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RECENT REGULATORY ACTIVITY

HHS Proposes Regulations on Fee Amount and Payment Methodology for Three-Year Transitional Reinsurance Program

As part of proposed regulations addressing benefit and payment parameters under the Patient Protection and Affordable Care Act (PPACA), the U.S. Department of Health and Human Services provided an estimate of the amount and numerous other details on the payment methodology for contributions required from employer-sponsored plans starting in 2014 to finance a new three-year transitional reinsurance program. A fact sheet from HHS is also available.

Under Section 1341 of PPACA, each state may establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years that the state health insurance exchanges are operational (2014 through 2016). If a state chooses not to establish a reinsurance program, HHS will do so for such state. Under the statute, the program is to be financed through "contribution funds from contributing entities," meaning contributions made from health insurance issuers and third party administrators on behalf of self-insured group health plans.

Previous regulations issued March 23 clarify that the contributions are based on the number of enrollees covered by the plan, including employees and non-employee beneficiaries such as spouses and dependents. The final regulations also addressed the timing, method and other aspects of the contributions as they apply to these plans.

The new proposed regulations provide the methodology that will be used to calculate the assessment. Specifically, Section III.C.3.(a) provides for a national contribution rate of $5.25 per covered life, per month in 2014, equivalent to $63 per covered life for the year. Comments are requested on this calculation.

HHS is also seeking comments on whether it has the authority to defer until 2016 a portion of the reinsurance payments that are to be paid to the U.S. Treasury to partially offset the government's cost for the Early Retiree Reinsurance Program (ERRP). If this amount is deferred, we estimate that the 2014 contribution rate for the transitional reinsurance program will be $4.38 per covered life, per month in 2014, or $52.54 per covered life for the year.

The proposed regulations also clarify:

- Contributions must be made by health insurance issuers and third party administrators on behalf of self-insured group health plans. According to Section III.C.2 of the proposed regulations, "with respect to insured coverage, issuers are liable for making reinsurance contributions. With respect to self-insured group health plans, the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion."

- Contributions will be made annually, instead of quarterly, as had previously been proposed by HHS.
- A contributing entity is required to make contributions on behalf of "major medical coverage" and is not required to make payments on behalf of coverage that is not major medical coverage or which is "excepted benefits". Therefore, health savings accounts (HSAs), as well as health reimbursement arrangements (HRAs) that are integrated with a group health plan, would not be subject to the assessment. However, assessments would be required for the group health plan providing major medical coverage that is typically associated with an HSA or HRA. In addition, no contributions would be required from (1) flexible spending accounts (FSAs), (2) employee assistance plans, wellness programs, and disease management programs (to the extent they do not provide major medical coverage and (3) self-insured group health plan or health insurance coverage that consists solely of excepted benefits.
- HHS will collect all contributions from health insurers and self-insured plans, even where a state decides to operate its own reinsurance program. This is intended to help streamline the collection process so that insurers and self-insured plans are not responsible for making payments to each individual state.
- While states that operate their own reinsurance program are permitted to collect additional reinsurance amounts beyond the amount that is collected by HHS, the proposed rules states that "nothing in Section 1341 of the Affordable Care Act or this proposed rule gives a state the authority to collect from self-insured group health plans covered by ERISA, and that federal law generally preempts state law that relates to an ERISA-covered plan."
- Contributing entities are permitted to use several different methods for determining enrollment and these methods are based on those previously allowed under the guidance issued to implement the assessments for the Patient-Centered Outcomes Research (PCORI) program.
- When an individual is enrolled in an employer-sponsored group health plan and has coverage under Medicare, the employer plan would only be required to make transitional reinsurance program contributions when the employer plan is primary. Therefore, for example, when an individual is still actively employed, covered under an employer plan and also covered under Medicare, the employer plan is considered primary and it would be subject to the reinsurance contribution for these individuals. The employer plan would not be responsible for making reinsurance contributions for retirees covered under an employer plan and Medicare where Medicare is the primary plan and the employer plan is secondary.
- Health insurance issuers will be able to treat the contributions as tax-deductible as an ordinary and necessary business expense. (The Internal Revenue Service (IRS) concurrently issued a Frequently Asked Questions document affirming this point.)

PPACA Regulations Issued, Covering Employer Wellness Programs, Essential Health Benefits, Market Reforms

The U.S. departments of Treasury, Labor (DOL) and Health and Human Services (HHS) released a package of long-awaited proposed regulations on November 20, most notably addressing the employer wellness program provisions of the Patient Protection and Affordable Care Act (PPACA). The package also included regulations proposed by HHS related to essential health benefits (EHB) and the determination of actuarial value of health plans in the individual and small group insurance markets, as well as proposed regulations to implement several insurance market reform provisions of PPACA, including the guaranteed availability of

coverage, limits on insurance premiums in the individual and small group markets and guaranteed renewability of coverage.

Wellness Programs

The proposed regulations addressing incentives for nondiscriminatory wellness programs under PPACA increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20 percent to 30 percent of the cost of coverage – and up to 50 percent for programs designed to prevent or reduce tobacco use. (A fact sheet on these proposed regulations is also available.)

The proposed rules closely follow existing guidance in effect for employer wellness programs since 2006. Those rules establish two categories for wellness programs offered in connection with a health plan or health insurance coverage:

- The first category is for "participatory wellness programs" that provide rewards based on participation in a program that is not related to an individual's health status. Programs in this category must be available to all similarly situated employees and there is no limit on the amount of the financial incentive to encourage participation in a "participatory wellness program."
- The second category is for "health-contingent wellness programs," which generally require individuals to meet a specific standard related to their health to obtain a reward. These programs must (1) provide an opportunity to qualify at least once a year; (2) limit the size of the reward to 30 percent of total cost of employee-only coverage (meaning employer plus employer contributions) or up to 50 percent in the case of a program designed to reduce or prevent tobacco use; (3) be available to all similarly situated individuals and provide "reasonable alternatives" to obtain the same reward by other means; (4) be reasonably designed to promote health or prevent disease and not a "subterfuge for discrimination based on a health factor" and (5) provide notice for other means for qualifying for the reward.

The new guidance provides several examples of "participatory" and "health-contingent" wellness programs.

The proposed rules also include new standards for determining when a program provides a "reasonable alternative" for obtaining the same reward as other participants in a "health-contingent wellness program". For example, if the alternative program is based on completion of an educational program, the plan or health insurer must make the program available and pay for the cost of the program, or in the case of a diet program, the membership or participation fee must be paid for by the plan or issuer, but not the food. Sample language is included in the proposed rule that may be used to notify individuals about the availability of alternative means to obtain the applicable reward.

Another important feature of the proposed wellness rules is that they would apply to both grandfathered and non-grandfathered plans in both the insured and self-insured markets.

These proposed rules would be effective for plan years starting on or after January 1, 2014. Comments on these proposed regulations are due 60 days after the proposed regulations are formally printed in the Federal Register.

Essential Health Benefits
The proposed essential health benefits (EHB) regulations establish the minimum benefits – including preventive, diagnostic, and therapeutic services and products within 10 specific categories – that must be covered by individual and small group market health plans, including those participating in state-based health insurance exchanges. The regulations also set forth the minimum actuarial value (AV) levels – the percentage of total average costs for covered benefits that a plan will cover – for the bronze, silver, gold and platinum versions of these health plans. Additionally, the rule proposes a timeline and application process for issuers offering coverage in a Federally-facilitated Exchange or State Partnership Exchange. (A fact sheet on these proposed regulations is also available.)

While the essential health benefits package directly applies to insured plans in the individual and small group markets, there are implications for large group and self-insured plans, as PPACA's prohibition on lifetime and annual dollar limits applies to group health plan coverage for any "essential health benefits," as determined in HHS guidance. Interim final regulations 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 "essential health benefits" for plan years that begin before final regulations are issued defining the term.

The proposed rules include three different ways for health plans in the individual and small group markets to determine whether they satisfy the 60 percent minimum actuarial value test established by PPACA. One method would be based on an actuarial value calculator that HHS would make available and which would determine a plan's actuarial value based on cost-sharing information entered into the calculator. A second method would be based on a checklist approach comparing key features of a health plan to plans typically offered in the employer marketplace. And a third method would be available based on a determination by an actuary if the first two alternatives methods cannot otherwise be used to determine the plan's value.

Although the preamble to the proposed regulation expressly states that the deductible limitations ($2,000 self only/ $4,000 other plans) "apply only to plans and issuers in the small group market and do not apply to self-insured plans or health insurance issuers offering health insurance coverage in the large group market" the preamble is silent with respect to the application of the out-of-pocket limitations that are linked to the limits set for Health Savings Accounts under Internal Revenue Code Section 223. The agencies reserved a section in the proposed regulation itself for "cost-sharing under group health plans", suggesting that additional clarification could be provided in final regulations or when regulations implementing Section 2707 are released.

These proposed rules would be effective for plan years starting on or after January 1, 2014. Comments on these proposed regulations are due 30 days after the proposed regulations are formally printed in the Federal Register.

Individual Market Reforms
The proposed regulations governing individual health insurance market reforms under PPACA establishes the rules for guaranteed issue and renewability of coverage, insurance premium restrictions, single statewide risk pools and catastrophic plans. The proposed regulations also make amendments to the rate review program. (A fact sheet on these proposed regulations is also available.)

Generally, these rules apply only to individual and small-group market health plans. However, the premium restrictions – in which premiums are prohibited from – would apply to the large group market if a state permits large employers to purchase coverage through an Exchange (which they are eligible to do beginning in 2017).

These proposed rules would be effective for plan years starting on or after January 1, 2014. Comments on these proposed regulations are due 30 days after the proposed regulations are formally printed in the Federal Register.

PBGC Announces New Enforcement Policy for Shutdown Benefits Under ERISA Section 4062(e)

On November 2, the Pension Benefit Guaranty Corporation (PBGC) formally announced a change to its enforcement policy under ERISA Section 4062(e), which provides for reporting of, and liability for, facility shutdowns that trigger material terminations of employment. The new approach focuses primarily on companies that are encountering financial difficulties, raising serious defined benefit plan policy issues. PBGC also issued a questions-and-answers document describing the program.

Under ERISA Section 4062(e), if an employer with a pension plan shuts down operations at a facility, and as a result of that shutdown, more than 20 percent of the employer's employees who are plan participants are separated from employment, the employer is required to provide the PBGC with short-term financial guarantees in the form of a bond or escrow amount based on the plan's unfunded termination liability. PBGC has in the last few years become very aggressive in its enforcement of this ERISA provision in many respects. A key element of the PBGC's approach has been a very broad definition of the shutdown concept.

Under the new PBGC enforcement approach. PBGC will generally maintain its current position as to (1) what a shutdown is, (2) in what circumstances Section 4062(e) is triggered, and (3) the liability that is created when Section 4062(e) is triggered. However, under the new approach, companies who meet "tests of financial soundness" (or with less than 100 employees) will not be required to provide financial guarantees.

According to the Q&A document, "creditworthiness" and "financial strength" will be determined through "standards already used by businesses throughout the world: common financial measures of financial soundness such as credit ratings, credit scores, indebtedness, liquidity, and profitability."

Concerns remain in the benefit community about the enforcement policy for a number of reasons:

- The new enforcement policy, and the PBGC proposed regulations addressing 4062(e) on which they are based, demonstrate a basic misinterpretation of the ERISA statute itself by radically re-defining what is a 'cessation of operations' and introducing vast new requirements that were not contemplated by Congress.
- The aforementioned proposed regulations have not yet been finalized or amended with the benefit of comments from the public. According to the Q&A document, PBGC is using this enforcement policy as a "pilot program to help us decide what changes to make in our proposed regulation."

- Under the new enforcement policy, PBGC is expected to create its own complex methodology for determining the creditworthiness of a company, including non-profit entities. Congress has roundly rejected creditworthiness as a measure of pension plan strength during recent negotiations of the Pension Protection Act of 2006 and recent PBGC premium increase legislation.

PBGC Announces 2013 Premium Levels

On November 5, the Pension Benefit Guaranty Corporation (PBGC) published the premium amounts payable by defined benefit pension plan sponsors for 2013. The numbers have been updated to reflect changes resulting from the Moving Ahead for Progress in the 21st Century Act (MAP-21), enacted in June, which allows for increases in these premiums based on inflation adjustments.

For 2013, the flat-rate premium for single-employer plans is set at $42 per participant, a 20 percent increase over the value in effect from 2010-2012. The flat-rate premium for multiemployer plans is set at $12 per participant, a 33% increase over the value in effect from 2008-2012.

The variable-rate premium is set at $9 per $1,000 of unfunded vested benefits, as in prior years, although the amount is now capped at $400 per-participant (although this may be less for plan sponsors with fewer than 25 employees).

IRS Finalizes New Rules for Defined Benefit Plans in Bankruptcy

The Internal Revenue Service (IRS) issued final regulations effective November 8 that will allow employer plan sponsors in bankruptcy to amend their defined benefit plans to eliminate the issuance of lump sums without violating the anti-cutback rules under the Pension Protection Act of 2006 (PPA), under certain circumstances.

In particular, the regulations permit a single-employer plan that is covered under Section 4021 of ERISA to be amended, effective for a plan amendment that is both adopted and effective after August 31, 2012, to eliminate an optional form of benefit (such as a lump sum) that includes a prohibited payment, provided that four conditions are satisfied on the later of the date the amendment is adopted or effective:

- The enrolled actuary of the plan must certify that the plan's adjusted funding target attainment percentage for the plan year that contains the applicable amendment date is less than 100 percent;
- The plan is not permitted to pay any prohibited payment because the plan sponsor is a debtor in a bankruptcy case;
- The court overseeing the bankruptcy must issue an order, after notice to each affected party and a hearing, finding that the adoption of the amendment eliminating that optional form of benefit is necessary to avoid a distress termination of the plan or an involuntary termination of the plan before the plan sponsor emerges from bankruptcy (or before the bankruptcy case is otherwise completed); and
- PBGC must determine that the adoption of the amendment eliminating that optional form of benefit is necessary to avoid a distress or involuntary termination of the plan before the plan sponsor emerges from bankruptcy (or before the bankruptcy case is otherwise completed) and that the plan does not have sufficient assets for guaranteed benefits.

In finalizing the regulations, the IRS elected not to impose additional conditions on the prospective elimination of the single-sum distribution option (or other optional form of benefit that includes a prohibited payment), as contemplated in the proposed regulations.

New GAO Report Recommends More Risk-Based PBGC Premiums

On November 8, the U.S. Government Accountability Office (GAO) issued a report, Pension Benefit Guaranty Corporation (PBGC): Redesigned Premium Structure Could Better Align Rates with Risk from Plan Sponsors, suggesting that Congress "consider revising PBGC's premium structure to better reflect the agency's risk from individual plans and sponsors."

The PBGC's current single-employer premium structure consists of a flat-rate premium (based on the number of plan participants, with rates assessed equally per plan participant across all sponsors) and a variable-rate premium (based on plan underfunding as the single risk factor). As the report notes, "one available option is to further increase rates within this current structure," as was recently enacted through provisions in the Moving Ahead for Progress in the 21st Century Act (MAP-21), enacted in June. The report further states, however, that "plan underfunding alone is a poor proxy for the risk of new claims. An alternative option is to redesign premiums to incorporate additional risk factors, such as a sponsor's financial strength (as currently being explored by PBGC) or a plan's investment strategy (as is currently done in the United Kingdom)."

Additionally, the report recommends:

- Giving PBGC access to additional information, perhaps through expanded plan sponsor reporting requirements under Section 4010 of ERISA;
- Establishment of an independent premiums advisory committee to assist in developing a new premium structure and other measures to reduce the agency's deficit; and
- A PBGC report to Congress on the agency's hypothetical model, analyzing various premium redesign options, with an assessment to identify any potentially disproportional hardships on smaller companies that may result from the redistribution of higher rates to riskier sponsors.

This credit rating approach was roundly rejected during recent negotiations of the Pension Protection Act of 2006 and MAP-21. We have consistently argued that, under such a system, an increasing burden would be imposed on the least well-funded companies, further weakening the defined benefit system.

Nevertheless, over the past several years the PBGC has actively pursued more expansive risk-based premium increases, including recent proposals that would give the agency unilateral authority to set premiums and effectively call the U.S. government to use determinations made by private credit agencies.

In a related matter, on November 14 the PBGC released its Fiscal Year 2012 Annual Report, including an announcement that its deficit increased to $34 billion (up from $26 billion in 2011). While this calculation is largely based on abnormally low interest rates, the figure itself – along with the GAO report – is likely to feed the erroneous perception that the PBGC is at risk of a "taxpayer bailout."

IRS, DOL Provide Additional Relief for Hurricane Sandy Victims

The Internal Revenue Service (IRS) issued Announcement 2012-44 on November 16, formally allowing employer-sponsored defined contribution plans to make loans and hardship distributions to victims of Hurricane Sandy and members of their families.

Affected 401(k) plan participants – as well as employees of public schools and tax-exempt organizations with 403(b) tax-sheltered annuities, and state and local government employees with 457(b) deferred-compensation plans – may take a hardship distribution or borrow up to the specified statutory limits from the victim's retirement plan. Additionally, a person who lives outside the disaster area can take out a retirement plan loan or hardship distribution and use it to assist a son, daughter, parent, grandparent or other dependent who lived or worked in the disaster area. Hardship withdrawals must be made by Feb. 1, 2013.

Specifically, under the relief:

- IRS is also relaxing procedural and administrative rules that normally apply to retirement plan loans and hardship distributions. As a result, eligible retirement plan participants will be able to access their money more quickly with a minimum of red tape.
- the plan can ignore the limits that normally apply to hardship distributions, thus allowing them, for example, to be used for food and shelter. If a plan requires certain documentation before a distribution is made, the plan can relax this requirement
- the six-month ban on 401(k) and 403(b) contributions that normally affects employees who take hardship distributions will not apply.
- plans will be allowed to make loans or hardship distributions before the plan is formally amended to provide for such features.
- though IRA participants are barred from taking out loans, they may be eligible to receive distributions under liberalized procedures.

In a related matter, the U.S. Department of Labor issued a news release on November 20 announcing that:

- Compliance with the relief provided in IRS Announcement 2012–44 will not be considered a violation of Title I of ERISA;
- Employers that are unable to forward plan participant payments and withholdings to retirement plans as a result of Hurricane Sandy will not be considered in violation of ERISA as long as they comply "as soon as practicable under the circumstances";
- Fiduciaries that were not able to provide the required written notice to participants regarding a blackout period (with respect to such periods related to Hurricane Sandy) will not be considered in violation with ERISA; and
- The guiding principle for plans, with regard to certain deadlines for filing health benefit claims and COBRA elections, must be "to act reasonably, prudently, and in the interest of the workers and their families, who rely on their health plans for their physical and economic well-being." Plan fiduciaries are asked to make reasonable accommodations to prevent the loss of benefits in such cases and should take steps to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes.

Further details on available relief can be found on the disaster relief page on IRS.gov.

IRS Announces Deadline Extension for Certain Pension Plan Amendments

On November 21, the Internal Revenue Service released Notice 2012-70, extending the deadline for pension plan amendments under Section 436 of the Internal Revenue Code, generally to the last day of the plan year beginning on or after January 1, 2013. (The previous deadline, as extended under IRS Notice 2011-96, was the last day of the plan year beginning on or after January 1, 2012 — meaning December 31 for calendar year plans.) Notice 2012-70 also refers plan sponsors needing sample plan amendment language to that contained in Notice 2011-96. The sample includes optional provisions for various types of plans and the notices make clear that certain changes can be made without losing the ability to rely on the model amendment for the required Section 436 amendment.

As a reminder, Section 436 of the tax code, as added by the Pension Protection Act of 2006 (PPA), sets forth a series of limitations on the accrual and payment of benefits under an underfunded plan. In general, when a plan's adjusted funding target attainment percentage (AFTAP) for the plan year is less than 60 percent or 80 percent, certain restrictions apply. If the AFTAP is less than 60 percent, for example, single-sum distributions are prohibited and benefit accruals under the plan must cease until the AFTAP increases above certain levels. If the AFTAP is less than 80 percent (but not less than 60 percent), only a portion of the benefit can be paid in a single lump sum and the plan cannot be amended to increase benefit accruals.

Notice 2012-70 again provides the same extension (to December 31, 2013, for calendar year plans) for "anti-cutback" relief for the Section 436 amendment. The anti-cutback relief is provided under tax code Section 411(d)(6), which generally prohibits plan amendments that decrease a participant's accrued benefit.

Treasury, IRS Issue Priority Guidance Plan for 2012-2013

On November 19, the U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) released their 2012-2013 Priority Guidance Plan, listing those issues that will be the subject of formal guidance during the next year.

The plan contains 317 regulatory projects to be completed through June 2013, including 39 items addressing retirement benefits (Pages 4-7 of the document) and 29 items addressing executive compensation, health care and other benefits, including items related to implementation of the Patient Protection and Affordable Care Act (PPACA) (Pages 7-9). A number of these items have already been completed, as indicated in the priority plan.

The section of the plan addressing executive compensation, health care and other benefits covers a number of guidance items widely anticipated with respect to PPACA, including:

- Final regulations on fees to fund the Patient-Centered Outcomes Research Trust Fund (No. B25). Proposed regulations were published on April 17, 2012.
- Regulations on shared responsibility for employers regarding health coverage (No. B27).
- Regulations on certain reporting requirements (No. B29).
- Guidance addressing employee consents obtained by employer to claim a refund of FICA taxes (B30).

This section also includes substantial guidance related to nonqualified deferred compensation under Section 409A of the Internal Revenue Code, as well as miscellaneous guidance on such

topics as stock-based compensation, post-retirement medical benefits and qualified transportation fringe benefits.

Other issues addressed elsewhere in the plan include consolidated returns; corporations and their shareholders; excise taxes; exempt organizations; financial institutions and products; gifts, estates and trusts; insurance companies and products; international issues; partnerships; subchapter S corporations; tax accounting; tax administration; tax-exempt bonds and other general tax issues. An appendix also lists additional routine guidance that is published each year.

Regulators Again Extend Deadline for PPACA Exchange Applications

The Center for Consumer Information and Insurance Oversight (CCIIO) – the division of the U.S. Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) tasked with implementation of the Patient Protection and Affordable Care Act (PPACA) – recently revised prior guidance to extend the deadlines for states to:

(1) provide HHS with a "declaration letter" indicating whether they intend to institute a state-based health insurance exchange (by November 16) and (2) file a comprehensive "blueprint application" (by December 14).

On November 15, in response to a request from the Republican Governors Association, the Obama Administration announced that the deadline for the "declaration letter" will be further extended to December 14. The deadline for the "blueprint application will remain December 14.

PPACA requires the HHS Secretary to determine by January 1, 2013, which states will operate state-based health insurance exchanges. In all other states, exchanges will either be operated entirely by the federal government or in partnership with states that choose to administer portions of the functions of an exchange. The law also requires that employers notify employees in March 2013 about the availability of health coverage through state or federal insurance exchanges starting in 2014 and the income-based premium tax credits for those with income up to 400 percent of the federal poverty level. HHS has not yet provided guidance on the content for this notice to employees.

Deadline Coming for Compliance with Deferred Compensation Regulations under 409A

As set forth under Internal Revenue Service (IRS) Notice 2010-80, December 31, 2012 is the deadline for compliance with certain requirements under Internal Revenue Code Section 409A governing severance, deferred compensation, and other arrangements that condition payment on the execution of a release or other document by the payee.

Under Code Section 409A(a), amounts deferred under a NQDC plan are includible in income unless statutory requirements, generally relating to the time and form of payment of amounts deferred under the plan, are met both in form and operation. By making corrections to plan documents, employers can avoid or reduce the current income inclusion and additional taxes applicable under the section.

In an October 24 alert to clients, the law firm of Miller & Chevalier describes the procedures for achieving compliance prior to the deadline and recommends that employers make any necessary plan amendments immediately to ensure the year-end deadline is met.

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