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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

Proposed Legislation Seeks to Protect Employee Benefits in Bankruptcy, Creates Presumption of Vesting for all Retiree Health Benefits

The Bankruptcy Fairness and Employee Benefits Protection Act (S. 2418), introduced June 3 by Senators Jay Rockefeller (D-WV) and Elizabeth Warren (D-MA), would restrict companies from making changes to benefit programs in the event of bankruptcy. The bill also creates a presumption of lifetime vesting of retiree health benefits under ERISA plans and collectively bargained arrangements.

According to a news release and summary issued by Rockefeller's office, "the bill would limit the ability of companies to reduce or terminate benefits for employees and retirees under the federal Bankruptcy Code, and entitle retirees to the continuation of health care benefits for at least two years following the restructuring of their former employer – even if the court rules that the company is eventually allowed to halt benefits."

In addition, S. 2418 amends Section 502 of ERISA to establish a presumption that retiree health benefits under the plan fully vest at retirement or completion of 20 years of service and cannot be modified or terminated for the life of the employee or (if longer) the life of the employer's spouse. In the event of litigation relating to the benefits of the retiree employee, this presumption could be overcome through the presentation of "clear and convincing evidence" that the group health plan allowed for modification or termination of benefits and "that the employee, prior to becoming a participant in the plan, was made aware, in clear and unambiguous terms" that the plan allowed for such modification or termination. ERISA currently does not provide for the vesting of retiree health benefits, unlike pension benefits.

Vesting of retiree health benefits is also under review by the U.S Supreme Court in *M&G Polymers USA, LLC v. Tackett*, a Sixth Circuit Court decision that applied an inference that union retiree benefits are intended to be vested in the absence of specific plan or bargaining agreement language to the contrary. Other appeals courts, including the Second, Third and Seventh Circuits, have ruled that retiree health benefits are not vested without specific durational language. The Supreme Court (in a decision next term) is expected to resolve a split among federal appeals courts regarding how to interpret collectively bargained agreements with respect to the duration of retiree health benefits.

S. 2418 would also:

- Require companies in bankruptcy to pay for retiree health care benefits for at least two years following the company's restructuring.
- Require companies to continue making payments to pension plans while bankruptcy proceedings are ongoing.
- Require companies to provide specific information to employees about the duration of their retiree health care benefits.
- Commission a study by the Government Accountability Office (GAO) on strategies some companies use to avoid paying promised benefits to their employees and retirees.

An official section-by-section summary is also available on Rockefeller's website.

House Subcommittee Hearing Discusses Risk Mitigation Provisions in PPACA

In a June 18 hearing of the U.S. House of Representatives Committee on Oversight and Government Reform Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, witnesses gave testimony on the three mechanisms to mitigate risk under the Patient Protection and Affordable Care Act (PPACA): reinsurance, risk adjustment and risk corridors. During the hearing, Poised to Profit: How Obamacare Helps Insurance Companies Even if it Fails Patients, Republican members of the subcommittee were thoroughly critical of the law and its consequences for participants.

They asserted that the risk corridor program effectively transfers money from insurers with lower-than-expected claims for qualified health plans sold in the individual and small-group markets (inside and outside of public exchanges) to insurers with higher exchange plan claims. PPACA requires insurers and health plans to pay into the reinsurance, risk adjustment and risk corridor program for three years, but the federal government would likely be called upon to pay a portion of the cost of the risk corridor program if insurance company payments are insufficient.

In his opening statement, Subcommittee Chairman Jim Jordan (R-OH) characterized the risk mitigation provisions as constituting a "bailout" of private insurance companies, citing inconsistent Congressional Budget Office (CBO) evaluations of the programs. He suggested that it was "crucial for us to understand how the Administration plans to funnel taxpayer money to health insurance companies to subsidize profits" and with what legal authority the Administration is able to do so.

Ranking Democratic subcommittee member Matt Cartwright (D-PA) said in his opening statement that each of the three provisions is funded in a way that reinforces the accuracy of the CBO's estimate of budget neutrality. He stated that rather than continuing to attack the PPACA, he hoped to reexamine ways to increase the efficiency and effectiveness of the law.
Ranking Democratic member of the full committee Elijah Cummings (D-MD) also provided an opening statement, noting that the risk mitigation provisions in the PPACA were previously included in Medicare Part D, passed and adopted by a Republican administration and Congress, and have been very successful thus far.

The subcommittee heard testimony from the following witnesses:

- Senator Jeff Sessions (R-AL) testified that PPACA did not meet the requirements to receive an appropriation from Congress to finance the risk corridor programs. He urged lawmakers of both parties to act in defense of Congress and the authority delegated to it by the Constitution.

- John R. Graham, senior fellow at the National Center for Policy Analysis, discussed how, despite the assurance from the CBO and the Department of Health and Human Services (HHS), that the risk corridor programs are budget-neutral, it is unlikely to occur in reality, and urged Congress "to ensure that [taxpayers'] liabilities in the risk corridors are limited and precisely quantified."

- Seth J. Chandler, foundation professor of law at the University of Houston Law Center, expressed his concern about how the risk corridors are being implemented and the calculation methodology used by CBO.

- Cori E. Uccello, senior health fellow at the American Academy of Actuaries, explained the inherent financial risks imposed on insurers under PPACA and stated that any revisions must be made with sensitivity to the possible impact on insurer risks, insurance availability, and insurance premiums.

- Edmund F. Haislmaier, senior research fellow in health policy at the Heritage Foundation, stated that the reinsurance and risk adjustment programs alone should be "more than sufficient to address the basic uncertainties - market selection and individual selection risks - that insurers face in the post-PPACA market" and urged Congress to eliminate the risk corridor program.

- Dr. Mandy Cohen, acting deputy administrator and director at the Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, stated that the access to health care for the previously uninsured under the PPACA effectively benefits those who had already been insured, as uncompensated costs are commonly passed to American families through higher taxes, premiums and health care costs.

During the question-and-answer period, the discussion centered on the accuracy of the CBO estimates, the possible liability for taxpayers, how the risk programs operate to reduce uncertainty and the impact of the law on health care costs.

Republicans to Challenge Obama's Executive Authority

Speaker of the U.S. House of Representatives John Boehner (R-OH) announced on June 24 that House Republicans plan to pursue a lawsuit against President Barack Obama, alleging abuse of executive authority. A formal announcement is expected to be issued shortly.

Boehner spokesman Michael Steel told reporters that such action is necessary because the Senate has declined to take up measures passed by the House that would check the power of the executive, including legislation to expedite potential House lawsuits against the president and targeting the use of executive actions beyond what has been authorized by Congress.

It is not yet clear what specific administrative activity will be targeted in the potential lawsuit. It is likely that the charges will reference executive action related to implementation of employee benefits policy, including the president's decision to delay the employer mandate of the Patient Protection and Affordable Care Act (PPACA).

As individual members of Congress do not have legal standing to sue the President, Congress as an institution would have to sue on the basis of its legislative powers being superseded. In order to do so, Boehner may assemble the Bipartisan Legal Advisory Group, a panel of leaders that votes on whether or not to sue on behalf of the House. The suit would have to prove the institutional injury and that no other private plaintiff has standing to challenge the suspension of executive action and that there are no other avenues for meaningful political remedies by Congress.

RECENT REGULATORY ACTIVITY

Administration Issues Final 90-Day Waiting Period 'Orientation Period' Rules

Late on June 20, the U.S. departments of Treasury, Labor and Health and Human Services released final regulations clarifying the maximum allowed length of "any reasonable and bona fide employment-based orientation period" consistent with the 90-day waiting period provision of the Patient Protection and Affordable Care Act (PPACA).

PHSA Section 2708 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 for coverage that exceeds 90 days. When the departments issued final regulations specifically addressing the 90-day limitation, they also issued proposed rules providing that "satisfaction of a reasonable and bona fide employment-based orientation period of up to one month may be used as a condition of eligibility under the plan."

These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. Until then, the departments will consider compliance with the proposed regulations to be compliance with PHS Act Section 2708.

CBO Presentation Posits Limiting Health Insurance Tax Exclusion

A presentation prepared by the Congressional Budget Office (CBO) for the Fifth Biennial Conference of the American Society of Health Economists on June 23 examined a number of approaches for limiting the current-law exclusion of the cost of employer-sponsored health insurance from employees' income tax.

The analysis, requested by the Joint Committee on Taxation, was developed "to stimulate discussion and critical comment" among members of Congress. It follows the CBO's list of options for reducing the deficit, issued in November 2013 in anticipation of legislative negotiations over the federal budget and tax reform.

The presentation set forth the positive and negative effects of the established tax exclusion - noting, in particular, that it promotes affordable employment-based coverage - and examined how the enactment of the Patient Protection and Affordable Care Act (PPACA) has changed the context for possible reform.

The presentation then compared three specific approaches for limiting the exclusion:

(A) Totally eliminate the tax exclusion for federal income tax and payroll tax purposes.
(B) Eliminate the tax exclusion for federal income tax but not for payroll tax purposes.
(C) Cap income and payroll tax exclusions at the median premium for employment-based plans.

The CBO concluded that the current tax treatment - in comparison to the three alternative approaches - maximizes employment-based insurance while minimizing the uninsured population, the exchange population and the Medicaid and CHIP population. These results persist even when broken down by income group. Of the three alternatives, Option (C) comes closest to replicating current law.

There is currently no timetable for comprehensive tax reform.

PBGC Projections Show Improvement in Single-Employer Plans, Multiemployer Plans at Serious Risk

The Pension Benefit Guaranty Corporation (PBGC) published its Fiscal Year 2013 Projections Report on June 30, revealing that the financial condition of the single-employer insurance program is likely to improve over the next decade, while multiemployer plans continue to pose serious concerns for participants and the PBGC.

According to the report, the projected deficit of $27.4 billion is projected to narrow to, on average, $7.6 billion by FY 2023 - a roughly $25 billion decrease from last year's ten-year projected deficit of $32.5 billion in FY 2022. "It is highly unlikely that the single-employer program will run out of funds in the next 10 years," the report notes. The PBGC attributes these improvements to strong market returns and rising interest rates, as well as recent premium increases.

The discussion of single-employer plans includes a section on "recent single-employer plan trends," in which PBGC acknowledges increasing "de-risking" activity, in which plan sponsors terminate healthy plans and purchase annuities for participants. The PBGC projection model does not currently account for this activity, although the agency expresses interest in investigating the matter in future reports.

In contrast to the single-employer program, the PBGC depicts a much more troubled outlook for multiemployer plans, projecting that the multiemployer program's 2013 deficit of $8.3 billion will widen to, on average, $49.6 billion by FY 2023. "Absent premium increases and/or changes in law, the program is more likely than not to run out of funds in eight years and highly likely to do so within 10 years." The multiemployer plan funding rules instituted by the Pension Protection Act of 2006 are scheduled to expire at the end of 2014 and it is unclear if Congress will be able to extend or address these rules before the end of the year.

The PBGC's report also details numerous changes to its Multiemployer Pension Insurance Modeling System (ME-PIMS)

The Obama Administration (in its proposed FY 2015 budget) and some lawmakers have recently proposed increasing premiums - on top of nearly $17 billion in increases over the past two years.

RECENT JUDICIAL ACTIVITY

Supreme Court Strikes Down Presumption of Prudence for Stock Fund Fiduciaries

In a unanimous decision handed down on June 25, the U.S. Supreme Court concluded that stock plan fiduciaries are not entitled to any *special presumption* of prudence and are subject to the same duty of prudence that applies to ERISA fiduciaries in general.

The case of Fifth Third Bancorp v. Dudenhoeffer centered on allegations that the defined contribution plan sponsor violated its fiduciary duty under ERISA by providing an investment option composed primarily of company stock when it was "imprudent" to do so. When the employer's stock price declined, retirement plan investment returns were negatively affected

(commonly known as a "stock drop" case). Dudenhoeffer was the first employer stock case brought under ERISA to be heard by the Supreme Court, though the matter has arisen in many other cases at the district and appeals court levels.

In a decision written by Justice Stephen G. Breyer, the Supreme Court ruled that:

- ESOP fiduciaries are not entitled to any special presumption of prudence and are subject to the same duty of prudence that applies to ERISA fiduciaries in general, except that they need not diversify the fund's assets.
- The Sixth Circuit, which had originally ruled in favor of the plan, should reconsider its criteria for whether a complaint meets the "pleading" standard for a breach of fiduciary duty.

While rejecting the prior law presumption that buying or holding employer stock in an Employee Stock Ownership Plan (ESOP) is prudent, the Court also provided new rules that could significantly reduce successful "stock drop" claims or allegations that a fiduciary should have taken an action based on "inside information." This is an important positive development for plan-sponsors with publically traded stock funds.

Supreme Court Exempts "Closely Held" Companies from Contraceptive Coverage Mandate

In a narrowly worded, five-to-four decision issued on June 30, the U.S. Supreme Court ruled that the preventive care regulatory provisions promulgated to implement the Patient Protection and Affordable Care Act (PPACA) do not require comprehensive coverage of contraceptive services where a "closely-held" employer holds religious objections to such coverage.

The plaintiffs in *Burwell v. Hobby Lobby Stores* and *Conestoga Wood Specialties Corp. v. Sebelius* challenged the PPACA regulations that mandate contraceptive coverage as violating statutory and constitutional protections of religious liberty. In both cases the for-profit company owners, as health plan sponsors, hold religious objections to providing coverage for some forms of birth control. (Religious institution employers and religiously-affiliated plan sponsors may claim an exemption under PPACA's implementing regulations.)

Specifically, the companies maintained that for-profit corporations are protected by the constitutional right to religious freedom and the Religious Freedom Restoration Act of 1993 (RFRA) and should be able to refuse to provide contraceptive coverage based on the religious beliefs of the corporations' owners. The government, however, argued such claims have not been historically recognized and are limited to individuals and non-profit religious groups.

The majority opinion, authored by Justice Samuel Alito, held that the contraceptive coverage mandate violates the RFRA, as it applies to "closely held corporations" by imposing a "substantial burden" on religion. Under the RFRA, the government may not impose a substantial burden on religion unless the government does not have a less restrictive means of achieving a compelling interest. (According to the IRS, a "closely held corporation" (1) has more than 50 percent of the value of its outstanding stock owned (directly or indirectly) by five or fewer individuals at any time during the last half of the tax year, and (2) is not a personal service corporation.)

The majority opinions cited the Obama Administration's accommodation of non-profit religious organizations, spelled out in final regulations issued in July 2013, as an approach that is less restrictive than requiring employers to fund contraceptive methods that violate their religious beliefs. Under these regulations:

- With respect to insured plans, including student health plans, affected religious organizations (such as schools or hospitals) would provide notice to their insurer. The insurer would then notify enrollees that it is providing them with no-cost contraceptive coverage through separate individual health insurance policies.
- With respect to self-insured plans, as well as student health plans, these religious organizations would provide notice to their third party administrator. In turn, the third party administrator would work with an insurer to arrange no-cost contraceptive coverage through separate individual health insurance policies.

The assertion that the contraceptive coverage is "no-cost" assumes that the actual cost of those individual policies covering contraception is not reflected elsewhere in an employer's overall health care costs or in the portion of the costs that employees are called upon to share. Nonetheless, that "solution" was acceptable for some, but not all, religious institutions that had raised objections to being required to pay for contraceptive coverage for employees.

Despite the way it is repeatedly described in the media, PPACA itself does not require coverage for contraception services. When enacted, the law required all new health plans to provide first-dollar coverage of preventive services that fall into certain categories. With respect to women's health, it identified "preventive care" as provided for in comprehensive guidelines to be supported by the Health Resources and Services Administration - an agency of the U.S. Department of Health and Human Services (HHS).

To inform the implementation of that requirement, HHS commissioned the Institute of Medicine (IOM) to publish a report recommending the guidelines to be supported. In August 2011, very shortly after the release of IOM's Clinical Preventive Services for Women: Closing the Gaps, HHS adopted the IOM's recommendations, including coverage of contraception methods without imposing any cost sharing. While it may be a distinction without a real difference, Congress never mandated health plan coverage for contraceptive services. Rather, it was the HHS implementation of the preventive care section of the law which requires that coverage.

Importantly, Alito noted in his opinion that the ruling was "very specific" and should not be construed as permitting for-profit corporations or commercial enterprises to "opt out of any law they judge incompatible with their sincerely held religious beliefs."

Congressional Democrats have largely criticized the ruling, although it is not certain whether the matter will be addressed legislatively.

Supreme Court Decision: Inherited IRAs Not Exempt from Debtor's Bankruptcy Estate

In a unanimous decision handed down on June 12, the U.S. Supreme Court ruled that inherited IRAs do not qualify as "retirement funds" that are exempt from a debtor's bankruptcy estate. This decision may have implications for retirement and estate financial planning.

In 2005, Congress amended the bankruptcy code to provide that "retirement funds" are exempt from a debtor's bankruptcy estate "to the extent that those funds are in a fund or account that is exempt from taxation" under certain sections of the tax code, including employer-sponsored retirement plans and IRAs. When an IRA owner dies, the IRA is categorized as an "inherited" IRA unless the beneficiary is the owner's spouse. However, the 2005 changes to the Bankruptcy Code did not explicitly address whether an *inherited* IRA is entitled to the same exemption under the bankruptcy code that is available to retirement plans and non-inherited IRAs. Circuit courts were unable to reach consensus on whether such inherited IRAs are exempt.

In the case of *Clark v. Rameker*, et al, the Supreme Court affirmed the conclusion and reasoning of the Seventh Circuit that the inherited IRA was not exempt from creditors under the bankruptcy code. To be exempt, the court ruled, two requirements must be met:

- The relevant funds must be "retirement funds."
- Those funds must be held in an arrangement that is exempt from taxation under one of the enumerated sections of the Internal Revenue Code.

The Court consequently ruled that inherited IRAs are not "retirement funds," based on three characteristics:

- The holder of an inherited IRA cannot make additional contributions to the account.
- The holder of an inherited IRA is required to withdraw money from the account no matter how close the holder is to retirement.
- The holder of an inherited IRA may withdraw the entire balance of the account at any time without imposition of the 10 percent penalty tax.

This is not the first time such issues have caught the eye of policymakers. Recent proposals in Congress and by the Obama Administration have sought to address "stretch IRAs," which are broader than inherited IRAs and refer to instances where a non-spouse beneficiary elects a distribution of the remaining interest over his or her life or life expectancy. These "stretch IRA" proposals would amend the required minimum distribution rules for inherited IRAs to require faster payouts (and thereby limit tax deferral) for certain non-spouse beneficiaries.