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New Regulations on Cash Balance and Pension Equity Plans

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On October 18, 2010, the IRS issued final regulations regarding hybrid defined benefit pension plans, such as pension equity plans and cash balance plans. Generally, the final regulations address the statutory requirements of the Pension Protection Act of 2006 ("PPA 2006") and the Worker, Retiree, and Employer Recovery Act of 2008, including special vesting rules, age discrimination safe harbor, interest rate requirements as well as requirements applicable to amendments converting a traditional defined benefit formula to a statutory hybrid formula. The final regulations generally apply to plan years beginning on or after January 1, 2011. At the same time, the Treasury and IRS proposed additional regulations and that address forms of benefit payment other than lump sums, provide an alternative method for satisfying the plan conversion rules, broaden the list of permitted interest crediting rates and provide relief under benefit accrual rules.

The final regulations generally follow regulations previously proposed and transition guidance issued in 2007. This article summarizes some of the more important aspects of the final regulations as well as the proposed regulations.

Relief under Section 411(a)(13)(A)

The distinctive feature of a cash balance or a pension equity plan (PEP) is that the accrued benefit is expressed as the value of an account or, in the case of a PEP, the value of an accumulated percentage of the participant's final average compensation. However, prior to PPA 2006, it was questionable whether such a plan could simply pay the hypothetical account balance or accumulated percentage and continue to satisfy the vesting and cashout rules under the Internal Revenue Code ("IRC").

As a result of PPA 2006, such plans will not be treated as failing to satisfy certain IRC requirements generally applicable to defined benefit plans simply because plan terms provide that the present value of the accrued benefit is equal to the then current balance of a hypothetical account or the then current value of an accumulated percentage of the participant's final average compensation. We refer to this relief as the section 411(a)(13)(A) relief.

Under the final regulations, section 411(a)(13)(A) relief only applies to a benefit provided under a lump sum based formula. A "lump sum based formula" is a benefit formula expressed as the current balance of a hypothetical account or as the current value of the accumulated percentage of the participant's final average compensation. The determination as to whether a formula is a lump sum based formula is based on how the benefit is stated under the terms of the plan, not on whether the plan provides for a lump sum payment option. A lump sum based formula also includes a defined benefit plan formula "that has an effect similar to a lump sum based formula."

The proposed regulations impose additional requirements for section 411(a)(13)(A) relief, including a requirement that at all times on or before normal retirement age, the hypothetical account balance or the accumulated percentage of the participant's final average compensation must not be not less than the present value of the accrued benefit (or portion thereof) determined under the lump sum based formula.

Section 411(a)(13)(A) relief is not available for benefits provided under a formula that is not a lump sum based formula, so benefits provided under non-lump sum based formulas must comply with the vesting, distribution and allocation rules generally applicable to defined benefit plans.

The final regulations only address lump sum based formula benefits paid in the form of a lump sum. However, the proposed regulations would extend section 411(a)(13)(A) relief to other optional payment forms if those other forms are actuarially equivalent to the hypothetical account balance or the accumulated percentage.

Special Vesting Rules

If any portion of a participant's accrued benefit is determined under a lump sum based formula, the plan must provide for 100% vesting of the benefit derived from employer contributions after the participant completes at least 3 years of service. This vesting requirement applies on a participant-by-participant basis and to the participant's entire accrued benefit (not just the portion derived from the lump sum based formula). In the case of a plan in existence on June 29, 2005, the 3-year vesting rule only applies to participants with an hour of service on or after January 1, 2008.

Safe Harbor for Age Discrimination

IRC section 411(b)(1)(H)(i) prohibits any reduction in the rate of benefit accrual under a defined benefit plan because of the attainment of any age. The final regulations describe certain safe harbor plan designs that are deemed to satisfy these age discrimination rules. A plan that does not satisfy the safe harbor is required to satisfy the general age discrimination rule of IRC section 411(b)(1(H)(i).

Under a safe harbor design, a participant's benefit accrued to date cannot be less than the benefit accrued to date of any similarly situated, younger person who is or could be a participant. A person is similarly situated to another individual if the individual is identical to that other individual in every respect that is relevant in determining a participant's benefit under the plan -- including, but not limited to period of service, compensation, date of hire, work history and any other respect -- but excluding age.

Conversion Protection

Amendments converting a traditional defined benefit plan formula to a lump sum based formula also must satisfy the age discrimination rules. The final regulations provide guidance on what constitutes a conversion amendment. For conversion amendments adopted after June 29, 2005, the amendment will satisfy the age discrimination rules if the participant's benefit after the conversion can be no less than the sum of the participant's accrued benefit as of the conversion date (including any early retirement subsidy with future growth) and the participant's accrued benefit earned after the conversion. In other words, "wear away" of the prior accrued benefit is not permitted. A plan is permitted to convert the prior accrued benefit into an account balance or an accumulated percentage; however, the plan must top up the opening account balance or accumulated percentage at benefit commencement if it is not at least equal to the present value of the prior accrued benefit at benefit commencement. Additional alternatives are addressed in the proposed regulations, including an alternative for cash balance (but not PEP) plans that does not require a subsequent comparison between the opening account balance and the present value of the prior accrued benefit.

Market Rate of Interest

Another aspect of the age discrimination requirements is that the interest credit rate under the lump sum based formula must not be greater than a "market rate of return." The final regulations provide several indices that are deemed not to be in excess of market rate: the interest rate on long-term corporate bonds (including 1st, 2nd and 3rd segment rates under IRC section 417(e)), certain other Treasury indices (and associated margins), actual plan rates of returns and annuity

contract rates. The proposed regulations also permit use of a fixed rate of return (including certain minimum rates of return) and the rate of return on certain regulated investment companies.

A plan with a lump sum based formula must specify how the plan determines interest credits and how and when (at least annually) interest is credited. The proposed regulations provide that interest credits are not required to be allocated on amounts distributed prior to the end of the interest crediting period.

The final regulations require a plan with a lump sum based formula to include a "preservation of capital" requirement, providing that interest credits will not result in a reduction of the account balance or accumulated percentage below the aggregate amount of the hypothetical allocations.

The proposed rules provide guidance on the special interest credit rules that apply upon plan termination.

Both the final and proposed rules contain special relief that would permit a plan to change the rate of crediting interest without violating the anti-cutback rules of IRC section 411(d)(6).

The effective date of the final rules on market rate of return, the time for crediting interest and the extent to which a plan may use a "greater of" two or more interest rates is delayed to plan years beginning on or after January 1, 2012. For plan years beginning prior to January 1, 2012, employers may rely on the final or proposed regulations.

Special 133⅓ Percent Test Rule

Generally, a defined benefit plan cannot "back-load" the accrual of benefits, which means the plan can not give employees disproportionately larger benefits during their last few years of service and defined benefit plan formulas must satisfy one of three accrual rules, including the 133⅓ percent rule. The proposed regulations provide special rules that will make it easier for plans with lump sum based formulas to satisfy the 133⅓ percent accrual rule.

Effective Date and Plan Amendments

As noted above, the final rules (other than certain rules regarding market interest rates) are generally effective for plan years beginning on or after January 1, 2011. In 2009 guidance, the IRS and Treasury extended the deadline for cash balance and PEP plans to adopt plan amendments to incorporate changes required under IRC section 411(a)(13) (other than section 411(a)(13)(A)) and section 411(b)(5) to the last day of the 2010 plan year. However, the preamble to the proposed regulations suggests that amendment deadline may be extended further. Specifically, the preamble provides that it is expected that when the proposed regulations are finalized, they will contain relief from the requirements of section 411(d)(6) for amendments adopted before the date the final regulations apply to the plan and the cutback is limited to the extent necessary to enable the plan to meet the requirements of section 411(b)(5).

King & Spalding would be glad to assist you in reviewing your plan for possible changes required by these rules.

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New Compensation Deduction Limit for Health Insurance Providers is Unexpectedly Broad

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The Patient Protection and Affordable Care Act included a little-discussed provision limiting the compensation deduction allowable for "health insurance providers." Significantly, the definition of "health insurance provider" under this provision is so broad that this limit likely will catch many companies by surprise. The new compensation deduction limit, which is codified in new Section 162(m)(6) of the Internal Revenue Code of 1986, as amended (the "Code"), generally limits the deduction allowable for compensation paid to a service provider by certain health insurance providers (and their related entities) to $500,000, effective for amounts deductible in tax years starting after December 31, 2012.

Background

Code Section 162(m), in general, limits the deduction allowed for compensation paid by a publicly-held corporation to a "covered employee" to $1 million. A "covered employee" is the CEO and four other most highly paid employees of the corporation with reportable (under the Securities Exchange Act of 1934) compensation. "Compensation" for purposes of this limit includes taxable wages but excludes commissions and other performance-based compensation.

There is also a $500,000 compensation deduction limit for compensation paid to "covered executives" by certain employers that participated in the Troubled-Asset Relief Program ("TARP"). "Covered executives" include the CEO, the CFO and the three other most highly-compensated employees of the employer. In addition, TARP limits the ability of these employers to pay or accrue bonuses, retention awards or executive compensation while any TARP obligation is outstanding.

Which Employers are Subject to the New Limit?

The new limit applies only to employers that are "covered health insurance providers." Code Section 162(m)(6) sets forth two different definitions of a "covered health insurance provider" for each of two different periods. (See Code Section 162(m)(6)(C))

For tax years starting after December 31, 2009, and before January 1, 2013, a "covered health insurance provider" is defined broadly as any employer that is a "health insurance issuer," such as an insurance company or HMO, that receives premiums from providing "health insurance coverage".

For tax years starting on or after January 1, 2013, a "covered health insurance provider" is defined more narrowly as an employer that is a "health insurance issuer" with respect to which not less than 25 percent of the premiums received by the employer from providing "health insurance coverage" is from the provision of the "minimum essential coverage" that individuals will have to maintain under the new health care reforms.

"Health insurance coverage" for both definitions means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer, but does not include the following supplemental or incidental-type benefits:

- Accident or disability income insurance,
- medical care coverage supplemental to liability insurance,
- liability insurance, including general liability insurance and automobile liability insurance,
- workers' compensation or similar insurance,
- automobile medical payment insurance,
- credit-only insurance,
- coverage for on-site medical clinics, and
- other similar benefits specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits

Notably, the following types of benefits qualify as "health insurance coverage" under the new rules, even if offered separately or as independent, non-coordinated benefits:

- Limited scope dental or vision benefits,

- benefits for long-term care, nursing home care, home health care or community-based care,
- coverage only for a specified disease or illness,
- hospital indemnity or other fixed indemnity insurance, and
- Medicare supplemental health insurance.

Unlike the general $1 million deduction limit under Code Section 162(m)(1), the new limit under Code Section 162(m)(6) is applicable to an employer without regard to whether it is publicly-traded. In addition, all compensation paid by any member of the controlled group must be aggregated to determine whether the $500,000 limit is exceeded.

What About Employers Related to a Covered Health Insurance Provider?

Code Section 162(m)(6) applies the Code Section 414 controlled group rules used for qualified retirement plans (other than the "brother-sister" and "combined group" rules) to make the new compensation deduction limit applicable to all members of a covered health care provider's controlled group. Thus, if any member of an employer's controlled group is a covered health care provider under these rules, the deduction limit will apply to that employer and every other member of that controlled group.

In addition, all compensation paid by any member of the controlled group must be aggregated to determine whether the $500,000 limit is exceeded.

How Does the Limit Apply?

Code Section 162(m)(6) will apply to both current and nonqualified deferred compensation. With respect to current compensation, Code Section 162(m)(6) provides that no income tax deduction will be allowed in the case of "applicable individual remuneration" in excess of $500,000 for any tax year beginning after December 31, 2012 in which an employer is a "covered health insurance provider" if such remuneration is attributable to services performed by an "applicable individual" during such tax year.

With respect to nonqualified deferred compensation, Code Section 162(m)(6) applies to compensation defined as "deferred deduction remuneration," which is remuneration relating to services an individual performs during any taxable year starting after December 31, 2009, in which the employer is a "covered health insurance provider," that is not deductible until a tax year starting after December 31, 2012, such as nonqualified deferred compensation. In the case of deferred deduction remuneration, the unused portion (if any) of the $500,000 limit for current compensation for the year is carried forward until the year in which the deferred compensation is otherwise deductible, and the remaining unused limit is then applied to the deferred compensation.

For example, assume that XYZ Corporation is a covered health insurance provider for 2013 and pays its valued employee Donna $400,000 in current compensation in 2013. In addition, Donna earns $200,000 in nonqualified deferred compensation in 2013, payable in 2015. Donna's $400,000 in current compensation is fully deductible in 2013 by XYZ Corporation since it is within the $500,000 limit for 2013. In 2015, when Donna's $200,000 in deferred compensation becomes payable, XYZ Corporation will only be able to deduct $100,000 of such deferred compensation, which represents the unused portion of the limit from 2013.

Note that any unused portion of the $500,000 deduction limit that is carried forward under these rules does not reduce the $500,000 limit for current compensation. Thus, if XYZ Corporation pays Donna $600,000 in current compensation in 2015, it would be able to deduct (in addition to the $100,000 in deferred compensation) $500,000 of Donna's current compensation.

What Compensation is Subject to the New Limit?

The new compensation deduction limit applies to "applicable individual remuneration," which essentially includes all current compensation, and unlike the $1 million deduction limit applicable to compensation paid by publicly-traded companies, there are no exceptions for commissions or performance-based compensation.

Which Service Providers are Subject to the New Limit?

The new compensation deduction limit applies to all "applicable individuals" with respect to a covered health insurance provider, which include any individual who is an officer, director, or employee or who provides services for, or on behalf of, the covered health insurance provider. Unlike the $1 million limit under Code Section 162(m)(1) and the $500,000 limit under TARP, which apply only to certain officers and highly-compensated employees, the new limit under Code Section 162(m)(6) applies to any service provider working for, or on behalf of, a covered health insurance provider. Moreover, if an individual is an "applicable individual" with respect to a covered health insurance provider for any taxable year, the individual is treated as an applicable individual for all subsequent taxable years (and is treated as an applicable individual for purposes of any subsequent taxable year for purposes of the special rule for deferred compensation).

King & Spalding would be pleased to assist you with understanding the implications of the new compensation deduction limit for health insurance providers under Code Section 162(m)(6).

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