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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 Christopher M. Smith, Employee Benefits attorney and Principal of Flexible Benefits Systems, Inc., csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Pension Relief Technical Corrections Added to Small Business Bill

Senate Finance Committee Chairman Max Baucus (D-MT) has added tax extenders language to the Small Business Jobs Act (H.R. 5297), including provisions related to employee benefit plans. An updated official summary of the language is also available.

Most notably, the most recent revisions include a narrow list of technical corrections to the defined benefit pension plan funding relief provisions of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (H.R. 3962). The specific items covered include:

- A correction that allows relief with respect to a year if the due date for contributions for that year occurs on or after March 10, 2010, rather than on or after the date of enactment (June 25, 2010);
- A correction to the effective date of the provision providing relief for Social Security "level income options" from the prohibited payment rules applicable to certain underfunded plans, so that the relief is prospective only;
- A one-year extension of the relief from the rule requiring underfunded plans to be frozen, so that if a plan is at least 60% funded for 2008, it need not be frozen in 2009, 2010, *or 2011*;
- A series of provisions correcting and strengthening relief for multiemployer plans; and
- A modification of the definition of an eligible charity plan. (Under the June legislation, such plans are retroactively subject to the pre-PPA funding rules. Under the modification, the definition is narrowed so that it only applies to plans that are maintained by charities that serve children and that operate in at least 20 states. Also, a plan is not an eligible charity plan unless the plan sponsor elects to be so treated. Finally, the provision is effective for 2010 unless the plan sponsor elects to have the provision apply earlier. These changes would solve the problem that some plans were being inadvertently made subject to the pre-PPA funding rules on a retroactive basis. On the other hand, this provision takes away relief from some charities that might have wanted their plans to be treated as eligible charity plans.)

H.R. 5297 also provides for “in-plan” conversions from traditional 401(k) or 403(b) defined contribution plan accounts to "Roth"-style accounts (for amounts that would otherwise be distributable from the plan) and creation of Roth accounts for state and local 457 plans. (These provisions are referenced on Page 5 of the official summary document.) The measure also provides for partial annuitization of nonqualified annuity contracts.

On July 29, the Senate failed to achieve closure and end debate on the measure and the Senate and the House of Representatives began an extended recess on August 9, making the timing for a final floor vote uncertain.

President Obama Signs Financial Services Bill; Colloquies on Pension Issues Available

On July 21, President Obama signed into law the Restoring American Financial Stability Act (H.R. 4173). The comprehensive financial reform legislation includes a number of elements related to retirement plan administration. (The Securities and Exchange Commission (SEC) has

requested feedback on certain regulatory issues. See the story in the Regulatory section, below.)

On July 15, two Senators engaged in colloquies (dialogue on the chamber floor meant to clarify lawmakers' intent) regarding the bill's impact on retirement plans:

- The first deals with the "independent representative issue," under which a swap dealer or "major swap participant" (MSP) must comply with certain standards set forth by the Commodity Futures Trading Commission (CFTC) (or the Securities and Exchange Commission (SEC) as applicable) when a swap dealer or MSP enters into a swap with a "Special Entity" (i.e., generally, a plan, government, or endowment). Under one such standard, the swap dealer or MSP must have a reasonable basis to believe that the Special Entity has a knowledgeable independent representative advising it with respect to the swap. The colloquy between Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Tom Harkin (D-IA) and Senate Agriculture, Nutrition and Forestry Chairwoman Blanche Lincoln (D-AR) indicates that the representative only needs to be independent of the swap dealer or MSP, and need not be independent of the Special Entity. The colloquy also indicates that the independent representative requirement applies to plans.
- The second colloquy relates to the study of stable value contracts. The legislation calls for the CFTC and the SEC to jointly study whether stable value contracts do and should fall within the definition of a swap. Stable value contracts in effect prior to the effective date of regulations implementing the agencies' determinations are not treated as swaps. The legislation defines stable value contracts for this purpose only to include such contracts that relate to funds "available as an investment in an employee benefit plan . . . subject to participant direction," a governmental 457(b) plan, a 403(b) plan, or a 529 qualified tuition program (emphasis added). In this colloquy, Senators Harkin and Lincoln indicate that the participant direction requirement can be satisfied not only by direct participant direction but also by fiduciary direction on behalf of participants, so that the delay in the application of the swap rules to stable value contracts would also apply in the context of defined benefit plans, health and welfare plans, and defined contribution plans where the fiduciary directs investments.

House Subcommittee Holds Hearing on Alternative Pension Investments

On July 20, the House Education and Labor Subcommittee on Health, Employment, Labor and Pensions held a hearing on Creating Greater Accounting Transparency for Pensioners, with a focus on retirement plan fund investment in alternative vehicles such as hedge funds and private equity. The purpose of the hearing was to identify and evaluate the tools presently available to pension plan fiduciaries in evaluating alternative investments.

In his opening statement, Subcommittee Chairman Rob Andrews (D-NJ) said, "In order for people to exercise their fiduciary duty in a proper way, transparency is needed. … One can not really understand the potential risks and rewards of an investment if the data which underlie the dynamics of that investment are not easily and readily understandable." While Andrews asserted that alternative investment vehicles should not be excluded from consideration by plan investors, he did suggest the need for access to "relevant, real-time" information so they can properly discharge their responsibility as fiduciaries.

The panel heard testimony from:

- Barbara Bovbjerg, managing director, education, workforce and income security for the U.S. Government Accountability Office (GAO), who testified on the results of the 2008 GAO study Defined Benefit Pension Plans: Guidance Needed to Better Inform Plans of the Challenges and Risks of Investing in Hedge Funds and Private Equity. In that study, GAO recommended that the U.S. Department of Labor (DOL) provide guidance to plans on the use of alternative investments.
- Robert Chambers, a partner with McGuireWoods LLP, who identified a number of existing sources of information that DOL can use to provide alternative investment guidance to plan fiduciaries. He also indicated that additional disclosure to plan participants would be superfluous, particularly in light of the recently enacted Restoring American Financial Stability Act (H.R. 4173).
- Matthew D. Hutcheson, an independent fiduciary, who spoke about the due diligence burden retirement plan fiduciaries have when investigating alternative investments. To protect retirement plan participants in light of these challenges, he recommended the formalization of standards for plan administration and disclosure.
- Jack Marco, chairman of the Marco Consulting Group, who spoke about the need for increased disclosure by the investment community and provided a list of best practices for private equity and hedge fund investing.

Questions and answers focused primarily on the need for additional rules with regard to alternative investments. Chambers responded that new legislation and regulations are not necessary at this time, but additional guidance may be pertinent after H.R. 4173 has been fully implemented.

In particular, the witnesses discussed the necessity for expanded disclosure by hedge funds and/or private equity funds to the government and the general public. Marco suggested that more disclosure was needed, while Chambers and Hutcheson said that disclosure between the parties conducting the transaction (as prescribed within H.R. 4173) was sufficient.

RECENT REGULATORY ACTIVITY

IRS Issues Defined Benefit Pension Relief Guidance

On July 30, the Internal Revenue Service (IRS) issued guidance for single-employer and multi-employer plans wishing to take advantage of the defined benefit plan funding relief provisions of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PRA 2010). This guidance clarifies the availability of relief in the near term and describes anticipated future IRS guidance.

Notice 2010-55 applies to single-employer defined benefit plans. As we reported in the July 2010 *Insider*, PRA 2010 permits a plan sponsor to reduce a plan's minimum required contribution for certain years by electing to use an alternative shortfall amortization schedule. Future guidance will be published regarding:

- calculation of the alternative amortization schedules permitted under PRA 2010 (and the effect on funding balances);
- the rules relating to installment acceleration amounts under Internal Revenue Code (IRC) Section 430(c)(7);
- the procedures for making the election to use an alternative amortization schedule, and
- the notice requirements of IRC Section 430(c)(2)(D)(vi).

In the case of a plan year that ends before the guidance is issued, the plan sponsor will be permitted to elect to use the alternative amortization schedule under PRA 2010 without regard to whether the Form 5500 (and Schedule SB) has been filed for that plan year. Accordingly, the guidance instructs plan sponsors to file the Form 5500 (and Schedule SB) in accordance with the applicable deadline, taking into account the rules for obtaining an extension. The future guidance will address reporting requirements if the plan's Form 5500 (and Schedule SB) for the plan year has been filed.

Notice 2010-56 applies to multiemployer defined benefit plans. The IRS will publish future guidance regarding:

- determination of the portion of the experience loss or gain attributable to net investment losses incurred in either or both of the first two plan years ending after August 31, 2008;
- the requirement under IRC Section 431(b)(8)(E) to notify participants and beneficiaries of application of the special rules; and
- the effect of application of the special rules on the certification of a multiemployer plan's status (i.e., endangered, critical or neither) under IRC Section 432(b), including certifications already made.

Like the single-employer guidance, in the case of an applicable plan year that ends before guidance is issued, the funding relief may be used for the applicable plan year (subject to certain IRC Section 431(b)(8) requirements) without regard to whether the plan sponsor has filed the Form 5500 (and Schedule MB) for that plan year.

SEC Proposes Regulations on Mutual Fund Fees

On July 22, the Securities and Exchange Commission released proposed regulations that would replace Rule 12b-1 of the Investment Company Act, which currently allows mutual fund companies to pay for marketing and advertising costs through fees charged to investors.

The new rule and amendments would continue to allow funds to bear promotional costs within certain limits, and would also preserve the ability of funds to provide investors with alternatives for paying sales charges. Unlike the current rule 12b-1 framework, the proposed rules would limit the cumulative sales charges each investor pays, no matter how they are imposed. The SEC is also proposing additional required disclosure about all sales charges in fund prospectuses, annual and semi-annual reports to shareholders and in investor confirmation statements. The new rule would be universally applicable and would therefore apply to mutual funds in retirement plans.

DOL Issues Final Disclosure Rules for Defined Contribution Plans and Service Providers

On July 15, the U.S. Department of Labor Employee Benefits Security Administration (EBSA) released a preliminary version of interim final regulations governing disclosure of defined contribution and defined benefit plan fees under ERISA Section 408(b)(2), which allows plans to contract for necessary services if the compensation paid for the services is reasonable. The interim final regulations were published in the Federal Register on July 16, 2010 and are effective July 16, 2011. The final rule will apply to pre-existing contracts or arrangements at that time.

Generally, the regulations provide a class prohibited transaction exemption for plan fiduciaries when plan service providers fail to comply with their disclosure obligations, provided certain requirements are met. The proposed regulations would require that service providers give plan fiduciaries written disclosures of certain fee and services information necessary to assist plan fiduciaries in assessing the reasonableness of compensation or fees paid by the plan, as well as the potential for conflicts of interest.

The Bush Administration originally issued proposed regulations and a proposed class exemption in December 12, 2007, as part of a series of defined contribution plan fee disclosure guidance. These regulations were expected to be finalized in early 2009, but were delayed indefinitely by the Obama Administration. EBSA has made significant changes to the proposed regulations and therefore issued them as "interim final" to allow for an additional comment period (within 45 days of publication in the Federal Register).

Additional resources are now available regarding 408(b)(2) disclosure rules. Along with the interim final regulations, DOL has released the following resources:

- An official fact sheet;
- A news release announcing the issuance; and
- A class exemption model notice.

Comments on the interim final regulations are due on or before August 30.

PPACA Regulations on Claims and Appeals Procedures Released

On July 22, the U.S. Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) released interim final regulations (IFR) for group health plans and health insurance issuers relating to internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act (PPACA). The White House has also released an official fact sheet on the IFR. The agencies are requesting comments on the IFR due 60 days after publication in the Federal Register.

The IFR sets forth rules implementing Section 2719 of the Public Health Service (PHS) Act for internal claims and appeals and external review processes for group health plans and health insurance coverage and establishes standards for the form and manner of providing notices in connection with these procedures. According to an HHS news release, "consumers in new health plans in every state will have the right to appeal decisions, including claims denials and rescissions, made by their health plans. This includes the right to appeal decisions made by a health plan through the plan's internal process and, for the first time, the right to appeal decisions made by a health plan to an outside, independent decision-maker, no matter what state a patient lives in or what type of health coverage they have."

The IFR generally applies to group health plans and group health insurance issuers for plan or policy years beginning on or after September 23, 2010, but does not apply to grandfathered plans.

With regard to internal appeals procedures, the IFR builds on existing ERISA claims regulations and provides separate rules for group health plan coverage and individual health insurance coverage. Group health plans and health insurance issuers offering group health insurance coverage must comply with the existing ERISA claims regulations and six additional new requirements. Specifically, the IFR:

- Includes rescission of coverage in the definition of “adverse benefit determination;"
- Shortens the current 72 hour timeframe for notifying a claimant of a benefit determination involving urgent care to “as soon as possible” and not later than 24 hours;
- Provides additional criteria to ensure that a claimant receives a full and fair review;
- Provides additional conflict-of-interest criteria;
- Includes new standards regarding notice to enrollees related to content and for providing notice in a “culturally and linguistically appropriate manner;” and
- Requires that, in the case of a plan or issuer that fails to “strictly adhere” to all requirements of the internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the process.

With respect to external appeals procedures, the interim final regulations provide a system for applicability of either a state external review process or a federal external review process and provide rules for determining which process applies. The regulations adopt an approach that generally build on existing state external processes, modeled on standards established by the National Association of Insurance Commissioners (NAIC) – states are encouraged to adopt the IFR standards before July 1, 2011. The interim final regulations include a broad range of elements from the NAIC Uniform Model Act that must be included for a state external review process to apply. These include:

- effective notice to claimants of their rights in connection with external review for an adverse benefit determination;
- specific requirements regarding exhaustion of the internal claims and appeals process;
- a requirement that issuers pay the cost of the external appeal under state law, with states forbidden from requiring consumers to pay more than a nominal fee;
- review by an independent body assigned by the state (the state must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest); and
- the decision must be binding on the plan or issuer, as well as the claimant, except to the extent that other remedies are available under state or federal law.

For group health plans not subject to existing state external review processes (including self-insured plans), a federal process will apply for plan years beginning on or after September 23, 2010. The preamble to the interim final regulations states that the agencies will be issuing more guidance in the “near future” on the federal external review process.

PPACA Preventive Care Regulations Released

On July 14, the U.S. Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) released a preliminary version of interim final regulations (IFR) setting forth the preventive care requirements of the Patient Protection and Affordable Care Act (PPACA). The IFR generally applies to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010, but does not apply to grandfathered plans.

Under PPACA, non-grandfathered plans are required to provide preventive care services (such as mammograms, colonoscopies and immunizations) without cost-sharing. The law also requires that the coverage be offered consistent with published recommendations from the United States Preventive Services Task Force, the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices and the Health Resources and Services Administration. The IFR includes a link to a HealthCare.gov Web site with a complete list of

recommendations and guidelines that are required to be covered and refers to those items and services as "recommended preventive services."

The IFR includes several examples for determining when a recommended preventive service must be covered without cost-sharing when the service is provided during an office visit. Most notably, the IFR clarifies that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. It further clarifies that a plan or issuer may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

PPACA grants the agencies authority to develop guidelines for group health plans and health insurance issuers to utilize value-based insurance design as part of their offering of preventive health services. According to the IFR preamble, the agencies are developing additional guidelines and are seeking comments related to the development of such guidelines for value-based insurance designs that promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services. Comments on the IFR will be due on or before the date 60 days after publication in the Federal Register.

HealthReform.gov Becomes HealthCare.gov

The U.S. Department of Health and Human Services (HHS) has changed its health care Web site from HealthReform.gov to HealthCare.gov, effective immediately, in conjunction with the ongoing implementation of the Patient Protection and Affordable Care Act (PPACA)

The redesigned Web site is targeted specifically at consumers, with a central database of health coverage options, combining information about public programs (including Medicare) with information from more than 1,000 private insurance plans.

HealthCare.gov provides information for employer plan sponsors as well, including the Implementation Center, where sponsors can find materials related to PPACA regulations, authorities, letters, grants, brochures and requests for comment. This area includes information published by the Office of Consumer Information and Insurance Oversight (OCIIO), the office within HHS responsible for implementing the law.

HHS Withdraws Final Regulations on HITECH Breach Notification

The U.S. Department of Health and Human Services has temporarily withdrawn final regulations implementing the breach notification provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of the American Recovery and Reinvestment Act of 2009, to allow for further consideration.

In August 2009, HHS published interim final regulations requiring covered entities and business associates to provide certain notices in the event of breach of unsecured protected health information. The interim final rule became effective on September 23, 2009.

HHS, upon reviewing the approximately 120 comments submitted during the 60-day public comment period on the Interim Final Rule, developed final regulations and submitted it to the Office of Management and Budget (OMB) for approval. The agency has since become aware of numerous complexities surrounding the issue and the withdrawal of these final regulations will

allow the administration to review and revise the rules where appropriate. HHS has indicated that it intends to publish a final rule in the Federal Register in the coming months.

Proposed HITECH Regulations Formally Released

The U.S. Department of Health and Human Services (HHS) has issued proposed regulations implementing modifications to privacy, security, and enforcement rules under the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of the American Recovery and Reinvestment Act of 2009. The proposed regulations were formally published in the Federal Register on July 14. (These proposed regulations are not directly related to the final regulations referenced in the prior story, above.)

Among the statutory provisions implemented by the proposed regulations are those that apply HIPAA security and privacy requirements directly to business associates, specify certain requirements for business associate contracts and extend HIPAA's civil and criminal penalties to business associates. The compliance date will generally be 180 days after final rules are published, although some provisions may have different compliance dates.

HHS will accept comments on or before September 13, 2010.

SEC Solicits Comments on Financial Reform Regulation

The U.S. Securities and Exchange Commission (SEC) is now soliciting public comments on the Dodd-Frank Wall Street Reform and Consumer Protection Act (previously known as the Restoring American Financial Stability Act, H.R. 4173), which was signed into law by President Obama on July 21. (See story in the Legislative section above.)

While proposed regulations, when published in the Federal Register, will provide separate comment periods and due dates, the SEC has established a Web site where the public can electronically offer input prior to these official comment periods. (A list of topics is available on the Web site.)

The U.S. Treasury Department and U.S. Department of Labor also have regulatory responsibilities under the statute but have not yet announced a similar comment outreach program.

IRS Announces a Decoupling of Schedule SSA from Form 5500 Effective with Plan Years Beginning in 2009

In the July 2010 Special Edition of Employee Benefit Plans News, the Internal Revenue Service (IRS) announced that the Form 5500 Schedule SSA has been eliminated beginning with returns for the 2009 plan year and has been replaced with Form 8955-SSA. The IRS will announce a special due date, expected to occur in 2011, for the 2009 Form 8955-SSA, which has not yet been released.

As part of the annual Form 5500 filing process, defined benefit plan sponsors are required to file detailed person-by-person information regarding deferred vested benefits for participants who separated during the plan year. Until now, this information has been filed as Schedule SSA of Form 5500. This can be an extremely lengthy document for a large company that undergoes a major restructuring, and it is not easily accommodated as part of an electronic Form 5500 submission. Under this announcement, this information will no longer be filed as part of the

Form 5500 submission. Rather, it will be submitted to the IRS annually as Form 8955-SSA. More information is currently available on the IRS Form 5500 Corner Web site.

ERISA Advisory Council Hears Testimony on Health Literacy

On July 1, the U.S. Department of Labor's (DOL) ERISA Advisory Council (EAC) met to hear testimony on health care literacy. The EAC intends to study this subject and make recommendations regarding standards for group health plans and insurance issuers and the development of educational and promotional tools for individuals. The witnesses testifying before the panel were:

- Dan Maguire, director of health plan standards and compliance assistance at the DOL Employee Benefit Security Administration;
- Helen Darling, president of the National Business Group on Health (NBGH);
- Lynn Quincy, senior policy analyst for Consumers Union;
- Brian Elbel, assistant professor of medicine and health care policy at the New York University Department of Medicine; and
- Theresa Hay, senior manager of outreach communications with Health Dialog, an organization that uses audience testing and focus groups to customize health information for a company's workforce.

All witnesses generally agreed that low health literacy is correlated with poor health outcomes, with the correlation particularly acute among those with low educational attainment, minorities, those with poor language skills or for whom English was not their primary language, the elderly, those with mental health issues or who were presented with a devastating diagnosis. The witnesses all noted the difficulty in improving health care literacy due to the complexity and personal nature of the underlying subject matter.

The witnesses generally urged standardization of medical terms, informational content and formatting, but there was substantial variation on specific details although consensus that the health communications should be overly simplified to be made clear to the individuals seeking information.

Maguire, from DOL/EBSA, told the panel that the agency recognizes the difficulty of making health information more accessible and useful to individuals with low literacy levels. He cited prior experience in dealing with health and pension disclosures that may be useful in developing future resources. He also discussed implementation of the Patient Protection and Affordable Care Act (PPACA), particularly those provisions that require DOL to examine the summary plan document and other communications to employees. Maguire did not confirm that there would be focus groups or audience testing of any models for disclosure or other materials due to questions about timing, contracting and other variables. He acknowledged that the agency would address cultural sensitivities and would work with the National Association of Insurance Commissioners to develop models.

Hay, from Health Dialog, discussed the organization's extensive research of health communications and its work in improving health communications at worksites. She told the panel that effective health communications must be tailored to the target audience, which would make standardization of materials, terms and even formatting difficult. She also suggested separating certain health information into tiers for different levels and types of decisions, such as obtaining information about a specific illness versus learning they have that illness, seeking care and caring for their health appropriately.

Darling, from NBGH, urged the DOL to reject efforts to redefine the term “welfare benefit plan” under ERISA due to the risks it would present to the employer provided health care system. he DOL had been preparing to issue a notice of proposed rulemaking on the subject, but indicated recently (in the U.S. government's amicus brief in the case of the Golden Gate Restaurant Association v. The City and County of San Francisco) that the proposal has been withdrawn. The Council will continue to urge rejection of such proposals should they arise again in the future.

The EAC will hold a second round of hearings on this and other topics in late August and early September.

President Obama Appoints New Leadership of CMS, PBGC

On July 7, President Obama made so-called "recess appointments" of two agency officials with responsibility for employee benefit matters. Because these appointments were made during a congressional recess, the nominees are temporarily able to bypass the formal Senate confirmation process. However, ultimately the Senate will need to act if the nominees are to retain their positions long-term. As a practical matter, the appointments will not likely remain in effect beyond the end of this calendar year when Congress adjourns unless the Senate confirms their nominations in the meantime.

The president nominated Dr. Donald Berwick as administrator of the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services, the agency responsible for coordinating public health plans with U.S. health care policy. Berwick most recently served as president and chief executive officer of the Institute for Healthcare Improvement, clinical professor of Pediatrics and Health Care Policy at the Harvard Medical School and professor of Health Policy and Management at the Harvard School of Public Health. Berwick's nomination has come under fire from congressional Republicans, who have criticized a number of policy positions that he has staked out in previous speeches and writings.

The president also appointed Joshua Gotbaum as director of the Pension Benefit Guaranty Corporation (PBGC), the governmental agency charged with guaranteeing the payments from terminated defined benefit pension plans. Gotbaum had most recently been an operating Partner at Blue Wolf Capital and previously served under the Carter and Clinton administrations.

DOL Releases Additional Guidance on Mental Health Parity Regulations

On July 1, the U.S. Department of Labor posted to its Web site additional guidance — in the form of a "frequently asked question" (FAQ) and answer — under the interim final regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. The guidance announces an enforcement safe harbor where a plan or issuer divides benefits into two sub-classifications within the outpatient classification for purposes of applying the financial and treatment limitation rules under the MHPAEA. The permitted sub-classifications are for office visits and all other outpatient items and services.

The MHPAEA prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or treatment limitations that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits. Under the complex "substantially all" test adopted under the regulations, in order for any type of financial requirement (or quantitative treatment limit) to apply to mental health or substance use disorder

benefits, that particular "type" of requirement must first apply to two-thirds of the medical and surgical benefits within a particular classification.

The new guidance, which applies until final regulations are issued, constitutes important relief for plans with respect to the outpatient classification testing problem.

RECENT JUDICIAL ACTIVITY

District Court Identifies Fiduciary Breach in Tibble v. Edison Case

In a decision that could be problematic for plan sponsors, on July 8, the District Court for the Central District of California ruled for the plaintiff in *Tibble v. Edison International*, finding that the retirement plan fiduciary breached its fiduciary duties by choosing retail-class funds for the plan's investment menu. This decision marks the first time that a court has found liability based on the use of retail rather than institutional funds. More specifically and significantly, the court found the plan liable because the fiduciary failed to ask for a waiver of minimum invested assets to qualify for the institutional funds.

According to the court, when deciding which funds to offer, the fiduciary did not consider or evaluate other share classes of funds. The court noted that while the fiduciary did consult a third party advisor (affiliated with the recordkeeper) when selecting the investment menu, the fiduciary failed to thoroughly investigate the different share classes available of the selected funds.

In his decision, District Court Judge Stephen V. Wilson held that because the defendants never considered or evaluated the different share classes of the three mutual funds at issue, they failed to conduct a proper investigation, thereby breaching their duty of prudence. The defendants argued that because they solicited and relied on advice from their third-party advisor, they had conducted a sufficiently thorough investigation. The court rejected this argument, suggesting that the defendants needed to show that they were reasonably justified in relying upon that advice.

While this decision is contrary to the conclusions of other courts, it is troubling for plan sponsors.

District Court Dismisses ADEA Allegations in Pension Discrimination Case

In an important and positive development for plan sponsors, on July 28, the U.S. District Court for the District of Colorado granted a request by El Paso Corporation, to dismiss the Age Discrimination in Employment (ADEA) claims in *Tomlinson v. El Paso Corporation*, a long-running lawsuit regarding a cash balance plan conversion. Under the facts of the case, the age discrimination claim was based on the existence of a “wear-away” period, under which an employee may not accumulate additional pension benefits for some period of time following a plan amendment.

In August 2009, the same court overturned a prior judgment for the defendants, holding that the Lilly Ledbetter Fair Pay Act of 2009 required a reversal of the original decision that the lawsuit was not timely filed. While the court’s earlier decision acknowledged that the Ledbetter statute preserves the existing law that payments from the plan would not extend the statute of limitations, the court noted that, under the Ledbetter statute, the allegedly discriminatory act was the lack of new accrual of benefits (due to the wear-away period) within the statute of limitations

period. Thus, the court's earlier decision to overturn the original finding for the defendant applied the Ledbetter legislation to open up the statute of limitations with respect to the filing of cash balance discrimination cases, such as wear-away cases.

With the dismissal of the ADEA elements, U.S. District Judge Walker D. Miller affirmed that the cash balance conversion did not violate ADEA Section 623(i)(4) because the defendant did not violate the statutory provision that makes it illegal to cut off or reduce the rate of an employee's benefit accrual because of age.