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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 Smith, employee benefits attorney and Principal of Flexible Benefits System, Inc. csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Nothing to report this issue.

The U.S. Senate and House of Representatives are in recess until after the mid-term elections. Both chambers are scheduled to return on November 12.

RECENT REGULATORY ACTIVITY

CMS Updates HPID Application Process to Eliminate Approval by Authorizing Official

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have posted an updated quick reference guide and Health Plan ID User Manual to help in obtaining a health plan identifier (HPID). The updated documents reflect changes to the HPID application process that eliminates the requirement that HPID applications be approved by an "Authorizing Official."

Health plans that are "controlling health plans" (a definition added by prior final regulations implementing the HPID requirements of HIPAA), with the exception of small health plans, are required to obtain an HPID by November 5, 2014. Such plans include employer sponsored self-insured health plans. CMS has also provided a dedicated CMS website with information on the application process and links to HPID frequently asked questions (FAQs).

Users that need to obtain a Controlling Health Plan (CMP) Health Plan Identifier (HPID) will go through the CMS Enterprise Portal, access the Health Insurance Oversight system (HIOS), and apply for an HPID from the Health Plan and Other Entity System (HPOES). The HPOES has been updated to reflect that the HPOES no longer requires the Authorizing Official to approve applications prior to HPID or Other Entity Identifier (OEID) assignment.

New FAQ Provides Updated Guidance on Reference-Based Pricing Under PPACA

A new **"frequently asked question" (FAQ) document** was released jointly by the U.S. Departments of Labor (DOL), Health and Human Services (HHS) and Treasury on October 10, updating prior guidance on the application of Patient Protection and Affordable Care Act (PPACA) cost-sharing limitations for plans using "reference-based pricing."

The new FAQ sets out specific factors that the departments will consider when evaluating whether a plan that uses reference-based pricing (or a similar network design) is using a "reasonable method" to ensure that it provides adequate access to quality providers at the reference base price.

Generally, reference-based pricing is a system under which the plan pays a fixed amount for a particular drug, procedure or other service (for example, a knee replacement), which certain providers will accept as payment in full. If an individual uses a provider that does not accept the reference price, the individual pays the difference between the reference price and the actual price of the service.

Under Section 2707(b) of the Public Health Service Act (PHSA), as added by PPACA, 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 2015, these limits are $6,600 for self-only coverage and $13,200 for other coverage, with future limits increased by a statutorily-defined percentage.

On May 2, FAQ Part XIX explained, among other things, that the Departments would not consider a large group market plan or self-insured group health plan that utilizes a reference-based pricing design plan as failing to comply with the out-of-pocket limitations of Section 2707(b) because the plan or issuer treats providers that accept the reference amount as the only in-network providers. This would be the case as long as the plan or issuer uses "any reasonable method" to ensure that it offers adequate access to quality providers.

In the May 2 FAQ, the Departments explained that while reference-based pricing is designed to encourage plans to negotiate treatments with high-quality providers at reduced costs, there was also concern that such a pricing structure could be a "subterfuge" for imposing otherwise prohibited limits on coverage without ensuring access to quality or an adequate network. As a result, the May 2 FAQ solicited comments on the application of maximum out-of-pocket requirements to such benefit designs, indicating a particular interest in standards that plans or issuers using reference-based pricing should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care.

The October 10 FAQs about Affordable Care Act Implementation (Part XXI), consists of a single question and answer. It states that pending issuance of future guidance, for purposes of enforcing the requirements of Section 2707(b), the Departments will consider "all the facts and circumstances" when evaluating whether a plan's reference-based pricing design (or similar network design) that treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers as using a "reasonable method" to ensure adequate access to quality providers at the reference price. The guidance specifies the following factors to be considered:

- *Type of services provided:* The guidance clarifies that limiting or excluding cost sharing from counting toward the out-of-pocket limitation with respect to providers who do not accept the reference-based price would not be considered reasonable with respect to emergency services.

- *Reasonable access to an adequate number of providers:* Plans should have procedures to ensure that an adequate number of providers that accept the reference price are in the network and are encouraged to look to state standards for adequacy, as well as reasonable geographic distance measures and wait times.

- *Reasonable quality standards:* Plans should have procedures to ensure that an adequate number of providers that accept the reference price meet "reasonable quality standards.

- *An "easily accessible" exceptions process:* The guidance indicates that such a process should be offered if access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time) or the quality of the service with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or safety issues).

- *Disclosure to plan participants:* Plans should automatically provide information regarding the pricing structure, including a list of services it applies to and the exceptions process, for example through the plan's Summary Plan Document or similar document. Disclosures to be made upon request by plan participants include: a list of providers that accept the reference price for each service, a list of providers that will accept a negotiated price above the reference price and information on the underlying data used to ensure adequacy of providers who will accept the reference price and quality standards.

The FAQ indicates that the Departments will "continue to monitor" the use of reference-based pricing and may provide additional guidance in the future.

ERISA Advisory Council Drafts Recommendations on Plan Outsourcing, Lifetime Plan Participation, PBMs

On September 29, the ERISA Advisory Council (EAC) met via teleconference to discuss their draft recommendations to the U.S. Department of Labor (DOL) on PBM fee disclosure, plan outsourcing and lifetime plan participation.

The EAC is a group of benefits experts established under the Employee Retirement Income Security Administration (ERISA) to identify emerging benefits issues and advise the Secretary of Labor on health and retirement policy. Its final report is due to the DOL on November 4, 2014. This teleconference session follows two previous 2014 hearings held in June (on which we have previously reported).

Outsourcing Employee Benefit Plan Services

The EAC is studying the outsourcing of employee benefit plan services, with a particular focus on the allocation of legal responsibilities and risk for activities of a service provider on behalf of a plan. The EAC drafted the following recommendations with respect to outsourced services:

- ***Educate plan sponsors on current practices for outsourced services.*** The EAC recommended the DOL provide industry information about the range of outsourcing options and types of providers, specifically with respect to "outsourced CIO [Chief Investment Officer]" arrangements, and provide information on contracting practices, such as termination rights, indemnification, liability caps and service level agreements, which might assist plan sponsors and other fiduciaries in negotiating service agreements. The EAC emphasized that any education offered by the DOL should not be prescriptive in nature.

- ***Clarify the legal framework under ERISA for delegating responsibility to service providers.*** The EAC recommended clarification of (1) plan sponsors' responsibility under ERISA Section 404 where the plan document designates a "named fiduciary" under ERISA Section 3(21)A that is not the plan sponsor, and (2) the scope of liability for a fiduciary who appoints a non-fiduciary service provider to perform functions necessary for the operation. The EAC also recommended (3) clarification on administration of the plan and application of the co-fiduciary provisions of ERISA Section 405, including whether the co-fiduciary liability provisions of ERISA Section 405(c)(2)(B) impose additional obligations of an appointing fiduciary beyond the duty to select and monitor an appointed fiduciary, and if so, the extent of those duties, the standard of knowledge required for co-fiduciary liability under ERISA Section 405(a) and contribution rights among co-fiduciaries.

In particular, the drafters of this recommendation intentionally avoided taking a position about whether delegating the "named fiduciary" function was a fiduciary act.

- ***Provide additional guidance on the duty to select and monitor service providers.*** The EAC recommended that the DOL provide guidance through: (1) consolidating prior guidance on a fiduciary's duty to select and monitor service providers, (2) providing guidance on the frequency and scope of monitoring requirements, (3) identifying "questions to ask" and other best practices in selecting and monitoring service providers, (4) providing guidance on managing potential conflicts of interest in engaging fiduciary service providers and (5) publishing clear examination and enforcement priorities with the publication of relevant examination findings.

- ***Facilitate the use of Multiple Employer Plans (MEPs) and similar arrangements as a means of encouraging plan formation by relieving plan sponsors of fiduciary obligations and administrative burdens.*** The EAC recommended the DOL accomplish this by (1) revisiting the requirement that there be a relationship among participating employers in a multiple employer plan as contemplated by Advisory Opinion 2012-04A (although this suggestion may change as a result of discussion within the EAC), (2) considering developing a sample structure for MEPs that will help insure that conflicts of interest, prohibited transactions and true fiduciary independence and disclosures are in place, and (3) developing safe harbors for MEP sponsors and adopting employers that would not expose them to liability from acts of non-compliant adopting employers. The EAC has agreed to revisit this subject at a November 3 meeting.

- ***Update and provide additional guidance on insurance coverage and ERISA bonding practices of outsourced service providers.*** The EAC suggested DOL update fidelity bond regulations and Field Assistance Bulletin 2008-04, and educate plan sponsors on the availability of fiduciary insurance coverage including information on scope of coverage, deductibles, policy limits, and ratings of insurers.

Facilitating Lifetime Plan Participation

The EAC is also studying the factors leading participants to leave their assets in or move them out of an employer-sponsored retirement plan. The EAC made the following preliminary recommendations with regard to facilitating lifetime plan participation:

- ***Provide education and outreach to participants and plan sponsors and develop a model notice for participants.*** Suggested measures include providing sample educational materials that can be used by plan sponsors and development of a "plain English" model notice that can be provided to participants prior to enrollment and throughout employment, to help them decide what to do with retirement assets particularly at job change and retirement or other distribution events. The EAC ultimately declined to endorse the position that staying with an employer plan is more beneficial for participants, because many factors could change this equation for various individuals and in various circumstances.

- ***Provide education to plan sponsors relating to plan features that encourage lifetime participation.***The EAC's final report will likely identify a list of "best practices" for this purpose.

- ***Provide additional guidance to encourage plan sponsors to offer lifetime income options.*** The EAC recommended the DOL provide additional guidance (including an updated defined contribution plan annuity safe harbor) and explore making certain tools (such as the agency's Lifetime Income Calculator) more integrated and available.

- ***To the extent that plan sponsors make loans available to participants, the DOL should encourage them to consider allowing continuation of loan repayments after separation.*** The DOL could also point out the advantages of loan initiation post-separation to prevent leakage. There was some debate among EAC members about whether the body should be encouraging plan loans at all.

- ***Allow for technological advances.*** The EAC recommends that the DOL: (1) create uniform sample forms for improving plan-to-plan transfers (roll-ins and roll-outs), (2) foster technology standards to simplify certain administrative functions and (3) ask a future Advisory Council to consider the issues related to standardized technology solutions for automatic account aggregation for job changers. These recommendations are based in part on recent efforts in the Australian system.

Pharmacy Benefit Manager Compensation and Fee Disclosure

The EAC also discussed recommendations concerning pharmacy benefit manager (PBM) compensation and fee disclosure, with a focus on whether PBMs should be required to comply with plan fee disclosure regulations under ERISA Section 408(b)(2).

After discussing a number of findings based upon witness testimony, including testimony from employers' regarding difficulty in getting compensation-related information from PBMs and concerns regarding possible conflicts of interest underlying the compensation arrangements, the EAC made the following recommendations:

- ***Consider making the 408(b)(2) regulations applicable to welfare plan arrangements with PBMs.*** The EAC noted that the testimony it received, on balance, supported further examination of the matter of PBM compensation. The EAC also concluded that the PBM's concerns about anti-competitive behavior and the release of proprietary information could be addressed through confidentiality agreements.

- ***DOL should issue guidance to assist plan sponsors in determining whether to and how to conduct a PBM audit of direct and indirect compensation.*** Many plan sponsors told the EAC that such audits are necessary to help them meet their fiduciary duties. However, while such audits are believed to be needed because they allow fiduciaries to confirm that PBMs are paid in accordance with the terms of the service contract, many plan sponsors have difficulty in obtaining the information they need to appropriately and efficiently conduct the audit. The EAC expressed the belief that DOL guidance will help clarify both the need for such audits and the plan fiduciaries' and PBMs' responsibilities in the conduct of such audits.

Notably, the EAC decided not to recommend further consideration of whether all health and welfare arrangements should be subject to a the ERISA Section 408(b)(2) regulatory regime. The EAC however, intends to include some related observations in its final report to DOL rather than through a formal recommendation.

The EAC reserved the right to change or edit the draft recommendations prior to presenting their final recommendations on November 4.

IRS Posts Updated Draft Forms for Compliance with PPACA Reporting Requirements

On October 1 and 2, the Internal Revenue Service (IRS) re-issued a series of proposed tax forms to be used by applicable large employers and insurers for reporting information regarding health care coverage and "minimum essential coverage" as required under the Patient Protection and Affordable Care Act (PPACA). The updated drafts are largely unchanged aside from some minor formatting changes.

The forms are to be used to fulfill the requirements specified in final regulations implementing the reporting of minimum essential coverage (MEC) under Section 6055 of the Internal Revenue Code) and the reporting of health insurance coverage under Section 6056 of the Internal Revenue Code. These reporting requirements were delayed for 2014 under previously issued Notice 2013-45 transition relief and will not be effective until 2015, making the first required reporting due in early 2016 (though the IRS is encouraging voluntary reporting for coverage in 2014).

- Form 1095-A, used to report information to the IRS about family members who enroll in a qualified health plan through the Marketplace, was re-issued without any changes.
- Form 1095-B, used to comply with Section 6055, has been updated with formatting changes to the boxes in Parts I and II.
- Form 1095-C, used to report the terms and conditions of the health care coverage provided to the employer's full-time employees during the year, was re-issued without any changes.
- Form 1094-C, used to transmit Form 1095-C, was re-issued without any changes.

The IRS is accepting comments on the draft forms which are expected be finalized later this year. Comments may be submitted on the Comment on Tax Forms and Publications page on IRS.gov. No comment deadline is identified for this purpose.

AQA 'Passes Baton' with Final Meeting on Health Care Measurement and Reporting

The AQA alliance, a multi-stakeholder coalition of clinicians, consumers, purchasers, health plans, and others, with the mission to improve health quality through performance measurement and reporting, is formally disbanding with the release of its final workgroup reports.

The AQA (formerly known as the Ambulatory Care Quality Alliance) was created in September 2004 to lead an expedited campaign to improve performance measurement, data aggregation and reporting in the ambulatory care setting. The organization eventually evolved into a multi-stakeholder national coalition of more than 135 organizations.

As part of the AQA alliance's October 3 meeting, the Steering Group released a **historical document** describing the organization's accomplishments and suggestions for successor groups.

The document notes that since the AQA was formed, the measurement and reporting landscape has matured significantly with the launch of the Physician Quality Reporting System (PQRS) and the National Quality Forum to prioritize, review and endorse performance measures. Given this more matured environment in 2014, "the AQA is passing the baton to successor organizations," the document explained.

To guide future efforts, AQA workgroups released final reports based on activity and research over the past year:

- The Measures and Improvement Workgroup, charged with examining how performance measures are developed and used in the clinical community, and how they influence quality improvement, released **Views on Performance Measurement from National Clinical Organizations**.

- The Reporting Workgroup released **The Health Care Quality Reporting Landscape**, examining factors influencing public reporting of health care costs and quality, as well as a number of policy options, payer actions, research directions and other strategies to address this environment.

RECENT JUDICIAL ACTIVITY

EEOC Files Second Lawsuit Challenging an Employer Wellness Program

On October 1, the U.S. Equal Employment Opportunity Commission (EEOC) announced a lawsuit challenging a wellness plan sponsored by a Flambeau, Inc. (a Wisconsin-based manufacturer with 1,600 employees) as violating the Americans with Disabilities Act (ADA). The EEOC lawsuit in *EEOC v. Flambeau, Inc.* alleges that the company's wellness plan required employees to complete biometric testing and a health risk assessment (HRA) on a day appointed by the employer. The complaint further alleges that an employee, who was on medical leave on the appointed day, did not complete the HRA or biometric testing, and was denied by the employer when they tried to complete the required HRA and biometric testing subsequently. The employee's health insurance was allegedly terminated for failure to complete the wellness requirements and the employee was informed that he could apply for "medical insurance" and pay the entire COBRA premium rate.

The EEOC's suit, filed in the U.S. District Court for the Western District of Wisconsin, argues that the biometric testing and health risk assessment constituted "disability-related inquiries and medical examinations" that were not job-related and consistent with business necessity as defined by Title I the ADA, which prohibits disability discrimination in employment, including making disability-related inquiries.

This is the second lawsuit filed by the EEOC in recent months (and its Chicago District Office, specifically) challenging a wellness program under the ADA. In August, the agency filed suit against Orion Energy Systems, alleging that the company fired an employee (after first making her responsible for her entire health insurance premium) when she would not submit to a medical exam and inquiry related to a wellness program. That lawsuit involves a participation-based wellness program requiring the completion of an HRA. The employee who declined to complete the HRA was permitted to enroll in the health plan, but was required to pay the full cost of the coverage ($413 per month for employee-only coverage). The employee objected to the penalty and allegedly was fired for not participating in the wellness program. The EEOC is alleging that

this wellness program is not "voluntary" and thus violates the ADA. *EEOC v. Orion Energy Systems* was filed in the U.S. District Court for the Eastern District of Wisconsin.

The EEOC announced in its most recent semi-annual regulatory agenda that it intends to issue regulations later this year addressing wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act of 2008 (GINA).