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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Neal Introduces Retirement Plan Simplification Legislation

On February 16, Representative Richard Neal (D-MA), a senior member of the U.S. House of Representatives Ways and Means Committee, introduced **the Retirement Plan Simplification and Enhancement Act (H.R. 4050)**, a measure designed to ease some of the burdens associated with employer sponsorship of defined contribution and defined benefit retirement plans.

As Neal said in his introductory remarks on the floor of the House of Representatives, "Our current retirement plan rules are very complicated. This bill includes a number of commonsense reforms that will simplify the rules while we still protect participants," with the goals of: (1) expanding coverage and increasing retirement savings; (2) encouraging small businesses to enter and remain in the employer retirement plan system; (3) preservation of income; and (4) simplification and clarification of qualified retirement plan rules.

Specifically, H.R. 4050 would:

- permit all required ERISA disclosures to be made available in an electronic manner (following advance notice and with the right to opt out), similar to the approach taken by regulatory agencies as part of the Summary of Benefits and Coverage final regulations issued under the Patient Protection and Affordable Care Act (PPACA) in which, for those eligible for coverage but not yet enrolled, a paper postcard may be sent either electronically or via regular mail alerting individuals to the website where the SBC materials may be provided;
- modify the automatic enrollment safe harbor to remove the existing 10 percent cap on employee deferrals;
- amend top-heavy rules to allow employers to test participants that have not met the minimum statutory age and service requirements separately for determining the top-heavy contribution standards;
- require employers to allow certain long-term, part-time employees to make elective deferrals to qualified plans;
- triple the qualified plan start-up credit for small businesses to $1,500;
- direct the U.S. Treasury and Labor departments to issue administrative guidance for multiple employer plans;
- except retirement savings under $100,000 from required minimum distribution rules;
- expand the IRS's Voluntary Correction Program; and
- consolidate various employee notices.

In addition to these defined contribution plan provisions, the measure also includes two provisions related to defined benefit plans:

- A provision related to partial terminations of defined benefit plans under Section 4062(e) of ERISA would clarify the definition of a "substantial cessation of operations" and prohibit Pension Benefit Guaranty Corporation (PBGC) regulations contravening this clarification. PBGC has indicated that it will soon finalize proposed regulations addressing 4062(e) matters.
- A revision of the nondiscrimination rules would allow employer plan sponsors to protect participants in frozen defined benefit plans. Under H.R. 4050, if a grandfathered group of

employees is a nondiscriminatory group when it is first formed, it would be treated as a nondiscriminatory group permanently (unless the group is modified by plan amendment). This would prevent these frozen plans from inadvertently violating the Treasury rules prohibiting discrimination in favor of highly compensated employees.

H.R. 4050 has been referred to the Committee on Ways and Means (of which Neal is the ranking Democrat on the Select Revenue Measures Subcommittee) and the Committee on Education and the Workforce. While it is unlikely that the House will take up this legislation as a whole, bipartisan support for the bill could persuade the House leadership to consider individual items within the package.

House Resolution Supporting Retirement Savings Tax Incentives Introduced

On February 17, Representatives Neal Gerlach (R-PA) and Richard Neal (D-MA) introduced a bipartisan concurrent resolution (H. CON. RES. 101) "expressing the sense of the Congress that our current tax incentives for retirement savings provide important benefits to Americans to help plan for a financially secure retirement."

The resolution also notes that:

- tax incentives for retirement savings play an important role in encouraging employers to sponsor and maintain retirement plans and encouraging participants to contribute to such plans;
- existing tax incentives have increased the number of Americans who are covered by a retirement plan; and
- a reformed and simplified Tax Code should include properly structured tax incentives to maintain and contribute to such plans and to strengthen retirement security for all Americans.

The resolution has garnered 106 co-sponsors from both sides of the aisle.

In the coming months, lawmakers will begin to discuss the broad outlines of comprehensive tax reform. It is likely that certain measures affecting defined contribution plans will be examined, including proposals to cap tax-deferred savings or use refundable tax credits to replace the current tax structure.

The bill has been referred to the House of Representatives Ways and Means Committee, of which Gerlach is a member and Neal is the ranking Democrat on the Select Revenue Measures Subcommittee.

Auto-IRA Legislation Introduced in House

On February 16, Representatives Richard Neal (D-MA), ranking Democrat of the Subcommittee on Select Revenue Measures of the Ways and Means Committee, and Earl Blumenauer (D-OR) introduced the Automatic IRA Act (H.R. 4049), legislation to provide for automatic enrollment of employees in payroll-deduction savings plans.

Under the H.R. 4049, employees who work for a private business with more than 10 workers and whose employer does not already offer a retirement plan would be defaulted into a program

in which they contribute payroll earnings to an individual retirement account (IRA). New businesses (in existence for fewer than two years) would also be exempted.

The legislation sets forth employer and employee eligibility, default investments, default contribution levels, model notices, penalties for employer non-contributions, tax credits for small employers and an employer's option to obtain affirmative elections. Notably, under H.R. 4049, if an employer does not select a private service provider, its employees' contributions would be defaulted into a Treasury bond to be held at the Treasury Department. The bill would also establish a 15-member Automatic IRA Advisory Group to make recommendations regarding automatic IRA investment options.

The measure is based on a provision included in each of President Obama's budget proposals. U.S. Senators Jeff Bingaman (D-NM) and John Kerry (D-MA) introduced the Automatic IRA Act (S. 1557), in September 2011 along with an official summary. Neal introduced similar legislation H.R. 6099 (and a summary) in the previous session of Congress.

Obama FY 2013 Budget Analysis: Health and Retirement Plan Proposals

President Obama released his Fiscal Year 2013 budget proposal on February 13, dedicating $3.8 trillion for the government's operation and setting forth a number of policy priorities for the next year. The White House Office of Management and Budget (OMB) released the detailed budget estimates by agency; historical tables, which illustrates budget data over the last century; and Analytical Perspectives, which provides a detailed discussion of certain budget concepts and Administration policies.

The budget is consistent with the tax "fairness" themes and initiatives articulated by the president in his recent State of the Union address. The thrust of the proposal consists of continued infrastructure investment offset by reductions in discretionary spending, coupled with sweeping tax reform that lowers rates for some taxpayers and eliminates deductions while broadening the base. In particular, the budget proposes reductions in the value of itemized deductions and other tax preferences (such as employer-sponsored health insurance and retirement contributions) to 28 percent for families with incomes over $250,000. Additionally, the president's "millionaire tax" proposal would entirely eliminate tax subsidies for "housing, health care, retirement, and child care."

The budget also addresses a number of health and retirement benefit initiatives:

Health Care Reform

- The 2013 budget proposal increases funding to the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) by nearly $1 billion to help implement the Patient Protection and Affordable Care Act (PPACA). According to the proposal, this budget increase is largely dedicated to "building capacity and creating infrastructure to establish exchanges, including the federally-facilitated exchange, and develops systems to help individuals enroll in the right health insurance coverage option."

- The budget specifically expresses support for initiatives that would move up the date when states will be eligible to apply for waivers from PPACA to develop their own health reform standards, from 2017 to 2014. Currently, states may apply for five-year "State

Innovation Waivers" from certain coverage requirements beginning in 2017, as long as the state program covers provides the same amount of coverage without increasing the federal deficit. In February 2011, Senators Ron Wyden (D-OR), Scott Brown (R-MA) and Mary Landrieu (D-LA) sponsored the Empowering States to Innovate Act (S. 248), which would accelerate the eligibility period to begin in 2014. A White House fact sheet supporting state innovation remains available.

- The proposal includes a number of reforms to Medicare and Medicaid policies to save $364 billion over ten years, including "payment innovations and other reforms that encourage high-quality and efficient care." These include premium increases for beneficiaries in Medicare Parts B and D with "higher incomes" and a surcharge on Medicare Part B premiums for new beneficiaries and those that purchase near first-dollar Medigap coverage.

- While the president's proposal expressly supports "permanent, fiscally responsible reform to Medicare's payments to physicians" through reform of the program's sustainable growth rate (commonly referred to as the "doc fix"), unlike prior budget proposals it does not include a legislative remedy.

Retirement Savings

- The budget proposes to give the Board of Directors of the Pension Benefit Guaranty Corporation (PBGC) the authority to adjust the premiums charged to defined benefit pension plans. Specifically, the proposal directs PBGC to "take into account the risks that different sponsors pose to their retirees and to PBGC." Such authority would begin in 2014, providing a study and public comment before any implementation and gradual phasing in of any increases. The proposal – identical to the president's 2012 proposal – is estimated to save $16 billion over ten years ($4 billion through flat-rate premium increases and $12 billion through variable-rate premium increases).

- As in the Fiscal Year 2011 and 2012 budget proposals, the president proposes an "automatic workplace pensions" initiative. Under the proposal, employers who do not currently offer a retirement plan will be required to enroll their employees in a direct-deposit IRA account that is compatible with existing direct-deposit payroll systems. Employees would be permitted to opt-out if they choose. Small employers (ten employees or fewer) would be exempt, though they would also be entitled to an additional credit of $25 per participating employee — up to a total of $250 per year — for six years.

- The 2013 budget proposal also includes familiar initiatives to double the small employer pension plan startup credit. Under current law, small employers are eligible for a tax credit equal to 50 percent (up to a maximum of $500 a year for three years) of the start-up expenses of establishing or administering a new qualified retirement or SIMPLE plan. To encourage small employers to offer pensions to their workers in connection with the automatic workplace pensions proposal, the budget would increase the maximum credit from $500 a year to $1,000 per year for up to four years.

- The Obama Administration proposes to exempt an individual from minimum required distribution requirements if the aggregate value of the individual's IRA and tax-favored retirement plan accumulations does not exceed $75,000 at the beginning of the year in

which the individual turns 70½ or, if earlier, the year in which the individual dies. (The president's 2012 proposal included a $50,000 cap.)

- The Administration's budget proposes a 60-day rollover opportunity for amounts distributed from a qualified plan or IRA to non-spouse beneficiaries (who presently may only do a direct rollover in the case of inherited plan assets and only a trustee-to-trustee transfer in the case of inherited IRA assets). This proposal appeared in the president's 2012 budget.

- As in the 2012 budget, the 2013 budget proposes to give the IRS the authority to require certain employee benefit plan tax information to be filed electronically as part of the annual Form 5500.

Other Issues

- As in the previous year's budget proposal, the president recommends a program to penalize and eliminate misclassification of employees as "independent contractors." The budget proposal specifically includes $14 million to combat misclassification (down from $46 million in the prior year's budget), including $10 million (down from $25 million) for grants to states to identify misclassification and recover unpaid taxes and $4 million (down from $15 million) for personnel at the U.S. Department of Labor (DOL) Wage and Hour Division to investigate misclassification.

- With regard to family leave issues, the budget also establishes a $5 million "State Paid Leave Fund" within DOL to provide competitive grants that would help states cover the start-up costs of launching paid-leave programs. This initiative was proposed in last year's budget at a level of $23 million. The budget proposal also earmarks an additional $6 million for the DOL Wage and Hour Division for increased enforcement of rules addressing wages, overtime and family and medical leave.

Of note, Page 261 of the Analytical Perspectives document lists federal income tax expenditures ranked by total Fiscal Year 2013-2017 projected revenue effect. According to this table, the largest expenditure is the "exclusion of employer contributions for medical insurance premiums and medical care," accounting for more than $1 trillion of foregone tax revenue over the next five years. If we combine the tax deferrals for 401(k) plans and the tax exclusion for employer-provided pension contributions and earnings, the total foregone tax revenue is $728.8 billion over the next five years, which would be No. 2 on the list. The significant revenue effects of these tax preferences could make the tax incentives for employer-sponsored benefits a lucrative target for tax reform as contained in the budget proposal.

Considering that 2012 is an election year, it will be very difficult for the President to enact many of the initiatives outlined in his budget plan, particularly those related to tax changes. However, these proposals may lay the groundwork for both regulatory activity or future consideration of more comprehensive tax reform measures after the election.

House Subcommittee Holds Hearing on PBGC, Defined Benefit Plans

The House of Representatives Committee on Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions held the hearing, Examining the Challenges Facing PBGC and Defined Benefit Pension Plans.

According to an official media advisory, the hearing was intended to "provide committee members an opportunity to learn about the fiscal and management challenges facing the [Pension Benefit Guaranty Corporation (PBGC)], as well as the continued difficulties confronting defined benefit plans." The hearing was also designed to prompt discussion of various reforms that have been proposed to strengthen the financial outlook of the PBGC, including increases to flat-rate and variable-rate premiums.

The Obama Administration and the PBGC have proposed substantial increases to premiums paid by defined benefit pension plan sponsors as well as sweeping changes to give the agency unilateral authority to modify future premium levels. The agency has frequently cited its self-reported deficit as a rationale for changes to the defined benefit plan system, such as the funding rules contained in the Pension Protection Act of 2006 (PPA). On November 15, the PBGC reported a deficit of $26 billion.

PBGC Director Joshua Gotbaum, the government witness before the committee, testified to the agency's ongoing efforts to support defined benefit plans, despite its reported deficit. Gotbaum disputed arguments that the PBGC uses inappropriate assumptions and methodologies for calculating its deficit and again called on Congress to give the agency the power to increase its premiums.

During the question-and-answer period, Representative Joe Wilson (R-SC) asked about PBGC's use of unusually low interest rates — rates even lower than the artificially low rates currently in effect. He also referenced research that suggested that a more reasonable calculation methodology would reveal a much lower deficit. Gotbaum argued that the size of the PBGC deficit required more conservative assumptions and suggested that pre-PPA accounting represented "dishonest" accounting.

With regard to the premium increase proposal, there was bipartisan concern — from the subcommittee's Ranking Democrat Rob Andrews (D-NJ) and Representative Joe Heck (R-NV) — about the Obama Administration's proposal to give PBGC unilateral authority to raise its own premiums.

Subcommittee Chairman Phil Roe (R-TN) also raised the recent criticism of PBGC's valuation audits, as was recently exposed in the PBGC Inspector General's November 2011 report and the Government Accountability Office June 2011 report. Gotbaum outlined the steps the agency is taking to eliminate these errors.

The subcommittee heard testimony from the following witnesses:

- Kenneth W. Porter, president of Benefits Leadership International, LLC described the current funding challenges faced by employer sponsors of defined benefit plans and endorsed measures to apply historically stable interest rates for funding purposes and for determining PBGC's true longer-term economic status.
- Gretchen Haggerty, Chief Financial Officer of U.S. Steel, described the impact of soaring pension plan contributions on her company's planned capital investment initiatives. She also supported interest rate and amortization reform to stabilize plan funding.
- Randy DeFrehn, executive director for the National Coordinating Committee for Multiemployer Plans, discussed the differences between the single-employer system and the multiemployer system.

- John McGowan, professor at Saint Louis University, described his research on the multiemployer plan system and specifically suggested reforms to the PBGC withdrawal liability rules.

In response to a question from Rep. Bobby Scott (D-VA), Porter and McGowan both asserted that basing premium levels on plan solvency or credit rating could have the unintended effect of continuing a downward spiral of plan funding by charging employers when they are least able to afford it.

RECENT REGULATORY ACTIVITY

DOL Issues Final 408(b)(2) Defined Contribution Plan Fee Regulations

On February 2, the U.S. Department of Labor (DOL) Employee Benefits Security Administration issued long-awaited **final regulations governing disclosure of defined contribution plan fees under ERISA Section 408(b)(2)**. The rule becomes effective on July 1, 2012 (extended from April 1, 2012).

These regulations, which supersede the interim final regulations (IFR) issued in July 2010 (official fact sheet here), 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 final regulations closely track the IFR, though it does include modifications in the following areas:

- *Covered plans:* Certain annuity contracts and custodial accounts described in Internal Revenue Code section 403(b) are excluded from the types of pension plans that are covered by the final rule.

- *Initial Disclosure Requirements:* Under the final rule, the information that must be disclosed by a covered service provider (CSP) to a responsible plan fiduciary (RFP) for "indirect compensation" has been enhanced, including a description of the arrangement between the payer and the service provider pursuant to which the indirect compensation will be paid.

- *Investment-related Disclosures (fiduciary services):* The final rule adds to the disclosure requirements for descriptions of annual operating expenses (e.g., expense ratio) of a "designated investment alternative." In addition, the final rule requires disclosure of information in the possession of a fiduciary service provider if the information must be provided to participants under the participant-disclosure rule.

- *Investment-related Disclosures (recordkeeping/brokerage services):* The final rule changes the focus of the so-called "pass-through" relief provided in the IFR for disclosures of investment-related information. CSPs may rely on information provided by an investment provider, but must act in good faith, must not know that the materials are incomplete or inaccurate, and must state that it makes no representations as to the completeness or accuracy of such materials.

- *Guide to Initial Disclosures:* The final rule reserves a place for the future development of provisions that would require the CSP to separately furnish a guide or similar tool designed to enable the RFP to locate compensation information disclosed through multiple or complex documents. (The preamble to the final regulations states that DOL will soon propose new regulations on this matter.)

- *Timing of Initial Disclosures:* The final rule changes the deadline for disclosures of all investment-related information to "at least annually." (The IFR had previously required that such information be disclosed within 60 days.) The deadline for disclosure of changes to other information that has been previously disclosed remains 60 days from the date a CSP is informed of such change.

- *Reporting & Disclosure Information:* the deadline for providing this information to a RPF upon request has changed under the final rule. The information must now be provided to the RPF "reasonably in advance of the date upon which" such RPF or covered plan administrator "states that it must comply with" applicable R&D requirements.

- *Disclosure Errors:* The final rule clarifies that disclosure of "changes" to information previously disclosed is covered by the "error disclosure" provision.

- *Definitions:* The final rule adds to the definition of "compensation," clarifying descriptions that may be made of compensation or cost, as expressed by monetary amounts, formulas, percentages, per capita charges, or other reasonable methods.

- *Exemption for RPF:* The final rule changes the language of one of the conditions required for relief under the class exemption. The change suggests that prompt decision making is required by a plan fiduciary when disclosure failures have occurred.

For more details, see the DOL's **new official fact sheet** and **official list of changes** to the IFR.

Also of note, for employer health plan sponsors:

- The preamble clarifies that Health Savings Accounts would not be considered to be a "covered plan" for purposes of this rule, although the language does not explicitly preclude HSAs from being covered by final 408(b)(2) regulations specifically addressing health and welfare plans.

- The regulations include a brief discussion regarding the extension of the final regulations to the health and welfare context, which would seem to confirm DOL intention to issue such rules.

Final Regulations on PPACA Summary of Benefits and Coverage Requirements Issued

The U.S. Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) issued **final regulations on Summary of Benefits and Coverage (SBC) and uniform glossary requirements** under the Patient Protection and Affordable Care Act (PPACA) on February 9. Issued in conjunction with the final regulations were **compliance guidance** (including templates, instructions and related materials) and an **official fact sheet**.

The HHS Center for Consumer Information and Insurance Oversight website also provides a Summary of Benefits and Coverage (SBC) Template and Uniform Glossary.

The SBC is intended to provide consumers with consistent and comparable information regarding health plan benefits and coverage. While the final regulations make a number of positive modifications from the proposed regulations issued in August 2011 — the final regulations continue to include an aggressive timeline for applicability of these rules and provide little relief in the uniform format and appearance for SBCs which must soon be provided to all current plan participants and newly eligible individuals.

The new rules will be formally published in the Federal Register on February 14 and become effective on April 14, 2012. The requirements to provide an SBC, notice of modification, and uniform glossary under the Public Health Service (PHS) Act Section 2715 and these final regulations apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 23, 2012 (i.e., applicable to the 2013 plan year). For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures to plans, and to individuals and dependents in the individual market, these requirements are applicable to health insurance issuers beginning on September 23, 2012.

Over 60 employers and trade associations recently joined in a letter to Treasury Secretary Timothy Geithner, Labor Secretary Hilda Solis and HHS Secretary Kathleen Sebelius urging a delay in the applicability date for the final rules related to these provisions and calling for a safe harbor for large employer plans.

Other changes include:

- *Electronic disclosure:* Current enrollees are eligible to receive the SBC electronically under the same ERISA rules that currently apply. For those eligible for coverage but not yet enrolled, a paper postcard may be sent either electronically or via regular mail alerting individuals to the website where the SBC materials may be provided.

- *Premium information not required:* The final regulations do not require the inclusion of premium amounts on the SBC.

- *Flexibility in form of SBC:* The SBC is generally required to be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font. However, the final regulations include instructions that provide flexibility for providing an SBC for a plan to the extent that the plan's terms cannot reasonably be described in a manner that is consistent with the template instructions, e.g., tiering for prescriptions and providers. The final SBC rules will allow plans and issuers to describe such terms using "best efforts."

- *Reduced number of coverage examples:* The agency has dropped "breast cancer" as a coverage example, leaving baby delivery and diabetes as the only two required

coverage examples, although the agencies reserve the right to require up to six coverage examples in the future. Coverage examples are specific health conditions which are required to be included in an SBC and are intended to show how the plan would cover the services typically required to treat that condition.

- *Elimination of stand-alone requirement:* The final regulations eliminate the requirement that the SBC be provided solely as a stand-alone document for group health plans, and allows the SBC to be provided as part of summary plan description (SPD) that is required to be provided by insured and self-insured plans in the group market as long as the SBC is "prominently displayed" in the summary plan document.

- *Timing of required updates:* If a material modification is made to any terms of the plan or coverage that would affect the content of the SBC, and it occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notification of the modification not later than 60 days prior to the date on which the modification will become effective.

- *Enhanced warning language on uniform glossary:* The final regulations include enhanced language on the uniform glossary providing that individual plan terms may differ from the general definitions provided in the uniform glossary.

New Health Care Guidance Addresses Automatic Enrollment, Shared Responsibility, Waiting Periods

On February 9, the Internal Revenue Service (IRS) issued **Notice 2012-17**, which provides guidance on various aspects of the Patient Protection and Affordable Care Act (PPACA) in the form of Frequently Asked Questions. (This issuance was also released by the U.S. Department of Labor (DOL) as Technical Release 2012-01 and by the U.S. Department of Health and Human Services (HHS) as a bulletin that has not yet been posted online.)

The guidance, which describes possible approaches and is generally intended as a preview of forthcoming regulatory activity, addresses PPACA provisions governing automatic enrollment of employees into health plans, employer "shared responsibility" requirements, and the 90-day limitation on waiting periods before enrollment.

Automatic Enrollment

Pursuant to PPACA, employers with more than 200 full-time employees are required to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period). Previous FAQ guidance, issued in December 2010, stated that employers are not required to comply before DOL completes its rulemaking process. The new guidance simply indicates that DOL has not established a timeline for issuing detailed guidance on this topic, considering "the need to coordinate the work it will be undertaking to develop guidance relating to automatic enrollment with the guidance being developed" regarding other provisions such as the employer shared responsibility requirements and the 90-day limitation on waiting periods. The new guidance provides that guidance related to automatic enrollment will not be ready to take effect by 2014.

Employer Shared Responsibility

The guidance addresses a number of issues related to the "shared responsibility" provisions enacted under Section 4980H of PPACA (also known as the "pay or play" mandate), which requires employers to offer health coverage for their "full-time employees" or pay a penalty under certain circumstances. Specifically, the guidance states that:

- The U.S. Treasury Department and IRS will issue proposed regulations (or other guidance) permitting employers to use an employee's Form W-2 wages (as reported in Box 1) as a safe harbor in determining the affordability of employer coverage, as described in Notice 2011-73.

- Treasury and IRS will issue proposed regulations (or other guidance) addressing how the employer shared responsibility provisions and the 90-day waiting period limitation are coordinated. The upcoming guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer responsibility payment under Code section 4980H.

- Treasury and IRS will issue proposed regulations (or other guidance) allowing employers to use a look-back/stability period safe harbor for purposes of determining whether an employee (other than a newly-hired employee) is a full-time employee, as based on the approach outlined in IRS Notice 2011-36. It is anticipated that the guidance will allow look-back and stability periods not exceeding 12 months. Treasury and IRS will also issue proposed regulations (or other guidance) for purposes of determining whether a newly-hired employee is a full-time employee. The guidance provides details on a possible approach for making this determination.

90-Day Limitation on Waiting Periods

Section 2708 of the Public Health Service (PHS) Act, as added by PPACA, provides that, in plan years beginning on or after January 1, 2014, a group health plan or group health insurance issuer shall not apply any waiting period that exceeds 90 days. Unlike Internal Revenue Code Section 4980H, PHS Act Section 2708 does not distinguish between full-time and part-time employees.. The new guidance:

- Confirms that employers will not be required to offer coverage to part-time employees or to any other particular category of employees when the 90-day limitation on waiting periods becomes effective in 2014.
- Describes a detailed approach for application of the 90-day waiting period limitation to an offer of coverage by an employer. The agencies intend to retain, for purposes of PHS Act Section 2708, the definition in existing regulations that the 90-day waiting period begins when an employee is otherwise eligible for coverage under the terms of the group health plan. Other conditions for eligibility under the terms of a group health plan would generally be permissible under PHS Act Section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

Upcoming guidance under PHS Act Section 2708 is also expected to address situations in which, under the terms of an employer's plan, employees (or certain classes of employees) are eligible for coverage once they complete a specified cumulative number of hours of service within a specified period (such as 12 months). It is anticipated that, under the upcoming

guidance, such eligibility conditions will not be treated as designed to avoid compliance with the 90-day waiting period limitation so long as the required cumulative hours of service do not exceed a number of hours to be specified in that guidance.

IRS Updates Website "Questions and Answers" on Form W-2 Informational Reporting Under PPACA

The Internal Revenue Service (IRS) has updated a set of **questions and answers** related to W2 informational reporting posted on its website. The updated webpage reflects Notice 2012-09, which restates and amends interim guidance for complying with Form W2 informational reporting of the cost of employer-sponsored group health plan coverage as required under Section 6051(a)(14) of the Internal Revenue Code (as added by the Patient Protection and Affordable Care Act). The U.S. Treasury Department and IRS recently issued Notice 2012-9 to address the requirements' applicability, timing, transition relief and other procedural issues.

Question 5 of the question-and-answer document references **a chart** listing many types of health care coverage and various other situations and explains whether W-2 reporting for these coverage types is required, prohibited or optional.

HHS Releases Additional Guidance on EHB Bulletin, Including Application to Large Group/Self-Insured Plans

The U.S. Department of Health and Human Services (HHS) has issued guidance in the form of Frequently Asked Questions with regard to the Essential Health Benefits Bulletin (the "Bulletin"). For employer health plan sponsors, the guidance specifically addresses, among other things, how the information set forth in the Bulletin may apply to the requirement under the Patient Protection and Affordable Care Act (PPACA) that group health plans not impose impermissible annual and lifetime dollar limits on essential health benefits (EHB).

Under PPACA, beginning in 2014, insured plans in the individual and small group markets (including those offered in a state-based health insurance exchange) will be required to provide coverage for all "essential health benefits," including preventive, diagnostic, and therapeutic services and products. This requirement does not apply to self-funded (and likely large group) plans. The Bulletin describes HHS' intended approach to developing regulations defining EHB under PPACA, which is to permit each state to define essential health benefits for coverage offered in such state pursuant to a benchmark plan selected by the state (with the benefits and services included in the selected benchmark plan being the required essential health benefits for that state).

While the requirement to provide coverage for all EHB will not apply to self-insured plans (and likely large group health plans, at least in the short term), today's guidance is likely to have implications for large group and self-insured plans nonetheless. This is because, as noted above, PPACA imposes certain prohibitions on the use of lifetime and annual dollar limits with respect to group health plan coverage for any EHB, 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 EHB for plan years that begin before final regulations are issued defining the term.

This guidance provides additional information on a number of outstanding issues related to the Bulletin as well as to the requirements regarding EHB more generally, including the process of

selecting and updating a benchmark plan, states' responsibility with respect to state-mandated benefits, and the application of benchmarks to plans that have enrollees in multiple states.

Most notably for employer plan sponsors, Q&A No. 10 states that, for the purposes of complying with the rules regarding the use of annual and lifetime dollar limits with respect to EHB, "the Departments of Labor, Treasury, and HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB … if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB."

Treasury, HHS Issues Final Regulations on State Waivers to PPACA

On February 22, the U.S. Treasury and Health and Human Services (HHS) departments released final regulations regarding the application and approval process for states that seek waivers of certain provisions of the Patient Protection and Affordable Care Act (PPACA). The Obama Administration's HealthCare.gov has also issued a fact sheet on the new release.

Section 1332 of PPACA authorizes the secretaries of HHS and Treasury to waive certain key provisions of the statute to give states greater flexibility to establish their own approaches to health reform, provided that the state's programs are at least as comprehensive and affordable as the coverage under the federal provisions. The state programs must also result in at least as many residents being covered with health insurance as they would under PPACA and may not result in an increase in the federal deficit. States may apply for these five-year "State Innovation Waivers" beginning in 2017.

The final regulations establish a process for states to submit initial applications for a State Innovation Waiver including:

- requirements for public notice and comment, including public hearings;
- the content of the waiver application;
- quarterly and annual reports to be submitted by participating states, including the tracking of measures regarding affordability, comprehensiveness of coverage, number of people covered and impact of the federal deficit; and
- criteria for evaluation of the waivers once they are in place.

The preamble to the final regulations cites comments submitted on the proposed regulations asking the secretaries to clarify the interaction between Section 1332 waivers and ERISA. The preamble affirms that while Section 1332 permits the secretaries broad discretion to determine the scope of a waiver, no federal laws or requirements may be waived that are not within the secretaries' authority. The preamble further indicates that states are encouraged to contact the Treasury Department and HHS to discuss specific waiver proposals.

The White House's Fiscal Year 2013 budget, released February 13, specifically expressed support for initiatives that would move up the application period for these waivers from 2017 to 2014. In February 2011, Senators Ron Wyden (D-OR), Scott Brown (R-MA) and Mary Landrieu (D-LA) sponsored the Empowering States to Innovate Act (S. 248), which would accelerate the eligibility period to begin in 2014.

CMS Actuarial Value Bulletin: Employer Contributions to HSAs, HRAs Will Be Included in Calculation

On February 24, the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) issued an Actuarial Value and Cost-Sharing Reductions Bulletin, outlining the agency's approach for defining the actuarial value of individual and small group health plans.

"Actuarial value" (AV), in this context, is a measure of the percentage of expected health care costs a health plan will cover and is calculated based on cost-sharing differences between plans. Under the Patient Protection and Affordable Care Act (PPACA), non-grandfathered individual and small group health plans are required to meet specified levels of coverage based on how much of the AV they cover.

The bulletin indicates that CMS will take into consideration the value of employer contributions when determining the actuarial value of high deductible health plans (HDHPs) linked to health savings accounts (HSAs) or health reimbursement accounts (HRAs).

According to the bulletin, CMS "intend[s] to propose that for purposes of calculating the AV of an employer health benefit plan, the annual employer contribution to the employee's HSA associated with a qualifying HDHP and the amount made available for the first time in a given year under a HRA that is linked to an employer health benefit plan shall be considered part of the benefit design of the health plan. In calculating the AV of the combined HDHP and HSA or combined employer health benefit plan and HRA, the calculation would assume that the employer contribution to the HSA or HRA is used by the employee to pay for cost-sharing. Accordingly, these amounts would be credited to the numerator of the AV calculation. This means that the AV calculator would include any current year HSA contributions and amounts first made available under an HRA as an input into the calculator that can be used to determine the AV of an employer health benefit plan."

IRS Proposes Regulations for Information Reporting under FATCA

On February 9, the Internal Revenue Service (IRS) issued sweeping proposed regulations relating to information reporting by foreign financial institutions and withholding on certain payments to foreign financial institutions (FFIs) and other foreign entities under the Foreign Account Taxpayer Compliance Act (FATCA). Most notably, the new rules appear to ease reporting for foreign retirement plans by expanding the category of plans that are considered to be "deemed compliant" FFIs and therefore exempted from the FATCA requirements.

FATCA, enacted in 2010 as part of the Hiring Incentives to Restore Employment (HIRE) Act, requires certain U.S. taxpayers holding financial assets outside the United States to report those assets to the IRS. Guidance issued by the IRS after the enactment of FATCA exempted payments beneficially owned by certain foreign retirement plans from tax withholding under Section 1471(a) of the Internal Revenue Code because such plans pose "a low risk of tax evasion" as described in Section 1471(f)(4).

The proposed regulations set forth the requirements that a retirement plan must meet to attain "deemed compliant" status as an FFI, including:

- The FFI must be organized for the provision of retirement or pension benefits under the law of each country in which it is established or in which it operates;
- Contributions to the FFI must consist only of employer, government, or employee contributions and must be limited by reference to earned income;
- No single beneficiary may have a right to more than five percent of the FFI's assets; and
- Contributions to the FFI must be excluded from the income of the beneficiary and/or taxation of the income attributable to the beneficiary must be deferred under the laws of the country in which the FFI is organized or operates, or the FFI must receive 50 percent or more of its total contributions from the government or employers.

Alternative criteria are provided for FFIs that provide retirement or pension benefits and that have fewer than 20 participants and meet certain other requirements.

The proposed regulations also initiate a phase-in of FFI reporting obligations, requiring only basic information (a taxpayer's name, address, taxpayer identification number, account number, and balance) to be reported in 2014 and 2015. Beginning with reporting in 2016 (with respect to calendar year 2015), in addition to the aforementioned information, income associated with U.S. accounts must be reported. Beginning with reporting in 2017 (with respect to calendar year 2016), full reporting, including information on the gross proceeds from broker transactions, will be required.

PBGC to Provide Premium Relief for Certain Delinquent Plans

On February 9, the Pension Benefit Guaranty Corporation (PBGC) released a policy statement announcing a limited window in which covered defined benefit plans that have never paid required premiums can pay past-due premiums without penalty.

Normally, such delinquent premium payments would be subject to substantial interest and penalties. As part of PBGC's review of its premium regulations pursuant to Executive Order 13563 (reducing regulatory burden), PBGC is adopting a voluntary compliance program in which it will waive premium payment penalties (as well as information penalties) for any such plan, if the plan administrator contacts PBGC, pays past due premiums, and files required information within the time frames described in the policy statement. (The relief provided in this notice does not apply to late payment interest charges.)

The policy statement indicates that once the amnesty period ends, PBGC will step up its efforts to enforce premium requirements for covered plans that have not paid any required premiums, including assessment of penalties.

DOL Engaging States on Worker Classification

On February 9, the U.S. Department of Labor (DOL) announced that it has "entered into a memorandum of understanding" (MOU) with the state of California "regarding the improper classification of employees as independent contractors." California is the twelfth state to reach such an agreement with DOL, joining Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Montana, Utah and Washington.

The DOL press release notes that "memorandums of understanding with state government agencies arose as part of DOL's Misclassification Initiative, which was launched under the

auspices of Vice President Biden's Middle Class Task Force with the goal of preventing, detecting and remedying employee misclassification."

Officials from the U.S. Department of Labor (DOL) and Internal Revenue Service (IRS) signed an inter-departmental MOU permitting the agencies to share information to "help reduce the incidence of misclassification of employees as independent contractors, help reduce the tax gap and improve compliance with federal labor laws." The MOU specifically indicates that DOL and IRS officials will meet on a regular basis and craft recommendations focused on "educating taxpayers/employers, promoting fairness and improved compliance, and creating a level playing field for law-abiding taxpayers and employers."

Legislative initiatives to address worker misclassification are likely to continue to draw renewed attention because they typically raise federal revenue by increasing tax collections.

Treasury, DOL, HHS Release Semi-Annual Regulatory Agendas

On February 10, the U.S. Departments of the Treasury, Labor (DOL) and Health and Human Services (HHS) formally released their semi-annual agendas, which describe the regulations that each department has issued or expects to issue and rules currently in effect that are under departmental or bureau review. While the full regulatory plan is posted on the government's RegInfo.gov page (on which users can scroll to the bottom and select the individual federal agency), the printed semi-annual agendas address only (1) rules that are in the regulatory flexibility agenda, in accordance with the Regulatory Flexibility Act, because they are likely to have a significant economic impact on a substantial number of small entities; and (2) rules that have been identified for periodic review under Section 610 of the Regulatory Flexibility Act.

Treasury Department

The Treasury Department printed agenda includes two items that may be of interest to benefit plan sponsors and service providers:

- Modification of Treasury regulations pursuant to Section 939A of the Dodd-Frank Wall Street Reform and Consumer Protection Act: Proposed regulations will modify existing Treasury regulations to remove any reference to, or requirements of reliance on, credit ratings in such regulations and substitute in their place other standards of creditworthiness that the Treasury determines to be appropriate for such regulations. Final action is expected in June 2012.
- User fees relating to enrolled agents and enrolled retirement plan agents: Final regulations, which were issued in April 2011, update and separate the user fees regarding enrolled agents and enrolled retirement plan agents. These regulations also impose user fees to take the competency examination to become a registered tax return preparer and to provide continuing education programs.

The full regulatory plan includes numerous other activities applicable to employer-sponsored benefit plans, including (but not limited to):

- Multiemployer Plan Funding Guidance
- Modifications to Minimum Present Value Requirements for Defined Benefit Plan Distributions
- Additional Rules Regarding Pension Plan Funding and Benefit Restrictions

- Determination of Minimum Required Pension Contributions
- Additional Rules Regarding Hybrid Retirement Plans
- Further Guidance on the Application of Section 409A to Nonqualified Deferred Compensation Plans
- Compensation Deferred Under Eligible Deferred Compensation Plans
- Fees on Health Insurance and Self-Insured Plans
- Employer Contributions to Health Savings Accounts
- Regulations Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The full Treasury Department plan also makes reference to regulatory activity pursuant to the Patient Protection and Affordable Care Act (PPACA), including grandfather status, market reforms, preventive coverage, adult child coverage and claims and appeals procedures.

DOL

The only item highlighted in the DOL printed agenda concerns filings required of Multiple Employer Welfare Arrangements (MEWAs) and certain other entities, relating to a proposed rule issued in December 2011 that would implement reporting requirements for multiple employer welfare arrangements MEWAs and other entities that offer or provide health benefits for employees of two or more employers.

The full regulatory plan includes actions related to the following topics:

- Definition of Fiduciary
- Guide or Similar Requirement For Section 408(B)(2) Disclosures
- Pension Benefit Statements
- Target Date Funds (TDFs)
- Annual Funding Notice
- Amendment of the Abandoned Plan Program
- ERISA Claims Procedures

HHS

The HHS printed agenda includes a number of regulatory activities under consideration by the Centers for Medicare and Medicaid Services (CMS), including revisions to certain Medicare and Medicaid payment systems and policies, though none of these directly affect employer-sponsored health plans.

The full regulatory plan includes numerous other activities applicable to employer-sponsored benefit plans, including (but not limited to):

- PPACA Waivers for State Innovation (Review and Approval Process)
- Establishment of Exchanges and Qualified Health Plans Part I
- Medicare Advantage and Prescription Drug Benefit Programs; Payments to Sponsors of Retiree Prescription Drug Plans

HHS (along with Treasury and DOL) recently issued final regulations on Summary of Benefits and Coverage (SBC) and uniform glossary requirements.

Pension Benefit Guaranty Corporation (PBGC)

While the PBGC did not issue a printed semi-annual agenda, the agency's full regulatory plan has been posted online and includes the following planned regulatory activity:

- Reportable Events under the Pension Protection Act of 2006 (PPA)
- Missing Participants under PPA
- Cash Balance Plans; Benefit Determinations and Plan Valuations for Statutory Hybrid Plans under PPA
- Liability for Termination of Single-Employer Plans; Treatment of Substantial Cessation of Operations
- Commercial Airlines Plans under PPA
- Treatment of Rollovers From Defined Contribution Plans to Defined Benefit Plans
- Owner-Participant Benefits under PPA
- Assessment of and Relief From Information Penalties
- Phase-In of Guarantee of Unpredictable Contingent Event Benefits under PPA

While these agendas include timetables with expected publication dates, it is important to note that these dates are tentative and flexible.

RECENT JUDICIAL ACTIVITY

Sixth Circuit Appeals Court Rules Against Employer in Stock Drop Case

In a decision handed down on February 22, the U.S. Court of Appeals for the Sixth Circuit ruled in favor of the plaintiffs' suit against their retirement plan with regard to a "stock drop" case by reversing a district court ruling and remanding the case for further proceedings.

In the case of *Raymond M. Pfeil and Michael Kammer v. State Street Bank and Trust Company*, General Motors' (GM) hourly and salaried 401(k) plans (both of which were employee stock ownership plans, according to the court) offered GM stock as an investment alternative. No amounts were invested in the GM stock fund absent an affirmative election by a participant, and the court reported that participants had the discretion to change their allocation in any investment on any business day.

The plaintiff-participants filed a class action in 2009, suing State Street (the only defendant, since State Street as trustee continued to hold GM stock in the GM retirement plans during the difficult period before the GM bankruptcy) for retaining the GM stock fund as an investment option after public information raised questions about GM's short-term viability outside of bankruptcy. The U.S. District Court for the Eastern District of Michigan held that the plaintiffs had sufficiently pleaded a breach of fiduciary duty, but nevertheless dismissed the case on the grounds that any alleged breach did not cause plan losses; plan losses were caused by participants' decisions to invest in GM stock or remain invested in GM stock.

In its decision to overturn the district court decision, The Sixth Circuit held that:

- Plan fiduciaries have a duty to offer only prudent investments. Plan fiduciaries cannot escape liability for imprudent investment options on the grounds that the participants have the choice as to whether to invest in such options.

- Section 404(c) does not protect fiduciaries from liability for offering imprudent investment options.
- Even if #2 above were not the case, Section 404 is an affirmative defense that must be proved by the defendants and cannot be considered on a motion to dismiss unless the plaintiffs raise the issue in their pleadings.
- Although there is a rebuttable presumption that an ESOP fiduciary's decision to remain invested in employer stock is reasonable, that presumption does not apply at the pleadings stage in the Sixth Circuit.