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Highlights of the Month

- 1. IRS Releases Final Regulations on Benefit Plan Contribution Limits**
- 2. EBSA Requests Comments on Disclosure of Fee and Expense Information to Plan Participants**
- 3. GAO Issues Report that Recommends Improvements in EBSA's Enforcement Program**
- 4. HIPAA Deadline for Using National Provider Identifiers is May 23, 2007**
- 5. Recent Court Decision Highlights the Necessity of Properly Determining Health Plan Eligibility**
- 6. Promised Pension Contributions were not Plan Assets**
- 7. IRS Releases Updated Form for Reporting HSA and Archer MSA Information**

IRS Releases Final Regulations on Benefit Plan Contribution Limits

The Internal Revenue Service (IRS) issued final regulations on the maximum benefits and contributions available under tax qualified retirement plans. This was the first comprehensive set of regulations under Internal Revenue Code (Code) § 415 since 1981. The final regulations consolidated miscellaneous guidance and statutory changes that have been made in Code § 415 since 1981 when the last set of final regulations were issued.

The statutory changes made since 1981 that are reflected in the final regulations include:

- ❖ Changes made in statutory limits by the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA);
- ❖ Changes made to the age adjustments under defined benefit plans with respect to the dollar limitations for benefits that begin before age 62 or after age 65;
- ❖ Changes to the rules for benefit adjustments under defined benefit plans;
- ❖ Phase-in of the defined benefit plan dollar limit over 10 years of participation under Code § 415(b)(1)(A);



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- ❖ Addition of the limit of the maximum compensation, i.e., Code § 401(a)(17), that can be taken into account in determining plan benefits and interaction of this requirement with the other benefit and contribution limits;
- ❖ Exceptions to the compensation based limit for governmental and multiemployer plans;
- ❖ Changes regarding integration of multiemployer plans with single employer plans for purposes of applying the compensation based limit of Code § 415(b)(1)(B) to a single employer plan;
- ❖ Repeal of the combined limitation on contributions to defined benefit and defined contribution plans;
- ❖ Changes made in conjunction with EGTRRA's repeal of the exclusion allowance under Code § 403(b)(2);
- ❖ Current rounding and base period rules for annual cost of living adjustments under Code § 415(d), most recently amended by EGTRRA and Working Families Tax Relief Act of 2004;
- ❖ Changes under which certain types of arrangements, e.g., individual retirement accounts other than Simplified Employer Plans (SEPs), are no longer subject to the defined contribution limit, and other types of arrangements have become subject to those limits, e.g., certain individual medical accounts;
- ❖ Inclusion of salary reduction amounts, e.g., elective deferrals under Code §§ 401(k) and 125, in compensation for purposes of calculating the maximum limits under Code § 415;
- ❖ Modification of distributions with annuity starting dates in plan years beginning in 2004 and 2005 made by the Pension Funding Equity Act of 2004 with respect to the interest rate assumptions in Code § 415(b)(2)(E) for converting certain forms of benefits to an actuarially equivalent straight life annuity; and
- ❖ The following changes that were made by the Pension Protection Act of 2006 (PPA)
 - Changes to the interest rate assumptions in Code § 415(b)(2)(E) that are utilized in converting certain forms of benefits to an equivalent straight life annuity;
 - Elimination of the active participation requirement in determining a participant's high 3 years of service in Code § 415(b)(3);
 - Exemption from the Code § 415(b)(1)(B) compensation limit for certain benefits provided under a defined benefit plan maintained by certain churches; and
 - Expansion of the definition of "qualified participant" under Code § 415(b)(2)(H) to include certain participants in a defined benefit plan maintained by an Indian tribal government.



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The final Code § 415 regulations are effective for plan limitation years beginning after July 1, 2007. In the case of governmental plans, the regulations generally apply to limitation years that begin no more than 90 days after the close of the first regular session of the legislative body with authority to amend the plan that begins on or after July 1, 2007.

EBSA Requests Comments on Disclosure of Fee and Expense Information to Plan Participants

On April 25, 2007 EBSA requested public comments on issues relating to the ERISA rules that require disclosure of plan administrative and investment-related fee and expense information to participants and beneficiaries in participant directed account plans. (72 *Fed Reg.* 20457, 4/25/2007) The purpose of the Request for Information (RFI) is to solicit views, suggestions, and comments from plan participants, plan sponsors, plan service providers, and members of the financial community, as well as the general public, as to what extent rules should be adopted or modified, or other action taken, to ensure that participants and beneficiaries have the information they need to make informed decisions about the management of their individual accounts and the investment of their retirement savings.

Under ERISA § 404(c) plan fiduciaries are relieved of responsibility for investment decisions made by plan participants if certain conditions are met. This relief is conditioned on the plan participants and beneficiaries being provided and having access to specific information regarding their plan and the investment options offered. The regulations implementing this section of ERISA were issued in 1992. Significant changes have been made in what and how information is communicated to plan participants and investors generally since 1992. Therefore, the RFI issued seeks information on what changes, if any, should be made to the existing regulations.

EBSA has requested comments on the following questions:

Disclosure of Information Relating to Plan Investment Options

1. What basic information do participants need to evaluate investment options under their plans? EBSA has requested that commenters include an explanation if in their view that information varies depending on the nature or type of the investment option.
2. What specific information do participants need to evaluate the fees and expenses (such as investment management and 12b-1 fees, surrender



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charges, market value adjustments, etc.) attendant to investment options under their plans? Once again EBSA has requested that the commenters include an explanation if the information varies depending on the nature or type of option and the particular fee arrangement relating to the options.

3. To what extent is the information participants need to evaluate investment options and the attendant fees and expenses not being currently furnished or made available to them? Who should be responsible for furnishing or making available such information? What, if any, additional burdens and/or costs would be imposed on plan sponsors or plans for such disclosures?
4. Should there be a requirement that information relating to investment options under a plan (including the attendant fees and expenses) be provided to participants in a summary and/or uniform fashion? Such a requirement might provide that:
 - All investment options available under a participant-directed individual account plan must disclose information to participants in a form similar to the profile prospectus utilized by registered investment companies; or
 - Plan fiduciaries must prepare a summary of all fees paid out of plan assets directly or indirectly by participants and/or prepare annually a single document setting forth the expense ratios of all investment options under the plan.

Who should be responsible for preparing the documents? Who should bear the cost of preparing the documents? What are the burden/cost implications for plans of making any recommended changes?

5. How is information concerning investment options, including information relating to investment fees and expenses, communicated to plan participants, and how often? Does the information or the frequency with which the information is furnished depend on whether the plan is intended to be an ERISA § 404(c) plan?
6. How does the availability of information on the internet pertaining to specific plan investment options, including information relating to investment fees and expenses, affect the need to furnish information to participants in paper form or electronically?
7. What changes, if any, should be made to Labor Reg. § 2550.404c-1 to improve information required to be furnished or made available to plan participants and beneficiaries, and/or improve likelihood of compliance with the disclosure or other requirements of Labor Reg. § 2550.404c-1? What are the burden/cost implications for plans of making any recommended changes?



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8. To what extent should participant-directed individual account plans be required to provide or promote investment education for participants? For example, should plans be required or encouraged to provide:
 - A primer or glossary of investment-related terms relevant to a plan's investment options, e.g., basis point, expense ratio, benchmark, redemption fee, deferred sales charge;
 - A copy of EBSA's booklet entitled "A Look at 401(k) Fees" (http://www.dol.gov/ebsa/publications/401k_employee.html), or
 - Investment research services? Should such a publication include an explanation of other investment concepts such as risk and return characteristics of available investment options? EBSA requested that commenters explain their views in addition to addressing costs and other issues relevant to adopting such a requirement.

Disclosure of Information Relating to Plan and Individual Account Administrative Fees and Expenses

9. What information is currently furnished to participants about the plan and/or individual administrative expenses charged to their individual account? Such expenses may include audit fees, legal fees, trustee fees, recordkeeping expenses, individual participant transaction fees, participant loan fees, or expenses.
10. What information about administrative expenses would help plan participants, but is not currently disclosed? EBSA asks that commenters explain the nature and usefulness of such information.
11. How are charges against an individual account for administrative expenses typically communicated to participants? Is such information included as part of a participant's individual account statement or furnished separately? If separately, is the information communicated via paper statements, electronically, or via website access?
12. How frequently is information concerning administrative expenses charged to a participant's account communicated?
13. What, if any, requirements should EBSA impose to improve the disclosure of administrative expenses to plan participants? Please be specific as to any recommendation and include estimates of any new compliance costs that may be imposed on plans or plan sponsors.
14. Should charges for administrative expenses be disclosed as part of the periodic benefit statement required under ERISA § 105?



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General Questions

15. What, if any, distinctions should be considered in assessing the informational needs of participants in plans that intend to meet the requirements of ERISA § 404(c) as contrasted with those of participants in plans that do not intend to meet the requirements of ERISA § 404(c)?
16. What (and what portion of) plan administrative and investment-related fees and expenses typically are paid by sponsors of participant-directed individual account plans? How and when is the information typically communicated to participants?
17. How would providing additional fee and expense information to participants affect the choices or conduct of plan sponsors and administrators, and/or that of vendors of plan products and services? EBSA requests that commenters explain any such effects.
18. How would providing additional fee and expense information to participants affect their plan investment choices, plan savings conduct, or other plan related behavior? EBSA requests that commenters explain any such effects and provide specific examples, if available.
19. EBSA asks that commenters identify any particularly cost-efficient (high-value but inexpensive) fee and expenses disclosures to participants, and to the contrary any particularly cost-inefficient ones. Any available estimates of the dollar costs or benefits of such disclosures should be provided.

Responses must be submitted to EBSA on or before July 24, 2007. Written paper responses (at least 3 copies) should be sent to:

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5669
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210
Attention: Fee Disclosure RFI

In the alternative comments can be submitted via email to: e-ORI@dol.gov or by using the Federal eRulemaking portal at <http://www.regulations.gov> (follow instructions for submission of comments).



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GAO Issues Report that Recommends Improvements in EBSA's Enforcement Program

The Government Accountability Office (GAO) issued a report entitled “Employee Benefits Security Administration: Enforcement Improvements Made but Additional Actions Could Further Enhance Pension Plan Oversight.” In this report the GAO recommended that EBSA:

- ❖ Evaluate its enforcement strategy in light of other agencies strategies;
- ❖ Determine how ERISA's filing deadlines affect its investigators;
- ❖ Increase coordination with the Securities and Exchange Commission (SEC); and
- ❖ Consider how attrition affects its operations.

GAO also recommended that Congress consider amending ERISA § 502(l) to give the U.S. Department of Labor (DOL) greater discretion to waive the civil penalty.

The only GAO recommendation that EBSA disagreed with was the recommendation to evaluate its enforcement strategy in light of other agencies. GAO stated that EBSA does not conduct routine compliance examinations and broad, ongoing risk assessments to focus its enforcement efforts like other agencies. Rather EBSA relies on various sources for case leads, e.g., participant complaints, agency referrals, and computer targeting. In GAO's view this method of case generation limits EBSA to leads discerned by plan participants and other governmental agencies or those disclosed by plan sponsors but not the more complex or hidden issues. GAO also faulted EBSA for not establishing a comprehensive risk assessment function. GAO contrasted EBSA's risk assessment activities with those of the IRS, SEC and Pension Benefit Guaranty Corporation (PBGC). GAO stated that the IRS and the SEC have dedicated compliance examination programs designed to regularly inspect a company's operations and financial records for violations and emerging trends that may warrant further review by enforcement staff. Additionally, GAO stated that SEC and PBGC have dedicated staff to regularly analyze information from various sources, e.g., investigations and academic research, in order to assess risk within the securities and pension industries in an attempt to better focus agency resources on areas of greatest risk.

HIPAA Deadline for Using National Plan Identifier is May 23, 2007

The Health Insurance Portability and Accountability Act (HIPAA) requires health plans to use a National Provider Identifier (NPI) when conducting certain HIPAA electronic data interchange (EDI) transactions beginning May 23, 2007. These rules do not apply to



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small health plans. The NPI will replace legacy identifiers, not the provider's taxpayer identification number (TIN) which is also required on claims transactions.

Concern about the readiness of the healthcare industry led the Centers for Medicare and Medicaid Services (CMS) to issue enforcement guidance on April 2, 2007. The CMS guidance gives health plan sponsors the green light to adopt NPI compliance contingency plans, if certain circumstances are present. Under such a contingency plan, a health plan could process non-compliant claims for 12 months, i.e., May 23, 2008, if it is necessary to ensure a smooth flow of payments.

The guidance makes clear that the health plans must have made and continue to make good faith efforts to comply with the NPI requirement. The guidance makes it clear that it is not an extension of the deadline but rather flexibility in how CMS will enforce the law in the event that a complaint is filed with CMS. Specifically, plans must be able to demonstrate that they made diligent and reasonable efforts to become compliant (including active outreach and testing with trading partners) before the deadline and that they continued to do so during the time the contingency plan was deployed in order to avoid the imposition of penalties for non-compliance.

It is critical for health plans to document their compliance efforts both before and after May 23, 2007. Such documentation is the only way to demonstrate good faith compliance. Some steps that would document good faith include:

- ❖ Evidence of planning with information technology staff to accept NPIs and phase out legacy identifiers.
- ❖ Conduct outreach to the provider community, such as letters to providers or information about NPIs on the plan's web site.
- ❖ Increase external testing of NPIs with health care providers.

If you adopted a similar contingency plan in 2003 prior to the compliance date of October 16, 2003 for the EDI transactions, you will be familiar with this process.

Recent Court Decision Highlights the Necessity of Properly Determining Health Plan Eligibility

A case recently decided by the U.S. District Court for North Carolina highlights the importance of correctly determining eligibility for an employer's health plan. In *Carolina Care Plan, Inc. v. Auddie Brown Auto Sales of Florence, Inc.* [2007 U.S. Dist. Lexis 24962 (D.N.C. 2007)] the HMO provided benefits to an employee who was not



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eligible at the time the expenses were incurred. When it was discovered that the employee had been terminated prior to the time the claims were incurred and, therefore, ineligible for benefits, the HMO sued the employer to recover the \$650,000 that was erroneously paid for the terminated employee's claims.

Under the terms of the contract between the HMO and the employer, the employer was responsible for certifying the correctness of plan eligibility. The employee terminated employment but the employer continued to pay premiums for her coverage. The HMO sued the employer in state court to recover the claims that had been paid to the ineligible participant. The employer moved the case to federal court on the grounds that ERISA controlled the lawsuit. The U.S. District Court held that the HMO did not have standing to sue. This decision was based on the fact that the HMO was not a fiduciary with respect to certifying eligibility status for the purpose of paying claims. The district court sent the case back to state court for final resolution.

While the thrust of this case is the jurisdictional issue, it does highlight the importance of properly tracking and certifying the eligibility of participants and their beneficiaries in health plans. This case dealt with a fully insured plan but the same issues can arise in a self-funded plan with a stop loss policy. In the self insured plan, the excess loss insurer could deny a claim for an ineligible participant and/or dependent and seek recovery of improperly paid claims from the employer. This case shows the necessity of periodically conducting eligibility audits for the employer's health plans to ensure that only eligible participants and beneficiaries are being covered by the health plans.

Promised Pension Contributions were not Plan Assets

The 8th Circuit recently held an employer did not engage in fiduciary breach when it did not make up promised plan contributions. (*Kalda v. Sioux Valley Physician Partners Inc.* (2007, CA8) 2007 WL 925245) In this case the employer had amended its money purchase pension plan to suspend contributions during a period of financial crisis. During the period of the financial crisis, the employer continued to prepare balance sheets that tracked the amount of contributions that would have been made to the money purchase plan from 1998 to 2001.

Background. Central Plains Clinic Ltd. (CPC) sponsored a profit sharing plan and a money purchase plan. The profit sharing plan provided for discretionary contributions. However, the money purchase plan provided that 25% of each participant's compensation would be contributed on an annual basis. When CPC began having financial difficulties in 1998, it adopted an amendment to the money purchase plan which provided that CPC would contribute 0% of each participant's compensation to the money purchase plan.



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In 2000, CPC began discussions with Sioux Valley Physician Partners, Inc. (SVC) and Avera McKenna Hospital (Avera) regarding a sale or merger of the businesses. SVC offered retention bonuses to CPC employees who transferred to SVC in amounts equal to the amounts that would have been contributed to the CPC money purchase plan if not for the 0% amendment. Avera promised to pay the CPC employees “all pension contributions” not made during the two years prior to the proposed merger. CPC approved the merger with SVC in 2001. However, prior to approval of the SVC merger, the CPC employees resigned from CPC.

The former CPC employees sued SVC (as successor employer) alleging that CPC had breached its fiduciary duties under ERISA by not making contributions to the money purchase and profit sharing plans after the merger. The district court rejected the former CPC employee claims and they appealed to the 8th Circuit.

Analysis. The 8th Circuit rejected the CPC employee claims that CPC had “unequivocally promised” that once the company became financially stable it would fund the plans in the amount that would have been contributed to the money purchase plan absent the 1998 amendment which reduced the contribution to zero. In rejecting the employee claims, the 8th Circuit stated that CPC had not promised that it would re-fund either plan upon the occurrence [of] a merger or other event. Moreover, CPC had no reason to know that the employees were laboring under a misunderstanding that would have triggered the duty to inform, since several plaintiffs testified that they had assumed CPC’s statements were promises to fund the plans.

The 8th Circuit also rejected the employees’ claims that CPC had breached its fiduciary duties in merging with SVC because it failed to adequately consider Avera’s proposal which included a make-up of missed pension contributions for the 2 year period prior to the merger. The court stated that the decision to merge with SVC and not Avera were business decisions made by CPC that were outside the scope of ERISA’s fiduciary duties.

Finally, the 8th Circuit rejected the employees’ claims that CPC had bargained away the money purchase and profit sharing contributions that had been tracked in its balance sheets since the 1998 amendment. CPC had chosen to track the amount of contributions that would have been due the plans if the 1998 amendment had not been made to the money purchase plan. The court noted that the DOL regulations defining plan assets refer to “ordinary notions of property rights.” The court stated that unpaid pension contributions were merely ledger entries with the possibility of future repayment which did not give the plans a beneficial interest in the unpaid contributions under ordinary notions of property rights. Therefore, the unpaid contributions in CPC’s balance sheets were not plan assets within the meaning of ERISA.



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IRS Releases Updated Form for Reporting HSA and Archer MSA Information

The IRS has released a revised version of Form 5498-SA for the 2007 tax year. In addition, it has released a revised version of the instructions for Form 5498-SA and 1099-SA to reflect changes that were made by the Tax Relief and Health Care Act of 2006 (TRHCA). These revised forms must be used for contributions that are made in 2007 but reported in 2008.

TRHCA permits two new types of contributions to HSAs. These new contributions are:

- ❖ “Qualified HSA distributions” which are direct rollover contributions made to HSAs from health flexible spending accounts (FSAs) and health reimbursement accounts (HRAs). And
- ❖ “Qualified HSA funding distributions” which are direct trustee-to-trustee transfers made into HSAs from IRAs.

The updated version of Form 5498-SA and its instructions indicate that qualified HSA distributions from health FSAs or HRAs that are contributed to HSAs for 2007 must be reported in Box 4 (Rollover Contributions) and that qualified HSA funding distributions from IRAs that are contributed to HSAs for 2007 must be reported in Box 2 (Total Contributions made in 2007). TRHCA did not affect the previously issued 2007 version of Form 1099-SA, which is used to report distributions from HSAs.