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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Senate Approves Fiscal Year 2014 Budget Resolution; Amendments Prepared, Introduced Addressing Benefit Plans

The U.S. Senate narrowly voted to approve its Fiscal Year 2014 budget resolution by a vote of 50-49 early on March 23 after disposing of a large number of amendments spanning a wide variety of issues.

The budget resolution is non-binding, instead merely conveying the chamber's policy priorities and budget philosophy for the coming year.

Most notably, Senators approved several amendments addressing health care benefits, particularly under the Patient Protection and Affordable Care Act (PPACA):

- Amendment No. 144, offered by Senator Susan Collins (R-ME), to "restore a sensible definition of full-time employee" under PPACA, was approved by voice vote.

- No. 297, offered by Sen. Orrin Hatch (R-UT), to repeal the PPACA excise tax on medical devices, was approved by a vote of 79-20.

- No. 438, offered by Sen. Jeanne Shaheen (D-NH), to "protect women's access to health care, including primary and preventative health care, family planning and birth control, and employer-provided contraceptive coverage" as provided under PPACA, was approved by a vote of 56-43.

- No. 624, offered by Sen. Mike Johanns (R-NE), to repeal the $2,500 federal cap on flexible spending accounts, as well as the requirement that individuals obtain a prescription from a physician before purchasing over-the-counter drugs with flexible spending account (FSA) or health savings account (HSA) funds, was approved by voice vote.

- No. 705, offered by Sen. Robert Menendez (R-NJ), to "address the eligibility criteria for certain undocumented immigrant individuals with respect to certain health insurance plans," was approved by voice vote.

The Senate also rejected numerous health-related amendments during debate:

- No. 187, offered by Sen. Pat Roberts (R-KS), to "prohibit the use of funds for promotional or marketing materials" promoting PPACA, was defeated by voice vote.

- No. 202, offered by Sen. Ted Cruz (R-TX), to provide for the repeal of PPACA and "encourage patient-centered reforms to improve health outcomes and reduce health care costs, promoting economic growth," was defeated by a vote of 45-54.

- No. 222, offered by Sen. Michael Crapo (R-ID), to repeal certain tax increases under PPACA "imposed on low- and middle-income Americans," was defeated by a vote of 45-54.

- No. 318, also offered by Crapo, to instruct the Senate Finance Committee "to achieve the Budget's stated goal of $275 billion in mandatory health care savings," was defeated by a

vote of 47-52.

- No. 535, offered by Sen. Patrick Toomey (R-PA), to repeal the PPACA provision that increased the income threshold for tax deductions for unreimbursed medical expenses, was defeated by a vote of 45-54.

- No. 614, offered by Sen. Jeff Sessions (R-AL), to prohibit illegal immigrants or illegal immigrants granted legal status from qualifying for federally subsidized health care, was defeated by a vote of 43-56.

- No. 630, offered by Sen. Deb Fischer (R-NE), to "protect women's access to health care, including primary and preventive care, in a manner consistent with protecting rights of conscience," was defeated by a vote of 44-55.

Additionally, several amendments addressing employer-sponsored retirement benefit plans were introduced but not considered during debate:

- Nos. 219, 220 and 221, offered by Sen. Richard Burr (R-NC), sought to preserve the current tax treatment of defined benefit plans, defined contribution plans and individual retirement accounts (including Roth IRAs).

- No. 571, offered by Sen. Johnny Isakson (R-GA), would have effectively prevented the U.S. Department of Labor "from promulgating any further definitions or expansions of the term 'fiduciary' " under ERISA. DOL is expected to issue its revised fiduciary definition regulation before the end of the year.

The Senate will now attempt to reconcile this budget with the Fiscal Year 2014 budget resolution passed by the U.S. House of Representatives, without amendment, on March 22.

Senate Committee Discusses Retirement Plan Leakage; SEAL Act Reintroduced

The Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing, Can We Do More to Keep Savings in the Retirement System, on March 19 to discuss loans and early withdrawals from retirement savings accounts, such as 401(k) plans. This was the HELP Committee's second meeting to discuss retirement policy this year, after the January 17 hearing Pension Savings: Are Workers Saving Enough for Retirement?

In his opening statement, Committee Chairman Tom Harkin (D-IA) said "addressing the retirement crisis means not only helping people save enough for retirement but also ensuring that the money is still there at retirement." He cited plan loans and hardship withdrawals as sources of "leakage," but noted that "giving people access to retirement savings is not all bad."

Harkin, who is retiring at the end of his Senate term in 2014, is soon expected to introduce a legislative proposal based on his July 2012 report, The Retirement Crisis and a Plan to Solve It, which recommends strengthening certain aspects of the Social Security program and creating new "USA Retirement Funds." USA Retirement Funds, which would resemble hybrid pension plans with benefits based on contributions, would be required vehicles for employers who do not offer retirement programs with automatic enrollment and a minimum level of employer contributions.

The following witnesses testified before the committee:

- Alison Thomas Borland, vice president, retirement solutions and strategies at Aon Hewitt, offered data on loans, withdrawals and cash-outs along with nine recommendations for decreasing leakage, including "promoting the employer system."

- Matt Fellowes, founder and CEO of Hello Wallet (a financial information software company), described how broader financial education can help 401(k) participants avoid counterproductive financial decisions. In January, Hello Wallet issued a white paper, The Retirement Breach in Defined Contribution Plans, in which the authors described defined contribution plans as "a marginal contributor to the actual retirement needs of U.S. workers."

- Christian Weller, professor of Public Policy and Public Affairs at the University of Massachusetts Boston and senior fellow at the Center for American Progress, described research showing that the availability of plan loans is directly related to higher plan contributions and also offered possible approaches for reforming 401(k) plan designs to reduce leakage.

During the question-and-answer period, Senator Michael Enzi (R-WY) mentioned the reintroduction of the Shrinking Emergency Account Losses (SEAL) Act (S. 606), an anti-leakage bill previously introduced in May 2011. The previous version of the measure (originally titled the Savings Enhancement by Alleviating Leakage in 401(k) Savings Act) sought to (1) extend the period of time for participants to make a rollover contribution for plan loan offset amounts, allowing employees to contribute the amount outstanding on their loan to an IRA by the time they file their taxes for that year; and (2) direct the U.S. Treasury Department to adjust its regulations to allow 401(k) participants to continue to make elective contributions during the six months following a hardship withdrawal.

Senator Elizabeth Warren (D-MA) asked the panelists to evaluate the 401(k) "debit card" option, which the panelists uniformly described as a "God-awful" idea and which Enzi noted is prohibited under the SEAL Act. Warren also solicited support from the panelists for extended waiting periods before they can obtain a loan from a defined contribution plan.

Asked by Harkin to offer one parting suggestion for the committee, Borland recommended "tackling the cash-out issue by, at a minimum, requiring employer funded contributions to remain in the tax-deferred system until retirement, similar to a traditional defined benefit plan." Weller recommended "a universal, secure retirement plan … a default option for people who are not covered" – similar to Harkin's USA Retirement Funds proposal.

Measure to Repeal Employer Mandate Introduced in Senate, House

Lawmakers in the U.S. Senate and House of Representatives have introduced legislation that would repeal the employer mandate of the Patient Protection and Affordable Care Act (PPACA).

The American Job Protection Act was introduced on February 28 as S. 399 in the Senate, sponsored by Senate Finance Committee Ranking Republican Orrin Hatch (R-UT) and Senate Health, Education, Labor and Pensions (HELP) Committee Ranking Republican Lamar Alexander (R-TN), and as H.R. 903 in the House, sponsored by Representatives Charles Boustany Jr. (R-LA), Pat Tiberi (R-OH) and John Barrow (D-GA). The measure would repeal Sections 1513 and

1514 and Subsections (e), (f), and (g) of Section 10106 of PPACA, effectively eliminating the "pay or play" mandate requiring employers with at least 50 employees to provide affordable health insurance for their employees or pay a penalty.

In a news release announcing the introduction, the bills' sponsors cited a recent study by the U.S. Chamber of Commerce in which 72 percent of small business owners said that the health care law would make it harder for them to hire, force them to limit workers' hours or compel them to reduce the size of their business. The legislation has been endorsed by a number of employer organizations, including the U.S. Chamber.

Identical legislation was introduced by Hatch in the previous two congresses but never received serious consideration. Considering the U.S. Supreme Court's ruling on the law in 2012 and the current balance of power in the White House and Capitol Hill, the newest iteration of the bill is similarly unlikely to progress.

House Subcommittee Hears Additional Testimony on Multiemployer Pensions

The U.S. House of Representatives Education and the Workforce Committee's Health, Employment, Labor, and Pensions Subcommittee, led by Chairman Phil Roe (R-TX) held the hearing Challenges Facing Multiemployer Pension Plans: Reviewing the Latest Findings by PBGC and GAO on March 5, the latest in a series of discussions of the multiemployer pension system. The subcommittee held previous hearings on this topic in the prior session of Congress.

The multiemployer funding provisions of the Pension Protection Act of 2006 (PPA) are scheduled to expire after 2014 and multiemployer plans are reportedly significantly underfunded. The Retirement Security Review Commission of the National Coordinating Committee for Multiemployer Plans (NCCMP) issued the report Solutions not Bailouts on February 19, offering recommendations for strengthening the multiemployer pension system.

The legislative and regulatory treatment of multiemployer plans is significant because they face similar pressures as the single-employer plan system. Though the two systems are subject to different rules, measures addressing one system can affect the other and legislation focused on multiemployer plans may have provisions targeted to single-employer plans. The multiemployer plan crisis also raises the profile of the Pension Benefit Guaranty Corporation (PBGC) and its deficit, which we have argued is misleading and a poor rationale for premium increases.

Joshua Gotbaum, director of the PBGC (which insures multiemployer plans as they do single-employer plans), testified that the past decade has been difficult for all defined benefit pension plans, and though most plans are recovering, multiemployer plans face unique difficulties. "While in the minority, a significant number of multiemployer plans today are severely distressed. These are plans in declining or highly competitive industries, often characterized by high rates of employer bankruptcies and high ratios of non-sponsored or "orphan" participants," Gotbaum said. He recommended a comprehensive review of PBGC's multiemployer insurance system, claiming that without changes, the agency will face its own financial shortfall.

Charles Jeszeck, director of the Education, Workforce, and Income Security division of the Government Accountability Office (GAO), previewed a forthcoming report on multiemployer plan issues. Thus far, GAO has found that "while the most distressed multiemployer plans have taken significant steps to address their funding problems, a substantial percentage of these plans have determined that they will not be able to return to a healthier funding status, and instead seek to

forestall insolvency." GAO has determined that without reform, PBGC's multiemployer insurance fund is projected to exhaust its solvency by 2023.

Other witnesses, representing unions and employers, expressed support for the NCCMP proposals.

Roe has said repeatedly that his subcommittee and the full committee will be very active on this issue and could prepare bipartisan legislation soon. During the question and answer period, he specifically discussed a number of broader economic factors imperiling defined benefit plans and mentioned the possibility of raising multiemployer premiums to the PBGC. Ranking Subcommittee Democrat Robert Andrews (D-NJ) referred to the NCCMP proposal as a "solid place for us to begin."

Senate staff have also indicated interest in considering multiemployer plan legislation this year.

Health Care Hearing Round-Up: Congressional Committees Discuss PPACA

The ongoing implementation of the Patient Protection and Affordable Care Act (PPACA) was the subject of two hearings in the U.S. Senate during the week of February 25 and another hearing in the House of Representatives on March 5.

SBC Requirements and Transparency

On February 27, the Senate Committee on Commerce, Science and Transportation hosted a hearing, The Power of Transparency: Giving Consumers the Information They Need to Make Smart Choices in the Health Insurance Marketplace, to discuss the Summary of Benefits and Coverage document requirement established by the PPACA.

In his opening statement, Committee Chairman Jay Rockefeller (D-WV) noted, "while there may still be room for improvement, these forms represent a major step forward in in helping consumers make informed decisions about their health care coverage." He also expressed an interest in "other steps to improve transparency in this market," asking, "What other information do consumers need to make good decisions? Are there better ways to present or format this information to maximize its effectiveness?"

Three of the four witnesses testifying before the committee applauded the development of the SBC while urging continued attention to health insurance cost transparency. However, Neil Trautwein, vice president and employee benefits policy counsel for the National Retail Federation, though acknowledging the positive aspects of the SBC, noted that it is an example of costly and time-consuming administrative burdens imposed on employer plan sponsors by the PPACA.

The Obama Administration issued final regulations on Summary of Benefits and Coverage (SBC) and uniform glossary requirements in February 2012, followed by a series of Frequently Asked Questions documents providing additional guidance (Part VIII and Part IX).

Delivery System Reform

On February 28, the Senate Finance Committee held a hearing, Delivery System Reform: Progress Report from CMS, to examine the preservation of Medicare and Medicaid through greater efficiency and coordination in patient care.

In a news release issued along with the hearing, Committee Chairman Max Baucus (D-MT) said, "Everyone agrees that the fee-for-service payment system drives volume, excess and waste. That's why health reform changed the incentives for providers to promote efficiency and cut down on costly readmissions."

Jonathan Blum, the head of Medicare at the Centers for Medicare and Medicaid Services (CMS), in his testimony, touted the government's promotion of the CMS Innovation Center, Accountable Care Organizations and the Comprehensive Primary Care Initiative as powerful tools for driving value-based payment reform.

PPACA Tax Provisions

On March 5, the U.S. House of Representatives Committee on Ways and Means Oversight Subcommittee held a hearing on the tax-related provisions of PPACA.

Subcommittee Chairman Charles W. Boustany Jr. (R-LA), in announcing the hearing, framed the discussion as a part of a broader economic debate, noting that "As the Committee moves forward with comprehensive tax reform, it is imperative that we examine the law's tax provisions and consider their impact on the administration of the tax code as well as on individuals, families, and employers."

Witnesses before the panel – consisting of economists and representatives from the medical service industry – highlighted a variety of revenue provisions in the health care law, such as the medical device excise tax, elimination of eligibility of over-the-counter medications for flexible spending account reimbursement, increased Medicare taxes and penalties applicable to the employer "shared responsibility" employer mandate provisions included in the statute.

While there were no witnesses representing large employer plan sponsors, Boustany, in particular, noted the administrative burden – in addition to the cost burden – of PPACA's employer mandate. At the close of the hearing, Representative Kenny Marchant (R-TX) recommended further hearings to discuss PPACA's administrative complexity, beyond tax and cost pressures.

RECENT REGULATORY ACTIVITY

Proposed Regulations Issued on PPACA 90-Day Waiting Period with Technical Amendments

Late on March 18, the U.S. departments of Treasury, Labor (DOL) and Health and Human Services (HHS) collectively released proposed regulations implementing the 90-day waiting period limitation under Section 2708 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (PPACA). The regulations, proposed to be effective for plan years on or after January 1, 2014, include technical amendments to make changes to existing requirements such as preexisting condition limitations and other portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because they have become moot or need amendment due to new market reform protections under PPACA.

PPACA 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 the employer responsibility provisions under Section 4980H of the Internal Revenue Code (governing

employer shared responsibility provisions of PPACA), PHS Act Section 2708 does not distinguish between full-time and part-time employees.

The proposed regulations generally follow Internal Revenue Service (IRS) Notice 2012-59, issued in August 2012, defining the term "waiting period" and addressing implementation with respect to variable-hour employees where a specified number of hours of service per period is a plan eligibility. The proposed regulations make a number of technical and conforming amendments, but do not make any substantial changes from the guidance.

In a conference call announcing the release of the proposed regulations, DOL officials noted that:

- No eligibility requirements may be imposed that could be considered avoidance of the waiting period;
- A plan may not have an eligibility requirement that involves a lapse of time that is longer than 90 days;
- Rules will be coordinated with measurement period rules under Code Section 4980H; and
- Three calendar months cannot be used as a substitute for 90 days.

The proposed regulations also include technical amendments stating that as of January 1, 2014, health plans will no longer be required to provide HIPAA certificates of creditable coverage.

The departments are soliciting public comments on the proposed regulations through May 20.

HHS Finalizes Transitional Reinsurance Fee Rules

Final rules regarding implementation of the Patient Protection and Affordable Care Act (PPACA) transitional reinsurance program fee (along with other PPACA benefit and payment requirements) were released by the U.S. Department of Health and Human Services (HHS) on March 1.

Under Section 1341 of the Patient Protection and Affordable Care Act (PPACA), during the first three years that state health insurance exchanges are operational (2014 through 2016), health insurance issuers and plan administrators (on behalf of self-insured group health plans) will be assessed a per-enrollee fee to finance the three-year transitional reinsurance program. The final regulations, which modify the proposed regulations issued in November 2012, provide an estimate of the amount and numerous other details on the payment methodology for employer contributions. Under this methodology, the proposed national contribution rate for 2014 is calculated to be $5.25 per covered life, per month, equivalent to $63 per covered life for the year.

Section III.C of the final regulations (pages 140-213) discusses the final changes to the transitional reinsurance program fee, including responses to public comment. The section on "contributing entities" begins on Page 152. Most notably:

- A self-insured group health plan may elect to make its reinsurance contributions directly to HHS or through a third-party administrator or an administrative-services-only contractor.

- The regulations confirm that health savings accounts (HSAs), health reimbursement arrangements (HRAs) and flexible spending arrangements (FSAs) do not constitute major medical coverage and are therefore excluded from reinsurance contributions, though a high-deductible health plan used in conjunction with an HSA or HRA is subject to the fee.

- The regulations confirm that employee assistance plans, disease management programs and wellness programs "typically provide ancillary benefits to employees that in many cases do not constitute major medical coverage," and are excluded from reinsurance contributions.

- The final regulations confirm that "paying reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of ERISA because the payment is required by the plan" under PPACA. The final regulations also reaffirm that these contributions are deductible for tax purposes, as discussed in more detail in Frequently Asked Questions issued by the IRS in November 2012.

- The regulations explicitly "exclude a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits from reinsurance contributions."

- Retiree pharmaceutical benefit plans – including employer group waiver plans ("EGWPs") and other employer-sponsored Medicare Part D plans) – are not subject to the fee. The regulations have been amended to provide that "a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits is excluded from reinsurance contributions. Since they only provide coverage for prescription drug benefits, these plans are not major medical coverage."

- Generally, however, the regulations also clarify that "employer-provided retiree coverage is subject to reinsurance contributions unless one of the general exceptions applies (for example, the coverage is not major medical coverage)." The regulations also contain "an exception for coverage provided by an issuer under contract to provide benefits under Medicare because these private Medicare plans are not part of an issuer's commercial book of business." (p 158)

- The regulations affirm that "COBRA or other continuation coverage is a form of employment-based group health coverage paid for by the former employee … Therefore, to the extent the COBRA coverage qualifies as major medical coverage (and no other exception applies), it is subject to reinsurance contributions."

- The final regulations "recognize that requests for reinsurance payments may be greater than predicted, or that collections may be lower than predicted." However, the final regulations retains their initial approach of using excess funds for reinsurance payments under the uniform reinsurance payment parameters for subsequent benefit years (i.e., the two years following the initial three years of the program).

- The regulations make no distinction with regard to whether the additional payments to Treasury – $2 billion in 2014 – are to be funded through contributions solely from insurers or from self-insured plans as well. In response to a similar request, the final regulations assert that PPACA "directs health insurance issuers and self-insured group health plans to make reinsurance contributions. HHS has set forth a national per capita contribution rate for the 2014 benefit year which applies to all contributing entities, including self-insured group health plans."

HHS also issued, along with the final regulations, an additional interim final rule and request for comments addressing how insurers are to use the proceeds from the transitional reinsurance fee to reduce cost-sharing.

The final regulations become effective May 10, 2013

IRS Proposes Regulations Implementing PPACA Health Insurance Provider Fee

The U.S. Treasury Department and Internal Revenue Service (IRS) released proposed regulations on March 1 providing guidance on the annual fee on health insurance providers under the Patient Protection and Affordable Care Act (PPACA). The fee does not apply to self-insured plans.

Section 9010 of PPACA imposes a fee, to be paid by September 30 of each year, beginning in 2014, on "covered entities engaged in the business of providing health insurance." The statute's definition of "covered" entities excludes self-insured employer plans, as well as governmental plans, non-profit entities or voluntary employees' beneficiary associations (VEBAs). While the fee does not apply directly to self-insured employer plans, it is possible that the cost of the fee will be passed through to enrollees and plan sponsors of insured plans (including large group plans) in the form of increased premiums.

The regulations set forth the total amount of revenue to be raised by the fee – including $8 billion for calendar year 2014 – and the methodology for calculating the fee for each covered entity, as well as tax treatment of the fee and penalties for reporting failures.

The IRS is soliciting written comments on the proposed regulations through June 3, 2013. That is also the deadline for applications to speak at an IRS public hearing on the matter, to be held on June 21, 2013, in Washington D.C.

DOL, EBSA Release Self-Compliance Tools for HIPAA, PPACA

The U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) has issued two documents in a series focusing on self-compliance under Part 7 of ERISA – the statutory provisions generally applicable to group health plans and group health insurance issuers. These documents, both released on March 1 and provided in checklist form, are intended to provide guidance for plans, issuers, plan sponsors, plan administrators and other parties as they seek to comply with various ERISA requirements.

The first document addresses HIPAA and other health care-related provisions, while the second document specifically covers provisions of the Patient Protection and Affordable Care Act (PPACA).

According to the PPACA-focused document, the DOL's implementation approach "will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices."

DOL Provides Guidance on Annual Funding Notice for Defined Benefit Plan Sponsors under MAP-21

The U.S. Department of Labor (DOL) issued Field Assistance Bulletin (FAB) 2013-1 on March 8, guidance for defined benefit pension plan sponsors with regard to the ERISA annual funding notice requirements as modified by the Moving Ahead for Progress in the 21st Century (MAP-21) Act of 2012.

MAP-21 included a provision to ease the cost burden of pension plan sponsorship by stabilizing the interest rates associated with plan funding calculations. The Internal Revenue Service (IRS) published the 25-year averages of the interest rates applicable for defined benefit plan funding purposes for the 2013 plan year on February 11.

In question-and-answer format, FAB 2013-1 describes how the annual funding notices, as required by Section 101(f) of ERISA, are to be provided to participants by plan sponsor users of MAP-21 funding stabilization. “The FAB sets forth technical questions and answers and provides a model supplement that plan administrators may use to discharge their MAP-21 disclosure obligations,” DOL said in a news release.

Specifically, the guidance covers such topics as the timing of notices; coverage requirements (including definition of “applicable plan year” and exceptions to coverage) and content requirements. Notably, plans may rely on good faith compliance with the statute (and therefore do not need to follow this new guidance) only if the annual funding notice was sent out before FAB 2013-1 was issued.

New PPACA FAQ Document Provides Relief for Expatriate Plans

The latest Frequently Asked Questions (FAQ) document issued by the U.S. departments of Treasury, Labor (DOL) and Health and Human Services (HHS) effectively provides a temporary delay for insured expatriate health plans to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA).

Specifically, FAQ Part XIII provides that "for plans with plan years ending on or before December 31, 2015, with respect to expatriate health plans, the Departments will consider the requirements of subtitles A and C of Title I of the Affordable Care Act satisfied if the plan and issuer comply with the pre-Affordable Care Act version of Title XXVII of the Public Health Service Act."

Under PPACA and the FAQ guidance, an expatriate health plan is defined as "an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage."

This guidance is expected to be helpful for many employer plan sponsors. The departments are soliciting feedback on this guidance through May 8.

IRS Issues Correction to PPACA Rule Addressing Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage

On March 25, the Internal Revenue Service (IRS) issued a correction to its February 1 notice of proposed rulemaking (NPRM), confirming that a private, self-funded, non-grandfathered group health plan qualifies as an eligible employer-sponsored plan.

The NPRM provided detailed guidance on an individual's liability for the shared responsibility payment for not maintaining minimum essential coverage (i.e., the "individual mandate" penalty). These proposed regulations address eligibility, exempt individuals, calculation of the payment and a definition of "minimum essential coverage." This definition of "minimum essential coverage" had explicitly includes eligible employer-sponsored coverage (including COBRA coverage and retiree coverage), among other kinds of coverage.

However, language used in the proposed regulations was unclear as to whether a private, self-funded, non-grandfathered group health plan constitutes an eligible employer-sponsored plan. Today's correction provides clarification that such a plan is an eligible employer-sponsored plan and thus constitutes minimum essential coverage.

A brief fact sheet and a questions-and-answers document describing the NPRM are still available.

ERISA Advisory Council Announces 2013 Discussion Topics

The ERISA Advisory Council (EAC), a group of benefits experts established by the U.S. Department of Labor (DOL) to identify emerging benefits issues and advise the Secretary of Labor on health and retirement policy, has released its working group topics for 2013. These topics are:

- missing and lost participants;
- pension buyouts, plan "de-risking," and choice of lump-sum payment from a defined benefit plan; and
- how to tailor education and communications to different segments.

The chair of the EAC for the 2013 term will be Karen Kay Barnes, managing counsel for McDonald's Corporation representing employers. Neal S. Schelberg, senior partner at Proskauer Rose LLP, also representing employers, will serve as vice chair.

IRS Releases New Procedures for 403(b) Plan Administration

On March 28, the Internal Revenue Service (IRS) issued Revenue Procedure 2013-22, setting forth the procedures for issuing opinion and advisory letters for pre-approved 403(b) plans (i.e., prototype and volume submitter plans).

Under the program established by this revenue procedure, the IRS will accept applications for opinion and advisory letters regarding the acceptability of prototype plan and volume submitter plan formats under Section 403(b) of the Internal Revenue Code.

HHS, OPM Issue Regulations on PPACA Exchange Programs

Also on March 1, federal regulators continued the process of readying the Affordable Insurance Exchanges established by the Patient Protection and Affordable Care Act (PPACA) and scheduled to be operational beginning in 2014.

The U.S. Department of Health and Human Services (HHS) released proposed regulations on the establishment of exchanges and qualified health plans in conjunction with the Small Business Health Options Program (SHOP), which is designed to assist eligible small businesses in providing health insurance options for their employees. Also on March 1, the U.S. Office of Personnel Management (OPM) released final regulations establishing the Multi-State Plan Program within the exchanges. Section 1334 of PPACA directs OPM to establish the MSPP to foster competition among plans competing in the individual and small group health insurance markets on the exchanges. OPM is directed to contract with private health insurance issuers (one of which must be non-profit) to offer at least two multi-state plans on each of the exchanges in each state. The law allows MSPP issuers to phase-in coverage, but coverage must be offered on exchanges in all states and the District of Columbia by the fourth year in which the MSPP issuer participates in the program. The first open enrollment period for plans offered through exchanges will begin on October 1, 2013, for coverage starting January 1, 2014.

RECENT JUDICIAL ACTIVITY

Supreme Court Oral Arguments Conclude in Same-Sex Marriage Cases

The U.S. Supreme Court recently completed two days of oral arguments regarding two cases addressing same-sex marriage laws. The ongoing same-sex marriage debate and the ultimate disposition of these cases could have a significant impact on employer sponsorship of health and retirement benefits for employees and their spouses.

On March 26, the court heard arguments in Hollingsworth v. Perry, which centers on the constitutionality of California's 2008 "Proposition 8" ballot measure that struck down a state supreme court ruling recognizing marriage for same-sex couples. On March 27, the court heard arguments in United States v. Windsor, which centers on the federal Defense of Marriage Act (DOMA), enacted in 1996 which provides that the word "marriage" in any federal law or regulation (including those that address employee benefits) means only "a union of a man and a woman." The U.S. Supreme Court will decide whether the various litigants have "standing" to challenge the laws and whether the Court has jurisdiction to rule on the matters. Assuming those two procedural matters do not present an obstacle to a Court decision on the substantive issues, the Court will address the constitutionality of each measure. A ruling is expected before the court completes its term in late June. Of course, the Court could decide to fully address one of the two cases and not the other.

Affected benefit provisions include:

- Employer-paid health coverage;
- Flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs);

- Federal COBRA continuation coverage;
- Survivor benefits in the form of qualified joint and survivor annuities (QJSAs) and qualified preretirement survivor annuities (QPSAs);
- Timing of death benefit payments;
- Qualified domestic relations orders (QDROs); and
- Application of Code section 415 limits to survivor benefits.

In states recognizing same-sex marriage, DOMA requires employers to treat employees with same-sex spouses as (1) single for the purposes of federal tax withholding, payroll taxes, and workplace benefits that turn on marital status, and (2) married for all other purposes under state law. Employers are therefore essentially required to operate two administrative regimes with regard to same-sex couples – one to handle benefits affected by DOMA, and another to comply with state law.

Several large and small employers, local business organizations and municipalities in filing an amicus (friend-of-the-court) brief in the Windsor case. The brief takes no position on the constitutionality of same-sex marriage but focuses exclusively on the unequal tax treatment that DOMA applies to employees who are legally married in states recognizing same-sex marriages and on the cost and administrative burdens the law imposes on employer sponsors of health and retirement benefits. Justice Elena Kagan referenced this amicus brief during oral arguments as part of a discussion of how DOMA's constitutionality could arise in private litigation.

Employers face legal and financial implications whichever way the Supreme Court rules. If the Court upholds DOMA, the costs and burdens associated with disparate treatment of some legally married employees versus other legally married employees would continue. But if the law is struck down, employer sponsors would likely need to amend their plan documents and practices to reflect the equal treatment of same-sex and opposite-sex spouses under federal law. This is because the term "spouse" for purposes of any federal law or regulation (including ERISA, the Code, COBRA, FMLA, etc.) would no longer be limited by federal law to an opposite-sex spouse.