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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 JUDICIAL ACTIVITY – Nothing to Report this Month

RECENT LEGISLATIVE ACTIVITY

House Committee Examines Tax Implications of PPACA

On August 2, the U.S. House of Representatives Oversight and Government Reform Committee held a hearing, IRS: Enforcing ObamaCare's New Rules and Taxes, to discuss the tax elements of the Patient Protection and Affordable Care Act (PPACA), with a focus on the health insurance premium tax credit.

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. Eligibility for advance credit payments will be based in part on the affordability of employer-sponsored coverage, as reported on W-2 tax forms, and 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. The IRS issued final regulations for implementation of this program on May 23. Representative Scott DesJarlais (R-TN) has introduced a House joint resolution (H.J. Res. 112) disapproving the rule submitted by the Internal Revenue Service relating to the health insurance premium tax credit.

In a statement previewing the hearing, Committee Chairman Darrell Issa (R-CA) questioned the ability of the Internal Revenue Service (IRS) to "deliver customer satisfaction in addressing disputes or questions with the public, according to key metrics and government surveys" or "handle the massive staffing and technology ramp-ups required to handle [individuals' personal] data."

IRS Commissioner Douglas Shulman testified before the committee, discussing the agency's early efforts, saying that "important progress on implementation has been made," including outreach communications to taxpayers and investments in information technology.

Issa and DesJarlais each pressed Shulman on the IRS' ability to manage the substantial enforcement challenges that will present themselves once the requirements go into effect. Shulman expressed confidence that the agency was up to the task, as long as it receives the necessary budgetary support.

The committee also heard testimony from Nina Olson, IRS' national taxpayer advocate (leading the division of IRS tasked with assisting taxpayers and addressing problems affecting taxpayers). She noted that while the agency has already made significant progress toward PPACA implementation, concerns remain, including shortfalls in public communication, extensive inter-agency coordination and the threat of identity theft.

The following witnesses also provided testimony to the committee:

- Mark Everson, vice chairman of Alliantgroup (and former IRS commissioner under President George W. Bush), expressed skepticism that IRS is fully capable of implementing health care reform. In addition to the infrastructure challenges cited by Olson, Everson noted that new policy responsibilities (such as the obligation to establish benefits eligibility and reconciliation process associated with the premium tax credit) could be particularly burdensome for the agency.

- Michael Cannon, director of health policy studies at the Cato Institute, argued that the IRS final regulations on the premium tax credit exceeds the agency's statutory authority, since the regulations also permit such credits under federal exchanges rather than state-based exchanges only. He suggested that "since this rule imposes an illegal tax on employers in states that opt not to create a health insurance 'exchange,' those employers and possibly those states could file suit to block this rule in federal court."
- Timothy Stoltzfus Jost, Robert L. Willett Family Professor of Law at Washington and Lee University School of Law, refuted Cannon's argument, asserting that the availability of tax credits through federally facilitated exchanges is recognized through the language of the [PPACA]" and "the legislative history of [PPACA] also establishes that Congress understood that premium tax credits would be available through both federal and state exchanges."

The House Oversight and Government Reform Committee have no legislative jurisdiction over health care or tax matters. House Republicans are expected to continue their scrutiny of PPACA through the 2012 election season.

IRS is expected to issue additional regulations sometime this year on the employer penalty provisions of PPACA, which 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.

Senate Committee Approves Measure with Mass Transit Parity Provision

In a mark-up session on August 2, the U.S. Senate Finance Committee formally approved a "tax extenders" package, the Family and Business Tax Cut Certainty Act, including a provision temporarily increasing the fringe benefit permitted for mass transit expenses. Many employers provide this benefit to employees or make the purchase of mass transit fares available on a pre-tax basis. Prospects for passage of the overall tax package, however, are unclear.

As described in the version prepared by Committee Chairman Max Baucus (D-MT), the measure would extend the increase in the fringe benefit for mass transit from $125 to $240 through 2013, making it equal to the fringe benefit provided for parking.

The previous extension expired at the end of 2011. This extension would be effective retroactive to January 1, 2012, so expenses incurred prior to enactment by employees for vanpool and transit benefits would be reimbursed by employers on a tax free basis to the extent they exceed $125 per month and are less than $240.

The provision is estimated to cost $271 million in federal revenue over the two years it is effective. The whole tax extenders measure carries a federal revenue cost of more than $205 billion and includes no revenue-raising offsets, making enactment in its current form very questionable. Final resolution of expired or expiring tax provisions will be a topic of intense debate in the post-election "lame duck" session and could easily spill over to 2013 consideration of broader tax legislation.

Senator Tom Coburn (R-OK) had prepared an amendment to strike the provision from the bill but elected not to raise it during committee consideration.

RECENT REGULATORY ACTIVITY

IRS, Other Agencies Issue PPACA Guidance on Definition of 'Full-Time Employee', 90-Day Waiting Period

OnAugust 31, the Internal Revenue Service (IRS) and U.S. Department of Labor (DOL) issued two pieces of important guidance relating to employer responsibilities under the Patient Protection and Affordable Care Act (PPACA).

Guidance on Definition of 'Full-Time Employee'

The IRS issued Notice 2012-58, which describes safe harbor methods employers may use (though they are not required to use) to determine which employees are treated as full-time employees for purposes of the shared employer responsibility provisions of Internal Revenue Code Section 4980H (as added by PPACA).

The "shared responsibility" provisions, which take effect in 2014, require employers to provide health insurance for their full-time employees or pay a penalty if even one full-time employee receives a premium tax credit for health coverage obtained through a health insurance exchange. Under PPACA, employers with 50 or more full-time employees that do not offer affordable health coverage to their full-time employees may be required to make a shared responsibility payment. The statute itself defines a full-time employee as one who, on average, works at least 30 hours per week, but employers have sought further guidance on how that calculation is to be determined.

The notice modifies and expands on approaches described in other previous IRS guidance, such as a look-back measurement period of up to 12 months to determine whether new variable-hour or seasonal employees are full-time employees (as previously described in Notice 2011-36). The notice also requests comments, due September 30, on a number of specific implementation issues.

Guidance on 90-Day Waiting Periods for Issuance of Coverage

Also on August 31, the IRS, in concert with the U.S. departments of Labor (DOL) and Health and Human Services (HHS), issued Notice 2012-59, guidance on the 90-day waiting period limitation under Public Health Service (PHS) Act Section 2708 (as instituted by PPACA).

This statute provides that, in plan years beginning on or after January 1, 2014, a group health plan or group health insurance issuer shall not apply any waiting period that exceeds 90 days. Unlike Section 4980H, PHS Act Section 2708 does not distinguish between full-time and part-time employees. The IRS previously issued implementation guidance under Notice 2011-36.

Specifically, Notice 2012-59 provides temporary guidance on what the agencies will consider as compliance with PHS Act Section 2708, effective through the end of 2014. The guidance defines the term "waiting period" and addresses implementation with respect to variable-hour employees where a specified number of hours of service per period is a plan eligibility condition. The guidance also provides example implementation scenarios and requests comments (also due September 30) on further examples or clarifications that may be needed.

Notice 2012-59 was also issued by DOL as Technical Release 2012-02.

Treasury Releases 25-Year Average Rates for Pension Funding Stabilization

The U.S. Treasury Department and the Internal Revenue Service (IRS) released Notice 2012-55 providing guidance on the 25-year averages required by defined benefit plan administrators to implement funding stabilization.

Of importance in Notice 2012-55:

> (1) For plan years beginning in 2012, the 25-year averages are:
>
> a. First segment rate: 6.15%
> b. Second segment rate: 7.61%
> c. Third segment rate: 8.35%
>
> (2) After application of the 10% corridor, the three segment rates are 5.54%, 6.85%, and 7.52%, respectively.
>
> (3) These figures are consistent with the independent estimates of the actuarial firms who also sent a letter to Treasury and IRS on July 19.

The timely release of this guidance will allow plan sponsors to act by the September 15, 2012, deadline (in the case of calendar year plans) for making contributions for 2011. Contributions for 2011 can result in benefit restrictions being lifted for the remainder of 2012 and can also affect the applicability of credit balances and benefit restriction presumptions for 2013.

The Treasury and the IRS are contemplating using a different means of calculating the 25-year averages in future years, but that different methodology would not affect 2012 plan years. Treasury and IRS officials have also indicated that they will issue additional guidance shortly on other funding stabilization issues including that related to benefit restrictions and transition issues.

PBGC Issues Guidance Related to Pension Funding Stabilization, Premiums

On August 29, the Pension Benefit Guaranty Corporation (PBGC) released Technical Update 2012-01, providing guidance on the effect of the Moving Ahead for Progress in the 21st Century Act (MAP-21) – specifically, its defined benefit pension plan funding stabilization – on premiums paid to PBGC by plan sponsors. This update will be reflected in the 2013 premium instructions.

The measure stabilizes interest rates for purposes of calculating defined benefit plan funding by constricting the segment rates used to determine funding status within 10 percent of a 25-year average of prior segment rates. As an additional revenue offset, the measure also substantially increases the insurance premiums paid by single-employer defined benefit plans.

Unfortunately, the stabilization rules do not apply to the discount rates used to determine the variable-rate premium "notwithstanding any regulations issued by [PBGC]." Thus, the stabilization rules do not apply to the discount rates used to calculate the standard premium funding target under ERISA and PBGC's regulations, or to the alternative premium funding target under PBGC's regulations. The guidance provides a table with the segment rates for

calculating an example plan's alternative premium funding target status, depending on whether an election is in effect for 2012.

The guidance also covers two other issues:

- *Variable-rate premiums and assets*: The asset value used to determine the variable-rate premium continues to be the amount determined under ERISA section 303 for funding purposes, taking into account current rules about disregarding averaging and certain prior-year contributions, even if contributions made after the valuation date were discounted for funding purposes using an effective interest rate that was based on stabilized rates.
- *Premium rates going forward*: Effective beginning in 2013, MAP-21 changes the flat and variable premium rates and puts a cap on the variable-rate premium. Each flat or variable rate is subject to a different inflation adjustment, and the variable-rate premium cap has its own inflation adjustment.

CCIIO Releases State Health Insurance Exchange Blueprint

On August 14, the Center for Consumer Information and Insurance Oversight (CCIIO), of the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) issued its final Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, describing the approaches states can take with regard to establishment and operation of an exchange.

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

Specifically, the blueprint outlines:

- functions that will be performed by exchanges run by the states, or "state-based exchanges;"
- functions performed by exchanges operated as partnerships between the federal government and states; and
- functions that states can perform in "federally facilitated" exchanges that HHS will set up in states that do not operate either of the other two types of exchanges.

States that want to establish an exchange — or enter into a partnership with the federal government — must file applications with HHS by November 16. HHS must approve the applications, or give conditional approval, by January 1, 2013.

Under the PPACA, the exchanges are scheduled to be operational beginning January 1, 2014. The exchanges will initially be open only to those in the individual and small group insurance markets through operation of a Small Business Heath Options Program (SHOP). States can set

the size of the small group market at either "1 to 50" or "1 to 100" employees until 2016. In 2016, exchanges must allow employers with up to 100 employees to participate. Beginning in 2017, states are authorized (but not required) to make health coverage under the insurance exchanges available to employer groups larger than 100. (The definition of "large" employer groups for this purpose will be based on separate state standards.) HHS issued final regulations governing the establishment of exchanges on March 12.

IRS Releases Revised Form 5558 for Deferred Vested Benefits that Does Not Require Signature

On August 16, the Internal Revenue Service (IRS) released a new version of Form 5558 that does not require a signature when submitting a request for an extension to complete certain employee plan reports.

Since the 2009 plan year, all Form 5500s have been required to be filed electronically using the department's new EFAST2 system. Under current law, while employers (and service providers acting on their behalf) are generally provided automatic Form 5500 filing extensions upon filing of a Form 5558 request, Form 8955-SSA extension requests required a plan sponsor signature. The revised Form 5558 reflects the proposed regulations' elimination of this signature requirement when employers request an automatic filing extension for both the Form 5500 and the Form 8955-SSA.

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