BENEFITS INSIDER
A Member Exclusive Publication

Volume 84, June 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 2

Defined Benefit Funding Update: Letter to Congress Supports Stabilization Measure 2
House Ways and Means Committee Approves Legislation Addressing Consumer-Directed Health Arrangements 2
House Ways and Means Majority Staff Releases Report on PPACA, Employer Coverage 4
House Subcommittee Examines Health Care Consolidation, Competition Under PPACA 5
House Subcommittee Hears Testimony on Health Care Costs 6
Senate Committees Discuss Health Care Delivery System Reforms 7
Aging Committee Discusses Older Worker Employment 10

RECENT REGULATORY ACTIVITY 11

DOL Issues New Guidance on Retirement Plan Fee Disclosure; Q&A No. 30 Presents Problem for Some Brokerage Window Arrangements 11
IRS Finalizes Regulations on PPACA Premium Tax Credit 13
DOL, EBSA Re-open Comment Period for Proposed Target Date Fund Regulations 14
DOL Releases Additional FAQs for SBCs and Corrected Templates 14
IRS Provides Transition Guidance for FSA Plan Year Limit 16
DOL Issues Advisory Opinions on Multiple Employer Plans, 403(b) Safe Harbor 17
HHS Issues New Final Regulations Supplementing PPACA Medical Loss Ratio Requirements 17
CPDP Writes CMS on Health IT "Meaningful Use" Project 18
GAO Issues New Report on 401(k) Plan Fees 19

RECENT JUDICIAL ACTIVITY 19

Supreme Court Upholds PPACA 19

RECENT LEGISLATIVE ACTIVITY

Defined Benefit Funding Update: Pension Coalition Letter to Congress Supports Stabilization Measure

Beginning on May 8, conferees from the U.S. Senate and House of Representatives began negotiations to resolve the differences between two versions of transportation funding measures. The Senate-passed bill, Moving Ahead for Progress in the 21st Century (MAP-21) Act (S. 1813), includes an important provision to stabilize interest rates for purposes of calculating defined benefit plan funding. The House version of the measure (H.R. 4348), does not include the interest rate stabilization provision.

In related discussions about pension funding policy, some House offices have expressed concern that addressing the funding obligation "input" (i.e., by regulating interest rates) would not accurately reflect liabilities, and therefore stabilizing the "output" (by capping increases or decreases in funding obligations) would be more appropriate. The American Academy of Actuaries Pension Practice Council advanced this view in a letter to the conferees suggesting that pension funding stability would be better accomplished better by smoothing outputs rather than inputs.

A number of associations and companies joined together under the umbrella of the Pension Coalition. The coalition has prepared a letter to Congress expressly supporting the funding stabilization measure. The letter also urges lawmakers to avoid imposing new Pension Benefit Guaranty Corporation (PBGC) insurance premium increases on plan sponsors along with (or separate from) interest rate stabilization language. As it has for many months, the PBGC continues to pursue increases in these premiums as well as unilateral authority to determine premium levels.

The likelihood of agreement on transportation funding legislation is very much unclear at this time. Even if the pension issues are not resolved as part of a transportation bill, however, these matters can be expected to arise as part of any legislative proposal requiring a federal revenue offset, since both funding reform and PBGC premiums are considered "revenue raisers."

House Ways and Means Committee Approves Legislation Addressing Consumer-Directed Health Arrangements

On May 31, the U.S. House of Representatives Ways and Means Committee approved a package of bills designed to expand and ease sponsorship of consumer-directed health arrangements such as health savings accounts (HSAs) and flexible spending arrangements (FSAs).

In a statement opening the mark-up session, Committee Chairman Dave Camp (R-MI) noted that 13.5 million Americans were enrolled in HSAs in 2011 and these arrangements have become an increasingly attractive option for consumers, and therefore necessitate increased flexibility.

The committee's ranking member, Representative Sander Levin (D-MI), cited two fundamental questions raised by the measures at hand: (1) how the committee (and Congress as a whole) would offset the significant federal revenue costs incurred by the legislation and (2) whether

these measures represent the best use of federal spending in the face of fiscal austerity. The lack of specific revenue offsets included in the legislation was a persistent subject of discussion, mostly by Democrats, throughout the markup session.

During the session, the committee approved the following specific measures:

- H.R. 5858, an untitled bill "to improve health savings accounts," was approved by a vote of 21 to 7. H.R. 5858 makes a number of modest improvements to HSAs, such as (1) permitting veterans who receive medical benefits for a service-connected disability under a program of the Department of Veterans Affairs to be eligible to contribute to an HSA; (2) allowing distributions from HSAs to be used by retirees between the ages of 55 and 65 to pay for retiree health insurance under an employer-sponsored health plan; (3) allowing spouses who are at least 55 years old to contribute their combined "catch-up" contribution to one HSA; and (4) providing a 60-day window after an individual's high deductible health plan coverage begins for an HSA to be established and used to pay for qualified medical expenses within that 60-day period. This measure has a federal revenue cost of $4.7 billion over ten years. A Joint Committee on Taxation summary of the measure is also available.

- The Restoring Access to Medication Act (H.R. 5842) was approved by a vote of 24 to 9. H.R. 5842 repeals the current disqualification of over-the-counter (OTC) drugs as eligible purchases through HSAs and FSAs. In 2010, 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. H.R. 5842 is a different bill than the Restoring Access to Medication Act (H.R. 2529), which would achieve the same purpose through repeal of the relevant PPACA section. A companion bill to H.R. 2529 (S. 1368) has been introduced in the Senate. This measure has a federal revenue cost of just over $4 billion over ten years.

  On April 25, the Ways and Means Subcommittee on Oversight held a hearing on limitations on the purchase of over-the-counter (OTC) medication with accounts like HSAs and FSAs. Employer, consumer and provider groups have expressed concern that the current OTC exclusion has effectively forced physicians to write more prescriptions, increasing costs and wait times within the health care system.

  The Medical Flexible Spending Account Improvement Act (H.R. 1004), a measure to modify the "use-it-or-lose-it" element of FSAs, was approved by a vote of 23 to 6. Specifically, H.R. 1004 would allow participants to cash out up to $500 of any remaining FSA balances at the end of the FSA plan year (including any grace period allowed by the plan), with those funds treated as ordinary, taxable wages. The FSA measure approved by the Ways and Means Committee has a federal revenue cost of just over $4 billion over ten years.

- The Protect Medical Innovation Act (H.R. 436), a measure to repeal the excise tax on medical devices, was approved by a vote of 23 to 11. This measure has a federal revenue cost of just over $4 billion over ten years.

On May 31, the Consumer-Directed Health Coalition, sent a letter to the leadership of the Ways and Means Committee supporting both H.R. 5858 and H.R. 5842. The letter cites the increasing popularity of HSAs, FSAs and Health Reimbursement Accounts (HRAs) and their ability to help

control health care spending and costs. “We urge the Committee to support these and other improvements to consumer directed health products to ensure they may be available in the future.”

H.R. 5842, H.R. 1004 and H.R. 436 were subsequently combined and approved by the full House of Representatives on June 7. See next month’s *Benefits Insider* for details.

This package, along with H.R. 5858, will effectively serve as a core component of Republican health care policy proposals and could see further consideration when Congress takes up comprehensive tax reform next year. Though less likely, it is possible these measures could be considered during a post-election “lame duck” session when Congress will have to confront numerous tax and spending measures before the end of 2012.

House Ways and Means Majority Staff Releases Report on PPACA, Employer Coverage

On May 1, the majority Republican staff of the U.S. House of Representatives Ways and Means Committee released a report, **Broken Promise: Why ObamaCare Will Force Americans to Lose the Health Care Coverage they Have and Like**, surveying 71 of the Fortune 100 companies on the probable cost impact of the Patient Protection and Affordable Care Act (PPACA).

The report's key finding is that the 71 companies surveyed could collectively save an estimated $28.6 billion in 2014 alone (and $422.4 billion from 2014 to 2023) by eliminating health insurance coverage for their more than 5.9 million U.S. employees and instead paying the $2,000 (in 2014) per full-time employee fine" under the PPACA. Individually, these major employers could save an average of $402.3 million in 2014 alone (and $5.9 billion from 2014 to 2023). The GOP Ways & Means Committee report states: "The Democrats' health care law contains a number of policies that create perverse financial incentives for employers to stop offering health insurance to their employees, perhaps none more so than the employer mandate," the report says.

While the report describes the cost savings that would result from dropping coverage, it does not assert the likelihood of these companies to do so, nor does it address various ancillary matters that would provide context for such a decision. For example, the Congressional Budget Office (CBO) has consistently assumed in its official estimates that most employers would be compelled to increase wages or other compensation, plus pay a penalty, if they chose not to provide health coverage. While this assumption may or may not be correct, it is not addressed by the Ways and Means report or figured in its calculations. In fact, as the Ways and Means report makes clear, these employers were not asked if they were likely to drop health coverage or the circumstances under which they might do so.

If and when PPACA is fully implemented, employers will most likely evaluate whether or not to maintain coverage, based on many factors, including:

- the composition of their workforce and their employees' eligibility for subsidies for coverage obtained in a health insurance exchange,
- the viability of the state health insurance exchanges as an alternative venue to obtain coverage
- the actions of their competitors

- potential increases or decreases in the size of the penalty imposed on employers who do not sponsor coverage
- employee preferences for the source of their health coverage and
- the overall burden of compliance with the law's many administrative requirements.

The Ways and Means report is unlikely to influence legislative policy at this point and primarily represents the ongoing Republican scrutiny of PPACA that is expected to continue through the 2012 election.

House Subcommittee Examines Health Care Consolidation, Competition under PPACA

On May 18, the U.S. House of Representatives Judiciary Committee's Intellectual Property, Competition and the Internet Subcommittee held a hearing, Health Care Consolidation and Competition after PPACA, to examine whether the Patient Protection and Affordable Care Act (PPACA) is reducing or improving competition in the health care market and how it is affecting overall costs.

In an opening statement, full committee Chairman Lamar Smith (R-TX) attacked the health care law on philosophical and policy grounds, arguing that "the Administration's regulatory approach reduces competition and leads to higher medical costs and lower quality care." He asserted that regulations issued under PPACA will stifle the ability of smaller, more innovative insurance companies and medical practices to offer innovative business models that might improve on current practices. In turn, he suggested, these small businesses will go out of business or consolidate into larger businesses, reducing competition.

In response, the full committee's ranking Democratic member, John Conyers (D-MI), defended PPACA as an important tool for expanding coverage and thereby broadening the market.

The committee heard testimony from the following academic experts:

- Dr. Scott Gottlieb, a clinical assistant professor at New York University and a resident fellow at the American Enterprise Institute, told the committee that PPACA is hastening medical practice consolidation by shifting financial risk onto providers in a bid to move away from the fee-for-service reimbursement model. As an example, he cited the establishment of Accountable Care Organizations (ACOs) which permit groups of health care providers to join in a shared accountability Medicare program.

- Edmund F. Haislmaier, a senior research fellow at the Heritage Foundation's Center for Health Policy Studies, enumerated the PPACA provisions and consequences that he said would reduce competition over time, such as standardization of coverage, widespread cost increases, minimum loss ratio requirements, insurance market consolidation and federal rate review.

- Thomas L. Greaney, Chester A. Myers Professor of Law and co-director of the Center for Health Law Studies at Saint Louis University School of Law, said that PPACA actually "encourages procompetitive consolidations through payment reforms and incentives to form efficient delivery systems such as [ACOs]." He blamed hospital market concentration on "merger waves" over the last twenty years, facilitated by erroneous

court decisions and lax antitrust enforcement and exacerbated by government policies limiting entry and competition.

The subcommittee had to adjourn before proceeding to questions and answers.

House Subcommittee Hears Testimony on Health Care Costs

On May 31, the U.S. House of Representatives Education and the Workforce Committee's Health, Employment, Labor and Pensions (HELP) Subcommittee held a hearing, Barriers to Lower Health Care Costs for Workers and Employers, to discuss the continually rising cost of health care.

A media advisory issued by Subcommittee Chairman Phil Roe (R-TN) announcing the hearing referred to a Kaiser Family Foundation study, which revealed the average annual premium for a family health care plan increased by 9 percent in 2011 and now exceeds $15,000, and a PricewaterhouseCoopers (PwC) survey estimating that employer health care costs will rise by 8.5 percent this year (though a more recent PwC survey indicates that spending "is expected to grow at a historically low rate of 7.5 percent" in 2013).

In his opening statement, Roe suggested that increasing flexibility for employers – particularly with regard to the establishment and administration of consumer-directed health care vehicles such as health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending arrangements (FSAs). "Consumer-directed health plans offer commonsense options to help millions of individuals secure a benefit plan that meets their health care needs at an affordable price. Unfortunately, recent policy changes threaten the success of these important plans," Roe said, alluding to the Patient Protection and Affordable Care Act (PPACA). He commended the House Ways and Means Committee for its consideration of HSA improvement legislation that same day.

The subcommittee heard testimony from a number of employer plan sponsors and health care benefit consultants on their experiences with health care costs:

- Ed Fensholt, senior vice president and director of Compliance Services for Lockton Benefit Group, acknowledged that "federal regulators are making a strong effort to listen to the employer community, to understand the concerns of employers, and to endeavor to balance the needs of employers with the needs of those individuals the PPACA was intended to benefit," but nevertheless, "PPACA has, to this date, bent the health insurance cost curve north, not south." He identified employer coverage mandates, assorted taxes and fees and administrative burdens as threats to continued health care plan sponsorship.

- Roy Ramthun, president of HSA Consulting Services, asserted that "account-based" health plans (such as HSAs) have helped slow the decline in employer plan sponsorship and can continue to help slow cost increases, though he expressed uncertainty "that even account-based health plans can overcome the new employer responsibilities and costs of complying with the Patient Protection and Affordable Care Act."

- Jody Hall, owner and proprietor of Cupcake Royale and Verite Coffee and member of a local network of small, independent businesses, described her personal challenges in managing the costs of health plan sponsorship. She voiced strong support for PPACA –

and the state health insurance exchanges, in particular – which she said would help "break down the barriers to lower health care costs and finally level the playing field for small businesses."

- Bill Streitberger, vice president of Human Resources for Red Robin International, said that "the rising costs of running our business, including significant and escalating health care costs, make the prospects for continued profitability, job creation and contributions to our communities increasingly difficult," and cited coverage mandates as a particular cost concern.

During the question-and-answer period of the hearing, much of the discussion centered on the elements of PPACA that may be increasing costs for employers. Fensholt suggested that recent claims data and client surveys show a clear correlation between enactment of PPACA and cost and premium increases, and said that additional regulations and notice requirements are also driving up costs for employers, resulting is costs being passed along to employees.

The subcommittee's ranking Democrat, Representative Rob Andrews (D-NJ) and Representative Scott DesJarlais (R-TN) engaged in a dialogue on whether the PPACA health insurance exchanges constitute a "government-run" plan, with DesJarlais arguing that it does – and creates a situation where individuals will lose existing employer-sponsored coverage.

Fensholt noted that providing health care coverage is also part of attracting a talented workforce. He said that employers closely monitor what their competitors are doing and will be reluctant to drop health coverage until their competitors do.

In response to questions about post-PPACA efforts to control costs, Streitberger said that cost-control is more difficult now but tort reform could still be effective. Hall reiterated her support of PPACA but recommended improvement of the small business tax credit.

With regard to HSAs and their current treatment under the law, Ramthun told the panel that these plans are not well understood and PPACA has made it more difficult for employers to use them.

House committees are likely to continue their scrutiny of PPACA throughout the remainder of the congressional session and up to the election.

Senate Committees Discuss Health Care Delivery System Reforms

On May 16, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing, Identifying Opportunities for Health Care Delivery System Reform: Lessons from the Front Line, to examine private sector innovators in health care delivery in the wake of the Patient Protection and Affordable Care Act (PPACA).

Senator Sheldon Whitehouse (D-RI), acting as chairman for Sen. Tom Harkin (D-IA), opened the hearing by identifying five key priorities for achieving delivery system reform that will reduce costs and improve quality outcomes: (1) payment reform, (2) access to primary and preventive care, (3) accurate measurement and reporting of quality performance, (4) administrative simplification and (5) use of health information technology.

Whitehouse expressed support for efforts to move away from the standard fee-for-service model and toward realigning incentives to focus on the quality of services rather than the quantity of services. He cited a number of provisions in PPACA that encouraged this evolution, including development of Accountable Care Organizations within the Medicare Shared Savings Program and the Comprehensive Primary Care Initiative. In March, Whitehouse issued a report on the health care law's delivery system reforms that he said "shows that the Obama Administration has made significant progress in implementing the [delivery system reform] provisions of the Affordable Care Act, and highlights the vast potential of these reforms to improve care for patients and lower costs."

The committee heard from witnesses with experience in this area:

- Dr. Al Kurose, president and CEO of Coastal Medical, described his provider group's unique practice model and organization structure that he said allows smaller practices to join together and embrace accountability for patients. He cited federal incentive programs as instrumental in his organization's success and observed "a widespread need for practices to have access to sophisticated analytic reports regarding utilization of services and cost of different types of care for their patient populations."
- Marcia James, director of provider engagement at Humana, described the characteristics of the new health care landscape, Humana's initiatives in delivery system reform and lessons learned from private sector efforts to maximize the opportunity for system-wide improvement. Her testimony specifically mentioned the Patient-Centered Primary Care Collaborative — a coalition of more than 900 employers, consumer groups, quality organizations, hospitals and clinicians — that Humana helped found in 2008.
- James C. Capretta, a fellow at the Ethics and Public Policy Center and a visiting fellow at the American Enterprise Institute, argued that the Medicare fee-for-service program has been the primary source of inefficiency in the health care system. He also expressed skepticism that the PPACA measures would produce meaningful results in this area.

No Republican senators attended the hearing. Questions from the panel largely focused on the witnesses' specific efforts and incentives rather than broad policy choices that would involve employer plan sponsors.

The Consumer-Purchaser Disclosure Project (CPDP), a group of leading employer, consumer, and labor organizations working toward the common goal of nationwide access to publicly reported health care performance information, and recently joined on a letter urging the U.S. Department of Health and Human Services (HHS) to "set the highest possible standards for public reporting and accountability related to hospital patient safety measures." The U.S. Department of Health and Human Services Partnership for Patients initiative, a multi-stakeholder program aimed at addressing preventable injuries and complications in patient care over the next three years.

On May 23, the Senate Finance Committee held a hearing, Progress in Health Care Delivery: Innovations from the Field, to hear testimony on new developments in health care delivery system reform in the wake of the Patient Protection and Affordable Care Act (PPACA).

Committee Chairman Max Baucus (D-MT), in his introductory statement, said that the hearing would examine the ways in which delivery system innovation helps to reduce health care costs and improve health care quality. “The private sector has always been at the forefront creating

innovative ideas," Baucus said, though he noted that "the private sector cannot do it alone, nor can Medicare and Medicaid. The only path forward is through partnerships between the public and private sectors." Baucus cited the Center for Medicare and Medicaid Services (CMS) Innovation Center – which identifies, develops, supports, and evaluates innovative models of payment and care service delivery for Medicare and Medicaid– as a positive step initiated by PPACA.

The committee's ranking Republican member, Orrin Hatch (R-UT), in his opening statement, criticized PPACA in general and the CMS Innovation Center specifically, noting that the program "has an enormous budget and very little accountability." He also noted that the standard fee-for-service payment system "provides little financial incentive to manage care properly. Instead, the incentive is to increase the volume of services. Reducing costs will require that patients receive the right care, in the right place, at the right time. Increasingly, it is private payers — on behalf of employers — who pressure providers to reduce costs, providing better care and better health outcomes."

The committee heard testimony from the following private-sector health care insurer and provider representatives:

- Dr. Richard Migliori, executive vice president of health services at UnitedHealth Group, recounted his organization's efforts to increase access to high-quality, affordable care by embracing wellness and prevention programs, providing individuals with tools and transparency to make better decisions, and instituting payment reform to better align incentives with quality outcomes. "public-private collaboration on delivery system reform will produce better results for the American people," he said.

- Dr. Lee Sacks, chief medical officer for Advocate Health Care and CEO for Advocate Physician Partners (Oak Brook, IL), described his organization's Clinical Integration Program, an accountable care organization (ACO) that allows payers, patients, physicians and hospitals to collaborate on health care efforts. Such collaborations "have the ability to …drive significant improvements in health outcomes and the patient experience while also reducing costs," he said.

- Marc Malloy, president and CEO of Renaissance Medical Management Company (Wayne, PA), talked about his organization's experience as a "pioneer" ACO selected by the CMS Innovation Center. He cited three primary areas of focus for improving quality and lowering costs: prevention and wellness efforts, screening and intervention for health risk factors and coordinated, evidence-based care by a physician team.

- Paul Diaz, president and CEO of Kindred Healthcare, Inc. (Louisville, KY), discussed his organization's efforts to provide clinical integration between acute and post-acute care and between post-acute providers. He also emphasized "the need for collaboration, trust and teamwork between providers, payers, and policymakers to achieve delivery system reform," noting that the ability to achieve immediate results "will depend critically on some measure of payment stability and confidence in the short-term and incremental reform of our current payment system."

During the question-and-answer period, Baucus asked how well insurance companies are coordinating with providers. Sacks argued that alignment of payment incentives and focusing on systems of care are essential to achieving good health care value. As an example, he cited the

efforts of large employers to redesign their benefit plans in a more patient-centered way to improve overall health.

The Senate Health, Education, Labor and Pensions (HELP) Committee recently held a similar hearing, Identifying Opportunities for Health Care Delivery System Reform: Lessons from the Front Line, in which Senator Sheldon Whitehouse (D-RI) cited his March report on the health care law's delivery system reforms that he said "shows that the Obama Administration has made significant progress in implementing the [delivery system reform] provisions of the Affordable Care Act, and highlights the vast potential of these reforms to improve care for patients and lower costs."

Aging Committee Discusses Older Worker Unemployment

On May 15, the U.S. Senate Special Aging Committee held a hearing, Missed by the Recovery: Solving the Long-Term Unemployment Crisis for Older Workers, touching on employer-sponsored benefits and retirement security issues.

Committee Chairman Herbert Kohl (D-WI), in his opening statement, suggested that older workers have been hit particularly hard by the economic recession and slow recovery. He cited a new Government Accountability Office (GAO) report, Unemployed Older Workers: Many Experience Challenges Regaining Employment and Face Reduced Retirement Security, that he said found "employers are wary of hiring older workers — sometimes because they are concerned about health care costs — but other times because they assume that if you are over 55 or have been out of work your skills are not up to date."

Kohl expressed an interest in government action to encourage employers to implement phased retirement programs. Kohl's Older Worker Opportunity Act (S. 145), introduced in January 2011, would provide a tax credit to employers who offer flexible or phased work schedules and meet certain requirements. He also voiced his support for the Protecting Older Workers Against Discrimination Act (S. 2189), a bill authored by Senate Health, Education, Labor and Pensions Committee Chairman Tom Harkin (D-IA) and Senator Charles Grassley (R-IA) aimed at restoring the rights of older workers to pursue claims of age discrimination.

The committee heard testimony from the following witnesses:

- Sheila Whitelaw, an unemployed resident of Philadelphia, described her difficulties finding work as a 71-year-old woman.
- Charles Jeszeck, director of Education, Workforce and Income Security at GAO, discussed the aforementioned report, noting that "Older workers tend to be out of work longer than younger workers, threatening their retirement savings during a period of their lives when they have may have less opportunity to rebuild them. ... As such, the effects of the recent recession highlight the limitations of our current retirement security system."
- Joseph Carbone, president and CEO of The WorkPlace, described his "Platform to Employment" program, which works individually with unemployed individuals to ensure they have updated skills to thrive in today's economy.
- Diana Furchtgott-Roth, senior fellow at the Manhattan Institute, disagreed with the GAO report's implication that the problems facing older workers require targeted policies that treat older workers differently than other workers. She suggested that a broad-based job growth strategy — including a reduction in industry regulation, stabilization of tax rates

and repealing the health care law employer mandate — would help all workers, including the elderly.
- Christine Owens, executive director of the National Employment Law Project, suggested that "older workers, though less likely to become unemployed in the first instance, are overwhelmingly more likely to become long-term unemployed if they do lose their jobs" and expressed support for S. 145 and S. 2189.

The hearing's question-and-answer period focused largely on the specter of discriminatory practices against older individuals by employers. There was relatively little discussion of phased or flexible retirement practices, in which an employee who is approaching retirement age is allowed to continue working with a reduced workload, and eventually transition from full-time work to full-time retirement. Phased retirement may include a pre-retirement, gradual reduction in hours (or days) of work and/or post-retirement, part-time or seasonal work.

Neither S. 145 nor S. 2189 have yet been taken up by the committees of jurisdiction or developed in the House of Representatives as a companion measure. Legislative action before the end of the congressional session is unlikely. Increased attention to these issues, however, may prompt a renewed discussion of employer-based phased (or "flexible") retirement programs.

RECENT REGULATORY ACTIVITY

DOL Issues New Guidance on Retirement Plan Fee Disclosure; Q&A No. 30 Presents Problem for Some Brokerage Window Arrangements

On May 7, the U.S. Department of Labor issued Field Assistance Bulletin (FAB) 2012-02, providing question-and-answer guidance clarifying various elements of the final regulations for participant-level retirement plan fee disclosure. The FAB also serves as guidance under the final regulations on fiduciary-level fee disclosure under ERISA Section (408(b)(2)) to the extent that the information covered service providers are required to disclose is necessary to comply with the disclosure obligations to plan participants.

The final participant-level regulations set forth the fiduciary requirements for fee disclosure to participants in participant-directed individual account plans (such as 401(k) plans). These regulations become effective on August 30. Along with the final regulations, DOL provided a fact sheet and revised model chart for helping participants compare investment options under their plan.

The final fiduciary-level regulations require that service providers give plan fiduciaries written disclosures of certain fee and services information necessary to assist plan fiduciaries in assessing the reasonableness of compensation or fees paid by the plan, as well as the potential for conflicts of interest. These regulations become effective on July 1.

FAB 2012-02 contains 38 specific questions that cover many topics including:

- The rule's scope (including coverage of 403(b) plans);
- Disclosure of plan-related information (such as administrative expenses, including use of forfeitures);
- Treatment of brokerage windows and mutual fund platforms;
- Benchmarks (including blended and variable rate);

- Glossary requirements (including a reference to a glossary developed by the Investment Company Institute and SPARK Institute);
- Disclosure of other investment-related information (such as necessary information at Internet website addresses and other information to be provided upon request);
- The form of disclosure;
- Non-registered investment alternatives;
- Certain definitions; and
- Transitional rules.

With regard to enforcement, the guidance provides that DOL "will take into account whether covered service providers and plan administrators have acted in good faith based on a reasonable interpretation of the new regulations. If they have acted in good faith based on a reasonable interpretation of the new regulations, enforcement actions generally would be unnecessary if the covered service provider or plan administrator, as applicable, also establishes a plan for complying with the requirements of this Bulletin in future disclosures."

Most notably, however, some employers have identified a problem with DOL's latest enforcement policy regarding brokerage and mutual fund windows.

FAB 2012-02 question-and-answer No. 30 addresses whether an investment platform itself, consisting of a large number of mutual funds of multiple fund families into which participants and beneficiaries may direct the investment of assets, can be considered a "designated investment alternative" for purposes of the regulations. Designated investment alternatives are subject to fiduciary review as to whether they are appropriate investments for the plan and must meet the fee disclosure requirements previously discussed.

The FAB's answer to this question affirms that "a brokerage window or similar arrangement is not a 'designated investment alternative,'" but indicates that individual investments available under the window could become designated investment alternatives if a sufficient number of participants and beneficiaries choose to invest in them.

The answer further asserts that "If, through a brokerage window or similar arrangement, non-designated investment alternatives available under a plan are selected by significant numbers of participants and beneficiaries, an affirmative obligation arises on the part of the plan fiduciary to examine these alternatives and determine whether one or more such alternatives should be treated as designated for purposes of the regulation."

The key language in FAB 2012-12 states:

> *If, through a brokerage window or similar arrangement, non-designated investment alternatives available under a plan are selected by significant numbers of participants and beneficiaries, an affirmative obligation arises on the part of the plan fiduciary to examine these alternatives and determine whether one or more such alternatives should be treated as designated for purposes of the regulation. Pending further guidance in this area, when a platform holds more than 25 investment alternatives, the Department, as a matter of enforcement policy, will not require that all of the investment alternatives be treated, for purposes of this regulation, as designated investment alternatives if the plan administrator— (1) makes the required disclosures for at least three of the investment alternatives on the platform that collectively meet the "broad range" requirements in the ERISA 404(c) regulation […] and (2) makes the required disclosures with respect to all*

other investment alternatives on the platform in which at least five participants and beneficiaries, or, in the case of a plan with more than 500 participants and beneficiaries, at least one percent of all participants and beneficiaries, are invested on a date that is not more than 90 days preceding each annual disclosure.

In practice, to meet this "safe harbor," employers and/or service providers would be required to examine each selection within the account of each participant or beneficiary made through a brokerage window or other investment platform to determine whether the selections meet the "designated investment alternative" threshold, which would then trigger additional disclosure obligations and possibly fiduciary review.

In response, DOL representatives pointed to question-and-answer No. 37 in the FAB as providing an enforcement transition period. They indicated it was their intent to provide a one-year transition period if plan administrators have acted in good faith based on a reasonable interpretation of the new regulations, provided they have established a plan for complying with the FAB in future disclosures. However, it should be noted that the transition period is limited to DOL enforcement, subjecting plan fiduciaries to the risk of participant lawsuits. In addition, it appears plan administrators must establish a plan for complying by the effective date of the fee disclosure rules.

In a news release announcing the issuance of FAB 2012-02, Assistant Secretary of Labor for the Employee Benefits Security Administration Phyllis C. Borzi said, "We also are working on a second set of frequently asked questions and answers focused more narrowly on the new rules for disclosure by covered service providers."

IRS Finalizes Regulations on PPACA Premium Tax Credit

On May 18, the Internal Revenue Service (IRS) issued final regulations for implementation of the Health Insurance Premium Tax Credit under the Patient Protection and Affordable Care Act (PPACA).

Section 1401 of PPACA amended the Internal Revenue Code to add Section 36B, allowing a refundable tax credit to help individuals and families afford health insurance coverage by reducing a taxpayer's out-of-pocket premium cost. State-based exchanges will determine whether an individual meets the income and other requirements for advance credit payments (based in part on the affordability of employer-sponsored coverage) and the amount of the advance payments.

Penalties will be imposed on employers for failing to provide affordable, "minimum essential coverage" to full-time employees who obtain subsidized coverage in the exchanges. Separate regulations will be issued by the IRS at a later date on the employer penalty provisions of PPACA and are expected to include an important safe harbor to permit employers to determine whether health coverage meets the statute's affordability test for "minimum essential coverage" based on an employee's wages as reported on Form W-2 rather than an employee's total household income.

The regulations do not address how the IRS will determine whether individuals who may enroll in an employer-sponsored health plan because of their relationship to an eligible employee (a related individual) have "affordable" coverage and under what circumstances they may be

eligible to receive a premium tax credit. The guidance states that this issue will also be addressed in future regulations.

The final regulations do, however, provide additional guidance for how companies are to determine "affordability" with regard to contributions to health savings accounts (HSAs) and health reimbursement arrangements (HRAs), and whether an employee is considered to be enrolled in "minimum essential coverage" by reason of the automatic enrollment provisions of PPACA if the plan is not affordable or does not provide minimum value. The final rule also seeks additional comments on the types of wellness program incentives offered by employers and their effect on the affordability of employer-sponsored coverage.

The IRS recently issued Notice 2012-31, requesting comments on three possible approaches for determining whether health coverage under an eligible employer-sponsored plan provides the necessary minimum value as defined under PPACA – 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.

DOL, EBSA Re-open Comment Period for Proposed Target Date Fund Regulations

The U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) has formally re-opened the comment period for proposed regulations relating to target date investment fund options (TDFs). The proposed regulations, issued in November 2010, would require more specific disclosure requirements for TDFs, modifying previously finalized regulations on (1) qualified default investment alternatives (QDIAs) under participant directed individual account plans and (2) participant-level fee disclosure rules.

EBSA is re-opening the comment period in light of recent activity initiated by the Securities and Exchange Commission (SEC). On April 4, the SEC re-opened the comment period for its own proposed regulations specifically addressing marketing and advertising disclosure requirements for TDFs. The SEC action was prompted by a Siegel+Gale report sponsored by the SEC, Investor Testing of Target Date Retirement Fund (TDF) Comprehension and Communications, which depicted substantial confusion among participants about TDFs. (The re-opened SEC comment period ended on May 21.)

While the re-opening of the DOL comment period will delay the release of final rules, 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.

DOL Releases Additional FAQs for SBCs and Corrected Templates

On May 11, the U.S. Departments of Labor (DOL), HHS and Treasury (collectively, "the Departments") jointly issued 14 new Frequently Asked Questions (FAQs) About Affordable Care Act Implementation (Part IX) related to the implementation of the Summary of Benefits and Coverage (SBC) requirements under the Patient Protection and Affordable Care Act (PPACA). The SBC is intended to provide consumers with consistent and comparable information regarding health plan benefits and coverage. The Departments also issued corrected versions

of the official template and completed sample for use in compliance with final regulations on the SBC and uniform glossary requirements.

The FAQs address several issues specific to health plan sponsors. Among the most important is a new additional safe harbor for the electronic delivery of SBCs to health plan participants and beneficiaries. As explained in FAQ No. 1, under the additional safe harbor, "SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. (In addition, for individual market issuers that offer online enrollment or renewal, the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations)."

This new additional safe harbor provides significant relief to plan sponsors who wish to provide SBCs electronically as part of their on-line enrollment processes. The new additional safe harbor is separate and independent of other existing FAQs and electronic delivery rules.

The new FAQ guidance provides additional clarifications:

- FAQ No. 8 affirms the Departments' basic approach to PPACA implementation by reiterating the circumstances under which penalties can be imposed for failure to provide the SBC or the uniform glossary. FAQ No. 8 affirms 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 comply."
- FAQ No. 9 states that "the Departments are developing a calculator that plans and issuers can use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion. The calculator will allow plans and issuers to input a discrete number of elements about the benefit package. Calculator inputs generally are expected to be taken from data fields used to populate the front portion of the SBC template." The calculator and algorithm will be posted at the Center for Consumer Information and Insurance Oversight (CCIIO) Resources page soon.
- FAQ No. 10 addresses the utilization and coordination of "carve-out arrangements," under which a plan or issuer contracts with a service provider to combine or manage certain benefits under the plan or policy. The FAQ clarifies that "Unless it contracts otherwise, an issuer has no obligation to provide coverage information for benefits that it does not insure. However, group health plan administrators are responsible for providing complete SBCs with respect to a plan. A plan administrator that uses two or more insurance products provided by separate issuers with respect to a single group health plan may synthesize the information into a single SBC, or may contract with one of its issuers (or other service providers) to perform that function." Additionally, FAQ No. 10 indicates that "during the first year of applicability, for enforcement purposes, with respect to a group health plan that uses two or more issuers, the Departments will consider the provision of multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements," as long as this is indicated to participants and beneficiaries along with contact information for additional assistance.
- FAQ No. 13 addresses the special treatment of expatriate plans, which the Departments acknowledge "face special circumstances and considerations in complying with the SBC requirements." The FAQ provides that "the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC with respect to expatriate coverage during the first year of applicability."

As clarified in the DOL's previously issued set of FAQs (Part VIII), for disclosures with respect to participants and beneficiaries who enroll or re-enroll through at open enrollment period, 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.)

IRS Provides Transition Guidance for FSA Plan Year Limit

On May 30, the Internal Revenue Service (IRS) issued Notice 2012-40, providing guidance on the effective date and amendment deadline associated with the $2,500 limit on contributions to a flexible spending arrangement (FSA) under Section 125(i) of the Internal Revenue Code. The notice also provides relief for corrected excess contributions and requests comments on modifications to the "use-it-or-lose-it" rule.

Code Section 125(i), added by Section 9005 of the Patient Protection and Affordable Care Act (PPACA), limits salary reduction contributions to an FSA for qualified health expenses to $2,500 (adjusted for inflation), effective for "taxable years" beginning after December 31, 2012.

Most significantly, the notice states that the limit will not apply for plan years that begin before 2013. Plans may adopt the required amendments to retroactively reflect the new $2,500 limit at any time through the end of calendar year 2014.

Additionally, Notice 2012-40:

- Clarifies that the $2,500 limit applies only to employee salary reduction contributions under a health FSA, and does not apply to certain employer non-elective contributions, to any types of contributions or amounts available for reimbursement under other types of FSAs, health savings accounts, or health reimbursement arrangements, or to salary reduction contributions to cafeteria plans that are used to pay an employee's share of health coverage premiums (or the corresponding employee share under a self-insured employer-sponsored health plan).
- Clarifies that the term "taxable year" in Section 125(i) refers to the plan year of the cafeteria plan as this is the period for which salary reduction elections are made;
- in the case of a plan providing a grace period (which may be up to two months and 15 days), unused salary reduction contributions to the health FSA for plan years beginning in 2012 or later that are carried over into the grace period for that plan year will not count against the $2,500 limit for the subsequent plan year; and
- relief is provided for certain salary reduction contributions exceeding the $2,500 limit that are due to a reasonable mistake and not willful neglect and that are corrected by the employer.

In light of the $2,500 limit, the Treasury Department and IRS are considering modification of the "use-it-or-lose-it" rule," which prohibits any surplus contribution or benefit under an FSA from reverting back to the employee or applying to a subsequent plan year or period of coverage. Notice 2012-40 requests comments on whether the rule should be modified to provide a different form of administrative relief (instead of, or in addition to, the current 2½ month grace period rule).

DOL Issues Advisory Opinions on Multiple Employer Plans, 403(b) Safe Harbor

On May 25, the U.S. Department of Labor released a series of advisory opinions – evidential legal rulings on a specific question of law – addressing certain inquiries related to employee benefit plans under ERISA.

- **Advisory Opinion 2012-04A** addresses "open" multiple employer 401(k) plans (MEPs) – single plans sponsored by an independent plan sponsor that cover the employees of a number of unrelated employers, with a centralized administrative and fiduciary structure. This advisory opinion essentially rejects the notion of an open MEP, concluding that where the participating employers are unrelated to each other except for the provision of benefits, the plan is not a multiple employer plan, but rather is a collection of single employer plans.

- **Advisory Opinion 2012-03A** addresses the validity of a proposed arrangement in which a single entity combines the assets and liabilities of defined contribution plans that have been abandoned by their employer plan sponsors. Based on reasoning similar to that of Advisory Opinion 2012-04A, DOL ultimately concludes that the arrangement is not a multiple employer plan, but rather is a collection of separate, albeit apparently abandoned, single employer plans.

- **Advisory Opinion 2012-02A** addresses the 403(b) "safe harbor" exemption from ERISA, under which a 403(b) arrangement is determined not to be "established or maintained" by an employer under Section 3(2) of ERISA and, therefore, is not an "employee pension benefit plan" subject to Title I of ERISA. Among other things, the safe harbor requires that employer involvement in the 403(b) plan be minimal, that employee participation in the 403(b) plan be completely voluntary, and that there are no employer contributions .

  The question DOL addresses here is whether an employer loses the 403(b) safe harbor if it makes matching contributions into a separate qualified plan based on the contributions the employee makes to the 403(b) plan. DOL concludes that a 403(b) plan does not fail the safe harbor merely because the employer maintains a separate qualified plan. However, if the receipt of employer contributions (i.e., matching contributions) in that separate plan are conditioned on contributions to the 403(b) plan, the 403(b) plan would fail the safe harbor. DOL reasons that because employer contributions to another plan are conditioned on participation in the 403(b) plan, it is no longer "completely voluntary" for an employee to make contributions to the 403(b) plan.

HHS Issues New Final Regulations Supplementing PPACA Medical Loss Ratio Requirements

On May 11, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) issued final regulations on Medical Loss Ratio (MLR) requirements under the Patient Protection and Affordable Care Act (PPACA). These regulations amend final regulations published December 7, 2011 by addressing the notice requirements applicable to certain health insurance issuers – a subject for which the agencies specifically sought public comment in the final regulations.

The MLR is the percentage of a health insurance plan's premium that pays for claims incurred for medical services and other plan expenses related to health care quality improvement. Under PPACA, health insurers must spend a minimum of 80 percent of premium revenue on clinical services and activities to improve health care quality for plans in the individual and small group markets, and 85 percent for plans in the large group market. Insurance companies that fail to meet the new standard are required to provide a rebate to consumers.

Under the December 7 final regulations, notice requirements applied only to issuers that owed rebates as a result of not meeting the applicable MLR standard. Today's final regulations establish a notice requirement for health insurance issuers that meet or exceed the MLR standards under PPACA , but only requires such notice for the 2011 MLR reporting year (the first year that the MLR rules are in effect) and does not require issuers to include information about their current or prior MLR reporting years. Issuers' MLR information will be publicly available on the HHS website, HealthCare.gov. According to the regulations, the new rule will ensure that all consumers, not just those owed a rebate, are informed of whether their issuers meet the minimum MLR standards under PPACA and "provide greater transparency to consumers regarding how premium dollars are used, promote informed decision-making in the purchase of health insurance, and ensure that efficiency in the use of premium dollars is properly valued by consumers."

CPDP Writes CMS on Health IT "Meaningful Use" Project

On May 7, the Consumer-Purchaser Disclosure Project (CPDP) (a group of leading employer, consumer, and labor organizations working toward the common goal of nationwide access to publicly reported health care performance information) sent a letter to the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) with recommendations for final regulations implementing the "Meaningful Use" incentive program for health information technology (Health IT).

The Meaningful Use program, established through enactment of the American Recovery and Reinvestment Act of 2009, is meant to provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified electronic health record (EHR) technology. (An official summary and timeline are available on the CMS website.)

In July 2010, CMS issued final regulations defining the minimum requirements under "Stage 1" of the program. On March 7, CMS issued proposed regulations specifying the "Stage 2" criteria that eligible professionals, eligible hospitals and CAHs must meet to qualify for incentive payments. The proposed rule also revises certain Stage 1 criteria, as well as criteria that apply regardless of stage, as finalized in the earlier final regulations.

The CPDP letter urges CMS to "finalize the progressive strides it makes in the proposed rule, especially those that enhance patient and family engagement," such as giving patients online access to their health information, motivating providers to engage patients to use it and facilitating secure messaging between patients and their health care providers. However, the letter also asserts that "the proposed regulations do not do enough to: (1) drive providers to share information with each other and (2) build the capability to report on quality measures that indicate whether providers are improving their ability to deliver high-value, coordinated care." The letter's extensive appendix provides more specific and detailed comments on the proposed regulations.

GAO Issues New Report on 401(k) Plan Fees

The Government Accountability Office (GAO) has issued a new report, 401(K) Plans: Increased Educational Outreach and Broader Oversight May Help Reduce Plan Fees, examining fees paid by participants and sponsors of defined contribution arrangements, such as 401(k) plans.

For 401(k) plans of all sizes, GAO examined:

- amounts plan sponsors and participants pay for services;
- challenges sponsors face in understanding how fees are charged, and
- actions the U.S. Department of Labor (DOL) has taken to help sponsors better understand and monitor the fees charged by service providers.

The GAO report is lengthy and covers a broad range of issues related to fee disclosure, such as the various kinds of fees (including revenue sharing arrangements), fiduciary obligations and information reporting as well as the recently finalized regulations for participant-level retirement plan fee disclosure and regulations on fiduciary-level fee disclosure under ERISA Section (408(b)(2)).

The GAO report notes in its findings that:

- plan sponsors paid recordkeeping and administrative and other fees, but small plans typically paid higher amounts and more of the fees;
- participants ultimately paid for 401(k) plan fees; and
- plan sponsors were challenged by complex fee arrangements and likely paid more than they realized.

Despite new fee disclosure rules that are now being implemented by plan sponsors and service providers, the GAO ultimately concludes that additional efforts are needed to effectively oversee fees charged by service providers. It recommends that DOL "develop and implement more proactive approaches to sponsor educational outreach, improve public access to annual Form 5500 data, and examine the definition of a fiduciary to determine if it captures the current relationship between sponsors and providers." DOL has reportedly agreed with the findings and will explore ways to implement these recommendations.

RECENT JUDICIAL ACTIVITY

Supreme Court Upholds PPACA

On June 28 the U.S. Supreme Court ruled in a 5-4 decision that the Patient Protection and Affordable Care Act's (PPACA) individual mandate is constitutional under Congress' taxation power. Because the mandate is constitutional, the court did not need to rule on what other parts of the law should be invalidated, or "severed". Therefore, the entire law stands.

While the court did not have a majority to uphold the individual mandate under the Obama Administration's primary defense – that it was a constitutional exercise of the commerce clause – the court ruled that the mandate is a tax and is a proper exercise of Congress' taxation authority. On a separate question, the court also ruled that the mere label of the individual mandate's penalty provision as a "tax" was not sufficient for purposes of the Anti-Injunction Act

(which would have delayed the courts from ruling on the matter until the funds were collected under the individual mandate penalty provision).

The Court did make a narrow ruling that PPACA's Medicaid expansion was constitutional as long as states are not denied existing federal funding if they fail to comply with the Medicaid expansion provisions under PPACA.