***BENEFITS INSIDER***
***A Member Exclusive Publication***

**Volume 106, January 16, 2013** (covering news from January 3 - 16, 2014)

WEB's ***Benefits Insider*** is a bi-monthly member exclusive publication providing the latest developments from Washington, DC, on matters of interest to employee benefits professionals. The content of this newsletter is being provided through 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.

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# RECENT LEGISLATIVE ACTIVITY

## Legislators May Seek Revenue from Benefit Changes

Despite a general slowdown in legislative activity, there are a number of important deadlines and policy priorities – such as federal appropriations and debt ceiling negotiations – that may spur action on measures affecting employer-sponsored benefit plans. To the extent that these measures have significant federal revenue costs, lawmakers may seek to offset that spending by adjusting or eliminating the tax incentives for certain employee benefits.

There were minimal substantive developments in the first few weeks of the year, but we will provide a summary and short-term outlook in the next edition of the *Benefits Insider.*

# RECENT REGULATORY ACTIVITY

## New FAQ Guidance Addresses Range of PPACA Topics

On January 9, the U.S. departments of Treasury, Labor (DOL) and Health and Human Services (HHS) released Frequently Asked Questions (FAQ) Part XVIII regarding implementation of the Patient Protection and Affordable Care Act (PPACA). FAQ Part XVIII addresses preventive care services, cost-sharing requirements (out-of-pocket maximums), wellness programs, expatriate plans and mental health parity.

*Preventive care*
Under Public Health Service Act (PHSA) Section 2713 (as added by PPACA) and interim final regulations issued in July 2010, non-grandfathered plans are required to provide preventive care services (such as mammograms, colonoscopies and immunizations) without cost-sharing. The coverage offered must be consistent with published recommendations and guidelines from the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration; if a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. The FAQ describes how plans and issuers must respond to USPSTF recommendations with respect to the treatment of breast cancer issued September 24, 2013. For plan or policy years beginning on or after that date, non-grandfathered group health plans and non-grandfathered health insurance coverage offered in the individual or group market will be required to cover medications to reduce breast cancer risk for women at an increased risk for breast cancer, without cost-sharing and subject to reasonable medical management.

*Limitations on Cost-Sharing and Out-of-Pocket Limits*
PHSA Section 2707(b) provides that any annual cost-sharing imposed under a non-grandfathered group health plan must not exceed certain limitations on out-of-pocket costs. For plan or policy years beginning in 2014, these limits are $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage, with future limits increased by a statutorily-defined percentage.

A previous FAQ (Part XII) provided guidance on out-of-pocket maximums for the first year of applicability where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket

costs. This guidance generally provided that, for group health plans and group health insurance issuers that utilize more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket costs, only for the first plan year beginning on or after January 1, 2014 (first year of applicability), the Departments would consider the annual limitation on out-of-pocket costs to be satisfied if the plan complied with the requirements with respect to its major medical coverage and to the extent that the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, that out-of-pocket maximum does not exceed the previously noted dollar amounts.

FAQ Part XVIII clarifies that:

- For plan years beginning on or after January 1, 2015, non-grandfathered plans and issuers are required to apply the out-of-pocket maximum across all essential health benefits.
- Plans are not required to apply the out-of-pocket limits to benefits that are not essential health benefits.
- Plans, such as those with multiple service providers, may divide the annual limit on out-of-pocket costs across multiple categories of benefits, rather than reconcile claims across multiple service providers if the combined out-of-pocket maximum for the year does not exceed the annual out-of-pocket cost limitation
- A plan that has a network of providers may, but is not required to count an individual's out-of-pocket expenses for out-of-network items and services toward the plan's annual maximum out-of-pocket limit; and
- A plan may, but is not required to count an individual's out-of-pocket costs for non-covered items or services (for example, cosmetic surgery) toward the plan's annual maximum out-of-pocket limit.

*Expatriate Plans*

A previous FAQ (Part XIII) effectively provided a temporary delay for insured expatriate health plans to comply with certain PPACA requirements.

FAQ Part XVIII defines "insured expatriate health plan" for the purposes of applying the temporary transition relief as "an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents, and also with respect to group health insurance coverage offered in conjunction with the expatriate group health plan. The 12-month period can fall within a single plan year or across two consecutive plan years."

The departments will consider additional regulations and guidance on these plans and states that "any new regulations or guidance that is more restrictive on plans or issuers will not be applicable to plan years ending on or before December 31, 2016," meaning that insured expatriate health plans can rely on the temporary transitional relief set forth in the FAQs Part XIII at least through those plan years.

*Wellness Programs*

Final regulations issued in June 2013 implementing the PPACA provisions related to nondiscriminatory wellness programs, including the increase in permissible maximum rewards under health -contingent wellness programs to 30 percent and 50 percent for programs designed to prevent or reduce tobacco use.

The FAQ provides additional guidance on wellness programs, clarifying that:

- if a participant who is a tobacco user initially declines the opportunity to participate in the tobacco cessation program, but joins in the middle of the plan year, the plan is not required to provide the opportunity to avoid the surcharge or provide another reward to the individual for that plan year. The plan may, however, allow the reward (or a pro-rated reward) for mid-plan year enrollment in the wellness program.
- If a participant's doctor advises that an outcome-based wellness program's standard for obtaining a reward is medically inappropriate for the plan participant, and suggests a weight reduction program (an activity-only program) instead, the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness, and the participant should discuss the different possible programs with the plan. (The FAQ suggests that the plan is not required to accept the specific weight reduction program suggested by the doctor).
- Plans and issuers are permitted to modify the model language (provided in the final regulations) communicating the availability of a reasonable alternative standard, provided that the notice includes the required content as set out in the final regulations.

*Mental Health Parity*
Final regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were released in November 2013, applicable to plan and policy years (for grandfathered and non-grandfathered plans) beginning on and after July 1, 2014 (January 1, 2015, for most calendar year plans). The final rules were accompanied by FAQ Part XVII, providing additional information on the use of multiple provider network tiers, exemptions, the process for claiming an "increased cost" exemption, the use of medical management techniques (such as preauthorization) and the process for disputed claims (including required disclosures to participants)

FAQ Part XVIII describes in greater detail the effect of PPACA on the mental health parity law for individual and small group market coverage.

*Fixed Indemnity Plans*
Fixed indemnity insurance provided under a group health plan is an excepted benefit under (and generally exempt from) PPACA market reforms if it meets certain regulatory requirements. FAQ Part XI provided guidance reiterating that, in order for a fixed indemnity policy to be considered an excepted benefit, it must pay on a per-period basis and not a per-service basis. For example, an indemnity plan that covers doctors' visits at $50 per visit, various surgical procedures at different dollar rates per procedure, or prescription drugs at $15 per prescription would not be considered excepted benefits because payment is determined on a per-service basis. The departments note that they "have noticed a significant increase in the number of health insurance policies labeled as fixed indemnity insurance."

The FAQ clarifies that fixed indemnity coverage that supplements other group health plan coverage may, nonetheless, qualify as excepted benefits under existing law even if it pays on per-service versus per-period basis. Furthermore, HHS intends to amend the federal regulations to allow fixed indemnity coverage sold in the individual health insurance market to be considered to be an excepted benefit if it meets the following conditions:
- It is sold only to individuals who have other health coverage that is minimum essential coverage;
- There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;

- The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and
- A notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual mandate.

If these proposed revisions are implemented, fixed indemnity insurance in the individual market would no longer have to pay benefits solely on a per-period basis to qualify as an excepted benefit. Until HHS finalizes its rulemaking, the FAQ states that HHS will treat fixed indemnity coverage in the individual market as excepted benefits for enforcement purposes if it meets the above conditions. HHS encourages states with primary enforcement authority to follow the same policy.

## FINRA Notice Provides Recommendations for Providers of IRA Rollovers

In Notice 2013-35, the Financial Industry Regulatory Authority (FINRA) sought "to remind firms of their responsibilities when (1) recommending a rollover or transfer of assets in an employer-sponsored retirement plan to an Individual Retirement Account (IRA) or (2) marketing IRAs and associated services." This notice applies directly to service providers for employer-sponsored defined contribution plans, specifically with regard to the recommendations those providers make to participants who are exiting a plan. FINRA, an independent organization authorized by Congress to write and enforce rules governing the securities industry, notes that "Reviewing firm practices in this area will be an examination priority for FINRA in 2014."

The notice begins with a description of IRAs in the U.S. retirement market and a list of participant considerations when making the decision to roll over one's assets (including potential fees). The notice then outlines what constitutes a "conflict of interest" and the provider's responsibility for "fair dealing." The notice recommends appropriate practices for a supervisory control system, training of registered representatives and communications with the public, and concludes, "A determination to roll over plan assets to an IRA rather than keeping them in a previous employer's plan or rolling over to a new employer's plan should reflect consideration of various factors, the importance of which will depend on the customer's individual needs, circumstances and options."

As the process moves forward, it will be particularly important to examine FINRA's approach in light of forthcoming U.S. Department of Labor (DOL) proposed regulations to define the term "fiduciary" with regard to investment advice. It is very possible that the DOL will classify IRA rollover recommendations as "fiduciary advice," placing new fiduciary responsibility on service providers.

## PBGC Establishes October 15 as New Flat-Rate Premium Payment Deadline for Large Plans

The Pension Benefit Guaranty Corporation (PBGC) has issued final regulations setting October 15 as the annual due date for all payers of defined benefit plan flat-rate premiums. This is the same date as the variable-rate premium due date for such plans. Previously, premium due dates depended on the size of the plan and the type of premium.

This new deadline applies only to large plans (those with 500 or more participants).

The rule was initially proposed in July 2013 as part of a regulatory package aimed at making premium payments less burdensome. The other elements of the proposed regulations - including the payment deadline for smaller benefit plans, changes to the variable-rate premium rules, coordinating the due date for terminating plans with the termination process, reducing the maximum penalty for delinquent filers that self-correct, clarifying the definition of "newly covered plan" and other simplification measures - will be addressed in a separate and future issuance. These changes are motivated in part by the White House's Executive Order 13563, in which President Obama directed his administrative agencies to improve the regulatory review process.

## RECENT JUDICIAL ACTIVITY

### Second Circuit Court Rules Against Pension Plan Sponsor in Case Addressing Offset Provisions

The U.S. Court of Appeals for the Second Circuit handed down a ruling on December 23 in the latest iteration of *Conkright v. Frommert*, finding against Xerox Corporation's pension plan and the plan administrator's interpretation of the plan's terms.

The case specifically involves interpretation of the retirement plan's offset provisions, which take into account prior distributions from the pension plan (for rehired participants). The plan originally calculated the offset by reference to what the participant's lump-sum distribution would have grown to had it remained in the plan. The Second Circuit Court originally struck down this method in 2008 on the grounds it was inadequately disclosed to participants in the summary plan description (SPD). The plan administrator then interpreted remaining plan terms to require an offset by the actuarial equivalent (taking into account the time value of money) of the participant's lump-sum distribution.

The district court rejected the Second Circuit's initial interpretation and held that the plan may offset only the nominal amount of the original distribution. The Second Circuit affirmed the district court decision but this decision was then vacated by the U.S. Supreme Court decision in 2010. The case was returned to the lower court, who ruled against the plaintiffs, who then appealed again to the Second Circuit.

In its December 23 decision, the Second Circuit rejected many of the arguments made by the plan, finding that:

- The plan's annuity formula was unreasonable;
- Even if the annuity offset calculation had been reasonable, the plan had not given adequate notice to participants;
- The plan was covered by the "blanket rule" that an SPD must describe the method of calculating an actuarial reduction or provide clarifying examples; and
- Requiring detailed calculations or examples would *not* make SPDs "so lengthy as to be unusable," as was argued by the plan.

The U.S. Department of Labor had issued a brief in support of the plan participants, arguing that the "plan participants' reasonable expectations" should be considered when evaluating a plan administrator's construction of plan provisions.

The case will now be remanded back to the U.S. District Court for the Western District of New York, which has consistently found in favor of the plan.