BENEFITS INSIDER
A Member Exclusive Publication

Volume 165, July 15, 2016 (covering news from July 2-15, 2016)

WEB's ***Benefits Insider*** is a bimonthly 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

Senate Introduces Measure to Move PBGC Premiums Off-Budget

A new Senate measure to ensure that Pension Benefit Guaranty Corporation (PBGC) premiums are no longer counted as general fund revenue was introduced in the Senate on July 14, matching a similar bill introduced in the House earlier this year.

Under current law, defined benefit pension plan insurance premiums paid by employers to the PBGC are considered "on-budget," and for accounting purposes the premium revenue can be used to "offset" general government spending, even though these premiums cannot be allocated to other government programs besides the PBGC. In the past five years alone, Congress has increased PBGC premiums a few times to offset unrelated spending measures. Most recently, the Bipartisan Budget Act of 2015 increased premiums to raise an estimated $7.65 billion through 2025.

The Pension and Budget Integrity Act of 2016 (S. 3240), sponsored by Senator Mike Enzi (R-WY), Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Senator Johnny Isakson (R-GA), eliminates the perverse incentive for Congress to raise PBGC premiums in order to pay for unrelated spending, thereby helping ensure that lawmakers do not raise premiums when they are truly not needed to pay guaranteed benefits to the participants in terminated pension plans.

S. 3240 is virtually identical to the bipartisan **Pension and Budget Integrity Act (H.R. 4955)**, sponsored on April 14 by Representatives Jim Renacci (R-OH) and Mark Pocan (D-WI).

House Approves Legislative Package Including HSA and Other Improvements

The U.S. House of Representatives approved the Restoring Access to Medication Act (H.R. 1270), legislation incorporating several different proposals addressing Health Savings Accounts (HSAs) and Flexible Spending Arrangements (FSAs).

Title I of the bill would restore over-the-counter medications to the category of "eligible expenses" with regard to HSAs, FSAs and Medical Savings Accounts, effectively repealing a provision of the Affordable Care Act (ACA). The ACA restriction creates an incentive that increases the cost of health care because, under current law, consumers must schedule doctor visits to obtain a prescription for over-the-counter medications in order to be reimbursed from their health care spending accounts.

This portion of the bill is scored as costing the federal government just over $4 billion in forgone revenue over 10 years.

Before passage by the House, two other measures were added to H.R. 1270:

Title II incorporates the text of the Heath Care Security Act (H.R. 5445), sponsored by Rep. Erik Paulsen (R-MN), as it was approved by the House Ways and Means Committee on May 18. This legislative language incorporates portions of the Health Savings Act (H.R. 4469). Specifically, the bill:

- Allows both spouses to make catch-up contributions to the same HSA.
- Includes a special rule for certain medical expenses incurred before establishment of the HSA.
- Increases the maximum contribution limit to HSAs such that it equals the maximum out-of-pocket limitation. Thus, for 2017, the contribution limit would be $6,550 in the case of self-only coverage and $13,100 in the case of family coverage.

The expansion of FSAs carries a revenue cost of $20.5 billion over 10 years.

Title III of H.R. 1270 incorporates the text of the Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act (H.R. 4723), designed to offset the revenue cost of the first two titles of the bill by eliminating the limitation on the recapture of overpayments of the ACA's premium tax credit. This portion of the bill is estimated to raise $26.7 billion over 10 years.

The bill passed the House with limited Democratic support and President Obama has already indicated that he will veto the measure.

New House Bill Would Provide Safe Harbor for Chronic Disease Treatment under HDHPs

A bipartisan measure introduced July 7 in the U.S. House of Representatives creates a new safe harbor for "medical management of a chronic disease," giving Health Savings Account -eligible high deductible health plans (HSA-eligible HDHPs) the option to cover certain drugs and services before enrollees meet their deductibles.

Current law includes a safe harbor allowing HSA-eligible HDHPs to cover certain preventive services before the deductible is met. However, the IRS' current definition of "prevention" is too narrowly defined, consisting only of primary preventive services.

The **Access to Better Care Act**, sponsored by Representatives Diane Black (R-TN) and Earl Blumenauer (D-OR), would create an additional safe harbor for the "medical management of a chronic disease" to provide more flexibility for plans and enrollees. Under the additional safe harbor added by the legislation, a plan would not fail to be treated as an HDHP by reason of failing to have a deductible for medical management of a chronic disease.

A Senate version of the bill is still under development. While the House measure is unlikely to be fast-tracked as a stand-alone measure, bipartisan support for the legislation suggests that it could be added to a larger health or tax package before the end of 2016.

Mental Health Bill Passes House Overwhelmingly

Legislation addressing mental health was approved by the U.S. House of Representatives by a nearly unanimous vote of 422-2 on July 6.

The Helping Families in Mental Health Crisis Act (H.R. 2646), sponsored by Representative Tim Murphy (R-PA), seeks to reform mental health care by improving access to treatment and ensuring compliance with the mental health parity law. The measure is similar in scope but dissimilar in substance from the measure unanimously approved by the Senate Health, Education, Labor and Pensions (HELP) Committee on March 16, the Mental Health Reform Act (S. 2680), although both measures share a provision that would strengthen enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Specifically, H.R. 2646 would direct the Administrator of the Centers for Medicare & Medicaid Services (CMS) – in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration (EBSA) and the Secretary of the Treasury – to submit to Congress a report "identifying federal investigations conducted or completed during the preceding 12- to 24-month period regarding compliance with parity in mental health and substance use disorder benefits, including benefits provided to persons with serious mental illness, serious emotional disturbance, and substance use disorders" under the MHPAEA.

The measure also directs the Government Accountability Office to prepare a report "detailing the extent to which covered group health plans (or health insurance coverage offered in connection with such plans), including Medicaid managed care plans … comply with the [MHPAEA]."

Furthermore, H.R. 2646 would also create the position of Assistant Secretary for Mental Health and Substance Use Disorders within the U.S. Department of Health and Human Services. The individual in this role will coordinate a national strategy to ensure that people have access to mental health and substance abuse treatment.

H.R. 2646 will now proceed to the Senate for its possible consideration, although Senate leaders may choose instead to take up S. 2680 and pursue a conference committee to resolve differences between the measures.

RECENT REGULATORY ACTIVITY

Proposed Updates to Form 5500, ERISA Reporting Rule Means Changes to Health, Retirement Plans

In conjunction with proposed Form 5500 revisions released on July 11, the U.S. Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) also released separate proposed regulations addressing required annual reporting and disclosure under ERISA.

According to the Fact Sheet accompanying the proposals, the revisions significantly increase the amount of information necessary to complete the forms "to address changes in applicable law, the employee benefit plan and financial market sectors."

The proposed ERISA reporting regulations generally implement the changes advanced by the Form 5500 proposal, designed to:

- Expand financial and investment reporting by pension plans, including reporting of alternative investments, hard-to-value assets, and investments through collective investment vehicles and participant-directed brokerage accounts. Most notably, The forms require more granular financial investment data and must include the fee disclosure comparative chart provided to participants. The proposal also clarifies that, for purposes of answering yes or no to the question about whether distributions were made, the lack of distributions made to lost or missing participants do not need to be included, as long as the plan fiduciaries have met the requirements of FAB 2014-01 in trying to locate the participants.

- Expand oversight of group health plans and ongoing implementation of the Affordable Care Act (ACA) by eliminating exemptions for plans with fewer than 100 participants from Form 5500 reporting.

- Implement the ACA's transparency provisions requiring non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to (1) provide DOL with a host of information on health plan enrollment and claims and (2) report annually to the DOL, HHS and the Treasury and to enrollees under the plan whether the benefits under the plan improve health outcomes, prevent hospital readmissions, improve patient safety and promote wellness. The DOL notes that it may propose collecting additional data in the future and specifically requests comments regarding "other plan characteristics that may be helpful for participants … in evaluating their plan."

- The DOL is also seeking public comments on the proposed annual reporting requirements for plans that provide group health benefits (including the new Schedule J) in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, in which the high court ruled that that Vermont's all-payer

claims health database reporting law was preempted by ERISA as it applies to self-funded employer plans.

- Make key retirement and health and welfare benefit data, including information on assets held for investment, more available and usable in the electronic filing and data environment.

- "Harmonize" the filing requirements with the 408(b)(2) disclosure requirements (disclosure of fees from service providers to plan fiduciaries).

- Improve benefit plan general compliance with ERISA and the tax code by adding selected new questions regarding plan operations, service provider relationships, and financial management of plans.

As with the proposed Form 5500 revisions, comments on the ERISA reporting regulations are being solicited through October 4.

EEOC Moves Forward With Burdensome Pay Disclosure Requirement

Under a formal notice to be published by the Equal Employment Opportunity Commission (EEOC) on July 14, large employers would be required to report new information regarding employees' earnings and hours worked.

The EEOC previously proposed a revision (referred to in the latest issuance as the "60-day notice") to the annual Employer Information Report (EEO–1) disclosure requirement. Currently, certain private industry employers with 100 or more employees and federal contractors with 50 or more employees are required to report annually on the EEO-1 the number of employees they have in ten job categories by seven categories of race and ethnicity and by sex.

In implementing the earlier proposal, the July 14 notice (referred to in the latest issuance as the "30-day notice") would require private industry and federal contractor employers with 100 or more employees to report, beginning in 2017, the EEO-1 employees' W-2 earnings and hours worked within 12 specified pay bands for each job category, race, ethnicity and sex.

The July 14 notice extends the due date for the new EEO-1 to March 31, 2018, and revises the "snapshot" period during which an employer must count its employees to be reported on the EEO-1 from the third quarter (a period between July 1 and September 30) to the fourth quarter (a period between October 1 and December 31).

Senator Lamar Alexander (R-TN), chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee, has introduced the EEOC Reform Act (S. 2693), legislation that would require the federal government to implement the revised EEO-1 for its own workforce and report back to Congress before the revision is imposed on the private sector, but the bill has not yet received committee consideration.

DOL Issues BICE Technical Correction to Fiduciary Rule

The U.S. Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) issued technical corrections to the Best Interest Contract Exemption (BICE), issued in connection with the fiduciary definition rule finalized in April.

The new rule broadly expanded the definition of "investment advice" by extending fiduciary status to a wide array of advice relationships. Advisors that are fiduciaries under the new rule can avoid prohibited transaction issues which would otherwise apply to the compensation they receive by meeting the requirements of the BICE.

Although the original BICE proposal would have required that advisors enter into appropriate contracts with all of their retirement plan clients, the final BICE only required a contract in the case of an IRA or other non-ERISA arrangement, and provided some flexibility on when to enter into the contract and permitted existing clients to agree to the new contractual protections by "negative consent."

The technical correction:

- Includes a 14-day relief period for financial institutions after a customer does not "negatively consent" and instead terminates existing contracts.
- Defines an "existing contract" as a contract executed before January 1, 2018, formerly reported in the preamble as April 10, 2017.
- Adds sales of investment products (in addition to purchases) as covered by the exemption.
- Modifies the BICE to provide that an "Adviser" can have discretionary authority over other plan assets as long as he or she does not have discretionary authority over the assets that are the subject of the Adviser's recommendation.
- Clarifies definition of an insurance company, making it clear that insurance companies can meet the requirements of the BICE.

IRS Issues Proposed Regulations on ACA Premium Tax Credits and 'Opt-Out' Arrangements

The Internal Revenue Service (IRS) published **proposed regulations** on July 8, 2016, related to the premium tax credit and individual shared responsibility provisions of the Affordable Care Act (ACA). While the proposed regulations affect individuals who enroll in marketplace coverage and eligibility for premium tax credits, employer plan sponsors will be affected by the provisions regarding how "opt-out arrangements" offered to employees who decline employer-sponsored coverage are treated for purposes of determining affordability of coverage for ACA purposes.

The provisions of the proposed regulations regarding opt-out arrangements generally follow the approach set out in Question 9 of Notice 2015-87, issued on December 16, 2015. With regard to opt-out payments ("opt-outs") generally, the IRS maintains its position as set forth in Notice 2015-87: forgoing an unconditional opt-out is economically equivalent to forgoing salary. As a result, cash incentives offered to an employee for opting out of group health coverage will count *against* the affordability of the health coverage (effectively making the coverage *less* affordable for the employee).

The proposed regulations clarify that an employer contribution to a cafeteria plan that can be used by an employee to purchase minimum essential coverage is not an opt-out payment, even if the employee could choose to receive the amount as a taxable benefit. However, per Notice 2015-87, such contributions cannot be counted toward the employee's required contribution for health coverage, and do not make the coverage more affordable for the employee.

According to the proposed regulations, amounts made available under conditional opt-out arrangements will not count against affordability if the arrangement satisfies certain conditions as an "eligible opt-out arrangement." An eligible opt-out arrangement is an arrangement under which the employee's right to receive the opt-out payment is conditioned on (1) the employee declining to enroll in the employer-sponsored coverage and (2) the employee providing reasonable evidence that the employee and all other individuals (for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies) have or will have minimum essential coverage (MEC) (other than coverage in the individual market, whether or not obtained through a Marketplace) during the period of coverage to which the opt-out arrangement applies.

The proposed regulations make clear that an employee cannot participate in an "eligible opt-out arrangement" if the employee, or anyone in the employee's "expected tax family" has or will have individual market coverage. The preamble to the regulations specifically notes that "if an opt-out payment is conditioned on an employee obtaining individual market coverage, that opt-out arrangement could act as a reimbursement arrangement for some or all of the employee's premium for that individual market coverage; therefore, the opt-out arrangement could operate as an employer payment plan." Therefore, employees would not be able to opt out of employer-sponsored coverage to obtain individual insurance on an exchange while receiving additional compensation from an employer without it negatively impacting the "affordability" of the employer sponsored coverage. (While not specifically addressed in the regulations, it does appear that an employee's access to Medicare or TRICARE coverage would be alternative minimum essential coverage that would satisfy the required condition for an "eligible opt-out arrangement.")

If an employee's alternative coverage subsequently terminates, the amount of an opt-out payment made available under an eligible opt-out arrangement may continue to be excluded from the employee's required contribution for the remainder of the period of

coverage to which the opt-out payment originally applied. This is regardless of whether the opt-out payment is required to be adjusted or terminated due to the loss of alternative coverage, and regardless of whether the employee is required to provide notice of the loss of alternative coverage to the employer.

The IRS considered, but declined, to provide special exceptions to the general opt-out rule for (1) conditional opt-out payments required under the terms of a collectively bargained agreement and (2) opt-out payments that below a de minimis amount.

The provisions regarding opt-out arrangements are proposed to be applicable for plan years on or after January 1, 2017, with regard to arrangements that were "adopted" on or before December 16, 2015 consistent with the applicability dates set out in Notice 2015-87.

Comments on the proposed regulations are due by September 6, 2016. The IRS has specifically asked for comments on the "eligible opt-out arrangements" rule, "including suggestions for other workable rules that result in the required contribution more accurately reflecting the individual's cost of coverage while minimizing undesirable consequences and incentives."

HHS Launches Updated Administrative Simplification Overview Website

The U.S. Department of Health and Human Services (HHS) launched a newly updated **administrative simplification website** as a source of information for health insurance plans (including self-insured plans), providers, payers, and other entities regarding rules under HIPAA and the Affordable Care Act (ACA).

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

The updated website provides detailed overviews of the electronic transactions, code sets and unique identifiers covered under the administrative simplification requirements, as well as a list of frequently asked questions related to administrative simplification.

RECENT JUDICIAL ACTIVITY

Sixth Circuit Rules that ERISA Does Not Preempt Michigan Claims-Paid Tax

In a unanimous July 1 decision, a three-judge panel of the U.S. Sixth Circuit Court of Appeals affirmed its ruling that a Michigan health care claims tax is not preempted by ERISA. The case had been remanded back to the Sixth Circuit by the U.S. Supreme Court for further consideration in light of its ruling in *Gobeille v. Liberty Mutual Insurance Company.*

The high court ruled in the *Gobeille* case that Vermont's all-payer claims health database reporting law was preempted by ERISA as it applies to self-funded employer plans. In *Self-Insured Institute of America (SIAA) v. Snyder*, the Sixth Circuit held in 2014 that a Michigan law imposing a one percent tax on all claims paid by plan administrators for medical services, and requiring quarterly returns to the state treasury was not preempted by ERISA. SIIA argued that by requiring carriers and third-party administrators to file reports and maintain certain records, the Michigan law created additional burdens and jeopardizes uniform administrative practice and warranted ERISA preemption. SIIA appealed to the U.S. Supreme Court which vacated the decision and directed the Sixth Circuit to review in light of *Gobeille.*

The Sixth Circuit, however, **affirmed its earlier decision** that Michigan's claims tax law was not preempted by ERISA because – unlike the Vermont law in *Gobeille* – the Michigan law "does not directly regulate any integral aspects of ERISA. The Act is, at its core, an Act to generate the revenue necessary to fund Michigan's obligations under Medicaid. Though it does touch upon reporting and record-keeping, the thrust of the Act is to collect taxes — not to amass data," and therefore, in the court's view, it does not impose additional burdens or interfere with uniform plan administration.

While the *Gobeille* case was an important decision for employer-sponsored ERISA plans, *SIAA v. Snyder* remains a concern regarding states' ability to impose taxes on such plans. Plaintiffs in *SIIA v. Snyder* are considering whether to pursue appeal of the Sixth Circuit decision to the U.S. Supreme Court.