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July 2012 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Plan Fiduciaries Should Have Received Service Provider Fee Disclosures by July 1, 2012

Plan fiduciaries should have received initial service provider fee disclosures from their retirement plans' covered service providers by July 1, 2012. Upon receipt of disclosures, plan fiduciaries should review the disclosures and determine whether the contract or arrangement with the service provider remains reasonable. If plan fiduciaries have not received a disclosure from a covered service provider, we recommend contacting plan counsel to discuss the specific steps a plan fiduciary must take to avoid involvement in a prohibited transaction.

New Participant Fee Disclosures Due August 30, 2012

Plan administrators of defined contribution plans that permit participant direction of investments must provide a new fee disclosure to plan participants by August 30, 2012. These disclosures will provide participants with detailed plan expense and investment information. For more information on these disclosure requirements, see our articles on the final regulations and recent FAQs in the November 2010 and June 2012 Employee Benefits Updates.

New Summary of Benefits and Coverage Required for Open Enrollment

Beginning with a group health plan's first open enrollment period after September 23, 2012, plan sponsors are required to issue a new summary of benefits and coverage (SBC) to participants or beneficiaries covered under the plan. For more information on this new requirement, see our article below under *Health and Welfare Plan Developments* describing the calculator that plan sponsors can use in completing the coverage examples for the SBC. Group health plan sponsors should also review open enrollment materials to confirm that they have been updated for any other legal or design changes.

RETIREMENT PLAN DEVELOPMENTS

IRS Eliminates Signature for Extending the Form 8955-SSA Filing Deadline

The Internal Revenue Service (IRS) issued proposed reliance regulations to add the Form 8955-SSA (Annual Registration Statement Identifying Separated

Participants With Deferred Vested Benefits) to the list of forms qualifying for an automatic 2-1/2 month filing extension and to eliminate the signature requirement for Form 5558. The changes extend the same rules to the Form 8955-SSA that apply to request an extension to file the Form 5500 series and can be relied on by taxpayers pending issuance of final regulations.

The Form 8955-SSA replaces the Schedule SSA that plan sponsors previously filed with the Form 5500 and is due on the same date as the Form 5500 (July 31, 2012 for calendar year plans). Before the IRS issued the proposed regulations, plan administrators could file Form 5558 to apply for a 2-1/2 month extension for both the Form 5500 and the Form 8955-SSA, but the extension relating to the Form 8955-SSA required a signature. Several commentators questioned the need for the signature requirement and contended that it complicated the extension request process and was burdensome to both filers and the IRS. In response to these comments, the IRS issued the proposed rule to amend the regulations and eliminate the signature requirement.

Highway Act Includes PBGC Premium Increases and Pension Liability Stabilization Provisions

On July 6, 2012, President Obama signed into law the Moving Ahead for Progress in the 21st Century Act (MAP-21). MAP-21 includes provisions to stabilize pension liabilities, increase Pension Benefit Guaranty Corporation (PBGC) premiums, change PBGC governance and permit transfers of excess pension assets to fund retiree health accounts or life insurance.

- Pension Stabilization. Beginning in 2012, MAP-21 adjusts the segment rates used to determine a plan's funding target or target normal cost if the segment rate is outside a specified range of average rates for the preceding 25-year period. (The segment rates are currently calculated using a 24-month window.) For 2012, the specified range is 90% to 110% of the 25-year average. The range increases each year until 2016, when the range is 70% to 130% of the 25-year average. Although generally effective for plan years beginning in 2012, a plan sponsor may elect to postpone application of these changes until 2013.
- Under MAP-21, if the segment rate determined for an applicable month under the regular rules for a plan year beginning in 2012 is less than 90% of the average segment rates for the 25-year period ending September 30, 2011, the segment rate would be adjusted to 90% of the average rate. Experts expect that these changes will substantially increase the current segment rates, which will decrease a plan's minimum required contributions for the next few years.

- PBGC Premium Increases. MAP-21 increases PBGC premiums for both single-employer and multiemployer defined benefit pension plans. For single-employer plans, the $35 per participant premiums will increase to $42 in 2013 and $49 in 2014, with inflation indexing thereafter. Variable-rate premiums of $9 per $1,000 of underfunding will increase to $13 per $1,000 for 2013 and $18 per $1,000 for 2014, plus inflation adjustments. Starting in 2013, variable-rate premiums will be capped at $400 (indexed for inflation) per participant. For multiemployer plans, the $9 per participant premiums will increase to $12 in 2013, with inflation indexing thereafter.
- Transfers of Excess Assets. MAP-21 extends the provisions under Internal Revenue Code (Code) section 420 that allow defined benefit plans to use excess pension assets to fund current year retiree medical benefits through December 31, 2021. MAP-21 also expands these provisions to include transfers to fund group-term life insurance coverage provided to retirees.
- PBGC Governance. MAP-21 expands ERISA provisions to clarify requirements for the PBGC board of directors, advisory committee, the PBGC director and other personnel. MAP-21 addresses the timing and procedures for board of directors' meetings and limits the PBGC director's term to five years. MAP-21 also establishes the Participant and Plan Sponsor Advocate to act as a liaison with the PBGC to ensure that participants receive the required disclosures concerning a plan termination and to resolve disputes between plan sponsors and the PBGC. Finally, MAP-21 requires the PBGC to contract with an outside agency to conduct an annual review of its insurance modeling systems and to develop internal quality review policies for actuarial work, management and recordkeeping. 3

IRS Audits Defined Benefit Pension Plans for PPA Compliance

The IRS has conducted a series of audits of single-employer defined benefit pension plans relating to changes to funding requirements and administrative practices required under the Pension Protection Act of 2006 (PPA). As reported by the IRS in a recent Employee Plans News, the purpose of the examination project was to train its agents, identify potential areas of noncompliance, outline consistent correction methods and report the findings. Although the project is still ongoing, the IRS noted that the following issues have been identified to date:

- Notices. Annual funding notices were late or undated. Relative value notices did not satisfy the requirements in the regulations.
- Contributions. Late quarterly contributions. Late contribution payments resulting in liquidity shortfalls. Funding in excess of the deduction limit.

- Elections/Certifications. Elections to use or reduce prefunding and/or carryover balances were late or undated. Elections to use balances to meet quarterly contributions were late or did not specify the dollar amount. Certification of the adjusted funding target attainment percentage was late.
- Errors in Calculating Benefits. No actuarial increase for late retirement benefits. Compensation used to calculate benefits did not match plan definition. Service calculated incorrectly. Incorrect interest rate used for payment options subject to Code section 417(e)(3).
- Miscellaneous. No definition of compensation under the plan for calculating benefits. Assets valued differently for minimum funding purposes and for funding-based restrictions. Life insurance premiums incorrectly included as plan expenses for the target normal costs.

The IRS noted that many of the failures relate to the funding rules and do not affect the qualified status of a plan. These failures, however, may result in the assessment of excise taxes or penalties. Qualification failures would need to be corrected in accordance with the Employee Plans Compliance Resolution System under Revenue Procedure 2008-50.

REINHART COMMENT: The information discovered by the IRS during its initial PPA audits can be useful to both plan sponsors and service providers. Sponsors of a defined benefit pension plan may wish to provide a copy of these results to the plan's actuary and recordkeeper to verify compliance with PPA requirements.

Accounting Standards Board Approves Financial Statement Changes for Governmental Defined Benefit Plans

The Governmental Accounting Standards Board (GASB) approved two new standards that will substantially change the accounting and financial reporting of public employee pensions by state and local governments. Statement No. 67, *Financial Reporting for Pension Plans*, revises existing standards for pension plans. Statement No. 68, Accounting and Reporting for Pensions, requires employers to report unfunded pension liabilities on their balance sheet for the first time. Key provisions in the standards are highlighted below.

- Balance Sheet Reporting. Employers must report net pension liability (total pension liability minus plan assets) on their balance sheet.
- Cost-Sharing Employers. Employers that participate in plans that pool or share obligations and use plan assets to pay benefits of employees of any employer must report a proportionate share of the collective net pension liability and expense for the cost-sharing plan.

- Actuarial Changes. A "blended" discount rate must be used to determine the present value of projected benefit payments if projected assets (including expected contributions) are insufficient to cover future payments. All plans are required to use the "entry age" normal cost allocation method to determine liabilities for the reporting period. Previously, plans could choose from six different methods.
- Annual Pension Expenses. Annual changes in net pension liability must be reported as pension expenses each year and cannot be deferred. Annual changes include plan amendments and experience gains or losses.
- Shorter Amortization Periods. Changes in liabilities for retired members and any changes due to plan amendments must be expensed immediately. Changes in liabilities for active members (other than for plan amendments) can be amortized over their future working lifetimes. Differences between actual and assumed investment returns must be recognized as pension expenses over a five-year period. Previously, the amortization period for recognizing changes in pension liability for both active and retired participants could be up to 30 years.
- Additional Disclosures. Substantial additional disclosures are required. These include a description of the plan, assumptions used to calculate pension liability, method for calculating contributions, changes in net pension liabilities over the past 10 years and a sensitivity analysis on how discount rate changes affect liabilities.

Statement No. 67 is effective for periods beginning after June 15, 2013 and Statement No. 68 is effective for fiscal years beginning after June 15, 2014. Copies of the statements will be available on the GASB website in August 2012.

IRS Proposes Changes to Anti-Cutback Regulations Permitting Elimination of Lump Sum Distributions under a Single-Employer Defined Benefit Plan of Plan Sponsor in Bankruptcy

The IRS issued proposed regulations providing a limited exception to the anti-cutback rules under Code section 411(d)(6) for a plan sponsor that is a debtor in a bankruptcy proceeding. The anti-cutback rules generally prohibit amendments to qualified retirement plans that reduce or eliminate accrued benefits, early retirement benefits, retirement-type subsidies or optional forms of benefits. The proposed regulations would allow an amendment to a single-employer defined benefit plan to eliminate a lump sum distribution option or other optional form of benefit providing for accelerated payments if certain requirements are satisfied.

The proposed regulations permit amendments to eliminate an optional form of

benefit that includes a prohibited payment described under Code section 436(d)(5) if (1) the enrolled actuary certifies that the plan's adjusted funding target attainment percentage is less than 100%; (2) the plan is not permitted to make prohibited payments because the plan sponsor is a debtor in a bankruptcy case; (3) the bankruptcy court (after a notice to each affected party and hearing) issues an order that the amendment is necessary to avoid a distress or involuntary plan termination and (4) the PBGC has issued a determination that the amendment is necessary to avoid a distress or involuntary plan termination and that the plan is not sufficient to guaranty benefits.

The regulations are proposed to apply to plan amendments adopted or effective after August 31, 2012. Written or electronic comments on the proposed regulations must be submitted by August 20, 2012.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Supreme Court Upholds PPACA and Individual Health Insurance Mandate

The U.S. Supreme Court held that the primary provisions of the Patient Protection and Affordable Care Act (PPACA) are constitutional. The Court ruled that the PPACA provision requiring individuals to buy health insurance or pay a "penalty" was a valid exercise of Congress' taxing power, even though it would not be permitted under Congress' power to regulate interstate commerce. For more information on the Court's reasoning and the impact on employers, see Reinhart's E-alert on the decision.

Supreme Court Agrees to Review *U.S. Airways v. McCutchen* Reimbursement Case

The U.S. Supreme Court granted certiorari to review *U.S. Airways, Inc. v. McCutchen*, 663 F.3d 671 (3rd Cir. 2011) and address a split among the circuits regarding whether equitable principles can limit an ERISA plan's reimbursement rights. In *U.S. Airways*, an employee who was injured in a car accident recovered $110,000 from third parties and paid a 40% contingency fee to his attorney (net recovery of $66,000). As permitted under the ERISA health plan's reimbursement provisions, U.S. Airways sought to recover from the employee the full amount of medical expenses the plan paid for his injuries, even though the plan's payments exceeded the amount of the participant's net recovery.

Relying on summary plan description language requiring reimbursement from "any monies recovered from a third party" and prior Third Circuit cases, the

district court held that U.S. Airways was entitled to recover the full amount paid by the plan. The Third Circuit reversed, holding that equitable relief under ERISA section 502(a)(3) can be limited by equitable defenses and principles that were typically available in equity. The Third Circuit applied the traditional equitable principle of unjust enrichment and concluded that requiring the employee to pay full reimbursement was inappropriate and inequitable relief because it would leave the employee with less than full payment for his emergency medical bills and provide a windfall to U.S. Airways. The Third Circuit remanded the case to the district court to engage in additional fact-finding to fashion "appropriate equitable relief."

In reaching its conclusion, the Third Circuit disagreed with the reasoning of the Courts of Appeals for the Fifth, Seventh, Eighth, and Eleventh Circuits that applying equitable limitations on equitable claims would be pioneering federal common law. Furthering the split among the circuit courts, the Ninth Circuit recently followed the Third Circuit's rationale and held that equitable principles may limit a plan's reimbursement rights. See, CGI Technologies and Solutions, Inc. v. Rose, 2012 WL 2334230 (9th Cir. 2012).

The Supreme Court has agreed to review whether the Third Circuit correctly held (in conflict with its sister circuits) that ERISA section 502(a)(3) authorizes courts to use equitable principles to rewrite clear plan language requiring full reimbursement for benefits paid.

REINHART COMMENT: *U.S. Airways* will be the third subrogation/reimbursement case that the Supreme Court has reviewed in the last decade. See also, *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006) and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Given the complexity and fluidity of this area of law, additional guidance from the Supreme Court would be appreciated. The Court's approach to this case should be interesting, considering its lengthy dicta last year on "appropriate equitable relief" permitted under ERISA section 502(a)(3) in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011).

HHS Issues Proposed Regulations on Data Collection for Essential Health Benefits and Accreditation of Qualified Health Plans

PPACA directed the Department of Health and Human Services (HHS) to define essential health benefits (EHB). As discussed in the January 2012 Employee Benefits Update, HHS issued a bulletin outlining its proposed method for defining EHB. HHS proposed that EHB be defined by individual states with each state

selecting a "benchmark plan." States may select their benchmark plan from one of four approved benchmark plans, including any of the three largest small group plans in the state by enrollment. The proposed rule requires issuers of the largest three small group market products in each state to report information to HHS on covered benefits, including information on all health benefits in the plan, treatment limitations, drug coverage and enrollment.

The proposed rule also establishes a two-phase process for the recognition of accrediting entities for purposes of certification of qualified health plans. In the first phase, the National Committee for Quality Assurance and URAC (formerly the Utilization Review Accreditation Committee) would be recognized as accrediting entities on an interim basis. In the second phase, a criteria-based review process would be adopted through future rulemaking.

The Departments Provide a Cost-Sharing Calculator for Coverage Examples on SBC

As reported in the June 2012 Employee Benefits Update, the DOL, HHS, and the IRS (the Departments) have issued a new set of FAQs on PPACA about the SBC that plan sponsors are required to issue beginning with the first open enrollment beginning on or after September 23, 2012. In these FAQs, the Departments indicated that they were developing a calculator that plan sponsors could use as a safe harbor for the first year the SBC requirement is applicable. Because the calculator is less accurate, it is considered a transitional tool to assist plan sponsors in completing the coverage examples in a streamlined fashion for the first year. The calculator, instructions and algorithm are available at the Center for Consumer Information & Insurance Oversight website.

Alaska Settles HIPAA Security Case for $1.7 Million

HHS Office for Civil Rights (OCR) settled its first enforcement action under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) against a state agency for $1.7 million. OCR began its investigation after the Alaska Department of Health and Social Services (DHSS) reported a breach as required by the Health Information Technology for Economic and Clinical Health Act (HITECH). The breach involved a USB hard drive possibly containing electronic protected health information (ePHI) that was stolen from the vehicle of a DHSS employee. During the investigation, OCR discovered that DHSS did not have adequate policies and procedures in place to safeguard ePHI and that DHSS had not completed a risk analysis or complied with other HIPAA rules. In addition to the $1.7 million

settlement, DHSS has agreed to take corrective action to properly safeguard the ePHI of their Medicaid beneficiaries.

GENERAL DEVELOPMENTS

IRS Provides Sample Language for Code Section 83(b) Election to Include Property in Income

As reported in the June 2012 Employee Benefits Update, the IRS recently issued proposed regulations under Code section 83 clarifying the meaning of "substantial risk of forfeiture" and tightening rules for deferring income when property is received in connection with the performance of services. Code section 83(b) allows an individual to make an election to include in gross income the fair market value of the property received as compensation for services (less any amount paid for the property) at the time the property is transferred to the service provider. The election must include specific information and be filed with the IRS within 30 days after the date the property is transferred.

The IRS has issued Revenue Procedure 2012-29, which provides examples of the tax consequences for making a Code section 83(b) election and includes a sample election form. If properly completed and executed, the election form will satisfy the requirements under the regulations. For the election to be valid, the taxpayer must comply with other applicable requirements, including attaching a copy of the form with his or her tax return and providing a copy to the service recipient.