

Legal Alert: Pension Protection Act of 2006 and Other Recent Changes to Health and Welfare Benefits

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While the [Pension Protection Act](#) is primarily focused on retirement plan issues, it includes several provisions intended to facilitate funding for current or future medical costs, either through transfers of excess pension assets to subsidize medical benefits or through expanded availability of other tax-efficient vehicles. This summary includes brief discussions of those changes, as well as changes in the Act and in [final](#) and [proposed regulations](#) to ERISA reporting and disclosure rules that affect welfare plans, and [final Treasury regulations](#) regarding employer contributions to health savings account (“HSAs”). Further explanation of the Act is provided in the [technical explanation](#) published by the staff of the Joint Committee on Taxation.

Transfer of Excess Pension Assets

Prior law permits a single-employer defined benefit plan to transfer excess assets once a year to separate retiree medical accounts provided under the plan, without adverse tax consequences, *i.e.*, without plan disqualification or a prohibited transaction or reversion excise tax. In general, excess assets are defined as the excess over the greater of the accrued liability or 125% of current liability under the plan. The amount transferred may not exceed the expected cost of retiree medical benefits for the year of the transfer. The availability of such a transfer is subject to a number of conditions, including that pension benefits under the plan are 100% vested and, generally, that the plan sponsor maintains retiree medical benefits at the same level for the year of the transfer and the next four succeeding years. The Act expands the scope of this provision in several respects, subject to its scheduled sunset on December 31, 2013.

- ***Multiemployer collectively bargained plans*** are permitted to make annual transfers to ***fund one year of retiree medical costs***. For purposes of this provision, all employers contributing to the plan are treated as a single employer, subject to rules to be prescribed by the Treasury Department adjusting for the multiplicity of plan sponsors. The expanded funding allowed single-employer plans under the Act (described below) is not extended to multiemployer plans.
 - ***Effective date:*** Transfers in tax years beginning after 2006.

- **Single-employer defined benefit plans** are provided an alternative of transferring excess assets to fund **from 2 to 10 years of estimated retiree medical costs** – a “qualified future transfer.” Under this alternative, excess assets are those in excess of the greater of accrued liability or 120% of current liabilities (with adjustments starting in 2007 to reflect the transformation of the funding rules for single-employer plans under the Act).
 - This decrease in the minimum level of funding required may mean that a qualified future transfer will be allowed in years when a current-year transfer is not allowed.
 - Beginning in 2008, however, a plan that elects to maintain a credit balance must reduce its assets by the credit balance before determining that it has excess assets, which may make it more difficult to attain the 120% minimum funding level.
- A plan that makes a qualified future transfer must maintain funding at least at the minimum level for the period for which retiree medical benefits are being provided through the transfer; if the plan’s funding falls below that minimum, the shortfall must be made up through additional employer contributions or a transfer back from the retiree medical accounts. During the year of the transfer and the four subsequent years, the plan sponsor’s average annual cost for retiree medical benefits must at least equal the cost assumed in determining the transfer. Otherwise, the rules and conditions for one-year transfers generally apply to qualified future transfers.
 - **Effective date:** Transfers after the date of enactment. The Treasury Department is to publish guidance with respect estimating the cost of future retiree medical liabilities.
- **Single-employer defined benefit plans** are also allowed to make transfers for retiree medical benefits provided pursuant to a collective bargaining agreement. These **collectively bargained transfers** are generally subject to the same rules as qualified future transfers, with the following modifications:
 - Collectively bargained transfers can be made only if (1) for the employer’s tax year ending in 2005, medical benefits were provided to retirees (and spouses and dependents) under all the employer’s benefit plans and (2) the aggregate cost of the retiree

medical benefits for that tax year is at least 5% of the employer's gross receipts for the year.

- In advance of the transfer, the employer designates in writing to each union that is party to the CBA that the transfer is a collectively bargained transfer.
- The cost that may be funded is the present value, as of the beginning of the tax year, of the amount the employer would otherwise pay for all collectively bargained retiree health benefits (including administrative expense) for that tax year and all subsequent tax years during the “collectively bargained cost maintenance period,” for retired and active plan participants and their spouses and dependents (other than certain key employees) entitled to retiree medical benefits under the CBA, less the value of assets in all health benefit accounts or welfare plans set aside to pay for those liabilities.
- The assets transferred may be used to pay benefits during the year of transfer and any other years in the collectively bargained cost maintenance period, which is the shorter of the remaining lifetime of or the period of coverage provided under the collectively bargained health plan for the covered retiree (and any covered spouse and dependents).
- Retiree medical benefits must be provided at the level determined under the CBA for the collectively bargained cost maintenance period.
- Special deduction rules and other rules for employer contributions towards the retiree benefits are provided.
- ***Effective date:*** Transfers after the date of enactment, although again the contemplation is that Treasury guidance will be provided to elucidate elements of the provision and to prevent duplicative tax benefits for the employer.

Transfers for Retired Public Safety Officers from Governmental Plans

The Act permits a public safety officer – a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew who worked for a public agency – who has retired as a public safety officer and attained normal retirement age, or is disabled, to direct up to \$3,000 annually from a governmental 401(a), 403(b) or 457 plan on a tax-free basis to pay the premiums on health or long-term care insurance. This provision does not permit a reimbursement arrangement; the insurance premiums must be deducted from plan distributions and paid directly to the insurer.

- **Effective date:** Tax years beginning after December 31, 2006.

Association Health Plans

The Act specifically provides for a deduction under Internal Revenue Code section 419A to fund a reserve for medical benefits (other than retiree medical benefits) for future years provided through a bona fide association as defined in the Public Health Service Act. These associations – generally, trade associations – establish self-funded plans that provide benefits to employees of members without regard to health status. The applicable section 419A account limit is 35% of the sum of (1) qualified direct costs for the tax year, and (2) the change in claims incurred but not paid for the tax year with respect to medical benefits other than post-retirement medical benefits.

- **Effective date:** Tax years ending after December 31, 2006.

Reporting and Disclosure

The Act requires that all employee plans subject to the ERISA reporting and disclosure requirements, including welfare plans, file basic and identifying information regarding the plan electronically with the Labor Department. The information is also to be displayed on the employer's Intranet site pursuant to DOL regulations.

- **Effective date:** Plan years beginning after 2007.

The Labor Department has issued final regulations that require electronic filing for plan years beginning after 2008; thus, the Act accelerates this requirement by a year. The Labor Department has also proposed a number of changes to the Form 5500 filing requirements, some of which affect welfare plans. Among the more significant changes proposed are revisions to the Schedule C disclosure on service providers required to be attached to Form 5500 for a large pension or welfare plan. Previously, disclosure was required only for service providers who

were paid by the plan. The DOL has proposed that the disclosure include information on all service providers receiving \$5,000 or more, directly or indirectly, for services to a plan for any applicable year, with limited exceptions. The proposed changes would also make certain revisions to Schedule A, Insurance Information, to clarify the extent of fee and commission disclosure required and would make available a new Form 5500-SF for plans covering fewer than 100 participants (if not otherwise exempt from filing) that meet certain conditions.

- **Effective date:** The year the electronic filing requirement is implemented.

Qualified Long-Term Care Coverage

The new legislation makes certain changes—which are for the most part liberalizing—to the treatment of qualified long-term care insurance contracts that are part of, or attached as riders to, life insurance and annuity contracts. The provisions of the new legislation include the following:

- **Qualified long-term care insurance contracts**, as defined in section 7702B(b) of the Internal Revenue Code, can be part of, or attached as riders to, *both* life insurance contracts and annuity contracts. Under prior law, there was no provision allowing qualified long-term care insurance to be part of, or attached as riders to, annuity contracts.
 - **Effective date:** Applies to contracts issued after 1996 with respect to taxable years beginning after 2009.
- Under section 72(e), as amended by the new legislation, charges for qualified long-term care insurance contracts that are part of, or attached as riders to, life insurance and annuity contracts, if subtracted from the cash value of the base contract, are not includible in income. Under prior law, such charges were treated as taxable distributions. Thus, **qualified long-term care insurance can be paid for out of the cash value of life insurance and annuity contracts on a before tax basis**. However, the **investment in the contract** is reduced (but not below zero) by the amount of such charges, resulting in the potential for current taxation of a larger portion of subsequent distributions from the contract.
 - **Effective date:** Applies to contracts issued after 1996 with respect to taxable years beginning after 2009.
- If charges for qualified long-term care insurance contracts that are part of, or attached as riders to, life insurance contracts designed to satisfy the **guideline premium limitation** of section 7702(c) are imposed against the base life insurance

contract's cash value and are not includible in income, such charges reduce the premiums paid under section 7702(f)(1), for purposes of the guideline premium limitation, thereby subsequently allowing additional premiums equal to the amount of such charges to be paid into the life insurance contract without violating the guideline premium limitation.

- **Effective date:** Applies to contracts issued after 1996 with respect to taxable years beginning after 2009.
- In addition, charges for qualified long-term care insurance contracts that are part of, or attached as riders to, life insurance contracts or annuity contracts cannot be deducted under section 213(a) if subtracted from the cash value of the base contract.
 - **Effective date:** Applies to contracts issued after 1996 with respect to taxable years beginning after 2009.
- **Exchanges** of life insurance contracts, endowment contracts, annuity contracts and qualified long-term care insurance contracts for qualified long-term care insurance contracts are eligible to be treated as tax-free exchanges under section 1035(a), and qualified long-term care insurance contracts that are part of, or attached as riders to, life insurance and annuity contracts do not disqualify such life insurance and annuity contracts from eligibility for such tax-free exchanges.
 - **Effective date:** Applies to exchanges occurring after 2009.
- Charges for qualified long-term care insurance contracts against the cash value of the base contract are subject to **new information reporting requirements** specific to long-term care insurance.
 - **Effective date:** Applies to charges made after 2009.
- The proxy “tax” under section 848 of the Internal Revenue Code for life insurance company **deferred acquisition costs** (“DAC”) (*i.e.*, the disallowance as a current deduction, and the capitalization and amortization over 10 years, of a portion of an insurance company’s general expenses based on the amount of premiums it collects) is the highest rate, namely, 7.7% of premiums, for life insurance and annuity contracts with qualified long-term care insurance contracts attached. Lower rates of 2.05% and 1.75% continue to apply to annuity contracts and group

life insurance contracts, respectively, without long-term care insurance contracts attached.

- **Effective date:** Applies for taxable years beginning after 2009.

Comparable Employer Contributions to HSAs

On July 31, the Treasury Department issued final regulations describing the rules that must be met for employer contributions to eligible employees' health savings accounts (HSAs) to be treated as "comparable." Under Internal Revenue Code section 4980G, if an employer makes contributions to employees' HSAs that are not comparable – other than contributions through a cafeteria plan – the employer is subject to an excise tax. The regulations are effective upon publication but apply to contributions made on or after January 1, 2007. In the interim, employers may rely on the proposed regulations published in August 2005 or the related guidance in IRS Notice 2004-2 and 2004-50.

The final regulations largely follow the proposed rules, and this summary primarily highlights the differences between the final rules and the proposed regulations. As under the proposed rules, the final regulations require that employers electing to contribute to their employees' HSAs make comparable contributions for all employees who (1) are eligible individuals enrolled in a high deductible health plan ("HDHP"), (2) are in the same category of employment and (3) have the same category of coverage. Generally, the three employment categories are:

- Current full-time employees
- Current part-time employees
- Former employees (excluding individuals on COBRA coverage).

In an important change, the final rules provide that *collectively bargained employees* covered by a bona fide collective bargaining agreement **need not be treated as comparable participating employees if** health benefits for those employees were the subject of collective bargaining. Similarly, former employees covered by a collective bargaining agreement are not comparable participating employees.

The proposed regulations provided for only two categories of coverage – self only and family. At least for certain purposes, the final regulations **expand the categories of coverage** to:

- Self-only coverage
- Self plus one
- Self plus two

- Self plus three or more.

To be considered comparable, an employer's contributions to an HSA for any eligible employee who is in the same category of employment and has the same category of coverage must be the same dollar amount or the same percentage of the HDHP deductible for other eligible employees in that category of employment and who have that same category of coverage. Generally each category of employment and coverage is tested separately for comparability, allowing the employer to differentiate among the categories in any manner. However, the final regulations add a requirement that the *contributions for the self plus two category may not be less than for the self plus one category*, and the *contributions for the self plus three or more category cannot be less than those for the self plus two category*. These rules and the related examples indicate that an employer could contribute only for employees with self only coverage and not contribute for any employees with any type of family coverage, but that if the employer chooses to contribute for employees with any type of family coverage the employer must contribute for employees in the same category of employment who have any of the three categories of family coverage.

Generally the rules for determining eligible individuals and the category of employment applicable to an individual are the same in the final regulations as in the proposed rules. Like the proposed regulations, the final rules *do not define when an individual will be treated as a former employee*. As a result, it is unclear which rules must be applied to determine whether individuals on, *e.g.*, certain types of leave, salary continuation or disability are current or former employees. The final regulations clarify that *if an employer contributes for former employees it must make reasonable efforts to locate missing former employees*, which include use of certified mail, the IRS letter forwarding program and the Social Security Administration letter forwarding program.

The final rules for timing of contributions are also generally the same as the proposed rules. The comparability rules apply, and compliance is tested, based on the entire calendar year. However, an employee's eligibility to make HSA contributions is determined as of the first day of each month, and an employer may only make contributions for eligible individuals. To coordinate these requirements, there are *three methods for the timing of contributions that will satisfy the comparability rules: (1) pay-as-you go, (2) look-back, and (3) pre-funding*.

If employees are required to establish their own HSAs, as will usually be the case, an employer is not obligated to contribute for an employee who has not yet established an HSA at the time the employer funds the accounts. The employer is required to make up any missed contributions when the employee eventually establishes an HSA, and the final regulations add a requirement that *the employer also contribute an amount to make up for lost interest on the contributions being made up*. Interest must be credited at a reasonable rate, and the Federal

short-term rate is deemed reasonable. The final regulations removed a rule that provided an employer would not be required to make up contributions for any year if the eligible individual did not establish an HSA by December 31 of the relevant year and reserved with respect to this rule.

As noted above, the comparability rules do not apply to contributions made through a cafeteria plan. The final regulations say contributions are made through a cafeteria plan “if under the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of *all or a portion* of an HSA contribution (meaning that *all or a portion* of the HSA contributions are *available as pre-tax salary reduction* amounts) regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction.” Examples in the regulations clarify that if the employer makes, *e.g.*, automatic contributions or matching contributions to employees’ HSAs that are *not available* to employees as cash or non-taxable benefits, the employer contributions *are treated as being made through a cafeteria plan*, as long as employees are also eligible to make salary reduction contributions to the HSAs.



Please contact any of the following members of our Employee Benefits and Executive Compensation practice if you have any questions regarding this development:

George H. Bostick	202.383.0127	george.bostick@sablaw.com
Daniel M. Buchner	202.383.0869	daniel.buchner@sablaw.com
Adam B. Cohen	202.383.0167	adam.cohen@sablaw.com
Ian A. Herbert	202.383.0644	ian.herbert@sablaw.com
Alice Murtos	404.853.8410	alice.murtos@sablaw.com
Robert J. Neis	404.853.8270	robert.neis@sablaw.com
W. Mark Smith	202.383.0221	mark.smith@sablaw.com
William J. Walderman	202.383.0243	william.walderman@sablaw.com
Carol A. Weiser	202.383.0728	carol.weiser@sablaw.com