strategies to improve governance identified by GAO were:

- Using "risk-based" oversight methods (rather than compliance-based methods), in which regulators develop a structured supervisory approach to identify potential risks faced by the defined contribution system and systematically assess the processes in place to address those risks;
- Simple and uniform disclosure statements that facilitate comparisons, including such features as a requirement that providers highlight the long-term impact of fees on participants' account balances or a statement that tells them what they would have paid had they chosen the lowest-cost option; and
- Targeted strategies, including consolidating and streamlining certain administrative services, establishing low-cost default funds and even direct regulation of fees, to keep these fees at reasonable levels.

In commenting on a draft of the report, the U.S. Department of Labor (DOL) generally agreed with the findings and said that it will consider GAO's recommendations carefully. As we have previously reported, DOL issued final regulations on defined contribution plan participant fee disclosure in October 2010, followed by final regulations on fiduciary-service provider disclosure of defined contribution plan fees under ERISA Section 408(b)(2) in February 2012.

While the future of defined contribution plans has been the subject of significant attention in the context of comprehensive tax reform, Democratic leaders, particularly in the House, continue to focus on regulation and enforcement of administrative matters such as plan fees and disclosure.

Puerto Rico Retirement Plans Update: Tax Amnesty Extended

On April 19, Puerto Rico Governor Luis Fortuño signed Act 64-2012, which provides for an extension of a statutory tax amnesty program until June 15, 2012. (The original expiration date had been February 29, 2012.) This amnesty program, enacted as part of the Act for the Strengthening of the Public Safety and Health (Act 218-2011), provides for the waiver of the payment of interest, penalties, surcharges and any other additions to the tax with respect to,

among others, income tax liabilities (including withholding taxes) under the former Puerto Rico Internal Revenue Code of 1994 (1994 Code).

Although generally intended for the payment of Puerto Rico income taxes due by individuals and corporations, the Tax Amnesty Program is also available to Puerto Rico qualified retirement plans — both Puerto Rico-only qualified plans and dual-qualified plans (i.e., plans qualified both in Puerto Rico and the United States) — that may have failed to comply with the 1994 PR Code's tax withholding and reporting requirements on distributions to participants in Puerto Rico. A closing agreement must be negotiated and executed between the Puerto Rico Treasury Department and the sponsor of the Puerto Rico qualified plan in order to participate in the Tax Amnesty Program.

A detailed summary of the amnesty program and extension, and associated retirement plan sponsor requirements, is attached courtesy of Groom Law Group.

Also attached is a memo describing Circular Letter No. 11-10, provided courtesy of Groom Law Group. CL 11-10 describes the recent Puerto Rico Treasury guidance for qualification of retirement plans under the Puerto Rico Internal Revenue Code of 2011 and also provides relief for the retroactive qualification of retirement plans under the 1994 PR Code.

Subsequent to the issuance of CL 11-10, the Puerto Rico Treasury issued Circular Letter No. 12-02, giving the option to certain trusts funding Puerto Rico qualified retirement plans (including dual-qualified plans) to file a copy of a plan's Form 5500, Annual Return/Report of Employee Benefit Plan, or Form 5500-SF, Short Form Annual Return/Report of Small Employee Benefit Plan instead of PR Treasury Form 480.70(OE), Informative Return for Income Tax Exempt Organizations, in order to comply with the annual filling requirement imposed by the 2011 Code. This Form 5500 guidance was described in a separate Groom Law Group memo.

IRS Releases 2013 Indexed Amounts for HSAs, HDHPs

On April 27, the U.S. Treasury Department and Internal Revenue Service (IRS) released Revenue Procedure 2012-26, which lists the 2013 indexed amounts, adjusted for inflation, for health savings accounts and high-deductible health plans (HDHPs). (In some cases, this resulted in no change from the prior year.) The following table lists the current 2012 amounts and the new 2013 amounts:

	Calendar Year 2012		Calendar Year 2013	
	Self-only	Family	Self-only	Family
Annual Contribution Limit	$3,100	$6,250	$3,250	$6,450
HDHP Minimum Deductible	$1,200	$2,400	$1,250	$2,500
HDHP Out-of-Pocket Limit (includes deductibles, co-payments and other amounts but not premiums)	$6,050	$12,100	$6,250	$12,500

The Revenue Procedure is effective for calendar year 2013.

RECENT JUDICIAL ACTIVITY – Nothing To Report This Month