Holifield & Associates, PLLC

Employee Benefits Law Update

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Upcoming Seminars

ERISA Basic National Institute
Oct. 22-24, 2012

ABA 6th Annual Section Labor and Employment Law Conference
Oct. 31 - Nov. 3, 2012

ABA Employee Benefits Committee Midwinter Meeting
February 15-18, 2013

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October 2012

As a service to our clients, Holifield & Associates, PLLC periodically issues a newsletter to keep you informed of developments in statutes, regulations, and case law in the field of employee benefits.

If you would like any assistance or further information about any of the matters described in this update, please call and we will be happy to discuss these issues with you further.

Health Care Reform Upheld by U.S. Supreme Court:

The United States Supreme Court upheld the Affordable Care Act on June 28, 2012. As you know, this Act contains many health care reforms for group health plans and health insurance issuers. The Court's decision means that health plans and issuers must comply with the health care reform provisions contained within the Act. Some of these reforms are already in place and health plans should be complying with these requirements, for example, continued covered of dependent children to age 26, elimination of lifetime limits on the dollar value of essential health benefits and restricted annual limits on the dollar value of essential health benefits. In addition, plans that meet the requirements for a "grandfathered" plan must provide notice of such status to its participants. The Act also contains some provisions that do not become effective until 2014; however, there are several new requirements that must be met for the 2013 plan year.

(A) Summary of Benefits and Coverage: Insurers and group health plans have a new disclosure requirement beginning with open enrollments on or after September 23, 2012. As part of the health care reforms contained in the Affordable Care Act, all individuals enrolling in health coverage must be provided with a Summary of Benefits and Coverage ("SBC"). The purpose of the SBC is to allow individuals to easily compare different healthcare options available to them. The Department of Labor ("DOL") has provided a template for use by plans and issuers to meet this requirement. While minor changes are allowed, the DOL has stated that the template must be used "as is" to meet this new disclosure requirement. The template can be found at www.dol.gov/ebsa/pdf/SBCtemplate.pdf. This template can only be used for coverage beginning before January 1, 2014, as changes are due to be made to coincide with provisions of the Affordable Care Act that become effective January 1, 2014. The DOL has also issued frequently asked questions at www.dol.gov/ebsa/healthreform/ to help insurers and group health plans prepare and distribute the SBCs.

The SBCs must be provided in the following circumstances:

1. As part of any written application materials for enrollment; if no written materials are provided (either in paper form or electronically), the SBC must be provided no later than the first day a participant is eligible to enroll in coverage;

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2. by the first day of coverage, if there have been changes in the information required to be included in the SBC;
3. to special enrollees no later than the date the summary plan description is required to be provided (90 days from enrollment); and
4. upon renewal, if a plan requires participants to actively elect to continue coverage or change coverage during open enrollment; if there is no requirement to renew coverage (i.e. an "evergreen" election) or if participants do not have the opportunity to change coverage, renewal is automatic and the SBC must be provided no later than 30 day prior to the first day of the new plan or policy year.

SBCs may be provided either in paper or electronic format. If utilizing electronic format, the plan must comply with ERISA rules regarding electronic disclosures to participants. If the SBC is posted on the internet (such as a company website), the plan must display it in a location that is prominent and readily accessible and must notify each individual that the information is available and inform them of where they can access it and that a paper version is available upon request

The United States Supreme Court's decision to uphold the Affordable Care Act on June 28, 2012 means that health plans and issuers must comply with the health care reform provisions contained within the Act.

Acknowledging the complexities involved in preparing the SBCs, the DOL has stated that during the first year the SBC requirement is in place it will not impose penalties on plans and issuers that are "working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations". *DOL, FAQs About Affordable Care Act Implementation (Part VIII), Question 2.*

(B) New Limit for Salary Reduction Contributions to Health Flexible Spending Accounts: The Affordable Care Act imposes a limit on salary reduction contributions by participants to health flexible spending accounts beginning in 2013. Previously, no cap existed and contributions could not exceed the limit, if any, chosen by plan sponsors. Effective for plan years beginning after December 31, 2012, salary reduction contributions during a plan year are limited to $2,500. This limit applies regardless of the number of other individuals (i.e., spouse, dependents) whose expenses are reimbursable under the FSA. The limit does not apply to non-elective employer contributions (such as "flex credits") to FSAs.

To meet this new requirement, cafeteria plan documents must be amended to reflect these changes. In addition, summary plan descriptions should also be changed to inform participants of the new limit.

(C) W-2 Reporting of Aggregate Cost of Employer-Sponsored Health Coverage: Another reporting requirement contained in the Affordable Care Act is the addition of the cost of health coverage on an employee's W-2. Originally this requirement applied to all employers; however, the IRS issued guidance stating that on an interim basis (at least until 2014 or further guidance is issued), only those employers required to file 250 or more W-2s for the preceding plan year are covered by the new reporting requirement. Additionally, employers are not required to report the cost of coverage provided under a self-insured plan that is not subject to COBRA.

Generally, employers covered by the requirement must report the cost of group health coverage provided to employees. Some types of health coverage are excluded from the requirement.

ERISA Service Provider Disclosures – Plan Sponsor Duties

Final regulations issued by the Department of Labor require covered service providers ("CSPs") to ERISA-covered defined contribution and defined benefit plans to provide disclosure of services provided to such plans and all direct and indirect compensation to be received by the CSP, its affiliates or subcontractors. The final regulations issued in February 2012 required these disclosures to be made to plans no later than July 1, 2012. This disclosure deadline directly impacts a disclosure deadline of the plans with participant directed investment to provide certain disclosures to plan participants. For calendar year plans, the initial annual disclosure of "plan-level" and "investment-level" information must be furnished to plan participants no later than August 30, 2012 (60 days after the July 1 effective date). Subsequently, the first quarterly statement must be furnished no later than November 14, 2012 (45 days after the end of the third quarter during which the initial disclosures were first required).

These disclosures are required by the DOL to provide plan fiduciaries with information needed to comply with their fiduciary duty to the plan and plan participants. This information is intended to assist the plan fiduciary with the following duties:

1. Assess the reasonableness of compensation received by the covered service provider, its affiliates, and/or subcontractors, both direct and indirect;
2. Identify potential conflicts of interest; and
3. Satisfy reporting and disclosure requirements under Title I of ERISA.

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The case of* Tussey v. ABB, Inc. *highlights the importance of reviewing all fee related information received from covered service providers and ensuring such fees are in the "best interest" of the participants.

Enforcement of Affordable Care Act through DOL Audits

Prior to the U.S. Supreme Court decision in June, which upheld the Affordable Care Act, the Department of Labor had begun issuing written audit requests to health and welfare plans regarding compliance with the Affordable Care Act ("ACA"). Now that the ACA has been upheld, these audits are sure to continue. In general, the audits fall in the three categories: substantiation of "grandfathered" status under the ACA, compliance with ACA requirements for non-grandfathered status plans and compliance with ACA requirements applicable to both grandfathered and non-grandfathered plans.

1. *Grandfathered plans:* The DOL audits in this category request documentation (a) showing the plan has made the required disclosure to participants and beneficiaries regarding its grandfathered status in material describing the benefits provided under the plan and (b) documenting the terms of the plan as they existed on March 23, 2010 and any other documentations to verify grandfathered status.

2. *Non-grandfathered plans:* The DOL audits in this category generally request the following documentation:

(a) the plan's choice provider disclosure notice and the list of participants who received such notice;
(b) documents relating to emergency benefits under the plan;
(c) documents relating to preventative services under the plan for

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If a plan sponsor does not receive the required disclosure information from a CSP or if the information is incomplete, the plan sponsor should contact the CSP and request that the missing or incomplete information be provided. If still not received, the plan sponsor must report to the DOL a CSP's failure to provide the required information. A failure to take action on this matter could involve a plan sponsor in a breach of fiduciary duty and involve the plan in a prohibited transaction.

Employers are encouraged to perform an ERISA audit of their plan at least once a year to ensure they are in compliance with laws and regulations.

Once the information is received from the CSP, the plan fiduciary must be able to review the information and determine whether the cost to the plan for the CSP is reasonable and in line with industry standards. To make this determination it may be necessary for the plan sponsor/fiduciary to perform a benchmarking analysis to compare the cost to the plan with that of other plans of comparable size in the industry.

This process is especially important in light of a recent court decision in U.S. District Court in Missouri, *Tussey v. ABB, Inc.* In March 2012, the district judge issued a judgment against the plan sponsor and the plan investment committee for $35 million for breaching their fiduciary duty with regard to plan fees and investments. The court held that although the plan sponsor and investment committee complied with DOL regulations regarding disclosure of fees and expenses, they failed to determine whether the fees charged to the plan participants were reasonable and if they were allocated to the participants in a reasonable manner. Furthermore, the court stated that the parties had a duty to monitor plan investment options and fees to ensure they satisfy the criteria set forth in the plan's investment policy statement.

This case highlights the importance of reviewing all fee related information received from CSPs and ensuring such fees are in the "best interest" of the participants.

In addition to reviewing the cost information for fiduciary duty purposes, the plan sponsor must also compile the information from all CSPs, for plans with a participant directed investment feature, and disclose this information to plan participants in the form of an initial disclosure and subsequent quarterly disclosures. This will involve collecting cost and fee information from all CSPs and preparing a plan-level summary of plan administrative expenses, individual participant expenses and investment-related information.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for pension plans in private industry. ERISA does not require any employer to establish a pension plan.

ERISA Self-Audits

Holifield & Associates strongly encourages employers to perform an ERISA audit of their plan at least once a year to ensure they are in compliance with laws and regulations. Given the complexity of the new fee disclosures, participant notices, summary of benefits and coverage and other items discussed in this newsletter, we recommend meeting with an ERISA attorney at the end of each year to make sure your plans are compliant to avoid DOL or IRS penalties for non-compliance and potential lawsuits by plan participants. Many of our clients routinely schedule meetings with us in October and early November to ensure their plans are in compliance prior to the annual enrollment period for retirement and welfare plans and to make sure the plans are amended to be legally compliant.

EEOC Issues Final Rule on "Reasonable Factors Other than Age"

In March, the Equal Employment Opportunity Commission ("EEOC") issued a final rule addressing what constitutes a "reasonable factor other than age". This rule was issued in response to two U.S. Supreme Court decisions from 2005 and 2008 relating to an employer's defense to an action under the Age Discrimination in Employment Act ("ADEA"), specifically a disparate impact claim. In such cases, the plaintiff alleges that an employer practice, although facially neutral with regard to age, has the effect of harming older workers more than younger workers. An employer's best defense is to show that the practice is based on a "reasonable factor other than age" (RFOA). The Supreme Court criticized existing EEOC regulations which required an employer to justify an alleged discriminatory practice as a "business necessity." The Court stated that in disparate impact cases, an employer is not required to show "business necessity"; it need only prove that that practice was based on an RFOA.

The new rule changes the existing regulations to be consistent with the Supreme Court holdings - the defense to a disparate impact claim under the ADEA is RFOA, not business necessity. The rule also provides an explanation of the RFOA defense.

An employment practice is based on an RFOA if it was reasonably designed and administered to achieve a legitimate business purpose in light of the circumstances, including its potential harm to older workers. The rule contains a list of relevant factors to be considered in determining whether an RFOA is reasonable. The factors listed must not all be present for the practice to be found reasonable. The rule stresses that the reasonableness test is an individualized consideration of the facts and circumstances in each situation. Factors to consider include:

1. the extent to which the factor is related to the employer's stated business purpose;

2. the extent to which the employer defined the factor accurately and applied the factor fairly and accurately, including the extent to which managers and supervisors were given guidance or training related to application of the factor;

3. the extent to which the employer limited supervisor discretion in assessing employees subjectively, particularly where the criteria to be evaluated are known to be subject to negative age-based stereotypes;

4. the extent to which the employer assessed the adverse impact of the employment practice on older workers; and

5. the degree of harm to individuals within the protected age group in terms of the extent of injury and the number of persons adversely affected, and the extent to which the employer took steps to reduce the harm in light of the burden on the employer to take such steps.

The new EEOC rule finally brings the regulations in line with existing case law and provides employers with regulatory guidance in defending age discrimination claims.

The new rule regarding what constitutes a "reasonable factor other than age" changes the existing regulations to be consistent with the Supreme Court holdings - the defense to a disparate impact claim under the ADEA is RFOA, not business necessity. The rule also provides an explanation of the RFOA defense.

Moving Ahead for Progress in the 21st Century Act

On July 6, 2012, the Moving Ahead for Progress in the 21st Century Act ("MAP-21") was passed. The purpose of this act was to provide pension funding relief in the form of increased interest rates which will be used to determine minimum funding requirements and also use these same interest rates to determine whether plans can pay certain types of benefits form, continue accrued benefits or provide additional benefits through plan amendments.

The following information is from IRS Notice 2012-61:
Section 430 of the Code specifies the minimum funding requirements that generally apply to single-employer defined benefit pension plans pursuant to § 412. Section 430(h)(2) specifies interest rates that are used for purposes of calculating the minimum required contribution. The interest rates that are used for this purpose are a set of three segment rates described in § 430(h)(2)(C)(i), (ii), and (iii), or, alternatively, a full yield curve described in § 430(h)(2)(D)(ii). These rates are used for a number of purposes under § 430, including:

The Moving Ahead for Progress in the 21st Century Act provides pension funding relief in multiple ways, one of which is to increase interest rates to help determine minimum funding requirements.

1. The calculation of target normal cost and funding target under §§ 430(b) and 430(d), in accordance with the rules of § 1.430(d)-1 of the Income Tax Regulations;
2. The calculation of the present value of remaining shortfall and waiver amortization installments for purposes of determining any shortfall amortization base established in the current plan year under § 430(c)(3);
3. The determination of amortization installments with respect to a shortfall or waiver amortization base under § 430(c)(2) or § 430(e)(2); and
4. The limitation on the assumed rate of return when determining the average value of assets under § 430(g)(3)(B).

Section 40211(a) of MAP-21 adds § 430(h)(2)(C)(iv), generally effective for plan years beginning on or after January 1, 2012. Section 430(h)(2)(C)(iv) provides that each of the three segment rates described in § 430(h)(2)(C)(i), (ii), and (iii) for a plan year is adjusted as necessary to fall within a specified range that is determined based on an average of the corresponding segment rates for the 25-year period ending on September 30 of the calendar year preceding the first day of that plan year. Under § 430(h)(2)(C)(iv)(II), for plan years beginning in 2012, each segment rate is adjusted so that it is no less than 90% and no more than 110% of the corresponding 25-year average segment rate. For later plan years, this range is gradually increased, so that the segment rates for plan years beginning after 2015 are no less than 70% and no more than 130% of the corresponding 25-year average segment rates. Notice 2012-55, 2012-36 I.R.B. 332, sets forth the initial set of MAP-21 segment rates under § 430(h)(2)(C)(iv)(II) for plan years beginning in 2012.

Sections 40211(a)(2) and 40211(b)(3) of MAP-21 amend the Code and ERISA to provide that the adjustments based on the 25-year average segment rates under § 430(h)(2)(C)(iv) do not apply for certain purposes involving:

1. Section 404(o) (relating to the determination of the maximum deductible limit under § 404);
2. Section 417(e)(3) (relating to the calculation of the minimum present value requirement for distributions);
3. Section 420 (relating to the determination of the amount of excess

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plan years on or after September 23, 2010;

(d) a copy of the plan's internal claims and appeals procedures;

(e) copies of notices for adverse benefit determinations, final internal adverse benefit determination, and final external review determination; and

(f) any contracts or agreements with outside independent review organizations or third-party administrators that provide external review services.

3. *Grandfathered and non-grandfathered plans:* DOL audits in this category request documentation to show compliance with the following ACA requirements applicable to both types of plans:

(a) dependent care coverage of children to age 26, including copy of notice describing enrollment opportunity;

(b) lifetime limits imposed since September 23, 2010;

(c) annual limits imposed since September 23, 2010; and

(d) a list of any participants who had plan coverage rescinded and the reason for such rescission.

As a general rule, plan sponsors and administrators must be able to produce plan documents and other documentation to show compliance with the ACA. This requires careful maintenance of plan records, including plan documents, amendments, notices and policies. The time to assemble such documentation is not after receipt of an audit notice from the DOL. Careful monitoring and record keeping will ensure on-going compliance with the law and regulations and will greatly reduce the work load in the event of an audit. If you do receive an audit notice, we recommend that you contact us as soon as possible.

As a general rule, plan sponsors and administrators must be able to produce plan documents and other documentation to show compliance with the ACA which requires careful maintenance of plan records, including plan documents, amendments, notices and policies.

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assets that can be transferred to retiree health and retiree group term life insurance accounts);

4. Section 4006 of ERISA (relating to the calculation of PBGC variable-rate premiums); and
5. Section 4010 of ERISA (relating to the requirement to report additional information to the PBGC that applies to contributing sponsors of certain underfunded plans).

In addition, section 40211(b)(2)(A) of MAP-21 amends section 101(f) of ERISA to require additional disclosures for certain plans as part of the annual funding notice to participants. Section 40211(c)(1) of MAP-21 provides that the amendments to the Code and ERISA made by section 40211 of MAP-21 are generally effective for plan years beginning after December 31, 2011.