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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.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Pension Funding Stabilization Included in Unemployment Insurance Extension

Lawmakers in the U.S. Senate has reportedly reached agreement on a measure to temporarily extend long-term unemployment insurance (UI) for four months. To offset the federal revenue cost of this extension, the measure includes a temporary delay in the phase-out of the pension funding stabilization provision originally enacted in the 2012 transportation bill.

The Moving Ahead for Progress in the 21st Century (MAP-21) Act enacted in July 2012 included a provision to ease the cost burden of pension plan sponsorship by stabilizing the interest rates associated with plan funding calculations. Essentially, the provision "smoothed out" the effect of historically and artificially low interest rates in recent years by constricting the segment rates used to determine funding status to be within 10 percent of a 25-year average of prior segment rates. The subsequent phase-out of the stabilization provision - under which the 10 percent corridor is gradually increased to 30% --has reduced the effectiveness of the measure to the point where many defined benefit plans face new funding challenges.

The UI measure essentially delays the phase-out until 2017:

If the calendar year is:	The applicable minimum percentage is:	The applicable maximum percentage is:
2012, 2013, 2014, 2015, 2016, or 2017	90%	110%
2018	85%	115%
2019	80%	120%
2020	75%	125%
After 2020	70%	130%

Because 2017 is the earliest year that pension interest rates could return to normal based on the Federal Reserve Board's monetary approach, this provision matches congressional intent with the Federal Reserve Board's announced policy. The provision effective date for this extension is for plan years beginning after 2012; however, there is a special rule that permits employers to elect whether to apply the new rule for 2013. The election not to adopt the new rule could apply for all purposes or only for benefit restrictions.

An additional revenue-raising provision allows prepayment of PBGC flat-rate premiums for up to five years.

The Senate is expected to bring the bill to the floor quickly, perhaps as soon as the week of March 24th, but consideration in the House is less certain.

House Subcommittee Discusses Legislation Addressing Medicare Advantage Plans

The Health Subcommittee of the U.S. House of Representatives Energy and Commerce Committee, which shares jurisdiction over health care legislation, discussed a number of

legislative measures at a March 13 hearing, addressing a variety of issues related to the Medicare Advantage program (MA, which covers Medicare-eligible seniors through private insurance) and Medicare Part D prescription drug plans.

The Centers for Medicare and Medicaid Services (CMS) recently proposed cuts in the 2015 rates for the MA program, with final rates to be set in April, after PPACA and subsequent payment changes resulted in a 6.7 percent rate reduction in 2014.

A background memo released by Republican committee staff in conjunction with the subcommittee hearing cited concerns with prospective MA cuts, speculating that "[t]he impact of any new payment cuts may be seen by seniors in late October 2014, when they may face fewer choices or higher costs during the open enrollment period for 2015 Medicare Advantage coverage."

Additionally, CMS announced on March 10 that it will not finalize certain elements of proposed regulations addressing MA and Medicare Part D plans. In particular, the agency will not finalize proposals to lift the "protected class" definition on three drug classes, to set standards on Medicare Part D plans' requirements to participate in preferred pharmacy networks, to reduce the number of Part D plans a sponsor may offer, and clarifications to the non-interference provisions.

In describing the reason for the announcement, CMS cited numerous concerns about those proposals from members of Congress, but noted that it *will* finalize proposals related to consumer protections (e.g., ensuring access to care during natural disasters), anti-fraud provisions that have bipartisan support (e.g., strengthening standards for prescribers of prescription drugs), and transparency (e.g., broadening the release of privacy-protected Part D data) after taking into consideration the comments received during the public comment period.

During the hearing, the subcommittee heard from the sponsors of the following measures:

- the Seniors' Rights to Know Act (H.R. 4201), sponsored by Representative Jeff Denham (R-CA), would require disclosure to MA participants of the changes to such plans as dictated by PPACA.
- the Medicare Beneficiary Preservation of Choice Act (H.R. 2453), sponsored by Rep. Keith Rothfuss (R-PA), would restore the January-March open enrollment period that existed prior to 2011.
- the H.R. 3392: Medicare Part D Patient Safety and Drug Abuse Prevention Act (H.R. 3392), sponsored by Rep. Gus Bilirakis (R-FL), would provide for a safety program to prevent fraud and abuse in the dispensing of controlled substances under Medicare Part D.
- H.R. 4177, sponsored by Erik Paulsen (R-MN), would allow Medicare beneficiaries participating in a Medicare Advantage MSA to contribute their own money to their MSA.
- H.R. 4180, sponsored by Dennis Ross (R-FL), would permit rollovers from health savings accounts to Medicare Advantage MSAs.
- The Seniors' Fairness Act (H.R. 4916), sponsored by Bill Johnson (R-OH), would eliminate cost-sharing subsidies within the exchanges to create a Medicare Advantage Improvement Fund.
- The Advantage of Medicare Advantage for Minorities and Low-Income Seniors Act (H.R. 4211), sponsored by Jackie Walorski (R-IN), would directs the Government Accountability Office to study the number of minority and low-income seniors enrolled in MA plans and assess the impacts of payment reductions under PPACA.

Subcommittee Democrats expressed frustration during the hearing that only Republican-sponsored measures were discussed during the hearing, with Ranking Democrat Frank Pallone (D-NJ) noting that his own bill, the Medicare Prescription Drug Integrity Act (H.R. 2960), would require sponsors of Medicare prescription drug plans to implement procedures to prevent fraud and abuse.

The subcommittee also heard testimony from a panel of expert witnesses including:

- Mitchell Lew, CEO and chief medical officer of Prospect Medical Systems
- Glenn Giese, principal at Oliver Wyman Consulting Actuaries
- Frank Little, a Medicare beneficiary with a Medicare Advantage plan
- Judith Stein, executive director for the Center for Medicare Advocacy
- Paul N. Van de Water, senior fellow at the Center on Budget and Policy Priorities

Senate Banking Committee Discusses Retirement Security, Plan Fees

The U.S. Senate Banking, Housing and Urban Affairs Committee's Economic Policy Subcommittee held a hearing on March 12 to examine The State of U.S. Retirement Security: Can the Middle Class Afford to Retire? During the question-and-answer period, a great deal of the discussion focused on plan fees for 401(k) plans and Individual Retirement Accounts (IRAs).

The Senate Banking Committee does not have direct jurisdiction over employee benefit plans. But Chairman Jeff Merkley (D-OR), citing the economic recession, the state of the Social Security program and student loan debt, said in his opening statement, "I hope we can have a robust conversation about the changes facing American families and how we can enhance U.S. retirement security as a whole."

The panel heard testimony from the following witnesses:

- Ted Wheeler, treasurer for the state of Oregon, described his ongoing efforts, as part of a state retirement savings task force, to analyze current trends and provide reform recommendations to the state assembly. In particular, this task force is examining how Oregon "can help incent more retirement savings" and "expand the availability of pooled and professionally managed funds for workers."

- Monique Morrissey, an economist at the Economic Policy Institute, described a "retirement crisis" in which she argued that many segments of the population are ill-served by the defined contribution system. She called for Social Security reform, preservation of defined benefit plans and sweeping reforms to 401(k) plans. In particular, she criticized the tax incentives that encourage sponsorship of workplace retirement plans.

- Robert Hiltonsmith, policy analyst at Demos, echoed many of Morrissey's criticisms of 401(k) plans and IRAs, citing "four major types of risk that 401(k)s face … market risk, longevity risk, leakage risk and contribution risk." He also suggested that "a new system to replace 401(k)s is urgently needed."

- Kristi Mitchem, executive vice president of State Street Global Advisors and head of the Americas Institutional Client Group, described how large employers are leveraging new tools and designs to improve defined contribution plan success. She also suggested ways that small businesses can adopt some of these strategies, including through multiple-employer plan designs with features such as automatic enrollment and automatic escalation.

During discussion, Senator Elizabeth Warren (D-MA) agreed that pooling of small business resources is the key to improving the system, but also criticized the effect of plan fees on balances. She asked if the recent regulatory effort to improve fee transparency had an effect on aggregate fee levels overall. Mitchem cited research that indicated fees have been lowered by 20 to 25 percent in the years since the disclosure requirements were finalized. In particular, Warren suggested that IRAs should be subject to the same kind of fee disclosure as 401(k) plans, since many 401(k) fees are rolled over into IRAs.

Hiltonsmith and Morrissey both argued that fee disclosure for 401(k) plans should be enhanced and prioritized on participants' benefit statements. Morrissey also recommended limiting investment options within plans.

In response to a comment from Morrissey that regulation of IRA fees was minimal, "like the wild, wild west," Mitchem noted that mutual fund rules already have comprehensive fee disclosure requirements and suggested that efforts should really focus on educating employees and user-friendly plan features.

Ranking Republican subcommittee member Dean Heller (R-NV) asked Hiltonsmith how he would replace the 401(k) system; Hiltonsmith said that the ideal system would adopt many features of the current system, incorporating risk pooling, portability and low-cost investment alternatives.

RECENT REGULATORY ACTIVITY

EBSA Proposes Rules for 408(b)(2) 'Guide' for Disclosures Between Service Providers, Fiduciaries

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) released long-awaited **proposed regulations** on March 11 generally requiring retirement plan service providers to furnish a separate explanatory "guide" (or similar tool) to plan fiduciaries along with initial standard information disclosures. Annual notice of any changes to the guide would be required, though EBSA is requesting comments on whether the entire guide should be provided to fiduciaries on an annual basis.

Under Section 408(b)(2) of ERISA (and final regulations issued in February 2012), service providers must make disclosures – including plan fees – to responsible plan fiduciaries in order for contracts or arrangements between the parties to be considered "reasonable." According to the proposed regulations, which would amend the 408(b)(2) final regulations, "A guide or similar requirement may assist fiduciaries, especially fiduciaries to small and medium-sized plans, in identifying and understanding the potentially complex disclosure documents that are provided to them or if disclosures are located in multiple documents." The guide would be required unless the disclosures are already in a single document containing all the information and that single document is under a (yet-to-be specified) page limit. The proposal does not include a model, although the preamble indicates that EBSA expects the guides to resemble the previously released model. The proposed regulations also request comments on whether a summary disclosure document should be required.

In addition, EBSA indicates that the guide must include not only the identity of the document, but also where the information can be located within the document. The proposal requests comments on two alternative methods of providing the location within the document: (1) identifying the page

on which the information can be found, and (2) a "sufficiently specific" locator, such as a section (but only if the plan fiduciary could "quickly and easily find" the information). In a nod to electronic disclosure, the proposal also allows "direct links to the required information on an Internet/webpage" but only if the link is directly to the required information, or a page or other sufficiently specific locator is furnished (and the website must be readily accessible to the fiduciary who must receive clear notification of how to gain access). The proposal would permit a choice of locator but asks for comments on whether the rule should require only one locator, and why. It appears EBSA may have selected the guide instead of a summary in the proposal out of concern that plan fiduciaries might rely on the summary rather than the actual disclosures.

Under the proposed regulations, the service provider must disclose the location of:

(1) the description of services to be provided to the plan;
(2) a statement concerning any services to be provided as a fiduciary and/or as a registered investment advisor;
(3) a description of all direct compensation (which generally means compensation received directly from the plan);
(4) a description of all indirect compensation (which generally means any compensation from any source other than the plan, the service provider or an affiliate, or the plan sponsor);
(5) a description of any compensation that will be paid among related parties;
(6) a description of any compensation that would be paid for termination of the contract or arrangement;
(7) a description of compensation paid for recordkeeping services; and
(8) for platform providers and fiduciaries of plan asset vehicle investments, the fees associated with the product (e.g., sales charges and the expense ratio).

The guide must also identify a person or office that the fiduciary can contact with questions about the disclosures.

EBSA is soliciting comments on the proposed regulations through June 9, with particular attention to:

- the regulatory alternatives discussed in Section 4 of the Regulatory Impact Analysis;
- the structure of the guide, as proposed, and whether its requirements are feasible and cost-effective (commenters are invited to provide specific and itemized cost data);
- comments and suggestions as to alternative tools that would assist plan fiduciaries in reviewing the initial disclosures; and
- as previously mentioned, whether the amendment instead should require that covered service providers furnish a summary of specified "key" disclosures.

EBSA proposes to make the guide requirement effective 12 months after publication of the final rules, although it is not clear whether the guide would be required for all plan service arrangements, or only those that are entered into or renewed after the effective date.

EBSA also announced its intention to conduct approximately 8-10 focus group sessions with approximately 80 to 100 fiduciaries to small pension plans (less than 100 participants). The focus group will explore current practices and the effects of EBSA's final regulation. According to EBSA, the focus groups may provide information about the need for a guide, summary or similar tool to help fiduciaries navigate and understand the required disclosures. Results of the focus groups will be made available to the public and the DOL may reopen the comment period on the proposed regulations to solicit comments on the results.

In conjunction with the proposed regulations, EBSA has also released two additional, related items:

- A **fact sheet** describing the proposed regulations; and
- An **information collection request (ICR)** regarding the "effectiveness of the 408(b)(2) disclosure requirements." Specifically, the ICR asks for comments on the agency's focus group project, which it says "is designed to explore current practices and effects of EBSA's final regulation and to gather information about the need for a guide, summary, or similar tool to help [responsible plan fiduciaries] navigate and understand the disclosures."

IRS Releases Final Regulations for Employer PPACA Reporting

The Internal Revenue Service (IRS) issued final regulations on March 5 governing information reporting by applicable large employers regarding their health coverage and information reporting of minimum essential coverage (MEC), as required by the Patient Protection and Affordable Care Act (PPACA).

As with the proposed regulations issued in September 2013, the final regulations were released in two parts to address separate sections of the Internal Revenue Code: final regulations addressing employer reporting of health insurance coverage (under Section 6056) and final regulations on the reporting of MEC (under Section 6055).

These reporting requirements were delayed for 2014 under previously issued Notice 2013-45 transition relief and will not be effective until 2015 (first reporting is due in early 2016). As stated in prior guidance and the proposed regulations, the IRS is encouraging voluntary reporting for coverage in 2014.

Reporting of Health Insurance Coverage under "Shared Employer Responsibility" Provisions

Under Section 6056, every applicable large employer (generally, an employer that employed on average at least 50 full-time employees (or equivalents) on business days during the preceding calendar year) must file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees during the year. The return is also required to include and certify detailed and specific information on the employer's full-time employees, including those who received the coverage and when they received it. This information will be also used to administer the premium tax credit for eligible individuals.

The final regulations for Section 6056 generally preserve the proposed rule's provisions regarding the content, manner and timing of information required to be reported to the IRS and to full-time employees. The final regulations adopt certain limited simplified reporting methods, although the IRS also rejected some of the proposed simplified methods that were contemplated in the initial draft of the rule.

Specifically, under the final regulations:

- Applicable large employers that sponsor self-insured plans can report the information required under both Section 6055 and Section 6056 on a single combined form.

- An applicable large employer can take advantage of simplified reporting obligations with regard to those employees for whom it can certify that that it offered minimum value MEC at an employee cost for employee only-coverage of no more than 9.5% of the federal

poverty line, and also offered MEC to the employees' spouses and dependents (defined in the regulations as a "qualifying offer").

- Solely for 2015, an applicable large employer which can certify that it has made a "qualifying offer" to at least 95 percent of its full-time employees and their spouses and dependents will be able to provide a simplified notice to employees regarding the coverage provided.

- An applicable large employer that can certify that it offered minimum value and affordable MEC to 98 percent or more of its employees (and dependents) does not have to determine whether each employee is a full-time employee or report the total number of full-time employees.

Reporting of Minimum Essential Coverage

Under Section 6055, as amended by PPACA, every entity that provides MEC (including health insurance issuers and sponsors of a self-insured health plan) is required to file an annual return reporting specific information for each individual for whom MEC is provided. The information reported under Section 6055 can be used by individuals and the IRS to verify the months (if any) in which they were covered by MEC. This reporting facilitates compliance with, and administration of, PPACA provisions related to individual responsibility requirements and premium tax credits.

The final regulations under Section 6055 largely reflect the proposed regulations. As discussed above, however, applicable large employers that self-insure health benefits will be able to report the information required under both Section 6055 and Section 6056 to the IRS on a single form, which does provide some limited relief.

HHS Finalizes Transitional Reinsurance Fee for 2015

In **final regulations** issued on March 5, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) set the health plan transitional reinsurance program (TRP) fee at ***$44*** *per covered life* for 2015.

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 a three-year transitional reinsurance program. The contribution rate for 2014 is $63 per covered life for the year.

The final regulations also adopt an exception for "self-insured, self-administered plans" from the requirement to make TRP contributions for the 2015 and 2016 years, as proposed in prior regulations. This exception applies to self-insured plans that do not use a third-party administrator for their "core administrative functions of claims processing or adjudication (including the management of internal appeals) or plan enrollment." The exception is more likely available to multiemployer plans that self-administer and not self-insured employer plans that typically use third party claims administrators.

The final regulations also incorporate the new collection schedule prescribed in the prior proposal, in which the fee will be collected in two phases each year. The actual reinsurance component of the fee will be due at the beginning of the following calendar year (i.e., in early 2015 for the 2014

fee) and the component of the fee attributable to the collection of Early Retiree Reinsurance Program expenditures will be due at the end of the following calendar year (i.e., in late 2015 for the 2014 fee). In addition, the final regulations provide that "major medical coverage" means, for purposes of the TRP, a catastrophic plan, an individual or small group market plan subject to certain actuarial value requirements, or health coverage for a broad range of services and treatments provided in various settings that provides minimum value.

Responding to Comments, CMS Announces it will Not Finalize Certain Medicare Rules

The Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services announced on March 10 that it will not finalize certain elements of proposed regulations addressing the Medicare Advantage (Part C, which covers Medicare-eligible seniors through private insurance) and Part D prescription drug program. The proposed regulations, issued January 10, offer changes to current law and implement certain provisions of the Patient Protection and Affordable Care Act (PPACA).

Specifically, the agency will not finalize proposals to lift the "protected class" definition on three drug classes, to set standards on Medicare Part D plans' requirements to participate in preferred pharmacy networks, to reduce the number of Part D plans a sponsor may offer, and clarifications to the non-interference provisions.

In describing the reason for the announcement, CMS cited numerous concerns about those proposals from members of Congress and stakeholders, stating that "Given the complexities of these issues and stakeholder input, we do not plan to finalize these proposals at this time. We will engage in further stakeholder input before advancing some or all of the changes in these areas in future years."

CMS noted that it *will* finalize proposals related to consumer protections (e.g., ensuring access to care during natural disasters), anti-fraud provisions that have bipartisan support (e.g., strengthening standards for prescribers of prescription drugs), and transparency (e.g., broadening the release of privacy-protected Part D data) after taking into consideration the comments received during the public comment period.

Agencies Request Information Regarding Provider Nondiscrimination under PPACA

The U.S. departments of Treasury, Labor, and Health and Human Services (the departments) are requesting comments on the provider nondiscrimination provisions under the Patient Protection and Affordable Care Act (PPACA), according to a March 12 **formal request for information (RFI)**.

Under Section 2706(a) of the Public Health Service (PHS) Act, added by PPACA, "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." The PHS Act does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in the PHS Act prevents "a group health plan, a

health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

In April 2013, the departments issued Frequently Asked Questions (FAQ) Part XV, confirming that the provision applies to non-grandfathered group health plans and health insurance issuers for plan years beginning on or after January 1, 2014. The FAQ clarified that until further guidance is issued, plans and issuers "are expected to implement the requirements of Section 2706(a) using a good faith, reasonable interpretation of the law." The FAQ stated that, "for this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law."

The FAQ further stated that Section 2706(a) of the PHS Act "does not require plans or issuers to accept all types of providers into a network" and also "does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations."

In **a July 2013 report** (Page 126), the Senate Committee on Appropriations expressed concerns that the FAQ advises insurers that "this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification." According to the report, Section 2706 of the PHS Act "prohibits certain types of health plans and issuers from discriminating against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law, when determining networks of care eligible for reimbursement. The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification."

The report further directed HHS to work with DOL and the Treasury Department "to correct the FAQ to reflect the law and congressional intent." The RFI, issued pursuant to this report, requests comments "on all aspects of interpretation, including, but not limited to access, costs, other federal and state laws, and feasibility.

Obama FY 2015 Budget Analysis: Summary of Retirement and Health Plan Proposals

The latest version of President Obama's federal budget proposal, while largely a political and philosophical statement and unlikely to receive serious consideration by Congress, includes a number of provisions that would substantially affect employer-sponsored benefit plans.

Obama's Fiscal Year 2015 budget proposal, released on March 4, requests $3.9 trillion for the government operation; the White House Office of Management and Budget (OMB) released the detailed budget estimates by agency in conjunction with the proposal. The bipartisan budget deal reached in December 2013 essentially set the budgets and appropriations levels for 2014 and 2015, rendering the president's budget largely inconsequential from a practical perspective. However, the president's proposal does illustrate his administration's policy priorities and approach for the coming year. Furthermore, several of these provisions could ultimately be taken

from the budget and considered separately as federal revenue offsets for larger legislation or as stand-alone measures.

The thrust of the President's proposal consists of continued investment in manufacturing, infrastructure and research and development, coupled with immigration reform and tax reform largely aimed at eliminating "loopholes" and minimizing deductions for high-income individuals. Generally, the proposal takes a less compromising tone than the FY 2014 Budget proposal, which was introduced as the president's attempt at a "grand bargain" with congressional Republicans. Specifically, the 2015 budget does not contain the "chained Consumer Price Index (CPI)" calculation, which sought to raise revenue by replacing the current methodology used for calculating cost-of-living adjustments (and would have instituted a less generous annual rate of increase for Social Security payments).

Most notably, as in the prior year's budget proposal, the FY 2015 budget proposes reductions in the value of itemized deductions and other tax preferences (including employer-sponsored health insurance and employee retirement contributions) to 28 percent for high-income earners. The proposal would also implement the "Buffett Rule," requiring wealthy millionaires pay at least 30 percent of their income (after charitable giving) in taxes.

The budget also specifically addresses a number of other retirement and health benefit initiatives.

Retirement Savings

- Like the 2014 budget, this proposal imposes a cap on the aggregate account balances and accruals in a taxpayer's IRAs and employer-based plans – including defined benefit plans and 401(k) plans. Under the 2015 proposal, the cap is set at "an amount sufficient to finance an annuity of not more than $210,000 per year in retirement," representing a cap of roughly $3.2 to $3.4 million. If the cap applies, contributions (or accruals) would be prohibited for the current year, but the taxpayer's account balance could continue to grow tax-deferred without amounts being forced out via distribution and taxed.

  While the FY15 budget's provision is worded in a substantially similar manner as the FY14 budget's provision, today's release does make a number of clarifications with regard to assumptions of a spouse's age and simplified reporting for defined benefit plans. Of particular note, however, the 2015 provision is estimated to raise $28.4 billion over 10 years. This amount is about three times as high as the $9.3 billion that OMB had estimated the near identical provision in the FY14 budget would have raised. It is not immediately apparently why the figure has increased so dramatically.

- In addition to the president's MyRA proposal, the centerpiece of the president's retirement policy agenda is once again the required automatic enrollment in IRAs for employees without access to a workplace savings plan. The proposal also includes a small employer tax credit and doubles the tax credit for small employer plan start-up costs.

- The president's budget proposes another $20 billion increase in Pension Benefit Guaranty Corporation (PBGC) premiums over ten years (beginning in 2017) by giving the PBGC Board of Directors the authority to adjust premiums in both single employer and multi-employer programs, "tak[ing] into account the risks that different sponsors pose." It is unclear how the $20 billion would be divided between single-employer and multi-employer plans, or between flat-rate and variable-rate premiums.

  These premium increases would be applied on top of the $9 billion in increases previously

enacted as part of Moving Ahead for Progress in the 21st Century (MAP-21) Act of 2012 and the $7.8 billion raised through the Bipartisan Budget Act.

- The budget proposal includes a new provision imposing required minimum distributions on Roth IRAs during the lifetime of the owner and prohibiting individuals from making additional contributions to Roth IRAs after they reach age 70½. Under current law, RMDs must be made from a Roth IRA only after the owner dies, and the owner can make contributions to the Roth IRA after age 70½. In contrast, traditional IRAs are subject to RMDs during the owner's lifetime and owners cannot contribute after age 70½. In addition, under current law designated Roth accounts within qualified employer-sponsored plans must make RMDs during the participant's life.

- The proposal prohibits so-called "stretch IRAs," meaning that non-spouse beneficiaries of deceased IRA owners and retirement plan participants (that do not meet certain conditions) would be required to take inherited distributions over no more than five years.

- The budget eliminates or reduces required minimum distributions for IRAs and other tax-qualified retirement arrangements with "low balances" (an aggregate value not exceeding $100,000 as of the "measurement date," with phase-ins up to $110,000).

- Non-spouse beneficiaries of IRAs and qualified plans would be allowed to roll their distributions over within 60 days.

- The budget proposal repeals – for publicly traded companies only – the deduction companies can currently take for employer stock dividends paid to the plan.

- The budget proposal seeks to give the Internal Revenue Service (IRS) new authority to require electronic filing of the Form 5500 for all plans, including small employers.

- The proposal establishes reciprocal reporting under the Foreign Account Tax Compliance Act (FATCA), expanding accounting and reporting requirements by certain financial institutions.

Health Care

- The 2015 budget proposal provides resources to continue to support implementation of the Patient Protection and Affordable Care Act (PPACA), including the Health Insurance Marketplace, premium tax credit and cost sharing assistance, and increasing federal support to states expanding Medicaid coverage for newly eligible low-income adults.

- As in prior years, the proposal "implements payment innovations and other reforms in Medicare and Medicaid and other Federal health programs that encourage high-quality and efficient delivery of health care, improve program integrity, and preserve the fundamental compact with seniors, individuals with disabilities, and low-income Americans." This is accompanied by $25 million over two years to monitor and prevent fraud, waste and abuse in the Health Insurance Marketplace.

- The budget retains a modified version of last year's proposal for income-related premiums. Specifically, the proposal would impose premium increases for beneficiaries in Medicare Parts B and D and impose a surcharge on Medicare Part B premiums for new beneficiaries and those that purchase near or full first-dollar Medigap coverage.

- The budget proposes a program to align employer group waiver plan payments with average Medicare Advantage plan bids.

- The budget proposes to expand mental health treatment and prevention services across the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention and make changes to the Medicaid program to increase access to mental health services, particularly for youth.

Other Issues

- As in the previous year's budget proposal, the president recommends a program to penalize and eliminate misclassification of employees as "independent contractors." The budget proposal specifically includes $14 million to combat misclassification (identical to the prior year's budget), including $10 million for grants to states to identify misclassification and recover unpaid taxes and $4 million for the U.S. Department of Labor (DOL) Wage and Hour Division (WHD) to investigate misclassification.

- With regard to family leave issues, the budget also again proposes a $5 million "State Paid Leave Fund" within DOL to provide competitive grants that would help states cover the start-up costs of launching paid-leave programs. The budget proposal also provides an increase of more than $41 million for the DOL WHD for increased enforcement of laws addressing wages, overtime and family and medical leave.

Deadline Postponed for Comments on HIPAA Compliance Certification Proposed Rules

The U.S. Department of Health and Human Services (HHS) has formally postponed the deadline for submission of comments on **proposed regulations** establishing new requirements for certification of compliance with the administrative simplification provisions of HIPAA. The deadline, previously set for March 3, has been extended to *April 3, 2014*.

Under the administrative simplification provisions of HIPAA, covered entities are required to conduct certain transactions electronically using standards and code sets designated by HHS. Transactions subject to these requirements include eligibility, claims & encounter information, claims status, enrollment and disenrollment, payment, premium payment and coordination of benefits. In addition to adding new transactions, The Patient Protection and Affordable Care Act (PPACA) mandated that health plans submit certain documentation and information to HHS that demonstrates compliance with electronic transaction standards and established new penalties for health plans that fail to comply.

Under the HHS proposed regulations, issued January 2, health plans that are "controlling health plans" (a definition added by prior final regulations implementing the unique health plan identifier (HPID) requirements of HIPAA) must submit: (1) documentation that demonstrates compliance using one of two available methods; and (2) its number of covered lives on the date. These requirements apply with respect to three transactions: eligibility for a health plan, health care claim status and health care electronic funds transfer and remittance advice. Under the proposed regulations, the required documentation and information will be due December 31, 2015.

RECENT JUDICIAL ACTIVITY

No stories this month