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RECENT LEGISLATIVE ACTIVITY

House-Senate Budget Agreement Includes Reconciliation Instructions for Health Reform

Republican leaders in the U.S. Senate and House of Representatives have reached agreement on **a joint budget resolution**.

Budget resolutions are non-binding, need not be signed by the President and do not become law, although they do establish a framework for a legislative policy agenda by setting specific spending levels for various executive branch agencies. The budget "resolution" sets the stage for a budget "reconciliation" process, where legislative policy changes are spelled out more precisely. Like President Obama's proposal released earlier this year, the original Senate and House resolutions express general views on the health care law and tax reform.

Most notable is that the budget resolution agreement reached by the Congressional leaders follows the Senate approach regarding the reconciliation process. Under Senate rules, a reconciliation bill cannot be filibustered but, rather, would only require a simple majority (rather than 60 votes) for passage in the Senate. This is highly relevant, because the Republicans only have a majority of 54 seats in the Senate. The most recent budget resolution, passed by both the House and the Senate in 2009, included a reconciliation instruction. Democrats, who at the time also held a majority, but did not have 60 seats, used the reconciliation process to achieve final passage of the Patient Protection and Affordable Care Act (PPACA) in 2010.)

The approach adopted in the final agreement this year (see Page 56 of the official conference report) provides general reconciliation instructions for the House committees of jurisdiction over health care (and retirement plans as well) to save $1 billion (each) over the ten-year budget period. The Senate Finance Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee are also directed to save $1 billion (each) over the ten-year budget period. It is expected that such instructions could be used to make changes to PPACA, especially if the U.S. Supreme Court's decision in the *King v. Burwell* case strikes down the subsidies provided in federally facilitated exchanges.

Rep. Courtney Introduces Legislation to Repeal PPACA Excise Tax

The **Middle Class Health Benefits Tax Repeal Act**, a measure to repeal the 40 percent excise tax on "high-cost" plans enacted as part of the Patient Protection and Affordable Care Act (PPACA), was introduced by Representative Joe Courtney (D-CT) on April 28. An official **one-page background document** is also available.

The nondeductible 40 percent excise tax, established under Internal Revenue Code (IRC) Section 4980I, applies to "applicable employer-sponsored coverage" in excess of statutory thresholds (in 2018, $10,200 for self-only coverage and $27,500 for family coverage). The tax was intended by framers of the law as a "revenue raiser" to pay for other aspects of PPACA and to address mitigate what perceived overly-generous health coverage.

The U.S. Treasury Department and Internal Revenue Service (IRS) have not yet issued rules for complying with the tax. In February, the IRS issued Notice 2015-16, which requests comment on possible approaches. Comments are due May 15.

Courtney's bill, which has 65 original cosponsors (including three Republicans: Rep. Frank LoBiondo (R-NJ), Leonard Lance (R-NJ) and Chris Gibson (R-NY)), explicitly deletes Section 4980I, thereby repealing the excise tax.

An effectively identical bill, the Ax the Tax on Middle Class Americans' Health Plans Act (H.R. 879) was introduced in February by Representative Frank Guinta (R-NH).

Because the Congressional Budget Office has estimated that the 40 percent tax will raise revenues by $87 billion over ten years, repealing this provision will increase the deficit unless Congress finds a way to offset decreased revenue. However, fully three-quarters of that revenue is based on the assumption that employers will substitute the cost savings from reducing health coverage by increasing taxable wages. Neither H.R 879 nor the Courtney bill include ways to pay for repealing the tax and next steps for the bills are unknown. No such legislation has yet been introduced in the Senate.

House Subcommittee Discusses Additional Multiemployer Pension Reform, Alternate Savings Plan

In an April 29 hearing, the U.S. House of Representatives Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions heard testimony from employers and union groups on what reforms were still necessary for the success of multiemployer pension plans. The hearing focused on alternative savings plan designs, including a proposed hybrid plan designed for multiemployer plan participants.

Many multiemployer plans struggled with underfunding prior to the enactment of the Multiemployer Pension Reform Act of 2014 (MPRA). MPRA was enacted as a part of the Consolidated and Further Continuing Appropriations Act. One provision in MPRA allows trustees in financially distressed multiemployer plans to intervene and make changes to already vested benefits to prevent the plans from becoming insolvent.

Based largely on the Solutions Not Bailouts proposal drafted by the Partnership for Multiemployer Retirement Security (PMRS), which includes unions and employers, MPRA made permanent the funding rules in the Pension Protection Act of 2006 (PPA) but also made a number of modifications.

In convening the hearing, subcommittee Chairman Phil Roe (R-TN) noted the successful enactment of MPRA and stated that in order to complete the necessary reformation, Congress needs to "modernize the multiemployer pension system" by providing workers with alternative savings plan designs, such as the "composite" model included in the PMRS proposal.

The composite plan is a hybrid model with features of both defined contribution and defined benefit plan features, including annuitized benefits to employees, but does not subject employers to many of the drawbacks associated with traditional multiemployer plans. According to the PMRS proposal (which refers to the composite plan as a "target benefit plan"), the composite model would "combine the retirement income security and economic efficiency of defined benefit plans with the predictable employer costs of defined contribution plans."

Ranking Democratic member Jared Polis (D-CO) said in his opening statement that "Phase II" of reforming the multiemployer pension system should encourage innovative new plans that provide some flexibility to employers while also providing employees with financial security in retirement.

He suggested that these new plans could provide options to strengthen employer-sponsored retirement plans.

The subcommittee heard testimony from the following witnesses:

- Randy DeFrehn, executive director of the National Coordinating Committee for Multiemployer Plans (NCCMP), a key member of the PMRS, commended the subcommittee for its work on the passage of MPRA and stated that alternative plan designs remain as the last step of needed reform. He said that the composite model is the "next logical step" in the evolution of multiemployer plans and noted that it supplies "the best of both worlds" as it provides employees with lifetime income and eliminates extended employer financial exposure beyond contractually negotiated contributions, as the plan is not a defined benefit plan and therefore is not subject to guaranty by the Pension Benefit Guaranty Corporation (PBGC) and also does not expose employers to withdrawal liability.

- Andrew Scoggin, executive vice president of human resources, labor relations, public relations & government affairs at Albertson's LLC, noted in his testimony that despite the improvements made under the Pension Protection Act of 2006 (PPA) and MPRA, there remains a need to modernize the regulatory framework for multiemployer plans and to provide employers with the flexibility to make changes to benefit programs.

- Mark McManus, general secretary treasurer of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the U.S. and Canada, described the negative effect withdrawal liability has on multiemployer plans. He noted that many new employers do not enter multiemployer plans in fear of withdrawal liability, which erodes the contribution base of a plan as employers increasingly leave multiemployer plans. He encouraged Congress to expand the options available to employers in multiemployer plans, including implementing the composite model.

- Stephen Sandherr, chief executive officer of the Associated General Contractors of America, also encouraged Congress to act and recognize the composite plan as an alternative plan design. He stated that having a "broader variety of retirement plan models, including the composite plan model, will minimize employer and PBGC liabilities in the future and provide more certainty for workers."

In the question-and-answer portion of the hearing, Roe asked witnesses to discuss the benefits of pooling longevity risk, a feature of the composite plan. DeFrehn said that as the plan provides lifetime income, pooled longevity risk helps retirees with longer lives avoid financial insecurity due to their increased longevity, a possible concern for plans with lump-sum distributions. Polis asked whether the composite model appealed to both labor and management; all witnesses responded that it appeals to both parties.

Roe asked how quickly this issue needed to be addressed by Congress. Scoggin replied that from an employer standpoint, they are "at a precipice" and that resolving this problem quickly is essential.

RECENT REGULATORY ACTIVITY

EEOC Issues Long-Awaited Regulations Governing Wellness Programs

In the wake of recent litigation challenging the legality of certain workplace wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Non-Discrimination Act (GINA) – as well as related congressional hearings – **the Equal Employment Opportunity Commission (EEOC) has released long-awaited proposed rules** that amend ADA regulations and interpretive guidance relating to employer wellness programs. Along with the proposed rules, the EEOC also issued a questions-and-answers document and a fact sheet for small businesses.

The proposed rules provide guidance on the extent to which employers may use incentives to encourage employees to participate in wellness programs that include disability-related inquiries and/or medical examinations. The ADA restricts employers from obtaining medical information from employees by generally prohibiting them from making disability-related inquiries or requiring medical examinations. The statute includes an exception, however, for "voluntary" medical examinations or medical histories which are part of an employee health program available to employees, including workplace wellness programs.

As explained in the Supplementary Information section of the proposed regulations, previous EEOC guidance stated that a wellness program is "voluntary" if an employer neither requires participation by employees nor penalizes employees who do not participate. However, neither the statute nor the EEOC's existing regulations or other guidance addressed the extent to which incentives may affect the voluntary nature of a wellness program.

The lack of clear guidance from the EEOC regarding the application of the ADA and GINA to employer-sponsored wellness programs has contributed to the sense of legal and regulatory uncertainty for such programs, particularly as the EEOC began to pursue litigation against wellness plan sponsors in late 2014.

The proposed rules explain:

- What an employee health program is.
- What it means for an employee health program to be voluntary.
- What incentives employers may offer as part of a voluntary employee health program.
- What requirements apply concerning notice and confidentiality of medical information obtained as part of voluntary employee health programs.

The proposed regulations list several requirements that must be satisfied to meet the "voluntary" standard. Specifically, an employer may not require employees to participate, may not deny access to health coverage or limit coverage under its health plans for non-participation and may not take adverse action or retaliate against or take similar actions against employees. In addition, if a health program is part of a group health plan, an employer must provide notice clearly explaining what medical information will be obtained, how it will be used, who will receive it and the restrictions on when such information may be disclosed.

The document also states that "the Commission believes that it has a responsibility to interpret the ADA in a manner that reflects both the ADA's goal of limiting employer access to medical information and HIPAA's and the [Patient Protection and] Affordable Care Act's provisions promoting wellness programs." Under the proposed regulations, with respect to wellness programs that ask an employee to respond to a disability-related inquiry or undergo a medical examination, an employer may offer limited incentives up to a maximum of 30 percent of the total

cost of employee-only coverage (whether in the form of a reward or penalty) to promote an employee's participation in the wellness program.

Although the Supplementary Information section appears to refer to 30 percent of the total cost of employee-only coverage as "the maximum allowable incentive available under HIPAA and the Affordable Care Act for health-contingent wellness programs," this appears to be an incorrect characterization of HIPAA and PPACA, which permit incentives of up to 30 percent of the total cost of coverage *enrolled in by the employee*. Thus, for example, when an individual and his or her spouse are enrolled in family versus self-only coverage, HIPAA and the ACA permit an incentive of up to 30% of the total cost of the family coverage (versus only self-only coverage). Whether the EEOC final rules will clarify that the HIPAA rules apply in this regard apply remains to be seen.

Additionally, PPACA gave the secretaries of Labor, Health and Human Services, and the Treasury authority to increase the reward available up to 50 percent of the cost of coverage if the secretaries determine that such an increase is appropriate. The EEOC proposed rule does not adopt this same flexibility.

The proposed rules also note that compliance with rules concerning voluntary employee health programs does not ensure compliance with all the antidiscrimination laws enforced by the EEOC (such as federal laws prohibiting discrimination based on sex, race or religion, for example). The Supplementary Information section of the proposed regulations also includes a footnote regarding the ADA's "safe harbor" provision applicable to insurance, which was applied by the court in *Seff v. Broward County* to find the county's wellness program ADA-compliant. Specifically, the Supplementary Information section states that the EEOC does not believe that this safe harbor is the "proper basis for finding wellness program incentives permissible."

The proposed regulations do not address GINA, including whether the use of incentives with respect to spousal health risk assessments (HRAs) or other inquiries regarding the spouse's medical information implicate GINA. The Supplementary Information section states, however, that a future EEOC rule will address the extent to which Title II of GINA affects an employer's ability to condition incentives on a family member's participation in a wellness program.

The EEOC notes that "while employers do not have to comply with the proposed rule, they may certainly do so. It is unlikely that a court or the EEOC would find that an employer violated the ADA if the employer complied with the NPRM until a final rule is issued." However, it’s possible that EEOC divisional offices may plan to continue to investigate claims of alleged ADA violations regarding employer-sponsored plans, and such offices may rely, in part, on these proposed regulations as part of their investigation and in determining their enforcement posture with respect to a given wellness program.

The U.S. Departments of Health and Human Services, Labor and the Treasury also issued guidance on wellness programs on April 16. (See story below.)

The EEOC is soliciting comments on the proposed regulations through June 19. The EEOC is requesting specific comment on several issues, including whether additional protections for low-income employees are needed; whether to be voluntary under the ADA, the incentives provided in a wellness program "may not be so large as to render the health insurance coverage unaffordable" under PPACA; and whether proposed notice requirements should also include a requirement that employees provide "prior, written, knowing confirmation" that their participation is voluntary.

Departments Issue Clarifying Guidance Regarding Employer Wellness Programs

The U.S. departments of Health and Human Services, Labor and the Treasury have issued "frequently asked question" (FAQ) guidance on a range of issues related to wellness programs. This guidance is in addition to proposed wellness plan regulations also issued on April 16 by the Equal Employment Opportunity Commission (EEOC) on wellness programs. (See story above.)

The agency guidance includes:

Tri-agency Frequently Asked Questions about the Affordable Care Act (Part XXV) address what it means for a health-contingent wellness to be "reasonably designed to promote health or prevent disease," as required by Public Health Service (PHS) Act Section 2705 – as added by the Patient Protection and Affordable Care Act (PPACA) – and related provisions of ERISA and the Internal Revenue Code that address requirements for wellness programs provided in connection with group health coverage.

According to this FAQ, "a program complies with this requirement if it (1) has a reasonable chance of improving the health of, or preventing disease in, participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discrimination based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease."

The FAQ further explains that a determination is made based on all relevant facts and circumstances and that the "wellness plan regulations are intended to allow experimentation in diverse and innovative ways for promoting wellness. The FAQ also includes examples of programs that would not be considered reasonably designed, or would be scrutinized and possibly subject to agency enforcement action. These include wellness programs "designed to dissuade or discourage enrollment in the plan or program by individuals who are sick or potentially have high claims experience. The FAQ also states that "A program that collects a substantial level of sensitive personal health information without assisting individuals to make behavioral changes such as stopping smoking, managing diabetes, or losing weight, may fail to meet the requirement that the wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals. Programs that require unreasonable time commitments or travel may be considered overly burdensome."

A second question and answer cautions that compliance with the three departments' wellness program regulations is not determinative of compliance with other laws, including the tax code, ERISA (including COBRA) or any other state or federal law, such as the Americans with Disabilities Act (ADA) or HIPPA privacy and security requirements.

HHS Center for Medicare and Medicaid Services (CMS) Frequently Asked Questions on Health Insurance Market Reforms and Wellness Programs clarify that (1) an issuer may not limit its offering of a wellness program in connection with a particular health insurance product to only certain employer groups enrolling in that product, (2) rating rules do not prevent an issuer from offering premium discounts, rebates or other incentives for wellness programs other than those designed to prevent or reduce tobacco use, and (3) an issuer may not take into account the penalties or rewards expected to be provided under a wellness program (whether health-contingent or participatory) when establishing the index rate and plan-level adjustments under the single risk pool provision.

HHS Office of Civil Rights Frequently Asked Questions address the application of HIPAA privacy, security and breach notification rules to workplace wellness programs. The guidance describes the circumstances under which the HIPAA rules apply to workplace wellness programs and describes the protections provided by HIPAA, where applicable. According to this document, "where a workplace wellness program is offered as part of a group health plan, the individually identifiable health information collected from or created about participants in the wellness program is [protected health information] and protected by the HIPAA Rules." The FAQ further states that "Where a workplace wellness program is offered by an employer directly and not as part of a group health plan, the health information that is collected from employees by the employer is not protected by the HIPAA Rules." Where a workplace wellness program is offered through a group health plan, a second question and answer discusses the protections that are in place under HIPAA with respect to access by the employer as plan sponsor to individually identifiable information of program participants.

The three departments issued final regulations in May 2013 implementing provisions of the Patient Protection and Affordable Care Act (PPACA) related to nondiscriminatory wellness programs.

CMS Embraces Value-Based Payment Approach with Implications for Employers

The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have recently announced plans and released a fact sheet on moving the U.S. health care system – and particularly Medicare – toward value-based care, emphasizing quality over quantity of services through new payment models, such as Accountable Care Organizations (ACOs). This restructuring of payment and delivery models have the potential to impact and expand employers' options for providing health care to their employees.

These initiatives are complemented by recent enactment of The Medicare Access and CHIP Reauthorization Act (H.R. 2), which repealed the "sustainable growth rate" used to determine Medicare reimbursements to physicians. In addition to the "doc fix" language, the bill also promotes the shift from "volume-to-value" by creating a two-tier payment system that provides incentives for practitioners to shift to value-based payment models, including ACOs.

An ACO is an organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program. They are used to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs.

The administration has discussed the importance of moving from fee-for-service towards value-based care since before the 2010 enactment of the Patient Protection and Affordable Care Act (PPACA) and the introduction of new payment models such as ACOs in 2011 but had not announced concrete plans or a timeline to implement changes until this year. According to the January 26 fact sheet, HHS has now set the goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent by the end of 2018. The fact sheet states that "this will be achieved through investment in alternative payment models such as [ACOs], advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees."

The release of this timeline provided a needed incentive for providers to increase adoption of alternative payment models, including the new ACO models. These new models attempt to replicate many of the benefits in the Medicare Advantage program for current fee-for-service programs, by aligning payment, benefit design and care delivery to the quality of care instead of the quantity of services.

Another possible benefit of the shift in payment delivery from volume to value is improved outcomes while reducing costs for both individuals and employers.

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 April 23. FASB is accepting comments on the proposal through May 18.

The proposal, developed by FASB's Emerging Issues Task Force, addresses defined benefit pension plans, defined contribution retirement savings plans, particularly as regards the use of benefit-responsive investment contracts. (Fully benefit responsive investment contracts are those that ensure that participants can take distributions from the investment - such as a stable value fund – at the "book" value, regardless of short-term fluctuations in the market value of the investment.) The proposal also has implications for health and welfare plans.

The stated goal of the proposal is "to reduce complexity in employee benefit plan accounting" consistent with FASB's Simplification Initiative, the objective of which is to identify, evaluate, and improve areas of generally accepted accounting principles (GAAP) for which cost and complexity can be reduced without adversely affecting the usefulness of the information to the users of financial statements.

Very generally, the proposed update would:

1. Designate contract value as the only required measure for fully benefit-responsive investments contracts.
2. Eliminate the requirement to disclose individual investments that represent five percent or more of net assets and the net appreciation or depreciation by general type (net appreciation or depreciation would be reported in aggregate).
3. Allow use of a month-end data that is closest to the plan's fiscal year end (when the fiscal period does not coincide with month-end) to measure investments and investment-related accounts.

According to the first part of the proposal, "Although contract value is used to measure fully benefit-responsive investment contracts for purposes of determining the net assets of an employee benefit plan, GAAP also requires fully benefit-responsive investment contracts to be measured at fair value for purposes of presentation and disclosure, including, when these measures differ, a reconciliation of contract value to fair value on the face of the plan financial statements. Under the proposed amendments, fully benefit-responsive investment contracts would be measured, presented, and disclosed only at contract value. A plan would continue to provide disclosures that help users understand the nature and risks of fully benefit-responsive investment contracts." FASB indicated that "contract value is considered the relevant

measurement attribute because it is the amount participants normally receive if they were to initiate permitted transactions (for example, withdrawals) under the terms of the underlying plan."

In the second part of the proposal, detailed reporting of assets consisting of five percent or more of net assets, split out by general types of assets, would be eliminated for both participant-directed and nonparticipant-directed investments. "The net appreciation or depreciation in investments for the period still would be required to be presented in the aggregate, but would no longer be required to be disaggregated and disclosed by general type."

The third part of the proposal would simply allow plans with fiscal year-ends that do not coincide with month-end to use a month-end date that is closest to the plan's fiscal year-end for purposes of measuring investments and investment-related accounts (for example, liability for a pending trade with a broker).

If finalized, the updates would be applied retrospectively to all periods presented beginning in a plan's fiscal year of adoption. The effective date will not be determined until after the Emerging Issues Task Force has reviewed stakeholder comments.

FASB is specifically requesting detailed feedback on specific questions in each portion of the proposal.

RECENT JUDICIAL ACTIVITY

Nothing to report this issue.