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For Your Benefit

A newsletter on current legal issues impacting employee benefits and executive compensation

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Do You Know the Financial Status of Your Union Pension Fund?

By Harvey M. Katz

Many employers with union employees contribute to multiemployer (or union sponsored) pension plans on behalf of those employees. Although most of these plans are traditional defined benefit plans – providing employees with a fixed monthly pension at retirement – the contribution paid by the employer is determined by collective bargaining. Many employers still operate under the misconception that their monthly contribution to the union pension fund represents the full extent of their liability to those employees for retirement benefits. However, nothing could be further from the truth, as financial pressures on multiemployer pension funds during the last 30 years have resulted in changes in the law that may cost employers millions.

Undoubtedly, most employers that contribute to union pension funds are aware they may become liable for a withdrawal liability payment in the event they stop contributing to the multiemployer pension fund. This may arise in the event of a sale of the assets of the employer, a bankruptcy of the employer or a decertification of the union. In 1980, Congress enacted the Multiemployer Pension Plan Amendment Act (MPPAA), requiring employers to pay their proportionate share of the multiemployer fund's "unfunded liabilities" upon withdrawal from the fund. Gradually, employers have become aware of their obligations under MPPAA, but most have assumed they would have no liability beyond their collective bargaining contribution obligation. This assumption was rendered false by the provisions of the Pension Protection Act of 2006 (PPA).

The multiemployer provisions of PPA generally are effective beginning in 2008 in order to address alarming funding problems encountered by many multiemployer plans. PPA gives trustees of multiemployer funds powerful tools to keep plans financially solvent. For this purpose, PPA established three categories (or "zones") of plans: (1) "Green Zone" for healthy; (2) "Yellow Zone" for endangered; and (3) "Red Zone" for critical. These categories are based upon the funding ratio of plan assets to plan liabilities. In general, Green Zone plans have a funding ratio greater than 80%, Yellow Zone plans have a funding ratio between 65 and 79%, and Red Zone plans are less than 65% funded.

Each plan's actuary must certify the plan status within 90 days of the start of the plan year. Participants and contributing employers must to be notified of the status of the plan. Each Yellow Zone plan must adopt a funding improvement plan designed to increase its funding percentage by 33% within 10 years. Such a plan likely will include a combination of increased contributions and reduced benefits in order to stabilize the plan's financial condition. For plans in the Yellow Zone, there is no "stick" to force the employer to adopt any increased contribution levels mandated by a funding improvement plan until the expiration date of the current collective bargaining agreement, at which time the plan becomes a subject of collective bargaining. If an agreement cannot be reached, the trustees of the plan have the authority to impose a default contribution schedule upon the employer.

Trustees of a plan in the Red Zone must adopt a rehabilitation plan designed to allow the plan to emerge from critical status within 10 years. Similar to Yellow Zone plans, trustees of Red Zone plans may force employers that fail to reach agreement at the next collective bargaining negotiations to adopt a default plan of mandated contributions. Trustees of Red Zone plans also may impose additional contribution obligations upon employers that do not immediately agree to the higher contributions proposed in the rehabilitation plan. Until the expiration of the current collective bargaining agreement, employers have a choice between accepting the higher rate of contribution or paying a 5% surcharge during the first year and 10% each year thereafter until the expiration of their collective bargaining agreements. Trustees of Red Zone plans have the power to

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eliminate certain "adjustable benefits," which include post-retirement death benefits, 60-month guarantees and other subsidized optional payment forms, disability benefits not yet in pay status, and early retirement benefits.

Employers in Red Zone plans faced with the choice of accepting a rehabilitation plan or paying a surcharge need to consider a variety of factors, which are too numerous to mention here and outside the scope of this article. Clearly, employers need to be cognizant of onerous "default" contribution schedules that may be imposed, if the rehabilitation plan is not adopted. Other particularly troubling concerns from an employer perspective are rehabilitation plans that grant discretion to fund trustees and managers to "adjust" contribution rates in the event the trustees determine that the rehabilitation plan has not achieved its goals. Employers should be especially wary about agreeing to an "open-ended" rehabilitation plan. The possibility of withdrawal from the plan as an alternative to drastically higher or open-ended contribution obligations is an option that almost always should be considered.

In conclusion, it is incumbent upon employers that participate in multiemployer plans (and wish to avoid unpleasant surprises) to take a proactive approach concerning their financial obligation to those plans. At minimum, the employer should consider the following:

- Investigate the financial condition of the multiemployer plan through review of information provided by the plan and other publicly available information.
- Request and review information made available, including withdrawal liability estimates, actuarial reports and financial reports of the plan.
- Monitor the funding status of the plan and review financial and bargaining options, even if it is not in Red or Yellow Zone status, and consider withdrawal from the plan before financial problems arise.
- Employers with plans in Yellow or Red Zones need to monitor fund status even more closely and consider the following alternatives:
  - In Red Zone status, compare cost of additional contributions, including the cost of additional possible increases, to the cost of surcharge.
  - Compare the cost of remaining in the plan versus the costs of withdrawal liability and funding alternative benefits.
  - Participation in a multiemployer plan involves a variety of issues in addition to the obvious financial concerns, including the degree to which the union is wedded to the multiemployer plan and its receptiveness to alternative structures.
  - Employers faced with union reluctance to alternatives should consider a right to withdraw or offset of other benefits in the event penalties or contribution increases are imposed.
- Evaluation of these considerations is as much of an art as it is a science. However, it is well worth the investment in time and effort.

Clearly, PPA imposes new, and very serious, obligations upon employers who contribute to multiemployer plans, and it is critical that those employers seek the advice of experienced and knowledgeable professionals in navigating those issues and obligations.

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To Be Taxed Now or Taxed Later? New Law Permits In-Plan Roth Conversion

By Susan Foreman Jordan

On September 27, 2010, President Obama signed into law the Small Business Jobs Act of 2010. Included in the law is a small revenue-raising provision that allows participants to convert their pre-tax 401(k) deferral contribution accounts into after-tax Roth 401(k) accounts inside the qualified plan. Prior to this change, conversion could be accomplished only by rolling the 401(k) account out of the plan and into a Roth IRA.

Unfortunately, the law does not provide the tax planning opportunity for which so many had hoped — namely that participants would be permitted to convert their accounts at any time simply by retitling the account and paying the associated income tax. Why? Well, to begin, the "inside-the-plan" conversion option is available only to the extent the participant is eligible, under the terms of the plan, for immediate distribution of the funds. In some cases, an in-service distribution is available upon attainment of age 59 1/2, but many plans condition entitlement to distribution upon actual termination of employment. At that point, the participant very well might prefer to roll the account to an IRA over which he or she would have greater autonomy. In addition, of course, the plan document must provide both for the Roth 401(k) option and the conversion feature.

The new law is effective immediately. However, unless and until the plan is amended to permit conversion (or until the IRS sanctions some extended remedial amendment period within which the changes can be made with retroactive effect), it is unlikely a plan sponsor will (or should) permit transfer to a Roth account inside the plan. In fact, in an October 20 presentation to the American Society of Pension Professionals and Actuaries, the associate benefits tax counsel at the Treasury Department warned plan

sponsors to wait for Treasury Department guidance before amending their plans or permitting in-plan conversions. Pointing out the law was "somewhat hastily crafted" and may not accurately reflect Congressional policy objectives, he explained that additional clarification will be needed.

Under pre-existing (though relatively recent) law, a participant may convert his or her 401(k) account by direct rollover to a Roth IRA. Moreover, the individual may revoke the conversion at any time prior to the (extended) due date of his or her tax return for the calendar year in which the conversion occurred. In fact, because of special tax treatment accorded to Roth IRA rollovers occurring in 2010 (which allows the taxpayer to pick up one-half of the taxable income in 2011 and the balance in 2012), the deadline for revocation may be much later. The Small Business Jobs Act of 2010 makes no mention of revocation of conversion inside the 401(k) plan. Barring additional guidance, then, we must assume conversion of a 401(k) account to a Roth 401(k) account within a qualified plan is irrevocable.

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Early Retiree Reinsurance Program: Are You Getting Your Slice of the $5 Billion Pie?

By Kenneth A. Rosenberg and Theresa Borzelli

Recently, Congress threw a $5 billion financial lifeline to employers, unions and state and local governments struggling with the astronomical cost of providing health insurance coverage to "early retirees" through the creation of the Early Retiree Reinsurance Program (ERRP). ERRP was created as part of the Patient Protection and Affordable Care Act and enables employers and unions ("sponsors") that maintain, whether directly or through an insurer, an employment-based insurance plan to obtain reimbursement for a portion of their medical claim costs for their "early retirees" and their spouses, surviving spouses and dependents ("covered individuals"). "Early retirees" are defined by ERRP as individuals age 55 and older, not active employees of the sponsor and not yet eligible for Medicare. ERRP will reimburse sponsors for up to 80% of the costs for certain medical claims between $15,000 and $90,000 incurred from June 1, 2010, through January 1, 2014. This article provides guidance on what sponsors need to do to obtain a piece of the $5 billion pie before it is all gone.

Eligible Claims

Generally, claims for items and services that are reimbursable under Medicare also will count towards the $15,000 threshold and for reimbursement under ERRP. This includes health benefits for medical, surgical, hospital, prescription drug and other benefits that may be specified by the U.S. Department of Health and Human Services (HHS), such as coverage for mental health services. However, while Medicare imposes various dollar, duration, and scope limits and restraints on certain items and services, (e.g., home health services and skilled nursing facility care), HHS guidelines clarify that these limits and restraints will not be applied to ERRP claims. Likewise, the guidelines provide that Medicare's medical necessity determinations, benefit restrictions that require the sponsor to develop a claims history (e.g., that an individual was in a hospital before being admitted to a skilled nursing facility) and restrictions on the site or circumstance of care will not apply. HHS guidelines, however, exclude the following 12 items and services:

(1) Custodial care (e.g., personal care by non-medically trained personnel, institutional care not meeting the requirements of skilled nursing facility care);

(2) Routine foot care (e.g., orthopedic shoes);

(3) Personal comfort items (e.g., hospital room TVs);

(4) Routine services and appliances for vision (e.g., glasses, contact lenses)

(5) Hearing aids and auditory implants;

(6) Cosmetic surgery (except for prompt repair of accidental injury or to improve the functioning of a malformed body part);

(7) Routine dental services;

(8) Assisted suicide;

(9) In-vitro fertilization, artificial insemination, sperm and embryo procurement;

(10) Abortion services (except where the pregnancy results from rape or incest or endangers the life of the woman);

(11) Drugs not covered by a standard Part D plan (unless covered under Parts A or B); and

(12) Items or services not furnished in the United States.

What Should Sponsors Be Doing Now?

In order to participate in ERRP and obtain a slice of the $5 billion pie, a sponsor must file an application with and have its application approved by HHS, be

able to document claims and demonstrate it can implement programs and procedures that generate or have the potential to generate cost savings for participants with chronic and high-cost conditions.

Sponsors must complete the application and provide relevant plan sponsor and key personnel information, information concerning the employment-based plan for which it is requesting ERRP payments, a signed plan sponsor agreement designating the plan sponsor's authorized representative, and a proposed program and procedures for containing chronic and high cost conditions that are defined as health benefit claims in excess of $15,000 per covered individual in a plan year. Sponsors also must include the intended use of the ERRP proceeds and banking information for electronic transfer of funds.

Caution must be exercised in fully completing the application and providing truthful information. Incomplete applications will be rejected, and sponsors accepted for ERRP will be subject to audits by HHS to ensure fiscal integrity.

While its application is pending, the sponsor should begin preparing its early retiree lists so claims can be filed promptly once the application is approved. According to a recent announcement from HHS, the sponsor's retiree list should be submitted prior to, but as close as possible to, the date on which the request for reimbursement is to be submitted. The list needs to be specific to the plan year for which reimbursement is being requested and must relate only to costs eligible for ERRP payments. Only covered individuals who have accumulated $15,000 or more in claim amounts on an individual basis for the plan year are eligible for reimbursement. The early retiree list should be submitted only after the plan sponsor completes the setup on the ERRP secure web site. Sponsors must designate whether their lists will be submitted through a mainframe connection to HHS' ERRP Center or through uploading to the ERRP secure web site. If mainframe submission will be used, sponsors are advised to call the ERRP Center as soon as possible to begin the setup process.

After a sponsor submits its early retiree list, the ERRP Center will send a response indicating the periods of time each individual is eligible for ERRP. Plan sponsors should use this response file when making their requests for reimbursement. HHS, on audit, will expect sponsors to demonstrate that only claims on the retiree list were used in their request for reimbursement.

Finally, sponsors participating in ERRP must provide a form notice to all covered individuals, notifying them that because the sponsor is participating in ERRP with respect to the plan, the sponsor may use the reimbursements to reduce plan participants' premium contributions, co-payments, deductibles, co-insurance or other out-of-pocket costs. The form notice can be obtained from the HHS web site. This notice may be delivered earlier but no later than a reasonable time after the sponsor receives its first ERRP reimbursement. The notice may be delivered to the covered individuals at their last known address, along with other plan materials, by regular mail, courier service or e-mail at the workplace, provided that covered individuals have access to e-mail. Additionally, one notice can be provided per family as long as the form is addressed to all plan participants who are family members.

Conclusion

HHS began accepting claims for reimbursement from sponsors in mid-October. Employers, unions and local and state governments should immediately determine whether they can qualify for ERRP and take the necessary steps to file an application to participate. Since HHS will be reimbursing claims on a first-come, first-served basis, potential sponsors should file applications or requests for claims immediately to ensure they obtain their slice of the pie. Once the $5 billion in appropriated funds is exhausted, the party will be over. Employers, unions and/or governmental entities that have questions regarding their eligibility to participate in ERRP and/or need assistance in completing the requisite forms should contact counsel for assistance.

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Information Disclosures Required by Interim Final Regulations Section 408(b)(2)

By Pauline W. Markey

On July 16, 2010, the Department of Labor's Employee Benefits Security Administration (EBSA) issued interim final regulations that require initial information disclosures to be made by certain service providers to plan fiduciaries. The primary purpose of these final regulations is to assist plan fiduciaries in fulfilling their responsibility of assessing the reasonableness of the compensation paid for services and any potential conflicts of interest that may affect the service provider's performance of service. The final regulations will become effective on July 16, 2011. In the interim, EBSA has requested that any public comments on the regulations be submitted in writing by August 30, 2010.

In general, ERISA §406(a)(1) prohibits a fiduciary from causing a plan to engage in a transaction between the plan and a "party in interest." Specifically, a fiduciary is prohibited from causing a plan to engage

in a transaction that constitutes a direct or indirect furnishing of goods, services or facilities between the plan and a "party in interest." Transactions prohibited under ERISA §406(a)(1) are commonly referred to as Prohibited Transactions. A "party in interest" as to an employee benefit plan includes a person providing services to such plan. Based on this definition of "party in interest," a transaction between a plan and a person providing services to such plan involving the furnishing of goods, services or facilities is considered a prohibited transaction unless such transaction qualifies for an exemption provided under ERISA §408. ERISA §408(b)(2) specifically exempts from classification as a prohibited transaction an arrangement between plans and service providers where: (1) the contract or arrangement is reasonable, (2) the services are necessary for the plan's establishment or operation, and (3) no more than reasonable compensation is paid for the services.

The prior regulations issued by EBSA under ERISA §408(b)(2) provided that a contract or arrangement was reasonable, if it permitted the plan to terminate the contract or arrangement without penalty and with reasonably short notice. The new interim final regulations impose more stringent information disclosure requirements whereby covered service providers must provide specified information to a "responsible plan fiduciary" for certain plans. If the required information disclosures are not made by the service provider, the contract or arrangement will fail to be reasonable, and thus, will *not* be exempt from the prohibited transaction rules.

The interim final regulations apply only to "covered plans," which include pension plans but not SEPs, SIMPLE plans or IRAs (or welfare plans). Although EBSA excluded welfare plans from these interim final regulations, it indicated, in its preamble to the regulations, that it plans to issue a comprehensive disclosure framework for "reasonable" service contracts or arrangements to welfare plans. Accordingly, the issued interim final regulations reserve a section for welfare plan disclosure. However, even without regulations for welfare plan disclosure, ERISA §404(a) obligates fiduciaries of welfare plans to obtain and consider information relating to the cost of plan services and potential conflicts of interest presented by such service arrangements.

A "covered service provider" under the final regulations is a service provider that enters into a contract or arrangement with the covered plan and reasonably expects to receive $1,000 or more in compensation, directly or indirectly, in exchange for providing certain services. Specifically, covered service providers include those who:

(1) provide services as an ERISA fiduciary or as a registered investment adviser;

(2) provide recordkeeping services or brokerage services to a covered plan that is an individual account plan and permits participants to direct the investment of their accounts, if one or more designated investment alternatives will be made available in connection with such recordkeeping services or brokerage services; and

(3) provide specified services to the covered plan and reasonably expect to receive "indirect" compensation or certain payments from related parties.

A person or entity, however, is not a covered service provider solely by providing services:

(1) as an affiliate or a subcontractor performing one or more services as a fiduciary or registered investment adviser, certain recordkeeping or brokerage services or other services for indirect compensation under the contract or arrangement with the covered plan, or

(2) to an investment contract, product or entity in which the covered plan invests other than services as a fiduciary.

The interim final regulations require a covered service provider submit to the plan fiduciary the requisite initial disclosure information in writing. These final regulations, however, do not set out a particular manner or format for which the initial disclosures must be made by the covered service providers. Unlike the proposed regulations issued by the Department of Labor on December 13, 2007, the interim final regulations do not require that any formal contract or arrangement itself be in writing or that any representations concerning the specific obligations of the covered service provider be included in a written contract or arrangement. Based on the preamble to the interim final regulations, EBSA has tentatively adopted this flexible approach because it was persuaded that, given the varying relationships between plans and their service providers, requiring formal contracts or arrangements in every instance may result in unnecessary burdens, complexity and costs. However, should it be convinced that the benefits of formal contracts and arrangements outweigh the costs, the final regulations may be revised to require covered service providers to furnish a "summary" disclosure statement that provides an overview of the requisite information.

The interim final regulations currently require a covered service provider to submit the following initial disclosure information to the plan fiduciary:

- A description of the services to be provided to the covered plan, other than non-fiduciary services;
- A statement that the covered service providers, affiliates and subcontractors will provide, or reasonably expect to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary or registered investment adviser;
- A description of all direct (either in the aggregate or by service) and indirect compensation;
- If applicable, a description of any compensation that will be paid among the covered service provider, an affiliate

and/or a subcontractor, in connection with services, if on a transaction basis (e.g., incentive compensation based on business placed or retained), or is charged directly against the covered plan's investment and reflected in the net value of the investment;

- A description of any compensation in connection with the termination of a contract or arrangement;
- In the case of covered service providers providing recordkeeping services:
  - (1) A description of all direct and indirect compensation expected to be received in connection with recordkeeping services, and
  - (2) A statement of whether the covered service provider reasonably expects recordkeeping services to be provided without explicit compensation, or whether compensation for recordkeeping services is offset or rebated based on other compensation received,
- A description of the manner in which compensation will be received, and
- In the case of fiduciaries for investment vehicles holding plan assets, a description of:
  - (1) Any compensation that will be charged directly against the amount invested in connection with the acquisition, sale, transfer or withdrawal from the investment contract, etc.,
  - (2) The annual operating expenses if the return is not fixed, and
  - (3) Any ongoing expenses in addition to annual operating expenses.

The initial disclosure information must be provided by the covered service provider to the plan fiduciary within a reasonable period of time before the contract or arrangement is entered into, extended or renewed. Any changes to the initially disclosed information must be submitted to the responsible plan fiduciary as soon as practicable, but in no event later than 60 days from the date the covered service provider is informed of such changes. In addition to providing the requisite initial disclosure information, covered service providers are required to provide, upon request by the plan fiduciary or plan administrator, any other information required for the covered plan to comply with the reporting and disclosure requirements of Title I of ERISA and its regulations. Notwithstanding the disclosure requirements imposed by the interim final regulations, no contract or arrangement will fail to be reasonable solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the required information so long as the covered service provider discloses the correct information to the responsible plan fiduciary no later than 30 days from the date on which such service provider knows of the error or omission.

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Health Care Reform: Regulations Issued on Preventive Health Services

By Daniel N. Kuperstein

On July 14, 2010, the Departments of Treasury, Labor and Health and Human Services (the Departments) issued interim final regulations on preventive health services under the Patient Protection and Affordable Care Act, as amended. The new rules generally apply to group health plans and group health insurance issuers offering group and individual health insurance coverage for plan years beginning on or after September 23, 2010.

With the goal of making evidence-based health services readily available, the new regulations preclude non-grandfathered plans from imposing cost-sharing requirements, such as co-pays and deductibles, on the following types of recommended preventive health services:

- Evidence-based services or items that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force with respect to the individual involved. The regulations note "preventive services given a grade of A or B by the Task Force have been determined by the Task Force to have at least fair or good evidence that the preventive service improves important health outcomes and that benefits outweigh harms in the judgment of an independent panel of private sector experts in primary care and prevention."
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. The mission of the Advisory Committee is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.
- With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) (not

otherwise addressed by the recommendations of the Task Force).

- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). The Department of Health and Human Services is developing these guidelines and expects to issue them no later than August 1, 2011.

It should be noted that nothing in the regulations prohibits plans or issuers from imposing cost-sharing requirements for preventive services not recommended in these rules.

With these new rules, the Departments anticipate that: (1) individuals will experience improved health; (2) healthier workers and children will be more productive; (3) the preventive services will result in savings due to lower health care costs; and (4) the cost of preventive services will be distributed more equitably.

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Two Items of Note With Regard to Plan Loans

By Susan Foreman Jordan

In late September 2010, the Financial Accounting Standards Board (FASB) approved its position that participant loans from defined contribution plans (profit sharing, 401(k) and money purchase pension plans) should be classified, for financial reporting purposes, as **receivables**. These are to be segregated from plan investments and reported at the outstanding principal amount plus accrued but unpaid interest. This classification guidance is to be applied prospectively for plan years ending after December 15, 2010, but may be adopted earlier.

The new position, however, is more a change in form than of substance. To this point, most plans have classified participant loans as plan **investments**. Since existing guidance dictates that plan investments be reported at fair market value, most plans have carried participant loans on the books at the unpaid balance, plus any accrued but unpaid interest, as that was deemed to be a good faith approximation of fair value.

While we are on the subject of participant loans … Effective July 1, 2010, the Federal Reserve amended Regulation Z under the Truth in Lending Act to exempt employer-sponsored retirement plans that make participant loans from the Truth in Lending Act disclosure requirements. In issuing the exemption, the Federal Reserve recognized that because payments of principal and interest by a plan participant are reinvested in the participant's account, and because plan loans are not subject to finance charges imposed by third parties, a participant who takes a loan from his or her retirement plan is not subject to the risks inherent in a commercial loan and, as such, and is not in need of the full disclosure protections afforded by Regulation Z. Nevertheless, it is important to remember not only must all plan loans be documented and administered properly, but fee, interest and repayment information must be disclosed to participants in order to ensure compliance with ERISA, the Internal Revenue Code and state consumer protection laws.

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