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WEB's ***Benefits Insider*** is a member exclusive publication providing the latest developments from the Nation's Capital on matters of interest to benefits professionals. The content of this newsletter is being provided as a result of a partnership with the American Benefits Council, a premier benefits advocacy organization, which provides its core content, and is edited by Corinne M. Tyler, Employee Benefits attorney and Senior Associate in the Cleveland Office of Baker & Hostetler LLP; ctyler@bakerlaw.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Ways and Means Committee Schedules Hearing on Issues Relating to Pension Funds

The House of Representatives Ways and Means Committee recently scheduled a hearing to cover a broad range of tax issues including some that relate to pension funds, to be made up of four panels: one on the economy generally, two on "carried interests" (income to fund managers derived from the profits of the investment partnership), and one on hedge funds. The Senate Finance Committee held two hearings on carried interests on July 11 and July 31.

Of particular concern is what the effect on pension plans might be of changing the tax rate on carried interests from 15 percent (the current long-term capital gains rate) to approximately 35 percent (a typical individual income tax rate). The Committee is also expected to review certain offshore high-yield investment accounts referred to as "UBIT blockers" as well as the Alternative Minimum Tax.

Mental Health Parity Update

The Mental Health Parity Act (S. 558) sponsored by Senators Edward Kennedy (D-MA), Pete Domenici (R-NM) and Mike Enzi (R-WY) was developed with the participation of a broad range of employer organizations, insurers and mental health advocates and allows employers the flexibility to design the mental health benefits covered by their health care plans. In addition, S. 558 makes clear that the medical management of these important benefits may not be prohibited by state or federal law and it ensures uniformity between federal and state parity requirements while maintaining states' current authority to regulate insurance.

Shortly before the congressional recess the Senate bill sponsors agreed to alter provisions in S. 558 that would have preempted state laws that differed from federal mental health parity standards. Under the new language, federal standards (such as those for mental health parity) are exclusive for self-insured group health care plans and serve as a "floor" above which the states may add additional requirements provided that they apply solely to fully insured health care plans. The bill then applied the preemption rule in current law, often referred to as the "HIPAA standard" after the preemption rule established as part of the Health Insurance Portability and Accountability Act of 1996.

Senate leaders were unsuccessful in an attempt to have S. 558 approved by unanimous consent before the recess, due to the concerns of Senator Jim DeMint (R-SC) who reportedly placed a "hold" on the bill. According to a DeMint spokesman, the Senator objected to passing the bill without a chance for debate or amendments, arguing that S. 558 constitutes a "large and costly mandate that could price a lot of Americans out of health insurance."

By modifying their bill to use the current law preemption rule, the Senate sponsors have indicated that they now intend to move swiftly for a vote on their measure, possibly before the congressional recess scheduled to begin shortly.

On September 7, the Congressional Budget Office (CBO) issued a cost estimate of H.R. 1424 indicating that the cost of covering mental health services under the bill would be similar with those for treatments of other kinds of illnesses. Under the estimate, the H.R. 1424 would reduce federal tax revenues by $1.1 billion over the 2008-2012 period and by $3.1 billion over the 2008-2017 period. The measure would also increase federal Medicaid spending by $310 million in 2008-2012 and by $3.1 billion in 2008-2017, slightly higher than the S. 558 estimate, which covered 2009-2012 and 2009-2017.

The Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424) has been approved by the Education and Labor Committee, one of three House committees with jurisdiction over the measure. Action by the remaining two House committees — the Committee on Energy and Commerce and the Committee on Ways and Means — is expected shortly after Labor Day when Congress returns from its August recess with a House floor vote likely to occur soon afterward.

The House bill is firmly opposed by the American Benefits Council (the "Council") and other employer groups because it includes a broad mandate that employers and health care plans must cover all mental health conditions and substance abuse disorders in the DSM-IV manual, if a health care plan covers any mental health benefits at all; broadly expands the ability of states to establish new remedies for health care plan participants in insured health care plans that would apply only to mental health coverage under their health care plan; and fails to fully protect the medical management practices of health care plans that are needed to ensure that health care plans only cover services determined to be medically necessary and appropriate.

PPA Technical Corrections Bill Introduced

The Chairmen and Ranking members of the Senate Health, Education, Labor and Pensions (HELP) Committee and the Senate Finance Committee recently introduced the Pension Protection Technical Corrections Act (S. 1974). While most of the bill simply corrects typographical errors and grammatical and other mistakes, the bill does contain a few clarifications to the Pension Protection Act of 2006 (PPA). No action is expected on either bill until this fall and additional legislation may be introduced later this year to address other issues. A summary of the legislation's highlights and a Joint Committee on Taxation (JCT) technical description of the Senate bill were recently released.

Clarifications in the bill address the following issues:

- Combined plan limit: The combined plan deduction limit for defined benefit and defined contribution plans does not apply to the defined benefit plan if contributions to the defined contribution plan are no more than 6 percent of compensation. If these contributions are more than 6 percent of compensation, only contributions in excess of 6 percent count toward the deduction limit. This clarification would reverse an Internal Revenue Service interpretation of the PPA provision.
- *Hybrid plans:* The new vesting rules for hybrid plans are effective on a plan year basis and only apply to participants with an hour of service after the applicable effective date. In addition, the new interest crediting rules for hybrid plans in existence on June 29, 2005, apply to years beginning after December 31, 2007,

unless the plan sponsor elects to apply the rules earlier. Clarification of the effective date of the vesting and interest crediting rules for collectively bargained plans was also included in the bill.

- *Funding rules:* The 2008 transition rule for determining at-risk status applies to both the 70 percent and 80 percent tests. Also, lump sums of $5,000 or less can be paid, even if the underfunded plan would otherwise be prohibited from paying lump sums.
- *Blackout periods:* The bill would expand the fiduciary relief that is currently available during a "blackout period" (which spans three consecutive days or more) to periods of less than three consecutive days.
- *Non-spouse rollovers:* The bill would require all plans to permit rollovers out of the plan for non-spouse beneficiaries.

RECENT REGULATORY ACTIVITY

Delay in 409A Regulations Requested and Granted

In response to a letter recently sent to the U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) by numerous law firms requesting the delay of the effective date of 409A final regulations by one year, the IRS issued Notice 2007-78.

The final regulations, originally published on April 17, 2007, set forth the rules for nonqualified deferred compensation under the Internal Revenue Code, including deferral elections and distributions. Under the final regulations, operational and documentary compliance is required as of December 31, 2007.

Under Notice 2007-78, the IRS extended the documentary compliance by deadline to December 31, 2008, as long as such provisions are made retroactively effective to January 1, 2008. Notice 2007-78 did not, however, extend the period by which nonqualified deferred compensation programs must be brought into operational compliance. Notice 2007-78 also clarified several provisions of the final regulations.

Treasury Issues Proposed Regulations on Funding Balances, Benefit Restrictions

The Treasury and the IRS released proposed regulations providing guidance under the PPA regarding (1) use of certain funding balances (previously referred to as credit balances but now differentiated between pre- and post-PPA effective date), and (2) benefit restrictions for certain underfunded defined benefit plans.

The benefit restriction guidance makes clear that benefit accrual restrictions will cease to apply to a plan as of the measurement date when the 60 percent funding target is met unless the plan specifically provides otherwise. In addition, a plan can be amended to provide that any benefit accruals that were previously limited under the benefit accrual restrictions will be credited once the limitation no longer applies, subject to applicable qualification requirements.

A participant who had an annuity starting date within a period during which accelerated benefit payment limitation rules applies (restrictions on lump sum payments and other accelerated payments), once the limitation ceases to apply the benefits will continue to be

paid in the form previously elected unless the plan permits the participant to make a new election. The proposed regulations would permit the plan to allow a new election, subject to applicable qualification requirements, and the new election will constitute a new annuity starting date for purposes of Internal Revenue Code Section 417.

Under the funding balance guidance, if a limitation on accelerated benefit payments would otherwise apply, the plan sponsor is treated as having made an election to reduce the funding balance by the amount necessary to raise the funding level to the percentage necessary for the benefit limitation not to apply to the plan and this applies whether or not a plan participant is eligible or elects to receive such a distribution during the plan year (so long as accelerated distributions are available under the terms of the plan). Deemed elections to reduce funding balances to avoid other benefit limitations apply to collectively bargained plans (at least 25 percent of participants are members of collective bargaining units). Neither deemed election occurs if the funding balance is insufficient to avoid the benefit limitations. The proposed regulations also provide presumptions that apply to plans prior to the actuarial certification of the funding status of the plan which are based on the prior year's funding status.

Senate Leaders Ask Treasury, IRS to Reconsider Position on Backloading Rules

Responding to the concerns of the business community, the leaders of the Senate Finance Committee and HELP sent a letter to the Treasury on August 29, urging the IRS to reconsider their interpretation of the backloading rules with regard to hybrid pension plans.

In the context of the recently opened determination letter process for hybrid pension plans and the PPA, the current IRS position on the application of the backloading rules to hybrid conversions would preclude the use of the "greater-of" transition in which participants receive the greater of the benefits calculated under the traditional plan formula or benefits calculated under the hybrid formula. This interpretation of the backloading rules as applied to the generous pro-participant approach to conversions could also negatively affect "greater-of" formulas in other contexts (such as traditional plans with a minimum benefit, or plans that provide the greater of the buyer's plan formula or the seller's plan formula immediately following a corporate acquisition).

In a recent letter, HELP Committee Chairman Edward Kennedy (D-MA) and Ranking Member Michael Enzi (R-WY) and Finance Committee Chairman Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA) state that the IRS interpretation "conflicts with the Service's position in other transition situations. A more reasonable and consistent interpretation would be to aggregate two benefit formulas in situations where one formula applies to a participant for a period of time, and a second formula applies after that date." The letter further emphasizes that "Congress recognized the need to protect plan participants in the event of a cash balance conversion under the PPA" and the IRS "should not set up unnecessary roadblocks to this pro-participant practice."

The letter strongly suggests that Treasury and IRS reconsider their current position and formally communicate this clarification to plan sponsors. Recently, a letter to the Treasury was sent urging the Treasury and IRS to stop any adverse actions and to protect the ability of plan sponsors to utilize "greater of" formulas in hybrid plan conversions.

The Treasury and IRS are expected to address the issue, but there is concerned that the solution will not be broad enough to sufficiently address the application of all "greater of" formulas.

IRS Issues Proposed Regulations Regarding Tax Treatment of Payments by Qualified Plans for Medical or Accident Insurance

The Treasury recently issued proposed regulations on the tax treatment of long-term care insurance, health insurance and disability insurance held by a 401(k) plan or other tax-qualified retirement plan. These regulations affect administrators, participants and beneficiaries of qualified retirement plans. The IRS has scheduled a public hearing on the regulations for December 6. The deadline for written comments on the proposed regulations is November 19.

In general, the proposed regulations provide that a premium charged against a participant's benefit in a plan for insurance covering the participant (such as a health insurance premium debited from a participant's account in a 401(k) plan) is treated as a taxable distribution from the plan. To the extent the premium is includible in income; the proposed regulations provide that benefits paid from the insurance would generally be excludable from income. The proposed regulations also address the tax treatment of accident or health insurance that is held as an investment by a plan, rather than as a benefit providing current coverage to a participant.

The proposed regulations would be generally effective for calendar years beginning after the date the final regulations are published. However, the proposed regulations also state that no inference should be drawn from the regulations that the payment of premiums from a qualified plan is not a taxable distribution if made in prior years.

Treasury and IRS Issue Priority Guidance for 2007-2008

The Treasury and IRS have released the government's 2007-08 Priority Guidance Plan, listing those issues that will be the subject of formal guidance during the next year. The plan contains 303 projects, many addressing employee benefit plans (Pages 2-5 of the document), to be completed by June 2008. An appendix also lists additional routine guidance that is published each year.

According to the plan, proposed regulations and/or guidance is expected to be issued regarding diversification requirements, hybrid plans, automatic enrollment, applicable interest and mortality assumptions, measurement of assets and liabilities, determination of the minimum required contributions and the funding of single employer plans, all of which were recently amended by the Pension Protection Act of 2006. Forthcoming guidance will also address nonqualified deferred compensation arrangements under Section 409A of the tax code and discrete issues regarding Health Savings Accounts.

The agencies issued a joint statement with the plan requesting feedback from the public, saying "The published guidance process can be fully successful only if we have the benefit of the insight and experience of taxpayers and practitioners who must apply the rules." The Council will continue to work closely with Treasury and IRS staff on all issues affecting employee benefit plans, and we encourage Council members to examine the Priority Guidance Plan in order to give us the benefit of your perspectives as we meet with Treasury and IRS staff and prepare formal comment letters.

EBSA Sets Forth Penalties for Diversification Blackout Notice Violations
The DOL's Security Administration (EBSA) concurrently published direct final regulations and proposed regulations establishing civil penalties for plan administrators that fail to notify participants of their right to diversify their plan portfolio by selling company stock. (The final regulations will take effect unless EBSA receives "significant adverse comments," in which case the proposed regulations will go through the standard review procedure.)

Under the regulations, the U.S. Secretary of Labor may assess civil penalties up to $100 per day for each violation. Section 101(m) of ERISA requires plan administrators of individual account plans to notify participants and beneficiaries of their right to sell the company stock in their accounts and reinvest the proceeds into other investments available under the plan. The notice must also inform the recipients of the importance of diversifying the investments in their accounts. The new regulations were mandated as part of the PPA.

Treasury Issues Proposed Regulations on Section 125 Cafeteria Plans
Treasury recently released proposed regulations on cafeteria plans under Section 125 of the Code. The proposed regulations replace the proposed regulations previously issued in 1984, 1989, 1997 and 2000. In addition to clarifying and/or restating many of the rules contained in the prior proposed regulations, the new proposed regulations establish new rules with respect to:

- qualified and nonqualified benefits in cafeteria plans;
- elections;
- flexible spending arrangements;
- substantiation of expenses for qualified benefits; and
- nondiscrimination.

Legislation Introduced Requiring Reform of 12b-1 Fee Disclosures
On July 31, Representatives Dennis Moore (D-KS) and Mike Castle (R-DE) introduced the Mutual Fund Fee Reform Act (H.R. 3225), a bill that would require the Security and Exchange Commission (SEC) to require the disclosure of 12b-1 fees charged to mutual fund investors. The proposed legislation is brief and does not specify the method or extent of this disclosure, but directs the SEC to issue rules "necessary in the public interest" within 180 days after enactment. The changes would then be effective one year after issuance of the SEC rules. The SEC's "12b-1" rule allows mutual fund companies to pay for marketing and advertising costs through fees charged to investors. The proposed legislation would not prohibit the collection of these fees but would attempt to make the investor more aware of the practice.

The bill has been referred to the House of Representatives Financial Services Committee, of which both Moore and Castle are members.

RECENT JUDICIAL ACTIVITY

Sixth Circuit Appeals Court Rules that Cash Balance Plans Are Not Age Discriminatory

The U.S. District Court of Appeals for the Sixth Circuit ruled on August 27 that cash balance plans are not age discriminatory. The decision came in the appeal of the case of *Drutis et al v. Rand McNally & Co*. from the ruling made by the U.S. District Court for the Eastern District of Kentucky. The appeals court generally followed the reasoning of a previous decision by the U.S. District Court of Appeals for the Seventh Circuit that cash balance plans should be tested for age discrimination on the basis of the plan's pay credits. Today's ruling is significant as three circuit courts have now ruled on the issue and consistently held that cash balance plans are not age discriminatory.

The plaintiffs in Drutis appealed in July a ruling in favor of Rand from the district court for eastern Kentucky. The plaintiffs argued that cash balance plans are unlawful and suggested that the appeals court define the rate of an employee's benefit accrual by reference to a projected benefit payable at normal retirement age.

U.S. District Court for the District of Columbia Orders Release of Medicare Data

A nonprofit consumer research organization recently prevailed in a lawsuit seeking disclosure of physician-identifiable Medicare claims data under a Freedom of Information Act (FOIA) request. Consumer's Checkbook requested the Medicare data for the purpose of conducting quality studies regarding the services provided by Medicare providers. Access to Medicare data has become increasingly important as employers, health insurers and researchers seek to combine Medicare claims data with their data for individual physicians to improve quality and cost measurement of physician services.

The plaintiff, Consumer's Checkbook/Center for the Study of Services (Consumer's Checkbook), sought disclosure of 2004 Medicare claims submitted by physicians from the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid (CMS) database for five jurisdictions: Washington, DC, and the states of Illinois, Maryland, Washington, and Virginia. CMS denied the FOIA request arguing that the requested data included financial information that would constitute an unwarranted invasion of the personal privacy of Medicare providers and was thus exempt from disclosure under FOIA. In its August 22 ruling, the U.S. District Court for the District of Columbia rejected CMS' argument, concluding that the requested information only concerned the business income of the physicians involved, and not intimate facts about their personal lives. The decision cited the public interest in obtaining information that would help the public make informed Medicare decisions and in providing more information as to how government funds are spent.

The court ordered the release of the requested documents by September 21, 2007. HHS has not indicated whether it will appeal the decision. According to its news release, Consumer's Checkbook's first use of the data will be to create a resource for the public to use to identify the frequency of various types of procedures performed be each physician and reimbursed by Medicare. The organization has similar FOIA requests pending for Medicare claims for all 50 states.

Third Circuit Court Declines to Rehear EEOC-AARP Retiree Health Case

The U. S. Court of Appeals for the Third Circuit has made a ruling that should help maintain the legitimacy of the long-held practice of providing a greater level of employer-sponsored health coverage to retirees who are not yet eligible for Medicare than is provided under an employer's plan to retirees who are eligible for Medicare. Support for this logical differential enjoys strong backing from the business and organized labor communities and the Equal Employment Opportunity Commission (EEOC), but has been challenged for several years by the AARP.

The Court has denied a petition by AARP for panel rehearing (a rehearing by the three appellate judges who rendered the decision) and en banc rehearing (a rehearing by the full appellate court) in *AARP v. Equal Employment Opportunity Commission (EEOC)*. The panel rehearing was denied unanimously, and the petition for rehearing en banc was denied by an 11-1 vote. The AARP was seeking a rehearing of the June 4 decision by the Third Circuit, which unanimously held that the EEOC properly exercised its exemption authority under the Age Discrimination in Employment Act (ADEA) when the agency proposed a regulation permitting the coordination of retiree health care benefits with Medicare eligibility.

The EEOC proposed the regulation in 2003 to exempt from the ADEA the practice of altering, reducing or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or a state-sponsored retiree health benefits program. The regulation was proposed in response to *Erie County Retirees Association v. County of Erie*, in which the Third Circuit held that, since Medicare eligibility is age dependent, the ADEA did not permit reduction or termination of retiree health benefits upon Medicare eligibility unless the employer met the "equal benefit or equal cost" test. Publication of the final regulation was blocked in 2005 when the AARP successfully challenged the EEOC's authority to issue the exemption.

The Third Circuit's official issuance of its decision denying AARP's rehearing petition is expected to lift the lower court stay that has prevented publication of the final regulation. Clearance by the Office of Management and Budget (OMB) is required prior to publication in the Federal Register. This is unlikely to be an obstacle, however, as the OMB previously cleared the regulation in 2005.

An amicus brief was filed in support of the EEOC in AARP v. EEOC and is a long-standing advocate for publication of the EEOC's final regulation.

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