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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

Proposed Senate Resolutions Would Nullify EEOC Wellness Rules

Lawmakers in the U.S. Senate have introduced a pair of joint resolutions that would invalidate two recently finalized rules governing the treatment of workplace wellness plans.

In May, the U.S. Equal Employment Opportunity Commission (EEOC) issued long-awaited final wellness plan regulations setting forth the compliance requirements for employer-sponsored wellness programs under Title I of the Americans with Disabilities Act (ADA) and Title II of the Genetic Information Nondiscrimination Act (GINA).

On July 14, Senate Health, Education, Labor and Pensions (HELP) Chairman Lamar Alexander (R-TN) – joined by Senators Johnny Isakson (R-GA), David Purdue (R-GA) and Pat Roberts (R-KS) – introduced:

- Senate Joint Resolution 37, which would formally disapprove of and nullify the GINA rule.

- Senate Joint Resolution 38, which would formally disapprove of and nullify the ADA rule.

The resolutions were filed under the Congressional Review Act, which means that the resolutions would be binding if passed by both chambers of Congress by a simple majority within 60 legislative days of the rule's publication (with no filibusters or amendments permitted) and the President's signature.

If the resolutions were to be considered and pass the Senate and House, it is likely President Obama would veto the resolutions. The resolutions would need significant bipartisan majorities, which is unlikely, to override the veto.

New Universal Retirement Bill Mandates Retirement Coverage, Contributions by Employers

New legislation introduced in the U.S. House of Representatives would require employers with at least 10 employees to provide an automatic-enrollment payroll-deduction retirement plan – including employer contributions – to all employees who are not otherwise covered.

Representative Joe Crowley (D-NY) introduced the Secure, Accessible, Valuable, Efficient Universal Pension (SAVE UP) Act (H.R. 5731) on July 14 to promote universal employer-based retirement coverage. The measure would establish a system of SAVE UP accounts to cover employees – including part-time and contingent workers – who are not already covered by their employer. Additionally:

- Employers will be required to directly contribute to each employee's account 50 cents per hour worked, with this amount adjusted yearly using the average annual wage growth.

- Employees would be auto-enrolled with a contribution of 3 percent of their pre-tax income, increasing to 5 percent by the fifth year, unless the employee opts out.

- The SAVE UP accounts will be overseen by a Board of Governors and will include a limited number of index fund options.

- Benefits will be paid out to retirees through an annuity.

- The market risk on these accounts will be mitigated through a flexible reserve fund, funded by investment returns above a set amount.

- Participants will have the ability to loan themselves up to $2,500 from their SAVE UP account to address immediate needs.

- Small businesses will be eligible for a tax credit valued at the level of their contributions into the accounts of up to 10 employees – equaling up to $10,400 a year for five years.

- SAVE UP Accounts would serve in addition to – and not in place of – Social Security.

The SAVE UP accounts will not be calculated in determining whether a person is qualified for a means-tested benefits program, or for college financial aid.

Clearly the bill is designed to address gaps in coverage within the small- and mid-size employer sector. The chart below describes access and participation levels among full-time and part-time workers and among companies of different sizes.

Retirement Plan Access and Participation, Civilian Population		
	Access	Participation
All workers	69%	53%
Full-time	80%	64%
Part-time	38%	20%
Companies with > 500 workers	91%	79%
Companies with< 50 workers	42%	33%
Source: U.S. Department of Labor Bureau of Labor Statistics, based on National Compensation Survey, March 2015		

Since the legislation would appear to also impose mandates and administrative requirements for larger companies that already sponsor a plan for most employees all employers will need to evaluate how the SAVE UP Act would affect their part-time and contingent workforces.

The measure has been referred to the House Ways and Means Committee for consideration. Action by the committee or the full House is unlikely this year.

RECENT REGULATORY ACTIVITY

Proposed IRS Regulations Address MEC Reporting

Proposed regulations released by the Internal Revenue Service on July 29 address a number of outstanding issues related to information reporting of minimum essential coverage (MEC) under Section 6055 of the Internal Revenue Code, as added by the Affordable Care Act (ACA).

Tax code Section 6055 requires issuers and employers that sponsor self-funded plans and other entities that provide MEC to file an annual report with the IRS and issue annual statements to covered individuals indicating the calendar months in a given year in which individuals were enrolled in MEC.

The proposed regulations address the following issues:

Exception to MEC Reporting for Supplemental Coverage
Existing regulations provide that MEC reporting is not required for certain supplemental coverage; however, there has been significant confusion regarding the circumstances under which this exception applies. The proposed regulations generally reflect the adjustments to this rule set forth by the IRS in IRS Notice 2015-68.

Under the proposed regulations, (1) if an individual is covered by more than one MEC plan or program provided by the same reporting entity, reporting is required for only one of the plans or programs; and (2) reporting is not required for an individual's MEC to the extent that the individual is eligible for that coverage only if the individual is also covered by other MEC for which Section 6055 reporting is required. The preamble to the proposed regulations confirm that MEC reporting is not required for a month if that coverage is offered only to individuals who are also covered by other minimum essential coverage – including Medicare, TRICARE, Medicaid, or certain employer-sponsored coverage – for which reporting is required.

TIN Solicitation
Reporting entities are required to provide the IRS with the taxpayer identification number (TIN) (generally, the individual's Social Security number) for each person with coverage. Failure to include a TIN could expose the entity to penalties for not properly completing the Form 1095-B or 1095-C. However, existing IRS regulations describe a three-step TIN solicitation process that an entity should undertake in order to establish it

has acted in a "responsible manner" when attempting to collect TINs. Acting in a "responsible manner" helps provide a basis for arguing that penalties should not apply, in the event the form is filed or furnished without the TIN.

This three-step TIN solicitation process was originally designed for financial institutions and did not necessarily apply well to health coverage providers. Therefore, the IRS has adjusted the missing TIN solicitation process for the purposes of Code section 6055 reporting as follows:

- *Initial Solicitation*: Must be made when an "account is opened" or a relationship is established. For purposes of Section 6055 reporting, an account is considered "opened" on the date the filer receives a substantially complete application for new coverage, or to add an individual to existing coverage. Accordingly, health coverage providers may generally satisfy the requirement for the initial solicitation by requesting enrollees' TINs as part of the application for coverage.

- *First Annual Solicitation:* Must be made no later than seventy-five days after the date on which the account was "opened" (i.e., the day the filer received the substantially complete application for coverage), or, if the coverage is retroactive, no later than the seventy-fifth day after the determination of retroactive coverage is made.

- *Second Annual Solicitation:* Must be made by December 31 of the year following the year the account is "opened."

Notably, different solicitation rules apply for *incorrect* TINs (as opposed to missing TINs). The solicitation rules for incorrect TINs were generally not changed by the proposed regulations, although the IRS did clarify that for purposes of those rules, an account is considered "opened" on the date the filer receives a substantially complete application for new coverage or to add an individual to existing coverage. Accordingly, filers may generally satisfy the requirement for the initial solicitation if they requested enrollees' TINs as part of the application process (including during open enrollment).

If an individual was enrolled in coverage on any day before July 29, 2016, the account is considered opened on July 29, 2016. Accordingly, reporting entities have satisfied the requirement for the initial solicitation of a missing TIN with respect to already enrolled individuals so long as they requested enrollee TINs either as part of the application for coverage or at any other point before July 29, 2016.

TIN solicitations (both initial and annual) made to the responsible individual for a policy or plan are treated as TIN solicitations of every covered individual on the policy or plan. However, filers must solicit TINs for each individual added to a policy under these rules. The provision of a renewal application that requests TINs for all covered individuals satisfies the annual solicitation provisions.

The proposed regulations also confirm that TIN solicitations may be made electronically and there is no requirement to provide a Form W-9 with the solicitation. However, solicitations made by mail must include a return envelope.

Reporting of Catastrophic Plans and Basic Health Programs
Health insurance issuers will be required to report MEC provided through catastrophic health insurance plans (as described in ACA Section 1302(e)) when enrolled through an exchange, effective for 2017 (with the relevant reporting occurring in 2018). This is consistent with prior IRS guidance on this issue.

States are allowed to establish Basic Health Programs (which also constitute MEC) under Section 1331 of the Affordable Care Act ("ACA"). The proposed regulations provide that the State agency administering coverage under the Basic Health Program is required to report that coverage.

Truncated TINs
Reporting entities are allowed to truncate the EIN of the employer sponsoring the plan on the Form 1095-B.

The IRS is soliciting public comment on the proposal through October 3, 2016.

FASB Proposes Updates to Accounting Standards for Retirement, Health Plans

The Financial Accounting Standards Board (FASB) – the independent organization tasked with establishing generally accepted accounting principles (GAAP) within the United States – proposed three updated employee benefit plan accounting standards on July 28 related to the reporting of interest in a master trust. FASB is accepting comments on the proposal through September 26.

The proposal, developed by FASB's Emerging Issues Task Force, addresses defined benefit pension plans, defined contribution retirement savings plans and health and welfare plans. Its purpose is to improve the utility of employee benefit plan financial statements by revising the standards for reporting a plan's interest in a master trust.

A master trust is a trust for which a regulated financial institution (bank, trust company, or similar financial institution that is regulated, supervised, and subject to periodic examination by a state or federal agency) serves as a trustee or custodian and in which assets of more than one plan sponsored by a single employer or by a group of employers under common control are held.

Under current standards, plans are currently required to disclose:

- the fair value of investments held by the master trust by general type of investment;
- the net change in the fair value of each significant type of investment of the master trust;
- the total investment income of the master trust by type;

- a description of the basis used to allocate net assets, net investment income or loss, and gains or losses to participating plans; and
- the plan's percentage interest in the master trust.

Because many employee benefit plans hold investments in master trusts and some stakeholders have raised concerns that these requirements are limited, FASB is proposing to require more detailed disclosures by the plan. The proposal would require all plans with a divided interest in the master trust "to disclose both a list of the general types of investments held by the master trust and the dollar amount of their interest in each of those general types of investments."

The proposal solicits feedback on a number of issues, including potential additional disclosures and the timing and formatting of reporting.

NTIS Releases Final Certification Program for Access to Death Master File

The U.S. Commerce Department's National Technical Information Service (NTIS) released the final rule on the certification program to provide access to the Death Master File (DMF) on June 1. The rule becomes effective November 28, 2016.

The DMF is a list of deceased individuals maintained by the Social Security Administration and distributed through the Commerce Department. These records, updated weekly, contain the full name, Social Security number, date of birth and date of death for listed decedents. Defined benefit and defined contribution plans commonly use these files for administrative purposes, such as determining when benefits to a deceased participant should be terminated or when a payment should be made to a surviving beneficiary.

Under the Bipartisan Budget Act enacted in December 2013, however (and effective as of March 26, 2014), the Secretary of Commerce must restrict access to the information in each individual's DMF for a three-year period beginning on the date of the individual's death, except to persons who are certified under a program to be established by the Secretary of Commerce. Only parties that have "a fraud prevention interest or other legitimate need for the information and agree to maintain the information under safeguards similar to those required of federal agencies that receive return information" may apply for certification.

On March 25, 2014, the NTIS issued an Interim Final Rule (IFR) establishing a temporary certification program for continued access to the DMF. In December 2014, NTIS published a proposed rule and request for comments on a proposed permanent certification program to provide access to the DMF.

The NTIS acknowledges that third parties that are qualified to evaluate a person's information safeguards, provide the required attestations, and conduct audits can "engage a 'firewalled' Accredited Conformity Body" upon meeting standards of practice outlined by and getting official permission from the NTIS.

The NTIS did not establish a safe harbor that allows Certified Persons under certain circumstances to disclose a participant's date of death to other parties involved in the administration of a plan without regard to whether those other parties meet the requirements for certification, stating that the "NTIS is without discretion to categorically exclude 'date of death' [as an exception to requirement for certification] through rulemaking." However, the NTIS also pointed out that the "fact of death" (unlike the "date of death") "is not an element of the statutory definition of the term 'Death Master file,'" apparently allowing a certified person to confirm that a participant has died (but not the date of death) to a non-certified plan representative.

IRS Determination Letter Process to Monitor Defined Benefit Plans Despite Phase-Out

The Internal Revenue Service (IRS) is now indicating that it will use its determination letter process to require identification of defined benefit plan "de-risking" language, despite the agency's ongoing efforts to limit the determination letter program for individually designed plans.

Recently updated language on the IRS website states that applicants requesting determination letters for their defined benefit plans must reveal whether their plan has "lump sum risk transfer" language. If it does, the language must satisfy "one of the four conditions in Notice 2015-49." If the plan does not meet any of the conditions of the notice, the risk transfer language must be removed for the applicant to successfully receive a determination letter.

In Notice 2015-49, the IRS announced that it intends to amend the required minimum distribution regulations under Internal Revenue Code Section 401(a)(9) to generally prohibit lump sum payments or any other accelerated form of distribution to participants already receiving an annuity distribution (joint and survivor, single life or other annuity currently being paid). The Notice indicated the regulations would be retroactive back to the date of the notice (July 9, 2015).

Revenue Procedure 2016-37 officially detailed the IRS's plan to significantly scale back its determination letter program for individually designed retirement plans (those that are *not* operating under a pre-approved vendor-sponsored master and prototype or volume submitter plan document), *except* upon plan creation and plan termination.

The website language will likely only directly affect plans in Cycle A that still have time to file for a determination letter on an individually designed plan. Preapproved plans with similar risk transfer language would also be subject to the new requirement.

Agencies Request Comments Related to Accommodating Religious Objections to Contraceptive Coverage

On July 22, the U.S. departments of Health and Human Services (HHS), Labor (DOL) and Treasury issued a request for information (RFI) on whether there are alternative ways to accommodate employers who object on religious grounds to providing coverage of contraceptive services as required under the Affordable Care Act (ACA).

The request was issued following a recent U.S. Supreme Court decision in *Zubik v. Burwell*, which considered claims by plaintiff employers that, even with the accommodations provided in current regulations, the ACA contraceptive coverage requirement violates the Religious Freedom Restoration Act of 1993 (RFRA).

Under regulations issued in 2013, 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 final regulations include accommodations for the rare cases in which a self-insured plan does not employ a third-party administrator. In June 2014, the Supreme Court ruled in *Hobby Lobby v. Burwell* that the requirement to provide contraceptive coverage could not be applied to certain "closely held, for-profit" corporations whose owners held religious objections to such coverage. (The agencies adopted final regulations governing the definition of "closely-held, for-profit corporations" for this purpose in July 2015.)

Following oral argument in the *Zubik* case, the Court requested a supplemental briefing from the parties addressing whether contraceptive coverage could be provided to the objecting employers' employees through the employers' insurance companies with such notice as required under accommodations established under existing regulations.

The agencies are issuing this RFI to determine, as contemplated by the Supreme Court opinion in *Zubik*, "whether modifications to the existing accommodation procedure could resolve the objections asserted by the plaintiffs in the pending Religious Freedom Restoration Act of 1993 (RFRA) cases while still ensuring that the affected women seamlessly receive full and equal health coverage, including contraceptive coverage."

As discussed in the RFI, the alternative processes under consideration would eliminate the employer notice requirements and require affected women to take affirmative steps to enroll in contraceptive-only insurance policies. The RFI also notes that the alternative process would not work with self-insured plans, and seek comment on any possible modifications to the accommodation for self-insured plans, including self-insured church plans, that would resolve organizations' RFRA objections while still providing seamless access to coverage.

Support for 'Cadillac Tax' Repeal Grows; Alliance Continues Legislative Push

Legislation in the U.S. House of Representatives to repeal the so-called "Cadillac Tax" on high-cost employer-sponsored health plans has surpassed 300 cosponsors, signaling a surge of support heading into election season. The Alliance to Fight the 40, a diverse coalition of employers, labor unions and consumer groups, continues to push for permanent repeal of the tax.

This tax, enacted as part of the Affordable Care Act (ACA), applies to the cost of employer-sponsored health coverage in excess of certain thresholds. In response to an intensive campaign led by the Alliance in late 2015, Congress delayed the onset of the tax from 2018 to 2020. The measure also made the tax deductible for employers and directed the Government Accountability Office to examine whether the adjustments for age and gender are sufficient.

The following four measures to repeal the tax have been introduced:

- The bipartisan Middle Class Health Benefits Tax Repeal Act (S. 2045), sponsored by Senators Dean Heller (R-NV) and Martin Heinrich (D-NM)

- The American Worker Health Care Tax Relief Act (S. 2075), sponsored by Senator Sherrod Brown (D-OH)

- The Middle Class Health Care Tax Repeal Act (H.R. 2050), sponsored by Representative Joe Courtney (D-CT)

- The Ax the Tax on Middle Class Americans' Health Plans Act (H.R. 879), sponsored by Representative Frank Guinta (R-NH)

As of July 14, there were 309 Representatives who had co-sponsored one or both House repeal bills; meaning that nearly 70 percent of Representatives support repeal of the "Cadillac Tax."

The recent surge in cosponsors garnered significant media attention, including coverage in Inside Health Policy (subscription required), Health Care Business, Best's Insurance News (subscription required), Forbes and Morning Consult, all referencing the Alliance's leadership on the issue.

Meanwhile, 39 Senators have also signed-on to one of the two Senate bills, and 90 members of the U.S. Senate voted to repeal the tax permanently in an amendment to a bill that was ultimately defeated.

The 2016 Democratic Party Platform, released on July 21, also includes support for repeal of the tax. "We will repeal the excise tax on high-cost health insurance and find revenue to offset it," the platform reads.

While the legislative calendar for the remainder of the year is murky, we will continue to pursue full repeal as part of any appropriate legislative vehicle that may be considered before the end of the year. If repeal is not enacted by year-end, new repeal legislation will need to be reintroduced in 2017.

The Alliance to Fight the 40 website features a "Take Action" section, which allows users to send a personalized letter to their congressional representatives and to President Obama urging repeal of the tax.

In related news, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on July 12, in which committee members and witnesses discussed the role of the employer-sponsored health coverage system and the potential effects of the "Cadillac Tax."

Among the witness was Tom Harte, president of Landmark Benefits, NH, who recommended a complete repeal or further delay of the "Cadillac Tax" as one method of addressing the affordability of health insurance. Considering a scenario in which the "Cadillac Tax" is repealed in conjunction with the imposition of a limit on the tax exclusion for employer-sponsored health coverage, Christopher Condeluci, principal at CC Law & Policy PLLC, suggested that any such limit must be "structured with precision" and correct what he called the "regressive" nature of the current exclusion.

Regardless of the outcome of "Cadillac Tax" repeal efforts, the health care exclusion will likely continue to be targeted by lawmakers given the large revenue cost attributed to it by Congressional cost estimators and its inclusion in the House Republicans' policy agenda. The GOP proposal suggests a cap on the current-law income and payroll tax exclusion of the value of employer-sponsored health insurance (though the level of the proposed cap and the methodology for calculating it are not specified in the report). Speaker of the House Paul Ryan (R-WI), stated that the cap would be set at a "reasonable level" to "help keep costs down," on the premise that an uncapped tax benefit encourages over-purchasing and overutilization of health insurance.

RECENT JUDICIAL ACTIVITY

Nothing to report this issue