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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. To inquire about membership with the Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Nothing to report this issue.

RECENT REGULATORY ACTIVITY

IRS Guidance Clarifies Treatment of Certain Health Coverage in Wake of MV Calculator Glitch

The U.S. departments of Health and Human Services (HHS) and Treasury **issued guidance** on November 4 to address the recently identified glitch in the HHS minimum value (MV) calculator, which is intended to be used to determine whether an employer-sponsored plan provides 60 percent minimum value within the meaning of the Patient Protection and Affordable Care Act (PPACA).

According to the departments, the online MV calculator is improperly qualifying certain group health plan benefit designs that do not provide coverage for in-patient hospitalization services. "It has been suggested that these and other effects resulting from excluding substantial coverage of in-patient hospitalization services may not be adequately taken into account by the MV Calculator and its underlying continuance tables. Similar concerns have been raised regarding the possibility of using the MV calculator to demonstrate that an unconventional plan design that excludes substantial coverage of physician services provides minimum value."
Internal Revenue Service (IRS) Notice 2014-69, issued on behalf of Treasury and HHS, reiterates the departments' view that "plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services (or for both) … ***do not*** provide the minimum value intended by the minimum value requirement." [emphasis added].

According to Notice 2014-69, the departments will shortly propose regulations formally stating this position with the intent of making the regulations applicable in 2015. The notice provides relief, however, for employers that have entered into a binding written commitment to adopt, or have begun enrolling employees in, a Non-Hospital/Non-Physician Services Plan prior to November 4, 2014, based on the employer's reliance on the results of use of the MV Calculator. The notice also clarifies that, pending issuance of final regulations, an employee will not be required to treat a "Non-Hospital/Non-Physician Services Plan" as providing minimum value for purposes of an employee's eligibility for a premium tax credit, regardless of whether the plan is a "Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan." An employer that offers such a plan, including a "Pre-November 4, 2014" plan, will be subject to certain disclosure requirements.

CMS Announces Delay in HPID Enforcement

According to **an announcement issued late on October 31**, the Department of Health & Human Services (HHS) is delaying enforcement of health plan identifier (HPID) regulatory requirements, including the requirement that large health plans (including self-insured health plans) obtain an HPID by November 5, 2014.

Effective October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS) –will delay, until further notice, enforcement of the regulations pertaining to health plan enumeration and use of the HPID in HIPAA transactions

adopted in final regulations issued in September 2012. This enforcement delay applies to all HIPAA covered entities, including healthcare providers, health plans and healthcare clearinghouses.

According to the announcement, "On September 23, the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, recommended that HHS rectify in rulemaking that all covered entities (health plans, healthcare providers and clearinghouses, and their business associates) not use the HPID in the HIPAA transactions. This enforcement discretion will allow HHS to review the NCVHS's recommendation and consider any appropriate next steps." Additional information regarding the health plan identifier is available on CMS' HPID website.

IRS Issues FAQs on Transitional Reinsurance Program

On October 31, the Internal Revenue Service (IRS) updated a set of frequently asked questions (FAQs) on the Transitional Reinsurance Program (TRP) of the Patient Protection and Affordable Care Act (PPACA) with two questions regarding the treatment of contributions made under the reinsurance program as ordinary and necessary business expenses.

Section 1341 of the PPACA established a transitional reinsurance program (2014 through 2016) intended to stabilize premiums in the individual insurance market. Health insurance issuers and certain self-insured group health plans will be assessed a per-enrollee contribution to fund this transitional reinsurance program. The contribution is $63 per covered life for 2014.

Specifically, the FAQs state that:

- a health insurance issuer may treat the contributions under the Reinsurance Program as ordinary and necessary business expenses; and
- a sponsor of a self-insured group health plan may treat contributions (including contributions made directly or through a Third Party Administrator or an Administrative Services Only contractor) under the Reinsurance Program as ordinary and necessary business expenses.

The U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) recently released the form for submitting the TRP annual enrollment count. The deadline for the 2014 benefit year's annual enrollment count submission has recently been extended to December 5.

DOL Releases Rules on Form 5500 Requirements for MEPs

The Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor released **an interim final rule (IFR)** on November 7 describing revisions to annual benefit plan filings for multiple employer plans (MEPs).

The Cooperative and Small Employer Charity Pension Flexibility Act (H.R. 4275), which was signed into law on April 7, imposed additional annual reporting requirements for multiple-employer plans covered by Title I of ERISA. These new annual reporting requirements are applicable for plan years beginning after December 31, 2013. The IFR formally changes the Form 5500 and Form 5500-SF Annual Returns/Reports to incorporate these changes.

A multiple-employer plan is defined in this context as a plan that is maintained by more than one employer and is not a "single employer plan" or a "multiemployer plan" for filing purposes. The requirements apply to all multiple-employer plans, including defined benefit pension plans, defined contribution plans, and welfare plans.

Specifically, forms 5500 and 5500-SF will now provide that the Annual Return/Report filed for a multiple-employer plan must include an attachment that identifies the participating employers in the plan by name and employer identification number (EIN) and includes for each participating employer an estimate of the percentage of the contributions made by each employer (including employer and participant contributions) relative to the total contributions made by all participating employers during the plan year. This attachment, entitled "Multiple-Employer Plan Participating Employer Information," supplements and does not replace other Form 5500 filing requirements that apply to multiple-employer plans.

The IFR becomes effective on November 10. EBSA is soliciting comments and suggestions for final revisions that will be adopted in connection with the 2015 or later year forms. Comments will be accepted through January 9, 2015.

GAO Issues Report on Public vs. Private Sector Defined Benefit Discount Rates

A new report issued October 30 by the Government Accountability Office (GAO) examined the different approaches used by public-sector defined benefit plans as opposed to private-sector defined benefit plans to determine defined benefit plans' discount rate – the interest rate used to determine the current value of estimated future benefit payments for defined benefit pension plans.

Public-sector defined benefit plans must use higher discount rates than private-sector plans, resulting in pension obligation projections that appear considerably lower than those of private-sector single-employer plans. The GAO report, Pension Plan Valuation: Views on Using Multiple Measures to Offer a More Complete Financial Picture, analyzes the significant implications of this difference on plan funding activity. It also looked at the approaches other countries take in choosing discount rates. The analysis was requested by Senator Tom Harkin (D-IA), chairman of the Senate Committee on Health, Education, Labor, and Pensions.

The report found that large differences in the valuation of a plan's obligations can cause vast differences in conclusions about a plan's health, the value of a plan's benefits, and the funding contributions required to meet them. Some experts interviewed by GAO estimated that public plans' approach to discount rates could provide incentives for them to invest in riskier assets by increasing the assumed-return discount rate and thereby lowering reported liabilities and reducing funding requirements. Public pension plan funding has been the focus of policy debate in Congress over the past few years, resulting in proposed legislation such as the SAFE Retirement Act (S. 1270, introduced by Senator Orin Hatch (R-UT)), which includes provisions intended to reduce underfunding in public plans while preserving life-time income for participants.

"Although our report illustrates the differences of opinion over pension discount rates, we found one significant area where there is some, but not universal, room for agreement. Specifically, many experts supported providing multiple measures of liabilities for different purposes to provide a more complete picture of pension plan finances," the report said. The report stopped short of making specific recommendations.

The report also examined the different approaches used by selected countries as well, including Canada, the Netherlands, and the United Kingdom. Plans in these countries that use long-term assumed rates of return are generally lower than the 7.5 to 8 percent used by many U.S. public plans under recent market conditions.

DOL Issues Guidance on State Regulation of Stop-Loss Insurance

On November 6, the U.S. Department of Labor (DOL) issued **Technical Release 2014-01** to provide guidance on state regulation of stop-loss insurance for self-insured group health plans. The guidance addresses state regulation of stop-loss insurance and specifically whether such laws would be preempted by ERISA.

Employers and other sponsors of self-insured group health plans purchase stop-loss insurance who to reduce the risk of large and fluctuating claims. Stop-loss insurance is an insurance contract or provision in a contract between a self-funded benefit plan and an insurance carrier that provides financial protection and insures the employer against losses if claims to the plan exceed a specified dollar amount over a set period of time. Stop-loss insurance contracts protect against claims that exceed a set amount, an attachment point, for either a single enrollee or for aggregate claims over a determined period. The employer self-insures claims costs below the attachment points.

The technical release asserts that "unless prohibited by state insurance law, a stop-loss insurer could offer insurance policies with attachment points [The point at which excess insurance or reinsurance limits apply] set so low that the insurer assumes nearly all the employer's claims risk … [which] effectively gives nearly all the risk protection of a conventional health insurance policy without the consumer protections required for such policies."

To address this matter, some states have considered measures to prohibit insurers from issuing stop-loss contracts with attachment points below a specified level, but have been unsure of their ability to regulate stop-loss coverage due to ERISA preemption of state regulation of private sector employee benefit plans.

According to Technical Release 2014-01, the Department of Labor takes the view "that states may regulate insurance policies issued to plans or plan sponsors, including stop-loss insurance policies, if the law regulates the insurance company and the business of insurance without ERISA preempting the insurance regulation." As discussed in the technical release, "Insurance regulation of group health insurance clearly limits insurance policy choices available to third parties, including employee benefit plans. Insurance regulation of stop-loss insurance can have similar consequence without ERISA preempting the insurance regulation."

ERISA Advisory Council Releases Final Recommendations; EBSA Provides Regulatory Update

On November 4, the ERISA Advisory Council (EAC) approved and presented **its final recommendations** to U.S. Secretary of Labor Thomas Perez and Assistant Secretary Phyllis Borzi of the Employee Benefits Security Administration (EBSA). Prior to the EAC's recommendations, Borzi gave a brief update on EBSA's regulatory agenda.

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. The final recommendations were based on hearings held in June and August. The panel released draft recommendations on September 29.

Borzi provided the following updates to EBSA's regulatory agenda:

- *Brokerage Windows:* The DOL will review responses from the August 20 request for information (RFI) and will not decide on any future regulatory action on to brokerage windows before finishing reviewing. Responses to the RFI are due on November 19.

- *Conflict of Interest ("Fiduciary Definition") Rule:* The DOL is currently working on a new proposed rule with the goal of re-proposing it in January 2015.EBSA originally issued proposed regulations in October 2010 that would have greatly expanded the definition of a fiduciary. However, in the face of bipartisan congressional criticism and concerns expressed by plan sponsor groups, DOL withdrew the regulations. The SEC currently has a related long-term project underway.

- *Limited Wraparound Coverage as an Excepted Benefit:* The DOL is drafting final regulations for wraparound coverage as an excepted benefit under the Patient Protection and Affordable Care Act (PPACA). There is not a specific timetable for the release of the regulation, but if the final regulation contains significant changes from the proposed regulations issued in 2013, the DOL will re-propose the regulation.

- *Proposed Rule for E-Filing of Notices:* The DOL proposed a rule on September 30 that would require electronic filing of top hat plan statements and apprenticeship and training plan notices. Comments are due on December 29.

Facilitating Lifetime Plan Participation

The EAC studied the factors leading participants to leave their assets in or move them out of an employer-sponsored retirement plan. The EAC made the following 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.

- *Provide education to plan sponsors relating to plan features that encourage lifetime participation.*

- *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 or My Social Security) 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.* Borzi said that the DOL may approach recordkeepers to inquire about the cost of establishing a system to better permit loan repayments after separation.

- *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) encourage a future EAC 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.

Outsourcing Employee Benefit Plan Services

The EAC also studied 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 gave 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 [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 402(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. It is important to note that the drafters of this recommendation 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) considering the benefits of MEPs and similar arrangements in rulings, regulations and interpretations, (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 addressed and (3) developing rules and safe harbors for MEP sponsors and adopting employers that would not expose them to liability from acts of non-compliant adopting employers. The DOL expressed particular interest in this portion of the EAC's report, specifically plan sponsor concerns about the current "nexus" requirement for multiple employer plans.

- *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.

Pharmacy Benefit Manager Compensation and Fee Disclosure

The EAC also gave 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). The EAC presented the conflicting viewpoints it received about PBM compensation, including testimony from PBM providers that information regarding fees is available to plan sponsors. On this point, Borzi was extremely skeptical, stating that this "hasn't been [her] experience." 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.

This concludes the EAC's activity for this term. New representatives and topics will be announced in Spring 2015.

PBGC Soliciting Focus Group Participants

The Pension Benefit Guaranty Corporation (PBGC) will be conducting online focus group research for purposes of evaluating and improving customer service to pension practitioners.

If you are a defined benefit pension plan sponsor and are interested in participating as a focus group member, please complete the PBGC's **focus group screening questionnaire**. If you have questions about the study, contact the agency at SurveyCallback@pbgc.gov.

RECENT JUDICIAL ACTIVITY

Supreme Court to Consider Matter of Subsidies in Federally Facilitated Health Exchanges

The U.S. Supreme Court announced on November 7 that it would take up *King v. Burwell*, a case that calls into question the legality of federal subsidies for individuals obtaining health coverage in federally facilitated insurance exchanges. The matter could have far-reaching implications for immediate and long-term implementation of the Patient Protection and Affordable Care Act (PPACA). The high court's decision is expected by June 2015.

The case, being heard on appeal from the U.S. Court of Appeals for the Fourth Circuit, springs from the wording of the subsidy provision in the health care law. The statutory language of the PPACA allows for the provision of subsidies to individuals in "state-based" exchanges. There are currently 36 states in which the exchanges are operated by the federal government, with an estimated five million individuals receiving subsidies in those exchanges. Almost since the law was enacted, this has led to questions whether subsidies were to be available to these individuals.

Treasury regulations have interpreted the law to permit subsidies for insurance plans available in the exchanges that the federal government runs for the states. However, that assertion has been challenged by numerous lawsuits, with different results at the appellate court level.
A three-judge panel of the Fourth Circuit Court of Appeals unanimously ruled on July 22 that PPACA subsidies are *indeed* allowed for policies purchased on federally facilitated exchanges.
However, a panel of the U.S. Court of Appeals for the District of Columbia Circuit released a 2-to-1 ruling on the same day saying that PPACA subsidies are *not* legally allowed for policies purchased on federally facilitated exchanges. The D.C. Circuit recently granted a re-hearing of that decision by a full panel of the court.

This litigation has significant implications for the future of PPACA. In particular, since the employer mandate penalty is specifically triggered by an employee's collection of a subsidy in an exchange, if the some employers may be relieved of penalties, or may have different levels of penalties, depending on which states their workers reside. Also, for those employers that have considered whether their employees might be better served through coverage in exchanges, especially where their workers move from job to job, the lack of subsidies for moderate income workers in some states certainly would change the dynamics in that decision making. Also uncertain is whether legislators and the President will seek to clarify or otherwise address this issue through legislative measures.

District Court Denies EEOC's Request to Block Employer Wellness Program

On November 3, the U.S. District Court for the District of Minnesota denied a request by the U.S. Equal Employment Opportunity Commission (EEOC) to block an employer wellness program.

The EEOC filed a request for a temporary restraining order and preliminary injunction against Honeywell International Inc.'s wellness program on October 27, alleging that it violated the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) by imposing penalties on employees who decline participation in the company's biometric screening program.

The district court's denial of the EEOC's request for a temporary restraining order and preliminary injunction relied on a finding that the program does not meet the legal standard that its continuation poses "irreparable harm" to participants.

This is the third lawsuit filed by the EEOC in recent months challenging employer-sponsored wellness programs. The EEOC is also pursuing a lawsuit challenging a wellness plan sponsored by a Flambeau, Inc. (a Wisconsin-based manufacturer with 1,600 employees) as well as a similar suit against Orion Energy Systems.

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 ADA and GINA. However, the actual timetable for the issuance of such guidance is uncertain.