BENEFITS INSIDER
A Member Exclusive Publication

Volume 79, December 2011/January 2012

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

Small Business Pension Bill Introduced

New, bipartisan legislation to promote retirement plan creation was introduced in the U.S. House of Representatives by Representatives Ron Kind (D-WI), Jim Gerlach (R-PA) and Richard Neal (D-MA) on December 5. The Small Business Pension Promotion Act (H.R. 3561) is intended to reduce administrative burden and encourage retirement plan formation and retention among employers of all sizes.

According to an official summary released by Kind's office, H.R. 3561 would:

- Adjust the rules for required minimum distributions for defined contribution plans and individual retirement accounts to allow market-related account decreases to be counted toward a required distribution;
- allow a Self-Employment Contributions Act (SECA) deduction for contributions to a qualified plan or IRA;
- eliminate the current defined benefit pension plan requirement that credit balances be subtracted from plan asset values in calculating the funding based benefit restrictions;
- repeal the current 10 percent excise tax on excess contributions to qualified plans; and
- clarify the term "normal retirement age" to specify that a plan is not treated as violating either qualified plan rules or ERISA merely because the plan has (as of December 5, 2011) a normal retirement age that is the earlier of attainment of a specified age or attainment of 30 or more years of benefit accrual service.

As part of the statute, the U.S. Treasury Department would be required to issue regulations no later than two years after the date of enactment revising existing rules "to provide greater flexibility and reduce plan sponsor burden, while taking into account the need for plan terms to reflect the benefits to which participants are entitled."

H.R. 3561 has been referred to the House Ways and Means Committee, of which all three of the bill's cosponsors are members. While no immediate action is expected on the measure, its bipartisan support augurs well for its possible consideration.

TAA Extension Bill Affects Health Coverage Tax Credit and COBRA Coverage

The Trade Adjustment Assistance (TAA) Extension Act, signed into law by President Obama on October 21, includes several provisions of note to employer sponsors of health plans. The measure modifies the health coverage tax credit (HCTC) as codified under Section 35 of the Internal Revenue Code as well as the rules governing health care continuation coverage under COBRA.

Health Care Tax Credit

Under the HCTC, certain qualifying individuals (TAA-Eligible individuals, ATAA eligible individuals and PBGC payees) may receive a refundable tax credit that can be used to reduce premium costs for the purchase of certain qualifying post-employment medical coverage, including COBRA continuation coverage. Prior to the enactment of the TAA Extension Act, the HCTC was equal to 65 percent of the qualified health insurance premiums for eligible individuals and their families. The new law retroactively increases the amount of the credit to 72.5 percent,

beginning with coverage months beginning after February 12, 2011. The new law also includes a termination date for the HCTC, which will cease to be available to individuals as of January 1, 2014.

COBRA Continuation Coverage

Very generally, COBRA provides workers and their families the ability to elect to continue certain employer-sponsored health coverage for limited periods of time under certain circumstances. Typically COBRA coverage lasts no longer than 18 months, although it can be extended in certain limited instances ("Maximum COBRA Coverage Period"). For eligible individuals, prior federal legislation extended coverage to the later of, but not beyond, the Maximum COBRA Coverage Period, or February 12, 2011. The new law extends coverage to such individuals to the later of, but not beyond, the Maximum COBRA Coverage Period, or January 1, 2014. The new law expressly states that the extension only applies with respect to periods of coverage which would end on or after 30 days after the date of enactment. Since the law was signed on October 21, 2011, the COBRA extension does not appear to apply to individuals whose COBRA coverage lapses before November 21, 2011. The new law does not appear to provide for any retroactive reinstatement or extension of COBRA coverage that has already terminated.

These modifications are more fully described in a summary prepared by Crowell & Moring LLP. The Internal Revenue Services' HCTC Office indicates that it is currently working to determine its effect on eligible taxpayers, as well as those participants currently receiving the monthly tax credit and that updates will be provided on an IRS HCTC website as new information becomes available.

House Committee Approves Measures Affecting Swaps

In a "mark-up" session on November 30, the U.S. House of Representatives Financial Services Committee approved three measures intended to modify the derivatives provisions of the Wall Street Reform and Consumer Protection (Dodd-Frank) Act:

- H.R. 2779, which would exempt inter-affiliate swaps from certain regulatory requirements put in place by the Dodd-Frank Act, was amended and approved by a unanimous 53-0 vote.
- The Swap Execution Facility (SEF) Clarification Act (H.R. 2586), which would clarify Congress' intent to permit SEFs to use any means of interstate commerce to execute swaps, was amended and approved by voice vote.
- The Business Risk Mitigation and Price Stabilization Act (H.R. 2682), which would prohibit regulators from imposing margin requirements on end users of financial derivatives (not including retirement plans), was approved by a voice vote.

Proposed regulations from the Commodity Futures Trading Commission (CFTC) regarding the business conduct standards could have the unintended effect of making swaps effectively unavailable to defined benefit pension plans.

The full committee has not yet taken up the Retirement Income Protection Act (H.R. 3045), which would ensure that ERISA pension plans can engage in swap transactions without their swap dealer counterparties being considered fiduciaries, or the SEC Regulatory Accountability Act (H.R. 2308), which would set forth specific factors that must be considered by the SEC in

connection with a cost-benefit analysis of any regulation or proposed regulation, both of which were approved by Subcommittee on Capital Markets and Government Sponsored Enterprises in a "mark-up" session on November 15.

RECENT REGULATORY ACTIVITY

HHS Bulletin Proposes Standards for Essential Health Benefits Under PPACA

On December 16, the U.S. Department of Health and Human Services (HHS) issued the Essential Health Benefits Bulletin (EHBB), which describes the agency's intended approach toward developing regulations defining "essential health benefits" (EHB). As required under the Patient Protection and Affordable Care Act (PPACA), the essential benefits package will establish the minimum benefits — including preventive, diagnostic, and therapeutic services and products — that must be covered by certain health plans, including those participating in state-based health insurance exchanges.

While the essential health benefits package will directly apply to plans in the individual and small group markets, there are implications for plans in the large group market, including self-insured plans. PPACA's prohibition on lifetime and annual dollar limits applies to group health plan coverage for any "essential health benefits," as determined in HHS guidance. Interim final regulations (IFR) issued in June 2010 implementing these limits stated that the regulatory agencies will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan years that begin before final regulations are issued defining the term.

Generally, the EHBB begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This intended approach addresses:

- four "Benchmark Plan" types for states to select as the standard for qualified health plans offered inside an exchange as well as small group markets;
- standards for defraying the cost of state-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market;
- the Benchmark Plan approach and the ten identified benefit categories, including habilitative services, pediatric oral and vision coverage and mental health and substance use disorder services and parity;
- benefit design flexibility; and
- periodic review of EHB.

HHS Releases Final Rules Regarding Medical Loss Ratios Under PPACA

On December 2, the U.S. Department of Health and Human Services (HHS) issued final regulations and a fact sheet on Medical Loss Ratio (MLR) requirements under the Patient Protection and Affordable Care Act (PPACA).

The MLR is the percentage of a health insurance plan's premium that pays for claims incurred for medical services and other plan expenses related to health care quality improvement. Under PPACA, health insurers must spend a minimum of 80 percent of premium revenue on clinical services and activities to improve health care quality for plans in the individual and small group

markets, and 85 percent for plans in the large group market. Insurance companies that fail to meet the new standard are required to provide a rebate to consumers. The final regulations are based on recommendations by the National Association of Insurance Commissioners (NAIC) issued in October 2010.

While interim MLR rules took effect on January 1, 2011, the December 2 final regulations make a number of notable modifications, including:

- provisions for increased transparency of certain MLR information, including specific data on limited benefit (also known as "mini-med") and expatriate plans;
- a phased reduction of the "special circumstances" adjustment for mini-med plans, in which the 2.0 multiplier for 2011 is phased down to 1.75 in 2012, to 1.5 in 2013 and to 1.25 in 2014 (mini-med plans will be banned by PPACA's prohibition on annual limits starting in 2014); and
- retention of the 2.0 multiplier adjustment for expatriate plans.

Along with the final regulations, HHS also released interim final regulations addressing non-federal government plans.

In conjunction with the HHS, the U.S. Department of Labor issued Technical Release 2011-04, addressing rebates to policyholders who are group health plans under ERISA. According to the guidance, if a group health plan is entitled to rebates under the MLR rules as a policyholder, rebates issued may constitute plan assets, and the policyholder would be required to comply with ERISA fiduciary provisions for handling the rebates. If the plan sponsor is the policyholder, the plan's portion of the rebate, if any, may depend on provisions of the plan or the manner of cost-sharing under the policy. Notably, the Technical Release leaves open the question of "when" the MLR rebate becomes an ERISA plan asset and, therefore, whether the issuer delivering the rebate could be an ERISA fiduciary with respect to (1) the determination of the rebate amount, and/or (2) the delivery of the rebate to the policyholder.

The MLR requirements have come under fire from Republicans in Congress, who have argued that such rules are overly restrictive in that they require plans to count fraud and waste prevention efforts as administrative activities rather than as medical expenses for the purposes of meeting the MLR thresholds. Several states have also sought waivers from HHS because of concern that attempts to implement the MLR rules in their states could destabilize their insurance markets. The MLR Repeal Act (H.R. 2077), introduced in June by Representatives Tom Price (R-GA) and Kathy McMorris Rodgers (R-WA), would entirely repeal these regulations.

CFTC Releases Final Rules for Business Conduct Standards; EBSA Affirms No Conflict with Fiduciary Rules

The Commodity Futures Trading Commission (CFTC) has released final regulations relating to business conduct standards for swap dealers and major swap participants in their dealings with counterparties, including ERISA plans, under the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the Dodd-Frank Act). The CFTC approved these final regulations in a January 11 public meeting, at which they also released a fact sheet and questions-and-answers document.

The final business conduct rules have been revised to provide increased flexibility for ERISA plans utilizing swap trades. ERISA plans commonly use swaps to hedge or mitigate risks endemic to plan liabilities and investments. Without the use of swaps, defined benefit pension funding obligations would become more volatile and force employers to find other less efficient ways to manage that risk — including setting aside large sums of cash to cover potential funding obligations.

In response to the adoption of the final regulations, U.S. Department of Labor (DOL) Assistant Secretary for the Employee Benefits Security Administration (EBSA) Phyllis Borzi formally wrote the CFTC to affirm that the final regulations "do not require swap dealers or major swap participants to engage in activities that would make them fiduciaries under the [DOL's] current five-part test defining fiduciary advice ... In the Department's view, the CFTC's final business conduct standards neither conflict with the [DOL's] existing regulations, nor compel swap dealers or major swap participants to engage in fiduciary conduct."

In a September 2011, News Release, DOL announced that EBSA would withdraw and re-propose regulations revising the definition of a "fiduciary." The new proposal is expected to be issued in the coming months. As part of her letter to CFTC, Borzi said that DOL "is fully committed to ensuring that any changes to the current ERISA fiduciary advice regulation are carefully harmonized with the final business conduct standards, as adopted by the CFTC and the SEC, so that there are no unintended consequences for swap dealers and major swap participants who comply with these business conduct standards."

DOL Revises Electronic Disclosure Guidance

On December 8, the U.S. Department of Labor (DOL) Employee Benefits Security Administration issued Technical Release 2011-03R, guidance outlining the agency's revised interim policy regarding electronic disclosure of certain ERISA-required notices. This release modifies the original Technical Release 2011-03, issued on September 13, which states that DOL will not take enforcement action based solely on a plan administrator's use of electronic media to make the required disclosures under the participant fee disclosure regulation if the administrator complies with the conditions in the technical release.

The DOL news release announcing the issuance indicates that the guidance has been revised to clarify that:

(1) continuous access websites are permissible if the administrator complies with the conditions in the technical release; and

(2) investment-related information under paragraph (d) of the participant-level fee disclosure regulation (i.e., the "comparison chart") may be furnished as part of, or along with, a pension benefit statement, either electronically under the conditions in the technical release or in paper form.

While this would appear to suggest that for the purposes of distributing benefit statements employers can use the approach outlined in DOL FAB 2006-03 — which established a process involving continuous website access with an annual notice of availability and information on how to request a paper copy — the actual text of Technical Release 2011-03R states that the comparison chart must be provided either in paper or meeting the requirements of Section C of

the guidance, which sets forth a number of information collection and notice requirements for employers.

Section A of the guidance allows the use of the FAB 2006-03 for participant statements (including fee disclosure now required to be included on participant statements) and a new Section B was added clarifying that the comparison chart can be included with the benefit statement but must either be provided in paper or meet the requirements of Section C.

Earlier this year, DOL formally requested information on the use of electronic media by employee benefit plans to furnish information to participants and beneficiaries covered by employee benefit plans subject to ERISA, as part of a review of the final regulations adopted in 2002. Under these rules, electronic delivery of information required under ERISA Section 404(c) is permitted only if use of the employer's electronic system is an integral part of the employee's duties or the participant has affirmatively consented to electronic delivery in a manner that reasonably demonstrates the participant's ability to access information in the electronic form.

IRS Extends Transition Relief for Puerto Rico Plan Group Trusts

On December 19, the Internal Revenue Service issued Notice 2012-06, formally extending the deadline for group trusts to spin off Puerto Rican participants in a U.S. qualified plan into a separate Puerto Rico (PR) plan. The notice also confirms that the transition relief previously provided to these plans will continue to apply while the U.S. Treasury Department evaluates PR plan tax issues.

This issuance effectively extends the terms of IRS Revenue Ruling 2011-01 (issued in late 2010), which modified the rules for group trusts described in Revenue Ruling 1981-100 and set the spinoff deadline at December 31, 2011 (from the earlier deadline of December 31, 2010). Revenue Ruling 2011-01 also indicated that, until additional guidance is issued, the PR trust may continue to participate in the group trust if either (1) the PR trust was participating in the group trust as of January 10, 2011, or (2) the PR trust holds assets that had been held by a U.S. qualified plan immediately prior to the transfer of those assets to the PR trust pursuant to the transition relief in Rev. Rul. 2008-40 (as modified by Rev. Rul. 2011-01).

Specifically, Notice 2012-06:

- extends the deadline for spinning off a PR-only plan investment in a group trust "until a deadline to be set forth in future published guidance" for those PR-only plans invested in domestic group trusts as of January 10, 2011 (The future deadline will be announced once the general issue of whether PR-only plans can continue to invest in domestic group trusts is resolved);
- extends the separate spinoff deadline for spinning assets out of a US qualified plan trust to a PR-only trust for one additional year — until December 31, 2012 — for all US qualified plans benefitting Puerto Rican residents (regardless of whether they participate in a domestic group trust) in order to give plans time to analyze extensive new requirements in the newly revised 2011 Puerto Rico Code; and
- extends the deadline for governmental retiree benefit plans to be amended to satisfy the "exclusive benefit" and other requirements for group trusts under Revenue Ruling 2011-1 until the earlier of the close of the first regular legislative session of the legislative body with authority to amend the plan that begins on or after January 1, 2012 or January 1, 2015.

Notice 2012-06 also requests comments on whether eligibility to participate in group trusts should be extended to other employee benefit plans exempt "under Code Section 501 or a similar rule." These comments are due by April 16, 2012.

Groom Law Group has prepared a summary of the new guidance.

IRS Extends Deadline for Certain Pension Plan Amendments

On November 29, the Internal Revenue Service issued Notice 2011-96, extending the deadline for pension plan amendments under Section 436 of the Internal Revenue Code, generally to the last day of the plan year beginning on or after January 1, 2012. (The previous deadline, as extended under IRS Notice 2010-77, was the last day of the plan year beginning on or after January 1, 2011 — meaning December 31 for calendar year plans.) The guidance also provides a sample plan amendment for plan sponsors to use for this purpose. The sample includes optional provisions for various types of plans and the Notice makes clear that certain changes can be made without losing the ability to rely on the model amendment for the required Section 436 amendment.

Section 436 of the tax code, as added by the Pension Protection Act of 2006 (PPA), sets forth a series of limitations on the accrual and payment of benefits under an underfunded plan. In general, when a plan's adjusted funding target attainment percentage (AFTAP) for the plan year is less than 60 percent or 80 percent, certain restrictions apply. For example, if the AFTAP is less than 60 percent, single sum distributions are prohibited and benefit accruals under the plan must cease until the AFTAP increases above certain levels. If the AFTAP is less than 80 percent (but not less than 60 percent), only a portion of the benefit can be paid in a single lump sum and the plan cannot be amended to increase benefit accruals.

Notice 2011-96 also provides the same extension (to December 31, 2012 for calendar year plans) for "anti-cutback" relief for the Section 436 amendment. The anti-cutback relief is provided under tax code Section 411(d)(6), which generally prohibits plan amendments that decrease a participant's accrued benefit.

IRS Extends Deadline for Certain Remedial Amendment Applications

On December 22, the Internal Revenue Service (IRS) issued Announcement 2012-03, guidance extending the deadline for service providers and document providers who sponsor pre-approved defined contribution plans to submit on-cycle applications for opinion and advisory letters (for the plans' second six-year remedial amendment cycle). The new deadline is April 2, 2012; under IRS Revenue Procedures 2007-44, 2007-02 and 2011-49, the submission period for these applications was scheduled to expire on January 31, 2012.

The extension provided by this announcement applies to the deadline for submitting on-cycle applications for opinion and advisory letters for mass submitter lead plans, word-for-word identical plans, master and prototype plan minor modifier placeholder applications and non-mass submitter defined contribution plans. It is important to note that this announcement does not provide more time for companies that adopt pre-approved defined contribution plans to make on-cycle individual determination letter requests. These filings (which will generally be eliminated effective May 1, 2012) would generally be considered "off-cycle." The announcement also does not provide more time for companies using individually designed plans that fall in "Cycle A" to file determination letter requests (that deadline remains January 31, 2012).

International Benefits Update: OECD Guidelines on Alternative Investments, Auto-Enrolment in the UK

A set of new "best practices" has been issued by the Organisation for Economic Co-operation and Development (OECD, a coalition of 34 countries whose mission is to promote economic progress and world trade) in conjunction with the International Organisation of Pension Supervisors (IOPS, the umbrella group for global pension regulators) for pension funds that invest in alternative investments, including hedge funds and derivatives. While adherence to these guidelines is not currently required, future plan governance is increasingly likely to reflect these new guidelines.

In addition, the UK government has announced that it will delay pension auto-enrolment until May 2015 for firms employing 49 or fewer employees (based on the number of employees subject to the Pay-As-You-Earn (PAYE) reporting system), meaning that even a large US company may be considered a "small company". Auto-enrolment for mid-sized employers — those with between 50 and 2,999 employees — will also likely be delayed to a date between August 2013 and March 2015. Large employers — with 3,000 or more employees — have an unchanged effective date of July 1, 2013, pending issuance of final rules.

A summary memorandum of these developments is available for your review.

CMS Finalizes Regulations Authorizing Release of Medicare Data for Performance Measurement

On December 5, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) issued final regulations making claims data from Medicare and private health purchasers available to "qualified entities" that would aggregate the information and develop profiles of provider performance. The rules also include important safeguards intended to assure that the information released to evaluate provider performance is accurate and used appropriately, while also safeguarding patient privacy.

Among the changes from the original proposed rule are provisions (1) making the data less costly for qualified entities, (2) giving qualified organizations additional flexibility in their use of Medicare data to create performance reports for consumers and (3) extending the time period for health care providers to confidentially review and appeal performance reports before they become public.

PBGC Issues Guidance on Determining Expected Retirement Age

On December 1, the Pension Benefit Guaranty Corporation (PBGC) published final regulations on the allocation of assets in single-employer plans and the determination of expected retirement age for participants in pension plans undergoing distress or involuntary termination with valuation dates falling in 2012. This table is used to compute the value of early retirement benefits and the total value of benefits under a plan.

PBGC's previous final regulations on terminations of single-employer pension plans, issued on June 14 address the broader set of rules for valuing and paying benefits under terminating single-employer defined benefit plans covered by the pension insurance system. The new final regulations — to be applied in conjunction with the prior final regulations — include a table to be

used to determine whether a participant has a low, medium, or high probability of retiring early, based on the year a participant would reach "unreduced retirement age" (URA, the earlier of the normal retirement age or the age at which an unreduced benefit is first payable) and the participant's monthly benefit at URA. The table applies only to plans with valuation dates in the current year and is updated annually by the PBGC to reflect changes in the cost of living and other factors.

PBGC Issues Guidance on Maximum Guarantees

On November 23, the Pension Benefit Guaranty Corporation (PBGC) published the maximum monthly guarantee tables for 2012, indicating the maximum pension benefit that may be paid by the PBGC with respect to a plan participant in a single-employer pension plan that terminates during the year. The maximum guaranteeable monthly benefit for 2012 is $4,653.41, up from $4,500 in 2011.

The values in the table for a calendar year apply to distributions with annuity starting dates in that calendar year. Under the benefit restrictions enacted by the Pension Protection Act of 2006 (PPA), single-employer plans that are between 60 and 80 percent funded may not pay lump sums or other accelerated distribution forms with values in excess of: (1) 50 percent of the amount that would be paid absent the restriction or, if smaller, (2) the present value of PBGC's maximum guarantee. On November 8, PBGC published its 2012 table of present values of the PBGC maximum guarantee for use by single-employer plans subject to the partial lump sum benefit restrictions.

RECENT JUDICIAL ACTIVITY

U.S. Supreme Court to Take Up 11th Circuit PPACA Case

The U.S. Supreme Court has announced that it will review a decision of the Eleventh Circuit Court of Appeals that ruled as unconstitutional the individual mandate contained in the Patient Protection and Affordable Care Act (PPACA). Oral arguments before the high court are expected to begin in March 2012, with a ruling handed down in June.

A panel of judges for the Eleventh Circuit ruled that PPACA's individual mandate — which requires that all individuals have health insurance — "exceeds Congress's enumerated commerce power," with reference to the Commerce Clause of the Constitution, which gives Congress the power to regulate interstate commerce. The court did determine, however, that the mandate is "severable" from the rest of PPACA, and therefore the entire law is not invalidated simply because the mandate was struck down.

The court will be called upon to resolve whether the individual mandate is constitutional, and if it is not, whether it is indeed severable or if it invalidates the rest of the law. The court will also rule on whether the federal government can impose increased Medicaid costs on the states or a mandatory level of health insurance coverage on state employees.

The Court elected to take up the Eleventh Circuit case, based on separate petitions by the National Federation of Independent Business, the 26 state plaintiffs (including Florida) and the Obama administration. A number of other circuits have weighed in on the matter, with the Sixth Circuit Court of Appeals and the U.S. Circuit Court of Appeals for the District of Columbia each ruling that the individual mandate is constitutional. The U.S. Fourth Circuit Court of Appeals

previously ruled that under the Anti-Injunction Act it was premature to consider the case brought by the Commonwealth of Virginia because no individual mandate penalty under PPACA is due until 2015. This essentially dismissed the case on procedural grounds. The Supreme Court agreed to hear that issue as well; although by virtue of the Court's agreement to hear the 11th Circuit appeal, it has already decided to consider the fundamental substantive issues of the case.