LEGISLATIVE AND REGULATORY UPDATE

PREPARED BY

PATRICK S. McELHONE, JD
PRINCIPAL
MERCER (US) INC.
1100 MEIDINGER TOWER
LOUISVILLE, KENTUCKY 40202

LOUISVILLE EMPLOYEE BENEFITS COUNCIL
LOUISVILLE, KENTUCKY
February 14, 2012

Severe obesity is an ADA impairment, court rules: An EEOC claim that an employer violated the ADA by firing a severely obese employee may proceed to trial, the US District Court for the Eastern District of Louisiana has ruled. The court held that severe obesity is an impairment under the law, even when the obesity had no underlying physiological cause or was the result of voluntary behavior. The ADA Amendments Act of 2008 has made it easier for severely or morbidly obese employees to qualify for ADA protection, increasing the risks for employers that discriminate against or refuse to accommodate these employees. **Full text of decision in EEOC v. Resources for Human Dev., Inc. (E.D. LA, 6 Dec 2011)**

Arbitration agreement barring class actions violates labor law, NLRB finds: An employer violated the National Labor Relations Act by requiring employees to arbitrate all employment disputes on an individual basis, the NLRB has ruled. To work for the employer, employees had to waive their right to sue in court and instead arbitrate employment claims without resorting to class or collective action. The decision illustrates the wide reach of Section 7 of the National Labor Relations Act, at least as interpreted by the board's Democratic plurality. Seemingly at odds with recent Supreme Court decisions favoring mandatory arbitration, the ruling is likely to be appealed. Full text of ruling in D.R. Horton, Inc., and Michael Cuda (NLRB, 3 Jan 2012)

Labor Department proposal would increase MEWA filing obligations: Multiple employer welfare arrangements (MEWAs) would face expanded information-reporting and filing duties, under recently proposed Department of Labor (DOL) rules. The proposal calls for MEWAs to file a new electronic M-1 registration form at least 30 days before starting operations in a state and within 30 days after certain plan changes. To help DOL detect fraudulent or financially at-risk operations, Forms M-1 and 5500 would require more details on MEWAs. Other changes would expedite DOL's ability to shut down and seize the assets of MEWAs suspected of fraud. Comments are due by March 5. Full text of proposed MEWA M-1 reporting rules (Federal Register, 6 Dec 2011); Full text of proposed changes to Form M-1 (Federal Register, 6 Dec 2011); Full text of proposed changes to Form 5500 for MEWA reporting (Federal Register, 6 Dec 2011); Full text of proposed enforcement rules for MEWAs (Federal Register, 6 Dec 2011); Labor Department website on proposed M-1 changes

IRS crafts rules to encourage lifetime income options in DB and DC plans: IRS released a guidance package Feb. 2 intended to encourage lifetime income alternatives in both defined benefit (DB) and defined contribution (DC) retirement plans:

Partial annuities from DB plans. Proposed regulations would change a long-standing rule that the annuity portion of a combined lump sum annuity payout from a DB plan is subject to Code Section 417(e). Under the proposal, only the lump sum portion would be subject to Section 417(e) valuation rules in many (but perhaps not all) situations. The proposal responds to employer and labor groups' concerns that applying Section 417(e) valuation rules to the annuity portion drives up costs, confuses participants and discourages offering combined optional forms. The rules would take effect when finalized.

Longevity annuity in DC plans. A second proposal would modify the minimum distribution rules to allow DC plan participants and IRA holders to apply up to $100,000 (increased for the cost of living after 2013) or 25% of their account balance, if less, to purchase qualified longevity annuity contracts (QLACs). QLACs must provide a fixed lifetime income starting by age 85 and meet other criteria on surrender rights and death benefits. Contract issuers must provide annual reports to covered individuals. The rules would take effect when finalized.

Applying QJSA and QPSA rules to DC plan annuities. Rev. Rul. 2012-3 clarifies how the qualified joint and survivor annuity and qualified preretirement survivor annuity rules apply to deferred annuity contracts purchased in profit sharing (including 401(k)) plans.

DB annuity purchased by rollover from DC plan. Rev. Rul. 2012-4 clarifies how employers may allow employees to roll over DC plan savings to purchase annuities from the employer's DB plan. The rollover must be credited with 120% of the federal midterm rate until the annuity starting date, and the annuity must be no less than the amount determined using 417(e) assumptions. Any excess annuity is an employer-provided benefit that must meet nondiscrimination rules and count toward the 415 limit.

Comments on the proposed regulations are due by May 3, 2012. A public hearing is scheduled for June 1, 2012. While helpful, today's guidance fails to address employers' key concern with offering annuities in DC plans: the fiduciary risks associated with selecting an annuity provider.

Press release (IRS, 2 Feb 2012); **Fact sheet (IRS, 2 Feb 2012)**

House panel urged to consider pension funding reforms, reject PBGC premium hikes: Witnesses at a Feb. 2 House hearing called for immediate and permanent changes to the Pension Protection Act (PPA)'s funding rules, cautioning that the government's policy of keeping interest rates at rock-bottom lows is creating an "artificial funding crisis" for plan sponsors. The resulting burden on employers is curtailing business plans and the economic recovery, speakers noted.

Funding reform urged. Because the "current interest rate environment is so much different" than the economic conditions when PPA was enacted, "I believe the interest rate rules developed would have been much different and more flexible than they are today," Gretchen Haggerty, CFO, United States Steel Corp., told the Education and Workforce Committee's Subcommittee on Health, Education, Labor and Pensions. Noting that some of her company's planned capital investments "could take backstage" to pension funding demands, Haggerty urged the panel to consider the business community's funding stabilization proposal. Under this proposal, plans would use discount rates calculated over a longer term and have 15 instead of seven years to get from an 80% to a 100% funding level.

Premium hikes debated. Haggerty also voiced strong opposition to proposals to raise PBGC premiums or to let the agency, rather than Congress, set premium levels. Those sentiments were echoed by Ken Porter of the consulting firm Benefits Leadership International. Porter asserted that PBGC's financial deficit is a temporary "illusion" caused by current low interest rates and the agency's very conservative assumptions for projecting investment returns on its assets. The agency "is clearly not underfunded by any responsible measurement of what might happen in the future," Porter testified.

PBGC Director Joshua Gotbaum countered that "no matter how PBGC's deficit is calculated, the agency's liabilities exceed its assets." Arguing for a White House proposal to raise premiums, Gotbaum told lawmakers that "if PBGC's finances aren't reformed, the agency will eventually run out of money to pay benefits. We cannot ignore our own future financial condition any more than we would of the pension plans we insure."

Outlook uncertain. Panel Chairman Phil Roe, R-TN, remarked, "We're facing a Catch-22: how to find a solution that can strengthen PBGC without harming job creation or discouraging participation in our voluntary pension system." Roe acknowledged the need for a longer-term view of pension liabilities, which may help prospects for the funding stabilization proposal. But lawmakers of both parties are strongly considering premium hikes to pay for other priorities.

IRS releases interim report on 401(k) plan questionnaire results: Preliminary findings from an IRS "compliance check" questionnaire highlight the prevalence of various 401(k) plan design features but offer few insights into plan defects or reasons for noncompliance. In a Feb. 3 interim report, IRS officials said survey results may help the agency enhance compliance tools, improve voluntary correction programs and define future projects and enforcement activities.

A snapshot of plan design and operation. Sent in May 2010 as part of an Employee Plans Compliance Unit initiative, the questionnaire focused on the 2008 plan year and was designed to give the IRS a "comprehensive look" into the health of 401(k) plans and a better understanding of compliance behaviors. Preliminary findings from the survey sample of just over 1,000 plans (most had no more than 100 participants) include the following:

- About 86% were preapproved volume submitter or master and prototype plans.
- The sponsors of about 68% matched participants' deferrals, about 58% imposed a one-year waiting period for the match and about 65% provided some form of nonelective contributions.
- About 22% accepted designated Roth contributions.
- About 43% were design-based safe harbor plans.
- About 62% allowed in-service withdrawals.
- About 1% allowed investments in company stock.

IRS's first web-based survey. The online questionnaire was sent to a random sample of 1,200 sponsors that filed a Form 5500 for the 2006 – 2008 plan years. Recipients failing to respond were audited. Topics included: eligibility and participation, contributions, top-heavy and nondiscrimination rules, distributions and loans, annual deferral and Section 415 limits, company stock, automatic contribution arrangements, Roth contributions, and prior corrections. Officials also wanted to know the extent to which employers were correcting errors and using IRS-developed compliance tools. The final report is expected by year-end. **Full text of interim report on 401(k) plan questionnaire (IRS, 3 Feb 2012); Highlights of interim report findings (IRS, 3 Feb 2012); Interim report FAQs (IRS, 3 Feb 2012)**

Final rules on health benefit summaries set new deadlines and allow merging with SPDs: Final regulations and related guidance on health plans' summaries of benefits and coverage (SBCs) required by the health care reform law set new ambitious deadlines and make other changes to earlier rules. The new scheme generally requires employers to provide SBCs to group health plan participants and beneficiaries during open enrollments starting on or after Sept. 23, 2012, and to new hires and special enrollees for plan years starting on or after that date. However, if continued enrollment is automatic at renewal, SBCs need not be given until 30 days before the new plan year begins. Calendar-year plans must create materials for open enrollment this fall and for new enrollees beginning Jan. 1, 2013.

Highlights for employers. Other noteworthy elements of the new guidance include:

- Employers can provide stand-alone SBCs or combine them with other plan materials, such as summary plan descriptions (SPDs), as long as the SBC is displayed at the start.
- SBCs do not have to give specific premium or cost-of-coverage information, thus reducing the need to prepare multiple SBCs for each benefit option. Group health plans must use the final government-supplied SBC template. If a plan's terms can't reasonably be described using the template and its instructions, the guidance allows flexibility to craft an accurate description of plan terms, including provider networks, drug tiers or cost-sharing differences for wellness program participants, that is as consistent "as reasonably possible" with the template and instructions.
- SBCs need not be provided automatically at renewal for benefit packages in which a participant isn't enrolled, eliminating unnecessary multiple versions.
- Employers can satisfy the SBC requirement if a third party, including the issuer of an insurance policy funding the group health plan, provides timely and complete SBCs.
- SBCs are required for all insured and self-funded group health plans (grandfathered or not), including stand-alone health reimbursement arrangements and health flexible spending arrangements. SBCs are not required for "excepted benefits" or health savings accounts.
- Plans whose only participants and beneficiaries live outside the US are largely exempt from providing SBCs. **Final SBC template (CCIIO, 9 Feb 2012); Final instructions on SBCs for group health coverage (CCIIO, 9 Feb 2012); CCIIO website with SBC guidance**

Health plan auto-enrollment will be delayed past 2014, agencies say in new FAQs: Health care reform's automatic-enrollment provisions won't take effect in 2014 since finalizing rules will take longer than expected, IRS, DOL and HHS say in new guidance. Issued as frequently asked questions (FAQs), the guidance also hints at how regulators plan to implement the 90-day limit on waiting periods for health coverage and the shared-responsibility penalties for employers failing to offer full-time employees affordable coverage. The public can comment on these items through April 9. **Full text of Notice 2012-17 (IRS, 9 Feb 2012); Full text of Technical Release 2012-01 (DOL, 9 Feb 2012); Full text of HHS FAQs (CCIIO, 9 Feb 2012)**

How to handle MLR rebates from health insurers: Employers with insured group health plans should begin planning how to handle any rebates from insurers failing to meet health care reform's medical loss ratios (MLRs) in 2011. Insurers generally must pay MLR rebates by Aug. 1 to group policyholders, such as employers, trusts or Taft-Hartley funds. DOL guidance details how ERISA plan sponsors must handle rebates, depending on premium cost sharing and other factors. HHS has issued similar guidance for state or local government and other non-ERISA plans. **Full text of final MLR regulations (HHS, 7 Dec 2011); Full text of interim final rule on MLR rebates for nonfederal governmental plans (HHS, 7 Dec 2011); Full text of Technical Release 2011-04 (DOL, 2 Dec 2011)**

Relaxed medical loss ratios continue for mini-med, expat insurance policies: Relaxed medical loss ratios (MLRs) for mini-med and expatriate health insurance policies will continue through 2013, under final rules from the US Department of Health and Human Services. For expatriate plans, MLRs will stay at 2011 levels: 42.5% of large-group and 40% of small-group or individual premiums. For mini-med plans, large-group MLRs increase to 48.6% in 2012 and 56.7% in 2013 (45.7% in 2012 and 53.3% in 2013 for other policies). Under the MLR rules, most insurers must pay rebates unless health care and quality expenditures total at least 85% of large-group (80% of other) premiums. **Full text of final MLR regulations (HHS, 7 Dec 2011)**