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

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Creative Divorce Planning: Applying the *QDROtic* Equation

By Mark H. Hess

Tax-qualified retirement plans such as defined benefit pension plans and 401(k) plans are granted substantial tax benefits by the federal government in order to encourage private retirement savings. This is why employers sponsoring those plans are entitled to a tax deduction for the year in which they make contributions to the plans while employees who will ultimately benefit from these contributions are not taxed until the benefits are actually paid to them from the plans, even if the employees are fully vested in their plan benefits many years before they receive distributions.

In order to help ensure that plan benefits are used for their intended purposes—i.e., to provide employees with retirement benefits—the Internal Revenue Code imposes a 10 percent penalty tax for benefits distributed prior to age 59-1/2, theorizing that distributions made at an earlier date are not being used by the employee for retirement purposes and, therefore, are to be discouraged. Similarly, the Internal Revenue Code institutes mandatory minimum distributions to employees when they attain age 70-1/2 in order to discourage employees who can afford to do so to leave all of their retirement benefits to their heirs, thereby again subverting the intent of the retirement plan legislation.

The recently decided Fifth Circuit decision, *Brown v. Continental Airlines, Inc.*, demonstrates how nine airline pilots and their spouses creatively used qualified domestic relations orders (QDROs) and state domestic relations law to circumvent the retirement plan rules. In *Brown*, the pilots, all married and over the age of 50, became concerned that Continental's pension plan might be adversely affected by financial troubles in the airline industry and therefore wanted to get their benefits distributed to them immediately rather than having to wait until retirement.

A QDRO is a domestic relations order (DRO) that creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of a participant's retirement plan benefits and meets certain other requirements. Among those requirements is not requiring the plan to pay a benefit not otherwise provided under the plan and not requiring the plan to provide increased benefits. A DRO is a judgment, decree or order, including the approval of a property settlement agreement, that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a participant and is made pursuant to a state domestic relations law.

In *Brown*, the pilots learned that under Continental Airlines' plan, alternate payees under a QDRO (in this case, the pilots' spouses), where the plan participants had attained age 50, could immediately be paid in a lump sum equal to 100 percent of the pilots' retirement benefits earned to date. Accordingly, the pilots filed for divorce in state court and the court issued a DRO stating that as part of the divorce, the spouses were to receive an immediate distribution of 100 percent of the plan benefits earned by the pilots.

Apparently the pilots and their spouses continued living together despite filing for divorce and remarried shortly after the spouses received their plan distributions. Additionally, the pilots continued working for Continental Airlines throughout this entire process. Perhaps the outcome here would have been different had the committee administering the Continental Airlines plan taken the position that the state court orders were not QDROs because these were sham divorces. However, the committee approved the DROs as QDROs and only later sued the pilots and their spouses for equitable relief in the federal district court in the Southern District of Texas, seeking restitution of the sums paid to the spouses.

The district court and, later, the Fifth Circuit Court of Appeals, held the committee may not refuse to treat a DRO as a QDRO unless the refusal is based on reasons set forth in the statute dealing with QDROs. Essentially, this means a plan administrator must treat a DRO as a QDRO unless the form of the DRO does not meet the requirements for a QDRO or if: (1) the DRO requires the payment of a type of benefit not provided by the plan; (2) the DRO requires the payment of an increased benefit; or (3) the DRO conflicts with a previously issued QDRO. Since

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none of these exceptions were present in this case, the district and circuit courts held the committee had no basis to seek restitution from the pilots and their spouses as the initial determinations that the DROs constituted QDROs were correct and there was no basis to challenge those determinations.

The courts recognized these divorces might be sham divorces but ruled the plan administrator was not obligated or entitled to question the decision of the state family law courts. Once the family law courts issued the DROs, it was the job of the committee simply to apply the rules of the Internal Revenue Code to determine whether the DROs were or were not QDROs.

There are two interesting side notes to *Brown*. First, the case would suggest that other creative ways to avoid some of the pension laws are now available. Many states, such as California, allow for a bifurcation of marital and property rights. In other words, a couple can file for divorce immediately and determine their property rights several years later. The opposite is also generally true in these jurisdictions: a couple can divide up their assets now and have the divorce ruling take place in the future.

Let us assume that a California couple in their 40s would like to make immediate use of their pension monies but do not wish to leave their jobs and are participants in retirement plans that allow lump sum distributions to an alternate payee at any time irrespective of the age of the participant. They could file for divorce but ask the judge to rule only on the division of their marital assets immediately and obtain a DRO giving each spouse 100 percent of the other spouse's pension benefits. They could then simply put off getting the determination of the dissolution of their marital status forever. Under *Brown*, a plan administrator would not be able to challenge this strategy. In addition to getting their money at a very young age, they also would not have to pay the 10 percent penalty tax on early withdrawals because payments under a QDRO are not subject to the penalty.

The second interesting side note to this case is that what these pilots did is nothing new. Twenty-one United Airlines pilots and their spouses did virtually the same thing in the mid-1990s after reading a pamphlet titled "Retirement Liberation Handbook." The pamphlet advocated, as a method of acquiring a distribution of pension plan benefits before retirement age, that participants and their spouses obtain a divorce for the sole purpose of securing a court order assigning pension plan benefits and then remarrying. The United Airlines plan administrator approved five of the applications and then became suspicious when the same law firm handled most of the applications and, in one case, two applications were submitted in the same envelope.

The United Airlines plan administrator sought an advisory opinion from the Department of Labor requesting guidance as to how the administrator should treat a DRO if there is reason to believe it is a sham or questionable in nature. The DOL ruled the plan administrator should notify the state courts of its suspicions. If, within the time period for making a QDRO determination (18 months from the date the DRO is received by the plan administrator), the state court does nothing, then the plan administrator must approve the application. The plan administrator cannot independently conclude the DRO is a sham and, therefore, not a QDRO.

If an employer wishes to avoid these issues, it can either design its retirement plans in a manner that does not allow lump sum QDRO distributions or that defers all plan distributions to age 65, regardless of whether the participant separates from service at a younger age. However, once the provisions for lump sum QDRO distributions at an early age are in a plan, they probably will be considered the type of accrued benefits that cannot be reduced or eliminated.

For more information regarding this topic, please contact Mark H. Hess at 310.598.4152 or mhess@foxrothschild.com or any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

First Dollar Coverage Required for Women's Preventive Health Care Services

By Susan Foreman Jordan

The Patient Protection and Affordable Care Act, the health insurance reform legislation signed into law in March 2010, is intended to make preventive care affordable and accessible by requiring health plans to cover preventive services and eliminating cost sharing for those preventive services. Last year, the Departments of Health and Human Services, Labor, and Treasury issued interim regulatory guidance as to the services subject to these requirements. The regulations identified four categories of preventive health services encompassed by the requirements: (1) certain individual services covered by recommendations of the United States Preventive Services Task Force, (2) immunizations as recommended by the Centers for Disease Control and Prevention, (3) guidelines for children and adolescents supported by the Health Resources and Services Administration (HRSA) and (4) preventive care and screening for women.

HRSA now has adopted amendments to the regulations to fill some of the gaps in existing guidance, specifically in the fourth category (preventive care and screening for women). These expanded guidelines are effective as of August 1, 2011. Non-grandfathered health plans and issuers are required to provide coverage without cost sharing (i.e., first dollar coverage) for the first plan year or policy year that begins on or after August 1, 2012; for calendar year plans and policies, the effective date will be January 1, 2013. Specifically, the following

preventive services must be provided without cost sharing:

- Well-women visits;
- Screening for gestational diabetes;
- Human papillomavirus testing;
- Counseling for sexually transmitted infections;
- Counseling and screening for human immune-deficiency virus;
- Contraceptive methods and counseling;
- Breastfeeding support, supplies and counsel; and
- Screening and counseling for interpersonal and domestic violence.

The regulations grant to HRSA the discretion to exempt certain religious employers and the group health plans sponsored by those employers from these guidelines insofar as contraception services are concerned. For purposes of this exemption policy, a "religious employer" is one that (1) has the inculcation of religious values as its purpose, (2) primarily employs persons who share its religious tenets, (3) primarily serves persons who share its religious tenets, and (4) is a nonprofit organization under Internal Revenue Code Section 6033(a)(1) and Internal Revenue Code Section 6033(a)(3)(A)(i) or (iii). (The latter two references apply to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious orders.) This definition of religious employer is based upon existing definitions used by most states that exempt religious employers from having to comply with state law requirements pertaining to coverage of contraceptive services.

For more information regarding this topic, please contact Susan Foreman Jordan at 412.391.1334 or sjordan@foxrothschild.com or any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

FASB Revises Rules on Multiemployer Plan Disclosure

By Keith R. McMurdy

The Financial Accounting Standards Board (FASB) had previously proposed a rule that would require companies to disclose potential withdrawal liability for multiemployer defined benefit pensions in which they participated, which would have put the pension fund's unfunded liability on the employers' books. However, on July 27, 2011, FASB notified Congress it has withdrawn this proposal.

Generally, employers that contribute to multiemployer plans do so according to contractually negotiated rates. However, they remain liable for satisfaction of the pension fund's unfunded liability and may become liable for withdrawal liability if they cease having a contribution obligation to the plan.

Under the original FASB proposal, employers would have had to "book" this liability by providing disclosure of the potential withdrawal liability from any multiemployer plan on its balance sheets, which would have created significant financial implications. Now, instead of reporting the withdrawal liability, FASB has revised its disclosure rules and set forth a new set of disclosure requirements.

The new proposed disclosures include:

- The amount of employer contributions made to each significant plan and to all plans in the aggregate.
- An indication of whether the employer's contributions represent more than five percent of total contributions to the plan.
- An indication of which plans, if any, are subject to a funding improvement plan.
- The expiration date(s) of collective bargaining agreement(s) and any minimum funding arrangements.
- The most recent certified funded status of the plan, as determined by the plan's so-called "zone status," which is required by the Pension Protection Act of 2006. If the "zone status" is not available, an employer will be required to disclose whether the plan is:
  - Less than 65 percent funded;
  - Between 65 percent and 80 percent funded; or
  - Greater than 80 percent funded.
- A description of the nature and effect of any changes affecting comparability for each period in which a statement of income is presented.

FASB expects these rules will become effective for fiscal years ending after December 15, 2011, for public entities and fiscal years ending after December 15, 2012, for non-public entities.

Presumably, the purpose of these disclosures is to provide information about potential unfunded exposure to pension liabilities to anyone accessing the financial statements of the employer. However, it is unclear whether those who read this information will understand the true nature of what is being reported and how the information actually impacts the financial health of the employer. While it is premature to make blanket conclusions about how bank or other financial institutions may view this information, it does seem likely that employers will see some impact and may need to explain the disclosure if asked for more information. Fox Rothschild is prepared to assist in explaining all aspects of multiemployer plan liability and can certainly help shed light on what the new disclosures actually mean.

For more information regarding this topic, please contact Keith R. McMurdy at 212.878.7919 or kmcmurdy@foxrothschild.com or any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

Hot Topics in Health Care

By Theresa Borzelli and Daniel N. Kuperstein

The first three quarters of 2011 saw significant changes to the federal health care reform laws (the Affordable Care Act or ACA). Laws amending the ACA in the early months of 2011 repealed provisions that had implemented free-choice vouchers and expanded Form 1099 reporting requirements. Early to mid-2011 also saw new rules issued on the ACA's internal claims and external review procedures and Accountable Care Organizations.

In more recent weeks and months, federal agencies have added new regulations and guidance to assist employers and others seeking to comply with the ACA. This article will briefly discuss some of these recent developments and clarify some older health care-related legal issues that continue to surface with our clients.

Development in Affordable Insurance Exchanges

On August 12, 2011, the Department of Health and Human Services (HHS) and the Department of the Treasury issued three proposed rules to help implement Affordable Insurance Exchanges (Exchanges), which are a state-based competitive marketplace where individuals and small businesses can seek out and, hopefully, purchase affordable private health insurance. Specifically, the proposed rules include:

- **Exchange Eligibility and Employer Standards:** This is an HHS-proposed rule that delineates the standards and processes for enrolling in qualified health plans and insurance affordability programs. It also outlines basic standards for employers' participation in the Small Business Health Options Program (SHOP), which was designed to be a new way for small employers to share in some of the benefits and to be clout that large employers currently enjoy when purchasing health insurance for their employees.
- **Health Insurance Premium Tax Credit:** Treasury-proposed regulations that detail how individuals and families will receive premium tax credits to help defray insurance costs. The premium tax credits were designed to assist middle class Americans with purchasing affordable health insurance.
- **Medicaid Eligibility:** This HHS-proposed rule attempts to expand and simplify Medicaid eligibility rules and to coordinate Medicaid and the Children's Health Insurance Program (CHIP) with the new Exchanges.

Is Health Care Reform Constitutional?

On August 12, 2011, the Eleventh U.S. Circuit Court of Appeals found that the part of the ACA that requires individuals to obtain health insurance (referred to as "the individual mandate") was unconstitutional. However, the rest of the statute was upheld. This ruling conflicted with an earlier ruling from the Sixth U.S. Circuit Court of Appeals that found that the individual mandate was constitutional.

These decisions presumably create a sufficient conflict between the circuits and should help get the law before the U.S. Supreme Court for review. When and how that might happen is subject to debate as there may be other hurdles that have to be crossed before it reaches the high court.

Delay in Discrimination Rules for Fully Insured Plans

Earlier this year, the IRS issued Notice 2011-1, which delays, until after regulations or further guidance are issued, the application of the ACA's provisions prohibiting insured group health plans from discriminating in favor of highly compensated individuals. Accordingly, and at least for the remainder of 2011, insured health plans do not have to worry about being penalized for failing to comply with the ACA's nondiscrimination rules.

For years, nondiscrimination rules prohibiting group health plans from discriminating in favor of highly compensated employees applied to self-insured and not insured group health plans. When the ACA was passed, it included provisions "similar to" the nondiscrimination rules applicable to self-insured group health plans, which are to apply to insured health plans. What "similar" means will be left to the future regulations or other guidance.

Clarification Regarding Coverage of Dependents and Tax Implications

Issues involving dependent care coverage under the ACA have continued to confuse many of our clients. The ACA generally requires group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available for an adult child until the age of 26, effective for the first plan year beginning on or after September 23, 2010. The ACA also amends the Internal Revenue Code to provide such coverage.

In April 2010, the IRS issued Notice 2010-38, which, among other things, extended the federal tax exclusion for employer-provided health coverage provided to such adult children who have not attained age 27 as of the end of the taxable year. This exclusion applies regardless of whether the child is the employee's "dependent" within the meaning of Section 152 of the Code. Thus, the age limit, residency, support and other tests described in Section 152(c) of the Code do not apply with respect to such a child for purposes of this exclusion.

Required Summary of Benefits and Coverage – Proposed Regulations

Effective March 23, 2012, a summary of benefits and coverage (SBC) must be provided to health plan participants and beneficiaries. The SBC consists of a four-page (double-sided) summary in a prescribed format and includes a glossary

of terms as well as examples of how certain conditions will be covered by the plan. It is a stand-alone document.

Responsibility for providing the SBC is placed on the health insurance issuer and the plan, in the case of an insured group health plan, or the plan sponsor, in the case of a self-insured plan.

A voluminous amount of information was generated to describe the SBC, including sub-regulatory guidance.

The three government agencies (HHS, IRS and DOL) responsible for issuing the regulations are seeking comments in many areas. Given the number of items on which the government is soliciting comments and what will probably be a large response by all interested parties, it appears unlikely that the 2012 effective date will hold.

The SBC must be a stand-alone document in a form authorized by the government and in accordance with instructions for completing (included in the sub-regulatory guidance). The SBC must not exceed four double-sided pages and must be in at least 12 point font.

The SBC may be provided in paper form or electronically if:

- The format is readily accessible by the plan sponsor;
- Provided on paper upon request at no cost;
- If the electronic form is an Internet posting, the issuer must advise the plan in paper form or e-mail that the document is available on the Internet and provide the Internet address; and
- If the DOL rules for electronic communication are satisfied.

A notice of modification must be provided no later than 60 days prior to the effective date if there are any material modifications made in any of the terms of the plan or coverage that would affect the content of the SBC, which is not reflected in the most recent SBC.

A uniform glossary must be provided in the specific format authorized in regulatory guidance and can be provided in paper or electronically.

If state laws require less information, then state law is preempted. If state law requires more information, then state law governs. A group health plan or issuer that willfully fails to provide the required information to a participant or beneficiary is subject to a fine of not more than $1,000 for each failure. The penalty can be assessed per participant or beneficiary.

What Should Plan Sponsors Do?

1. Seek assistance or guidance from a consultant/broker/attorney.
2. If you offer insured health plans, stay in frequent contact with your insurance carrier to ensure its compliance with the regulations.
3. If your health plans are self-insured, compare the SBC content requirement with what you currently provide. You may find you already provide much of the required information, which means you will be required to repeat it in the stand-alone SBC.
4. Stay up to date on these requirements, especially if there is no delay in the effective date.

The End of COBRA Subsidies

Do you remember those COBRA subsidies originally introduced in March 2009? Generally, the federal COBRA subsidy program provided that 65 percent of the cost of COBRA health insurance premiums would be covered by the employer for up to 15 months. To be subsidy eligible, recipients had to become eligible for COBRA as the result of an involuntary termination of employment occurring between September 2008 and May 2010.

It appears this subsidy is coming to an end. The last group of eligible recipients (those who began receiving assistance in May 2010) would have ceased to be subsidy eligible as of August 31, 2011. Presently, no action from Congress to extend the subsidy further is pending; therefore, we recommend employers that had COBRA participants receiving the subsidy provide them with some notice that their subsidy eligibility has ended. Because there is no specific notice requirement, such a notice could be relatively simple, telling those qualifying beneficiaries that the subsidy period has expired and they are now responsible for 100 percent of the COBRA premiums if their COBRA coverage period has not ended and they want to continue coverage.

The authors gratefully acknowledge the input of Mary Andersen of ERISAdiagnostics in the preparation of this article.

For more information regarding this topic, please contact Theresa Borzelli at 973.992.4800 or tborzelli@foxrothschild.com, Daniel N. Kuperstein at 973.994.7579 or dkuperstein@foxrotshchild.com or any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

IRS Announces 2012 Cost-of-Living Adjustments for Qualified Retirement Plans

Last month, the IRS announced the cost-of-living adjustments to the various dollar limitations applicable to qualified retirement plans for 2012. Most of the limitations, which had been unchanged for two years, have increased. Set forth below is a summary of the material changes.

1. **Compensation Limit**. The maximum amount of compensation that may be counted for plan purposes for plan years beginning in 2012 is $250,000, up from the $245,000 limitation applicable in 2009 through 2011. This limitation applies for calendar year 2012 and for limitation years beginning in 2012.
2. **Contribution and Benefit Limits**. The maximum limit on annual additions to a defined contribution plan is increased from $49,000 to $50,000. Similarly, the maximum annual benefit that may be accrued under a defined benefit plan is adjusted from $195,000 to $200,000. These limitations are applicable for calendar year 2012 and for limitation years ending within 2012.
3. **401(k) Deferral Limit**. The maximum limitation on voluntary salary deferrals for calendar year 2012 is increased from $16,500 to $17,000, but the limit on catch-up deferrals by those age 50 or older remains set at $5,500.
4. **Highly Compensated and Key Employees**. Effective for plan years beginning in 2012, a highly compensated employee is any employee: (a) who was a five percent owner during the current or preceding year; or (b) who received compensation from the employer during the preceding year in excess of $115,000. Previously, the dollar threshold was $110,000. The dollar limit used to define a key employee in a top heavy plan is increased from $160,000 to $165,000.
5. **Taxable Wage Base**. The Social Security taxable wage base for 2012 will be $110,100, up from $106,800, which was the wage base for 2009 through 2011. For plan years that operate on a fiscal year basis, this wage base will be effective for plan years beginning in 2012.

For more information regarding this topic, please contact any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

Relief for 403(b) Plan Compliance Failures

By Susan Foreman Jordan

The IRS maintains the Employee Plans Compliance Resolution System (EPCRS), which affords to retirement plan sponsors several avenues of relief for compliance failures. These include self-correction, voluntary correction by application to the IRS and resolution of failures discovered on audit.

For qualified retirement plans, including pension, profit sharing and 401(k) plans, EPCRS extends to document failures, including failure to have amended on a timely basis, operational failures and demographic failures. However, the correction program is not as extensive when it comes to tax-deferred annuity programs under Internal Revenue Code Section 403(b). Although 403(b) operational and demographic failures can be resolved through EPCRS, 403(b) plan sponsors are prohibited from correcting document failures, including the failure to have adopted a written plan document by December 1, 2009, and obtaining relief from adverse tax consequences through the program.

In the course of an IRS teleconference on August 25, in which a number of the members of our practice group participated, the IRS confirmed that an update and expansion of EPCRS is expected in the "near future" so as to extend all correction opportunities, including remediation of document failures, to 403(b) plan sponsors. In the meantime, the IRS made it clear that if a sponsor of a 403(b) plan has not yet adopted a written plan document as required by law or if that document is deficient, the sponsor immediately should adopt a written plan document and then submit an application under EPCRS when the new procedures are issued. If your 403(b) plan has not been reduced to writing or if you have any concerns about the adequacy of your written plan document, please contact us for guidance.

For more information regarding this topic, please contact Susan Foreman Jordan at 412.391.1334 or sjordan@foxrothschild.com or any member of Fox Rothschild's Employee Benefits & Compensation Planning Practice Group.

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