June 2011

MERCER

Legal & Regulatory Update

Important information about legislative, regulatory and compliance developments that affect the administration of your employee benefit plans

IN THIS ISSUE

Breaking News

Proposed Extension for Participant Fee Disclosure

Under a proposal from the Department of Labor (DOL), the required compliance deadline for providing new fee disclosures to defined contribution plan participants would generally be extended four months. For example, disclosures for a calendar year plan are extended to April 30, 2012. For practical purposes, these additional four months provide more time in which to ensure compliance with the new rules.

As we have been reporting, late last year the DOL issued new regulations requiring sponsors of defined contribution plans to provide new disclosures to participants regarding plan expenses and plan investments. The newly required disclosures comprise a comprehensive notice describing plan fees and including a detailed chart comparing the plan's investments – required to be provided to all participants before they are eligible to direct their investments and annually thereafter – and quarterly reporting of actual fees charged to participant accounts.

The effective dates of the rules as currently written are somewhat confusing. For calendar year plans, sponsors would have until February 29, 2012, to send the initial notice to participants who are eligible to participate in the plan as of January 1, 2012. For participants who become eligible between January 1 and February 29, the rules appeared to require the notice to be provided sooner, i.e., before the date these participants are eligible to direct investments in the plan. Effectively, this meant plan sponsors would have needed to comply with the new notice requirement as early as January 1, 2012 (for calendar year plans).

The DOL proposal clarifies the effective date rules and extends the date for delivery of the initial notice to all eligible participants to April 30, 2012. The proposal makes clear that the quarterly reporting requirement applies to the first quarter statement of 2012. While this extension is currently in the form of a proposal, it is viewed as likely to be finalized in at least as favorable a form as the proposal.

Under the proposal, the provider-to-plan-sponsor fee disclosures under new ERISA Section 408(b)(2) regulations would be due by January 1, 2012, as previously announced by the DOL. These regulations, which were issued in "interim form," have not been finalized as of the mailing of this *Update*.

Breaking News

Supreme Court Decides Case Concerning Remedies for a Misstated Summary Plan Description (SPD)

The Supreme Court recently issued a long-awaited decision in the case of *Cigna v. Amara* concerning what remedies participants may claim when they receive a summary plan description and other plan communications that inaccurately describe their retirement benefit. It was anticipated that in this decision the Supreme Court would articulate the standards for what harm a participant needed to show in order to prevail and what types of damages would be available. Prior Supreme Court opinions as well as cases in the lower federal courts generally indicated a high barrier for participants to receive money damages in the case of misstatements about plan terms.

As it turns out, the case provides little additional certainty on this important legal issue and seemingly may invite further participant claims. As in prior decisions, the current decision reinforced that, for participants to succeed in these cases, they need to show they would be entitled to damages under the rules of "equity," a particular branch of common law founded on very specific and complicated legal principles. In the past, the application of these principles had presented the greatest barrier to participants recovering money damages. In this decision, the Court suggests that there may be legal theories in "equity" that allow money damages and that other courts have not necessarily considered or applied them. However, the Court refrains from spelling out guidelines for applying other theories of "equitable remedies." In essence, the Court seems to have opened the courthouse door wider to participant claims based on misstatements, but without providing clear instruction on how courts should decide them.

One significant legal issue the Supreme Court did settle once and for all with this decision is whether an SPD should be treated as a plan document and override the terms of the plan when the SPD contradicts the plan. The Court made extremely clear that a summary plan description does not constitute a plan document and, therefore, a participant may not sue for benefits simply on the basis of a misstated SPD as if it were the plan. Instead, the participant must make a claim on the basis of an "equitable remedy," which, even under a more expanded view of these remedies, would be a more difficult route than a suit for benefits under the plan.

SAS 70 Transition to SSAE 16

New Service Organization Reporting Standards

During 2010, the Auditing Standards Board of the American Institute of Certified Public Accountants (AICPA) issued Statement on Standards for Attestation Engagements (SSAE) No. 16, *Reporting on Controls at a Service Organization*, (SSAE 16), which replaces Statement on Auditing Standards (SAS) No. 70, *Service Organizations*, as the new service organization reporting standard effective June 15, 2011. The following information explains how these changes will affect our service organization reports in the future.

Background

A report prepared in accordance with SAS 70 is intended to provide you and your auditors with information on the design and operating effectiveness of our controls that are likely to be relevant to your system of internal control. It is intended to help you and your auditors to plan and perform relevant assessments and audits, including the requirements of the Sarbanes-Oxley Act and PCAOB Auditing Standard No. 5 (AS 5). SSAE 16 supersedes SAS 70 and provides new guidance to auditing firms in response to changes in global assurance standards and corporate governance and control.

Similarities

Mercer's future service organization reports will be prepared in accordance with SSAE 16 and will look very similar to the reports you receive today. Mercer's SSAE 16 reports will continue to contain the service auditor's opinion, a description of the systems and processes, a section describing the control objectives and controls, and the service auditor's tests of operating effectiveness and results of those tests. You and your auditor will be able to continue using Mercer's service organization reports in the same way you always have; however, as you prepare to review the new reports, there will be some differences from the SAS 70 service organization reports.

Key Changes

Written Assertion: A key difference will be the inclusion of management's written assertion, which will be located between the service auditor's opinion and Mercer's system description. The management of the service organization will be required to prepare a written assertion about the description and operation of our system.

System Description: The existing standard, SAS 70, required the service organization to provide a "description of controls." Under SSAE 16, Mercer will be responsible for providing a "description of the system" as designed and implemented. While the term "system" has many different definitions, a common and useful definition is "the procedures, people, software, data and infrastructure organized to achieve a specific objective." Mercer's revised system description will closely resemble the existing description of controls when we adopt SSAE 16.

Service Auditor's Opinion: The actual wording of our service auditor's opinion will also change when we adopt SSAE 16. While our service auditor will still provide their opinion on the fairness of our description and the operating effectiveness of our controls, it will use new language regarding management's assertion that has been established by the AICPA. This new language should make the auditor's opinion easier to understand and use.

Preparing for SSAE 16

Mercer is working closely with our service auditor to facilitate a seamless transition to SSAE 16. We are actively preparing our organization for the required changes and expect to be fully compliant with the new standards by the effective date.

Health Plan Administration after the First Wave of Health Care Reform

Since the enactment of the **Patient Protection and Affordable Care Act** (PPACA) just over a year ago, there has been considerable regulatory activity, with the agencies charged with overseeing health care reform issuing the guidance necessary to implement the first of the health care reform changes. More changes are likely as interim final regulations are finalized and new regulations and guidance are issued. Even as the foundation of health care reform – including individual mandates, state exchanges, automatic enrollment and shared employer responsibility, which all become effective in 2014 – is being challenged in the courts, Congress and state legislatures, the Washington regulators continue developing guidance and working toward implementing the 2014 changes. States, which are charged by PPACA with developing exchanges to allow individuals to purchase coverage, continue working toward developing a design and infrastructure for these exchanges. Employers as well continue moving forward with their plans for meeting the 2014 requirements.

Court challenges. The constitutionality of health care reform has been challenged in numerous cases. The lawsuits have primarily focused on the "individual mandate," which requires that nearly every US citizen maintain a minimum level of health insurance coverage beginning in 2014 or pay a penalty. Several district courts have found health care reform to be constitutional, while two district courts have overturned all or part of the law. Other suits are working their way through the federal courts, in a number of states. Several cases are on appeal, and it is expected that the US Supreme Court will ultimately decide the issue. The Supreme Court has declined to "fast track" a ruling on health care reform; a decision is not expected until June 2012, at the earliest. And, even a Supreme Court ruling may not end the uncertainty over the future of health care reform – if the Court only finds the individual mandate rather than the entire law to be unconstitutional, components of the law may continue to be litigated.

Legislative opposition. Efforts are also under way in Congress to repeal health care reform as well as eliminate the funding necessary to carry out its implementation. Although the House has voted to repeal PPACA, it is highly doubtful that any repeal legislation would pass in the Senate as currently constituted. Even if Congress passes legislation, President Obama certainly would veto the bill. There is also opposition to PPACA at the state level, where legislators in at least 41 states are seeking to limit, alter or prevent the implementation of federal health care reform.

"Free-choice" vouchers repealed. PPACA required employers to make voucher payments to certain employees to help make state exchange coverage more affordable. The provision, which was slated to take effect in 2014, fell victim to budget cutting. The free-choice vouchers were repealed in April as part of the fiscal 2011 government funding bill. Compliance with the free-choice voucher requirement presented an administrative challenge, and with its repeal employers can focus on plan design to comply with the upcoming 2014 PPACA requirements.

The guidance that has been issued under PPACA in the past several months has added a number of "to dos" and decision points for employers regarding health plan administration. The following is not a discussion of the PPACA law, but a summary of the most important of the PPACA action items. Plan sponsors should continue to consult their benefit advisors about any additional steps that may be required to keep plans in compliance with the requirements of health care reform.

Issue	Action Items
Develop process to comply with W-2 reporting rules	PPACA requires employers to include the "aggregate cost" of employer-sponsored health coverage on each employee's Form W-2. The initial 2011 tax year reporting requirement was delayed until guidance was issued. On March 29, 2011, the IRS issued Notice 2011-28, providing interim guidance on the W-2 reporting requirement. The guidance was for the most part employer-friendly, even easing the PPACA requirements by eliminating the reporting requirement for some types of previously included health benefits. **When effective.** Most employers must report the aggregate cost on 2012 Forms W-2, generally effective for those W-2s required to be issued in January 2013. Employers who decided to begin reporting for the 2011 tax year can continue to do so and can rely on the Notice. **Benefits subject to reporting.** Common benefits such as medical and prescription drug coverage, mini-med plans, supplemental Medicare plans and certain on-site medical clinics must be reported. Contributions to HSAs or HRAs are not required to be reported. The plan design impacts the reporting of other common benefits – health care FSAs are not subject to reporting, as long as there are no employer contributions or flex credits. Stand-alone dental and vision plans are not subject to reporting, but integrated dental and vision plans are. **Who is subject to reporting requirement.** Employers must only report the value of employer-provided health coverage to individuals who are otherwise required to receive a Form W-2. Generally, W-2s will not be required for surviving spouses, most retirees and COBRA beneficiaries, and those on disability leave. Employers still may be required to report the value of health coverage to some former employees, such as employees receiving nonqualified deferred compensation payments. **Valuation.** The "aggregate cost" of coverage includes both employer and employee contributions, both pretax and after-tax dollars, and any coverage "imputed" as income to the employee. Employers can calculate the cost in the same manner as the COBRA premium (not including the 2% administrative fee). In limited circumstances, such as when the employer subsidizes COBRA or when the COBRA premium does not reflect the coverage tier, a modified COBRA premium method may be used. If there are midyear changes in coverage tier or benefit option, the value must take into account the resulting changes in coverage and costs associated with the coverage. ☐ **Employers should identify plans subject to the W-2 reporting.** ☐ **Employers should review with their payroll departments or payroll providers any changes that may be necessary to generate the 2012 W-2s.** ☑ **Mercer can work with employers, for plans it administers, to develop a process for capturing the necessary information for W-2 reporting.**

Issue	Action Items
Review plan's disenrollment process	PPACA allows a "rescission" of group health plan coverage only in the event of fraud or a material misrepresentation of a fact in connection with the coverage, or due to nonpayment of premiums. Agency guidance issued in October 2010 also recognized some routine administrative situations in which canceling coverage retroactive to the date of an event like employment termination or divorce is not a rescission if no premiums were paid after the date of cancellation. However, this guidance did not go far enough to address the impact of the rescission rule on other common life events where coverage may be terminated retroactively. It appears to be a reasonable good faith position that a retroactive termination of coverage due to certain life events in the normal course of business (such as a newly married employee dropping coverage to be covered under the spouse's plan or termination of dependent coverage for failure to submit supporting documentation) should not be treated as a rescission. ☐ **Employers should review their plan's practices with their ERISA counsel and direct Mercer as to the appropriate date to cancel coverage for the plan's life events. Employers should also review their position with the plan's carriers, since carriers have taken different positions on the date that coverage will be terminated.** ☐ **Employers should review their payroll practices to make sure that any provisional deductions for coverage that was terminated due to a life event are promptly credited to the employee.**

Issue	Action Items
Coordinate new notice requirements	PPACA added a number of new notice requirements that employers will need to work into their employee communications plans. We are awaiting guidance on the specifics of the new reporting requirements, so it is unclear whether 2012 open enrollment will be affected. **Uniform health plan summary.** No later than March 23, 2012, employers must provide new enrollees and current participants a summary of benefits and coverage, both at open enrollment and when an individual becomes eligible for benefits. The summaries are intended to help individuals choose among the available health plans by providing standardized information in a uniform format. Regulators missed the March 23, 2011, target for issuing guidance, but it is expected soon. **Material modification notice.** Group health plans must give all enrolled individuals 60 days' prior notice of any premium and cost sharing increases or benefit reductions. The effective date of the notice requirement was not clear in the law. Agency guidance clarified that plans are not required to comply with this requirement until guidance is issued on the required summary of benefits and coverage. ☐ **Employers should coordinate the new reporting requirements with other ERISA-required benefit disclosures and other plan communications.** ☑ **Mercer can coordinate the employee communications with the plan sponsor and assist in distributing the notices for plans it administers.**
Review timing of Medicare Part D notice of creditable coverage	Health plans which provide prescription health coverage to individuals eligible for Medicare's Part D prescription drug benefit must provide such participants with notice of whether the prescription coverage is creditable or noncreditable coverage. The notice must be provided at several times, including before each annual Medicare Part D enrollment period. This period currently begins November 15 of each year, but PPACA advanced the Medicare Part D open enrollment period to start on October 15 and end on December 7. Therefore, starting in fall 2011, employers will need to provide the Medicare Part D creditable coverage notice by October 14 instead of the current November 14 requirement. ☐ **Employers that included the notice with their open enrollment materials will need to review whether the OE will coincide with the Medicare Part D open enrollment.** ☐ **Employers should update their Medicare Part D creditable coverage notices to reflect the new open enrollment period. (CMS has updated the model notice with the new open enrollment dates.)** ☑ **Mercer can work with employers to distribute the notice for plans it administers.**

Issue	Action Items
Update tax treatment of adult dependent children	PPACA made two changes regarding health coverage for adult children – the coverage rule, which requires group health plans to cover children up to age 26, and the taxation rule, which allows tax-free treatment of employer-provided coverage until the end of the calendar year in which a child turns age 26, regardless of the child's tax dependency. While some state tax laws automatically conform to the federal tax code, other states still must enact laws to match the federal tax-free treatment. Most states have updated their tax codes to follow the federal codes or are in the process of doing so. ☐ **Employers should work with their payroll departments or tax advisors to make sure that employees are being taxed appropriately for state tax purposes.**
Confirm "grandfathered" status for benefit options	"Grandfathered" plans must comply with most health care reform requirements, such as the age 26 coverage mandate, prohibition on rescission and no lifetime limits, but there are a number of mandates that do not apply to them – including the stricter appeals and review process, no-cost coverage of preventive health services and patient protections (such as primary care provider designations, OB-GYN referrals and out-of-network services). As employers update their plan designs for the new plan year, those changes can result in loss of the plan's grandfathered status. ☐ **Employers that had any grandfathered benefit options in 2011 should review with counsel the grandfathered status of their benefit options for the upcoming plan year.** ☐ **Employers with any grandfathered benefits should take steps to comply with recordkeeping and notice requirements necessary to preserve grandfathered status – including the PPACA required statement of grandfathered status in plan materials provided to participants.** ☑ **Mercer can work with employers to include the grandfathered notice in employee communications materials or update the text of system-generated communications to reflect any necessary changes due to the loss of grandfathered status for plans it administers.**

Issue	Action Items
Update annual benefit limits	Under PPACA, group health plans are prohibited from imposing annual dollar limits on "essential health benefits." The requirement is phased in over the next three years, with a complete ban by 2014. For 2012, the annual dollar limit increases from $750,000 to $1,250,000. ☐ **Employers should review other employee communications and make any necessary revisions to reflect the higher limit.** ☑ **Mercer can update the text of system-generated communications and web content to reflect the revised limit for plans it administers.**
Delays in effective dates of PPACA appeal and review process	PPACA requires "nongrandfathered" plans to comply with the current ERISA rules as well as new, stringent internal claims and appeals requirements and a new external review process. The all-new requirements originally were effective on January 1, 2011, for calendar year plans (or plan years starting on or after September 23, 2010), but regulatory guidance has delayed some of the requirements to allow employers extra time to comply. As a result of the grace periods allowed under DOL Technical Releases 2011-10 and 2010-2, the effective dates of the various requirements differ as follows: ▪ **Already in effect – January 1, 2011 (plan years beginning on or after February 23, 2010):** expanded disclosure of grounds for claim denials, eliminating conflict of interest, continued coverage during appeal process, scope of claim (which includes rescissions) and external review of denied claims ▪ **January 1, 2012 (plan years beginning on or after January 1, 2012):** 24-hour determination of urgent care claims, expanded required information for claims and appeal notices, and the "strict adherence" and foreign language notice requirements ▪ **January 1, 2012 (plan years beginning on or after July 1, 2011):** denial notice codes ☐ **Employers should continue working on making the changes necessary to comply with the new requirements, including coordinating processes with the plan's claims administrator.**
Review data transmission standards for HIPAA compliance	Although not a health care reform requirement, compliance with the HIPAA privacy requirements is essential for every group health plan. The HIPAA regulations have long prescribed standards for transmitting data that is subject to the HIPAA privacy and security rules. Since 2003, the standard for health plan enrollment and disenrollment transactions has been the "ASC X12N 834 – Benefit Enrollment and Maintenance, Version 4010, May 2000" standard. In January 2009, the DOL issued regulations upgrading the requirements to a new Version 5010 of the 834 standard. For the period March 17, 2009, through December 31, 2011, either Version 4010 or Version 5010 can be used. As of January 1, 2012, the 5010 version is required. ☑ **Mercer can work with employers and their carriers to upgrade to the 5010 version for plans it administers.**

Cafeteria Plan Amendments for Over-the-Counter Drug Restriction Due by June 30

By now employers have put into effect the health care reform restriction that prohibits tax-free reimbursements for over-the-counter drugs – other than insulin – from group health plans, including health flexible spending arrangements (FSA) and health reimbursement arrangements (HRAs), health savings accounts and Archer medical savings accounts. The ban took effect January 1, 2011 (except for certain debit card transactions), regardless of plan year, coverage period or any health FSA grace period.

Cafeteria plan documents should be reviewed to determine if any amendments are required. Not all cafeteria plan documents address permitted reimbursements, but those that specifically allow tax-free reimbursements of over-the-counter drugs must be amended to reflect the new restriction. Although cafeteria plans generally are not permitted to adopt retroactive amendments, the IRS has provided an extended adoption date for cafeteria plan amendments and will allow amendments adopted by June 30, 2011 for expenses incurred after December 31, 2010, or after January 15, 2011, for debit card transactions for FSAs and HRAs.

IRS Provides Informal Observations on Plan Administration

At an early February meeting with the benefits practitioner community, representatives of the Internal Revenue Service (IRS) informally addressed certain important issues to plan sponsors related to commonly found plan administration errors, an initiative related to large-plan audits and the 401(k) Compliance Check Questionnaire Project.

Keeping an Eye on Your Plan's Administration

Plan sponsors and plan administrators need to ensure that they are operating their plan in accordance with the plan document provisions and Internal Revenue Code and ERISA rules. Following are some items that should be considered by plan administrators:

- For calendar year plans, now is the time to concentrate on completing your year-end actual deferral percentage, actual contribution percentage and other nondiscrimination testing
- Make sure that your plan document is up to date based on your plan's five-year restatement cycle and the annual interim amendment requirements. For plan sponsors utilizing the Mercer prototype plan document, Mercer's Outsourcing business, as the prototype plan sponsor, generally takes care of keeping the document's legal requirements up to date.
- Periodically review your plan's definitions of compensation with your payroll department or other provider, for purposes of determining employee and employer contributions

- Create a procedure for periodically determining if all eligible employees are being included in your participant enrollment process
- Periodically review your process for depositing employee contributions and participant loan repayments to see that they are being transferred to the trustee in a timely manner
- Periodically review the operations of your other plan administrative processes and procedures, for example, hardship withdrawal approval, vesting and loan procedures

If you discover an inadvertent administrative error, follow the correction methods outlined in the IRS Employee Plan Compliance Resolution System (EPCRS, IRS Revenue Procedure 2008-50).

Large-Plan Audits

The IRS' Employee Plans Team Audit (EPTA) is concentrating on large plans, with an internal control pilot program focusing on the West Coast of the United States. The EPTA is reviewing selected large plans' written processes and procedures for administering the plan and correcting operational errors. They could request that a plan administrator run sample participant transactions in order to evaluate the plan's internal controls. The EPTA will use the results of this review in determining the plans and areas to be audited. Plans can be selected for the EPTA review by:

- A point system based on type of plan, industry and location
- Referral from another government agency

Generally, the EPTA is under no obligation to disclose the reason a particular plan is selected for audit.

To assist plan sponsors in evaluating their plan's internal controls, the EPTA has posted an internal controls questionnaire to the IRS Retirement Plans Community Plan Sponsor/Employer website.

401(k) Compliance Check Questionnaire Project

In 2010, the IRS sent 1,200 plan sponsors a compliance questionnaire for completion and submission to the IRS. The purpose of the questionnaire was to gather information the IRS could use to develop better benefits-community guidance, education and outreach, and better focus their enforcement efforts. The answers received are being analyzed, with a goal of issuing a preliminary report in the second half of 2011. Plan sponsors that completed the questionnaire should not be subject to audit. However, if a plan sponsor's answers raise a possible compliance issue, the IRS will contact the plan sponsor to request that they review and correct the error. Plan sponsors will be reminded that the questionnaire was not an audit, and all EPCRS correction methods should be available. Plan sponsors that did not return the questionnaire should expect to be audited. The IRS suggested that all plan sponsors utilize the questionnaire in evaluating their plan's administration.

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Qualified Plan Second Restatement Cycle Has Begun

When it comes to thinking about updating and restating your qualified plan, time has flown. On February 1, 2011, the second restatement cycle began for custom plan documents and the Mercer prototype plan.

Mercer Prototype Plan

The second six-year restatement cycle has begun for the Mercer prototype plan. Mercer will be submitting its updated prototype plan document with the IRS for an Opinion Letter[1] prior to the October 31, 2011, submission deadline. If you are using the Mercer prototype plan, you do not need to do anything now, and may continue to administer your plan as normal. We will keep you informed about this IRS required second restatement cycle.

Individually Designed Plan Documents

Under the current IRS restatement cycle, once every five years, plan sponsors maintaining individually designed plan documents have to update and submit their plans for IRS Determination Letters.[2] The submission dates are based on staggered five-year remedial amendment cycles based on the last digit of the plan sponsor's EIN. Each cycle has a specific one-year period during which affected plan sponsors may submit updated plan documents to the IRS for a Determination Letter. The updated documents should reflect any changes adopted since the last IRS Determination Letter was issued. Plans maintained by an employer whose EIN ends in 1 or 6 generally are Cycle A plans, which should be amended and restated to reflect the IRS' 2010 cumulative list of required plan provisions. The restated plan document should be submitted to the IRS for a Determination Letter on or before January 31, 2012. See the table below.

EIN's last digit	Plan's cycle	Beginning of the first 5-year cycle	End of the first 5-year cycle	Beginning of the second 5-year cycle	Restatement and Determination Letter filing date	End of the second 5-year cycle
1 or 6	A	2/1/2006	1/31/2011	2/1/2011	1/31/2012	1/31/2016
2 or 7	B	2/1/2007	1/31/2012	2/1/2012	1/31/2013	1/31/2017
3 or 8	C	2/1/2008	1/31/2013	2/1/2013	1/31/2014	1/31/2018
4 or 9	D	2/1/2009	1/31/2014	2/1/2014	1/31/2015	1/31/2019
5 or 0	E	2/1/2010	1/31/2015	2/1/2015	1/31/2016	1/31/2020

[1] IRS Opinion Letters are issued by the IRS to Mercer confirming the qualified status of our prototype plan under IRS Section 401(a), et seq. The Opinion Letter speaks to the form of the prototype plan documents and not to the individual plan design elections made by the plan sponsor. Each of the Mercer Adoption Agreements has its own Opinion Letter. Plan sponsors utilizing our standardized Adoption Agreement (AA #006) may rely on its Opinion Letter and do not need to file for an IRS Letter of Determination.

[2] IRS Letters of Determination are issued by the IRS to the individual plan sponsor confirming the qualified status of the plan sponsor's plan design elections under IRS Section 401(a), et seq. The Letter of Determination speaks to the individual plan design elections made by the plan sponsor. In order to receive an IRS Letter of Determination, the plan sponsor must request the letter using the forms prescribed by the IRS. Mercer DC Consulting can assist the client in completing and filing these forms, negotiating with the IRS and obtaining the Letter of Determination, for an additional fee.

Special rules apply to some plans:

- Multiple-employer plans must be submitted in Cycle B
- Government plans must be submitted in Cycle C
- Multiemployer/union sponsored plans must be submitted in Cycle D
- Plans maintained by members of a controlled group may make an election to use the parent company's EIN to determine the filing cycle or may elect to file all single-employer plans maintained by controlled group members under Cycle A
- Government plans and non-calendar-year Cycle D plans that elected to file during the first Cycle E (ending January 31, 2011) must return to Cycle C or D, as applicable, when requesting a new determination letter

You could be eligible to extend your filing deadline by certifying your intention to adopt the Mercer prototype document prior to the end of your applicable custom document deadline. The certification could allow you to take advantage of our prototype document's six-year remedial amendment cycle. Please speak with your legal counsel to ensure that your plan is updated by your individual restatement deadline.

Final Phase-in of PPA Lump-Sum Interest Rates Approaching

The Pension Protection Act of 2006 (PPA) contained a number of significant provisions that affected defined benefit plans from the plan design, funding and participant communications standpoints. One such provision required changes to the interest rates and mortality assumptions that plans use to determine lump-sum payment amounts for participants who elect to forego the plan's normal annuity payment form. This article will focus specifically on the lump-sum interest rate changes, as we are now approaching the end of the phase-in period for adopting the new interest rates.

Prior to the changes brought about by PPA, lump-sum payment amounts were determined based on 30-year Treasury bond interest rates. Per Section 302 of PPA, plans are now required to use interest rates that are based on a three-segment "yield curve" for investment-grade corporate bonds. These new interest rate rules are being phased in over the five-year period from 2008 through 2012. In general, because the new interest rates are higher than the pre-PPA rates, lump-sum distributions will be reduced as a result.

Three-Segment "Yield Curve"

The actual PPA rate to be used in a particular participant's lump-sum calculation is determined by using a three-segment "yield curve" of investment-grade corporate bonds. The timing of these segment rates corresponds with the timing of when the annuity benefit would have been payable to the participant had they not selected the lump-sum alternative. The portion of the annuity that would have been payable within five years is valued using the first segment (a short-term corporate rate). The portion payable in 6–20 years is valued using the second segment (a medium-term corporate rate), and the portion payable in more than 20 years is valued using the third segment (a long-term corporate rate).

Phase-in

As mentioned above, the change from the use of 30-year Treasury bond rates to corporate bond rates is being phased in from 2008 through 2012. This is being done through the use of a blended rate comprised of weighted portions of the old and new rates. For example, in 2008, the 30-year Treasury bond rate was weighted at 80% and the corporate bond interest rate was weighted at 20% in order to create the rate to be used to calculate lump sums. This weighting gradually shifted each year in order to place a higher weight on the PPA corporate bond rate over time. This will culminate in 2012, when the new rates will be used in full.

The five-year phase-in breakdown of interest rates is as follows:

- 2008: 80% Bond – 20% PPA
- 2009: 60% Bond – 40% PPA
- 2010: 40% Bond – 60% PPA
- 2011: 20% Bond – 80% PPA
- 2012 forward: 0% Bond – 100% PPA

Effect on Lump-Sum Payments

What effect will the new interest rates have on participants who wish to take lump-sum distributions as opposed to annuity payments from a plan? Interest rates on corporate bonds have historically been higher than the interest rates on Treasury bonds of similar maturities. Because the lump-sum present value of an annuity is inversely related to the interest rate used to calculate it, the new rates will tend to reduce lump sums. How much this change will affect the value of a participant's lump sum will depend on their age and the difference between the Treasury bond interest rate and the corporate bond interest rate in each segment of the yield curve.

It is important to keep in mind that plan sponsors are not required to use these new rates to calculate lump sums; they are, however, prohibited from paying lump sums that are less than the amounts that would result from their use. A plan sponsor may elect to use a lower interest rate, which would result in larger lump-sum amounts. If they choose to do so, PPA requires the plan sponsor to take the additional cost into account when calculating the plan's liabilities and funding requirements.

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