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RECENT LEGISLATIVE ACTIVITY

House Again Votes to Repeal PPACA; Committees Hear Testimony on Health Care

The U.S. House of Representatives passed the Repeal of Obamacare Act (H.R. 6079), a measure to repeal the Patient Protection and Affordable Care Act (PPACA), by a vote of 244 to 185 on July 11. Five Democrats joined the entire Republican caucus in voting for the measure, though the legislation is very unlikely to be considered in the Democratic-controlled Senate. (The House previously passed a similar repeal measure, H.R. 2, in January 2011.)

Republican leaders have vowed to continue their campaign against the law and have suggested that if Republicans take the Senate and the White House in the 2012 elections, repeal of PPACA (or portions of the law) could be attempted through the reconciliation process (which would require only a simple majority of Senators rather than the 60-vote threshold).

Various House committees continued their scrutiny of PPACA.

House Ways and Means Committee

The House Ways and Means Committee held a July 10 hearing on "the tax ramifications of the Supreme Court's ruling on the Democrats' health care law," focusing on Chief Justice John Roberts' majority opinion that PPACA's individual mandate is constitutional on the grounds that it is a tax, underscoring Congress' broad power to levy taxes beyond the scope of raising revenue. All tax legislation must originate in the House and is subject to the jurisdiction of the Ways and Means Committee.

In his opening statement, Committee Chairman Dave Camp (R-MI) observed that "as a result of the court's opinion, the limits on the Congress's taxing power are now anything but clear. … We must consider whether a future Congress will restrain itself from using the power to control individual lives and decisions or whether this is just a first step into that brave new world."

Ranking Democratic committee member Sander Levin (R-MI), in his opening statement, characterized the individual mandate as a "conservative" concept and suggested that Republicans' repeal efforts were aimed at "taking away extra protections against insurance company abuses."

The committee heard testimony from the following attorneys:

- Steven G. Bradbury, partner at Dechert LLP, expressed concern that the decision to uphold the minimum-coverage provision could "unleash the coercive power of the federal government" and argued "now that the Supreme Court has announced to the whole world that the minimum-coverage provision is not a legal mandate but only a tax assessment, it's equally logical to assume that the actual number of individuals who will choose to pay the tax rather than purchase insurance will be greater than originally projected."
- Carrie Severino, chief counsel and policy director at the Judicial Crisis Network, also described the implications of the "new tax authority" for Congress, noting "the majority's interpretation of the taxing power creates a previously unheard-of form of tax that is

triggered by mere inactivity. Taxes are primarily designed to raise revenue and only secondarily to influence behavior." Severino addressed the Council's Board of Directors discussing this issue a few weeks before the court's decision was handed down.

- Lee A. Casey, partner at Baker Hostetler, voiced support for the Court's majority rulings regarding the Medicaid expansion and the limitations on the Constitution's Commerce Clause but also decried the assertion of Congress' taxing power. He suggested that "Congress can put some limitation on the taxing power, albeit a self-imposed one, by stating plainly when it is and when it is not invoking its power to lay and collect taxes."
- Walter Dellinger, partner at O'Melveny & Myers LLP, called the ruling "a completely unremarkable application of settled precedent about the authority of Congress to exercise its power under the clause giving it the right to raise revenues through taxes, excises, imposts and through other revenue devices" and advocated the overall benefits of PPACA. Dellinger is the former Acting U.S. Solicitor.

The question-and-answer period included a broad discussion of the political and economic implications of the court's decision. Most notable was a discussion of adverse selection and the individual mandate, in which Bradbury said, "if there isn't a legal requirement, a direct legal mandate, a lot more people are going to choose to pay the tax than buy insurance, thereby undercutting the purpose for the mandate that Congress had in mind and leading, I believe, to a strong impulse in Congress to try to raise the level of the tax and the penalties that apply to enforce it."

House Oversight and Government Reform Committee

Also on July 10, the House Oversight and Government Reform Committee, held two hearings on PPACA.

The full committee held the hearing, Examining the Impact of Obamacare on Job Creators and the Economy, to discuss the recent and projected macroeconomic effects of PPACA.

Committee Chairman Darrell Issa (R-CA), in a preview statement, cited data indicating that the health care law will increase health care costs, discourage business expansion, incentivize the hiring of part-time workers rather than full-time workers, impede small-business hiring, increase federal spending and disproportionately affect young, female and minority individuals.

The committee heard testimony from the following witnesses:

- John Goodman, president and CEO of the National Center for Policy Analysis, called PPACA "Arguably the most radical piece of legislation ever passed by Congress" and outlined projected increases in costs, taxes and economic uncertainty pursuant to full implementation.
- Jamie Richardson, vice president of White Castle Systems, Inc. (on behalf of the National Restaurant Association), described the unique challenges for the restaurant industry. Among the regulatory issues that require urgent guidance are the rules surrounding the definition of a "full-time employee" and employer reporting requirements.
- Mary Miller, president and CEO of JANCOA Janitorial Services Inc. (on behalf of the U.S. Chamber of Commerce), described challenges specific to a "large" employer with a low-wage workforce. Miller said that she may be forced to drop coverage or transition her workforce to part-time.

- Michael Fredrich, president and owner of MCM Composites, argued that a "market-based system" – such as a health savings account (HSA) approach – is "the only solution to rising health care costs" and suggested building on the HSA model.
- Daniel Wolf, Massachusetts State Senator and founder and CEO of Cape Air, described the positive effects that Massachusetts' state health care law has had on his business, including strong job creation and lower health care premium increases.

House Subcommittee Approves Appropriations Bill Cutting Funding for PPACA Programs

In a formal mark-up session on July 17, the U.S. House of Representatives Appropriations Committee's Labor, Health and Human Services, Education, and Related Agencies Subcommittee approved a draft fiscal year 2013 Labor, Health and Human Services funding bill, which would establish a blueprint for the funding of these agencies' regulatory activities.

Generally, the draft bill includes $150 billion in discretionary funding, which is $6.3 billion below the 2012 fiscal year level and $8.8 billion below President Obama's budget request for the forthcoming fiscal year. Most notably, the measure would actively defund and prohibit new discretionary spending on implementation of the Patient Protection and Affordable Care Act (PPACA).

According to a press release and bill summary prepared by the subcommittee, "the legislation contains several policy provisions … [that] will help reduce harmful and unnecessary regulations that tie the hands of employers and undermine job creation, ensure the protection and respect of human life, and limit bureaucratic overreach."

In particular, the measure would:

- Cut $409 million in funding for the Centers for Medicare and Medicaid Services and prohibit any new funds for the new Center for Consumer Information and Insurance Oversight, a key regulatory body tasked with implementing PPACA – including the state-based health insurance exchanges.
- Effectively eliminate the Agency for Healthcare Research and Quality – the federal agency charged with improving health care quality, safety, efficiency, and effectiveness – by cutting its budget entirely.
- Eliminate funding for patient-centered outcomes research. (The Patient-Centered Outcomes Research Institute (PCORI) established under the PPACA is partially funded through fees paid by issuers of certain health insurance policies and plan sponsors of certain self-insured health plans.

Efforts could be made in the Senate to impose similar restrictions on its version of appropriations measures. However, they are less likely to succeed in the Democratically controlled Senate. If no agreement is reached, the agencies will eventually need to be funded through a "continuing resolution," which would generally maintain current funding levels.

Republican leaders have vowed to continue their campaign against the law and have suggested that if Republicans win control of the Senate and the White House in the 2012 elections, repeal of PPACA – or portions of the law – could be attempted through the reconciliation process (which would require only a simple majority of Senators rather than the 60-vote threshold).

Harkin Releases Reform Report Introducing USA Retirement Funds

On July 27, Senator Tom Harkin (D-IA), chairman of the Senate Committee on Health, Education, Labor and Pensions released a report entitled **The Retirement Crisis and a Plan to Solve It**. The report recommends strengthening certain aspects of the Social Security program and creating what are referred to as USA Retirement Funds.

The proposal defines the USA Retirement Funds as required vehicles for employers who do not offer retirement programs with automatic enrollment and a minimum level of employer contributions. The USA Retirement Funds could also be offered in addition to an employer's other retirement plans. Participating employers would automatically withhold a portion of employee pay for investment in "privately run, licensed, and regulated retirement plans ... overseen by a board of trustees consisting of qualified employee, retiree, and employer representatives". The Funds would have professional asset management and conservative investments. Participating employers would not have fiduciary responsibilities with respect to investment selection, program operations or payable benefits.

Under the proposal, employees could opt out of participating in the Funds. Money invested would be portable so that participants could move them from one Fund to another.

The USA Retirement Funds resemble hybrid pension plans with benefits based on contributions. It is not clear from the report, however, how earnings would be credited to contributions. The report does mention a proposed earnings guarantee on the investments adjustable based on market conditions. Distributions from the Funds would follow rules similar to those applicable to pension plans such as selection of an annuity with spousal survivor benefits. A lump-sum option was not mentioned in the report.

Senate Aging Committee Examines Women's Retirement Issues

On July 25, the U.S. Senate Special Aging Committee held a hearing, Enhancing Women's Retirement Security, to examine the unique personal finance challenges women face as they enter retirement.

In his opening statement, Committee Chairman Herb Kohl (D-WI) noted that "as Congress addresses Social Security's pending insolvency, we must also work to modernize the program to ensure it remains a safety net for those most in need," particularly women over the age of 65.

Specifically, Kohl suggested "One bipartisan solution that should be included in any reform package is to enhance the special minimum benefit," a program that increases Social Security benefits for low earners. "This can be done at a reasonable cost, and it would help ensure that career low-wage workers, who have little opportunity to save on their own, can avoid being stuck in poverty throughout their retirements," he said.

In conjunction with the hearing, the Government Accountability Office (GAO) released a report, Retirement Security: Women Still Face Challenges. This report found that over the last decade, working women's access to and participation in employer-sponsored retirement plans have improved relative to men. Women over age 65, however, continued to have less retirement income on average and live in higher rates of poverty than men in that age group, with divorce and widowhood having disproportionate effects on their financial security.

Barbara Bovbjerg, GAO director of Education, Workforce and Income Security Issues, indicated that a number of policy approaches were available to address the matter, such as the expansion of existing tax incentives (such as the automatic IRA) to encourage women to save more for retirement and providing an additional Social Security benefit to beneficiaries over the age of 80 or 85.

Also testifying before the committee was LaTina Burse Green, assistant deputy commissioner for retirement and disability policy at the Social Security Administration (SSA), who described the outreach and available tools provided by SSA to all beneficiaries. She noted that while the SSA is conscientious about providing accurate information to beneficiaries, particularly about the critical decision of when to begin collecting benefits, the SSA is very careful about not influencing beneficiaries' choices in one direction or the other.

The committee also heard testimony from the following policy experts:

- Kelly O'Donnell, vice president of Financial Engines (a Council member company), emphasized that, for women, the financial impact from optimal Social Security decisions can exceed savings from 401(k) plans. She also described some of the asset management resources provided by Financial Engines to help women maximize their retirement savings, such as their Income+ service.
- Sabrina Schaeffer, executive director of the Independent Women's Forum, urged substantial reform to the Social Security system, including raising the retirement age, means-testing and modifying the cost-of-living adjustment formula.
- Joan Entmacher, vice president and director of family economic security at the National Women's Law Center, echoed both Schaeffer's call for Social Security reform and Kohl's suggestion for modifications to the special minimum benefit rules.

RECENT REGULATORY ACTIVITY

DOL Issues Revision of FAB 2012-02 and Q&A No. 30

On July 30, the U.S. Department of Labor (DOL) issued FAB 2012-02R, a revision of the prior iteration released on May 7, providing guidance on issues related to final regulations for participant-level retirement plan fee disclosure and final regulations on fiduciary-level fee disclosure under ERISA Section (408(b)(2)).

The original FAB indicated that investments available through a brokerage window – and in which a significant number of participants are invested – may need to be treated as a DIA for purposes of the regulations governing plan fee disclosure to participants. The original Q&A No. 30 set forth a “safe harbor” for compliance with DOL’s interpretation. However, it would have required employers and/or service providers 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 DIA threshold, which would have triggered additional fiduciary obligations.

The revised FAB generally modifies and replaces Q&A No. 30 with Q&A No. 39 and makes corresponding adjustments to Q&A Nos. 13 and 29, resulting in the following changes:

- The "manageable number of investment alternatives" requirement has been deleted. Q&A No. 39 states that "[the participant disclosure] regulation does not require that a plan have a particular number of DIAs, and nothing in this Bulletin prohibits the use of a platform or a brokerage window, self-directed brokerage account, or similar plan arrangement in an individual account plan." However, Q&A No. 39 states that for plans covered by the participant disclosure regulation, the failure to designate investment alternatives, for example, to avoid disclosure "raises questions under ERISA Section 404(a)'s general statutory fiduciary duties of prudence and loyalty." This appears to suggest that participant-directed plans that offer only a brokerage window or similar arrangement and do not designate investment alternatives may continue to be concerned about the application of the disclosure regulation.
- The requirement to monitor for significant investment through a brokerage window has been deleted.
- The safe harbor test, which essentially required that participant disclosures be provided for any investment selected through a brokerage window by at least one percent of participants, has been deleted.
- DOL has affirmed its position that fiduciaries "are still bound by ERISA Section 404(a)'s statutory duties of prudence and loyalty to participants and beneficiaries who use the platform or the brokerage window, self-directed brokerage account, or similar plan arrangement" and also indicates that DOL will engage in discussions with interested parties about compliance issues and may, if necessary, embark on a regulatory project.
- The definition of a DIA has been clarified somewhat to state that whether an investment is a DIA "depends on whether it is specifically identified as available under the plan."
- It is affirmed that the guidance does not apply to SEPs and SIMPLE IRAs.
- While Q&A No. 39 is listed under the heading, "Mutual Fund Platforms and Brokerage Windows," the language in the Q&A does not specifically mention mutual fund windows possibly causing some to question whether the answer specifically addresses mutual fund platforms. However, the language does state "The regulation does not require that a plan have a particular number of DIAs, and nothing in the Bulletin prohibits the use of a platform or brokerage window, self-directed brokerage account, or similar plan arrangement in an individual account plan."

It appears that this revision will alleviate concerns for defined contribution plan sponsors.

On July 24, Senator John Kerry (D-MA), drafted a letter to DOL Secretary Hilda Solis requesting that the department consider withdrawing the guidance and instead pursue the issue through formal rulemaking. Similarly, Representative Rush Holt (D-NJ) solicited support from other members of the U.S. House of Representatives for a communication to DOL.

CMS Provides Technical Guidance on MLR Issues

On July 17, the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight released a bulletin providing question-and-answer guidance on the Medical Loss Ratio (MLR) reporting and rebate requirements under the Patient Protection and Affordable Care Act (PPACA). The MLR requirements apply to insured individual and group health coverage.

The MLR requirements call for health insurers to spend a minimum of 80 percent of premium revenue on clinical services and activities to improve health care quality for plans in the individual and small group markets, and 85 percent for plans in the large group market. The

U.S. Department of Health and Human Services (HHS) issued final regulations and a fact sheet on the MLR requirements in December 2011. At the same time, the U.S. Department of Labor issued Technical Release 2011-04, addressing rebates to policyholders who are group health plans or sponsors of group health plans.

Specifically, the July 17 bulletin provides question-and-answer guidance on:

- The notice of rebate to recipients in group markets: According to the guidance, "an issuer must provide notice of rebate to all subscribers enrolled in the group. This means that all subscribers enrolled in the group during the MLR reporting year except those who are no longer enrolled at the time the issuer provides the notice of rebate will receive a notice of rebate."
- Notice of MLR information and definition of plan document: The guidance affirms that, for an issuer whose MLR meets or exceeds the applicable MLR standard, the applicable plan notice can be provided separately from the first plan document that the issuer provides to enrollees on or after July 1, 2012. Additionally, the guidance defines a "plan document" under the MLR regulations as "a document pertaining to the plan or policy that is distributed to all policyholders in individual and group markets and all subscribers in group markets. Examples of plan documents include policies, summary plan descriptions, benefits summaries, and group contracts."

DOL Issues Additional Guidance for Compliance with Mental Health Parity Rules

On July 13, the U.S. Department of Labor's (DOL) Employee Benefits Security Administration released an updated version of its self-compliance tool for use in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).

Enacted in 2008, the MHPAEA prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or quantitative treatment limitations (such as a limit on the number of outpatient visits or inpatient days covered) that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits. Most recently, in November 2011, DOL issued a set of Frequently Asked Questions (FAQs) that partially addressed the permissibility of certain non-quantitative treatment limitations imposed by plans.

The revised self-compliance tool released on July 13 is to be used by group health plans, plan sponsors, plan administrators, health insurance issuers and other parties to determine whether a group health plan is in compliance with some of the provisions of Part 7 of ERISA (relating to group health plan requirements).

HHS Provides Document to Facilitate States' Essential Health Benefit Benchmarking

On July 3, the Center for Consumer Information and Insurance Oversight (CCIIO) – a division of the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) – released a document intended to facilitate states' selection of benchmark plans that would serve as the reference plans for essential health benefits (EHB) under the Patient Protection and Affordable Care Act (PPACA).

Under PPACA, beginning in 2014, insured plans in the individual and small group markets (including those offered in a state-based health insurance exchange) will be required to provide coverage for all “essential health benefits," (EHB) including preventive, diagnostic, and therapeutic services and products. Self-insured plans and large group plans are not required to provide EHB.

This new document complements the Essential Health Benefits Bulletin, issued in December 2011, in which HHS announced its intended approach to defining EHB. Under that approach, each state would be permitted to define essential health benefits for coverage offered in such state pursuant to a benchmark plan selected by the state (with the benefits and services included in the selected benchmark plan being the required essential health benefits for that state). Specifically, the new document provides an updated list of the three largest small group insurance products ranked by enrollment for each State, as well as lists of the three largest nationally available Federal Employee Health Benefit Program plans (which is one benchmark option under the intended approach outlined in the bulletin). It also provides the single largest Federal Employees Dental and Vision Insurance Program plans respectively, based on enrollment.

While the requirement to provide coverage for all EHB does not apply to self-insured plans or large group plans, EHB guidance has implications for such plans because PPACA imposes certain prohibitions on the use of lifetime and annual dollar limits with respect to group health plan coverage for any EHB, as determined in HHS guidance. Interim final regulations (IFR) issued in June 2010 implementing these limits stated that the regulatory agencies will take into account good faith efforts to comply with a reasonable interpretation of the term EHB for plan years that begin before final regulations are issued defining the term.

IRS Issues Notification Requirements for Pension Plan Benefit Limitations

On July 3, the Internal Revenue Service (IRS) issued Notice 2012-46, providing additional guidance in the form of questions and answers for single-employer plan administrators that are required to provide written notice to plan participants and beneficiaries of funding-related benefit limitations. ERISA and the Internal Revenue Code require that a plan administrator of a single-employer defined benefit plan provide written notice to plan participants and beneficiaries generally within 30 days after the plan becomes subject to benefit limitations.

Generally, if a plan’s adjusted funding target attainment percentage (AFTAP – generally, the value of the plan assets relative to the adjusted funding target, expressed as a percentage) is below 60 percent for a plan year, all benefit accruals must cease as of the valuation date for the plan year and no “prohibited payments”, such as lump sums, may be made. No prohibited payments may be made by a plan that is less than 100 percent funded if the plan sponsor is in bankruptcy. Also, no more than half of a prohibited payment may be made if the plan is between 60 percent and 80 percent funded.

Subject to limited exceptions, a plan that provides for any unpredictable contingent event benefit – such as a benefit triggered by shutting down a plant or facility – must provide that the benefit will not be paid to a plan participant if the AFTAP is less than 60 percent in the year the event occurs. Again, subject to exceptions, a plan that is less than 80 percent funded may not be amended to increase benefits.

Notice 2012-46 addresses a number of timing issues regarding written notices to participants and beneficiaries of benefit limitations, and provides an illustrative notice.

RECENT JUDICIAL ACTIVITY – Nothing to Report This Month