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MULTIEMPLOYER REVIEW
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FASB Adopts New Disclosure Requirement for Employers Participating in Multiemployer Plan(s)

Update No. 2011-09, Subtopic 715-80

Introduction

In recent years, the Financial Accounting Standards Board (FASB) has become concerned that the current disclosure requirement for employers participating in multiemployer plans lacks transparency about the risks to which such employers are exposed. The FASB has issued a new standard under Subtopic 715-80 designed to provide the users of financial statements access to sufficient information to assess the risks associated with an employer's participation in multiemployer plans.

Implementation

For *public entities,* the new disclosure is required beginning with the first fiscal year ending after December 15, 2011. For *nonpublic entities*, the new disclosure is required beginning with the first fiscal year ending after December 15, 2012. Early adoption of the new requirement is allowed.

In the initial adoption period, the new disclosures must be provided for current periods, as well as any prior periods presented in the financial statement.

The Current Requirement

Employers are currently required to disclose the total amount of contributions made to multiemployer pension or other postretirement benefit plans. In addition, withdrawal liability estimates or maintenance of benefits contributions must be provided in the footnotes if such an event is either probable or reasonably possible (see Topic 450 of the FASB Accounting Standards Codification).

The New Requirement

The new requirement encompasses the current requirement, and also requires additional footnote disclosures for each multiemployer plan in which an employer participates. The additional information is provided as tabular and narrative data, and should be readily available through the employer's internal records as well as the required notices each plan must provide to the employer under ERISA. The example provided in Accounting Standards Update 2011-09 is very helpful and thorough (see pages 10-13 of the Update).

Materials an Employer Needs to Complete the New Requirement

Having the following materials available for each multiemployer plan for which the employer has an obligation to contribute will minimize the effort required to prepare the new disclosure. Together, these materials contain nearly all of the information needed.

- Annual Funding Notices
- 5500 Follow-on Report, sometimes called ERISA 104(d) Notice
- Notices of Endangered or Critical Status, if applicable
- Funding Improvement Plan (FIP) or Rehabilitation Plan (RP), if applicable
- Employer's Records including collective bargaining agreements and contribution data

Tabular Data

Tabular data must be provided for each *significant* plan to which an employer contributes. The determination of whether a plan is significant is based on the amount of the employer's contributions to the plan as well as other factors, such as the severity of the underfunded status of the plan. The information provided should be the most recently available for each plan.

The table on page 2 shows the items that must be reported in a tabular format, along with where these items can be found. Also shown is an example of the disclosure items for a sample plan.

The table should also provide total contributions for all non-significant plans as well as total contributions of the employer made to all multiemployer plans.

Reporting Requirement	Where to Obtain Information	Sample Plan Disclosure
Plan's legal name	Plan's Annual Funding Notice, Main Heading or Introduction	Best Industry Pension Plan
Plan's Employer Identification Number and Plan Number	Plan's Annual Funding Notice under "Where to Get More Information" at the end of the notice	EIN: 91-1234567 Plan No.: 001
Most recently available certified Zone Status[1]	Plan's Annual Funding Notice under the "endangered or critical status" section; also if the plan is endangered or critical, a notice of plan status has been provided	The plan was Critical in 2010, Endangered in 2011
FIP/RP Status Pending/Implemented	"No" if the plan is not endangered or critical, "Pending" if the plan is endangered or critical but FIP or RP has not been provided by trustees, "Implemented" if FIP or RP has been provided by Trustees	Implemented
Employer contributions[2] (provide for the years disclosed in the financial statements)	Employer Records	$200,000 in 2011, $195,000 in 2010, $190,000 in 2009[3]
Surcharge Imposed	Employer Records: "Yes" if surcharges were paid in the fiscal year, otherwise "No"	No
Expiration date(s) of collective-bargaining agreement(s)[4]	Employer Records	12/31/2012 to 12/31/2015

[1] If zone status is not available, the funded percentage range may be provided. See Subtopic 715-80-50-5 (c). This information is available in the most recent actuarial valuation for the plan.

[2] Provide a description of any future minimum contributions due to collective bargaining agreements, statutory obligations, or contractual obligations.

[3] For each period presented, identify if the employer's contribution to the plan exceeded 5% of the plan's total contribution and for which years this occurred. This information is available from the Form 5500 Follow-on Report (sometimes called the ERISA 104(d) Notice) or the Form 5500.

[4] If the employer contributes to the plan under more than one collective bargaining agreement, provide the expiration date for each significant agreement in a footnote to the tabular data, identifying the relative significance of each agreement by portion of contributions or portion of covered employees, etc.

Note: For plans for which there is no publically available data, employers must provide as much tabular data as is available and provide additional disclosures in the footnote to the tabular data (see Subtopic 715-80-50-7 for details).

Narrative Data

Employers must provide a general description of multiemployer pension plans, indicating how the risks of participating in multiemployer plans are different from the risks of participating in single-employer plans. The example in the Update has a very good starting point for this disclosure. Certain tabular data may also require a narrative description (see the footnotes of the tabular data above for details).

Consistent with current requirements, the nature and effect of any significant changes affecting comparability from period to period must also be disclosed. Such changes may include business combinations and divestitures, changes in contractual contribution rates, or changes in number of employees in the plan.

Other Affected Plans

This new accounting standard affects more than employers participating in multiemployer pension plans. There are also some new disclosure requirements for:

- Multiemployer plans that provide postretirement benefits other than pensions (OPEB)
- Subsidiaries and not-for-profit organizations that fall under Subtopic 715-30

Please contact your Milliman consultant for details.

Next Steps

Employers will need to prepare the new disclosure requirements for each multiemployer plan they participate in. This may result in data requests to the administrative office. Trustees and administrators may want to discuss their options with plan counsel about how they can facilitate efficient distribution of applicable plan data to employers.

Contact your Milliman consultant for more information or to discuss the new requirement further.

Health Reform: A Roundup of Recent Developments

Federal agencies with authority over regulations to implement provisions in the health reform law, the Patient Protection and Affordable Care Act (PPACA), have issued guidance recently for employers that sponsor group health plans or insurance for their workers. Some of the regulatory guidance is in proposed form, and thus may not be relied upon, but it does offer insights into how the IRS and the Departments of Labor (DOL) and Health and Human Services (DHHS) may address some key issues. In addition, the president has signed into law bills that repeal two provisions enacted under PPACA. Separately, some federal appeals courts have announced their decisions on PPACA, and the U.S. Department of Justice requested review by the U.S. Supreme Court, setting the stage for a decision on the potential repeal of part or all of PPACA before the November 2012 elections.

Preventive Services

The IRS, DOL, and DHHS issued an Aug. 3 interim final rule (IFR) requiring new (i.e., nongrandfathered) health plans to cover certain women's preventive health services without any cost sharing. The requirement, which applies to plan or policy years beginning on or after Aug. 1, 2012, is part of PPACA's mandate that preventive services for women be covered without copayments, coinsurance, or deductibles. Among the preventive services covered are contraception (with an exemption available for religious institutions), well-woman visits, breast-feeding supplies and support, domestic violence screening, screening for gestational diabetes, sexually transmitted infection counseling, and human immunodeficiency virus screening and counseling.

Claims, Appeals, and External Reviews

The IRS, DOL, and DHHS on June 24 published an amendment to the July 2010 IFR (see ***Client Action Bulletin 10-17***) relating to PPACA's requirements for nongrandfathered group health plans and insurance regarding internal claims and appeals and external review processes. The amendment, effective July 22, modifies the original IFR to address several concerns raised about such issues as: claims and review notices that must be provided in a culturally and linguistically appropriate manner, the urgent claims review period, and the scope of claims eligible for external reviews. The DHHS also separately issued technical guidance on obtaining and following the "culturally and linguistically appropriate" standards of the IFR.

In addition, related separate guidance has been issued as follows:

- The DOL and DHHS issued *Technical Release 2011-02*, providing until Jan. 1, 2012, for state external review process implementation, and a set of 16 temporary standards that apply until Jan. 1, 2014.
- The DHHS issued instructions for self-insured, nonfederal governmental health plans and health insurance issuers on electing a federal external review process by the earlier of Jan. 1, 2012, or the date they use the federal external review process.

Uniform Summary and Coverage Glossary

The IRS, DOL, and DHHS published a proposed rule on Aug. 22 requiring that, starting Mar. 23, 2012, all group health plan participants be given a standardized summary of the benefits and coverage offered. The proposed rule specifies when and how the summaries are to be provided, as well as their content. Along with the proposed rule, the agencies released a draft template for the "Summary of Benefits and Coverage" and a standardized glossary of terms commonly used in health plan coverage, such as "copayment" and "deductible." The agencies are accepting comments on the proposed rule and related documents until Oct. 21.

In general, the summary was designed to be given to consumers before they purchase or enroll in a plan. The summary would have to provide key information for each benefit package a participant is eligible for, including premiums, deductibles, covered benefits, and coverage limitations and exceptions. The summary also would have to contain examples showing how much a plan participant would pay in three specific scenarios: having a baby, treating breast cancer, and managing diabetes. Consumers must be notified 60 days in advance of any significant change made to the terms of coverage as reflected in the summary.

The proposed rule acknowledges that the sample template and related documents were drafted "primarily for use by insurance issuers," and thus appears open to comments about the proposed rule's effects for self-insured plan sponsors.

Other Regulatory Guidance

In other PPACA-related regulatory developments:

- The IRS proposed eligibility standards for premium tax credits available to subsidize the purchase of exchange-based insurance by taxpayers with household incomes between 100% and 400% of the federal poverty level (FPL). ***Separately***, the IRS, DOL, and DHHS proposed an Aug. 17 rule on the health insurance exchanges that states may establish. The proposed rule, which includes a 75-day comment period, addresses the eligibility requirements for uninsured individuals and employees of small businesses, and how the exchanges will handle eligibility determinations for low-income individuals applying for expanded Medicaid benefits.
- The DHHS issued supplemental guidance on the annual limits for "mini-med" waivers, modifying the requirement for health reimbursement arrangements (HRAs). Under the guidance, stand-alone HRAs are exempt from PPACA's annual limit restrictions for essential health benefits for plan years beginning before Jan. 1, 2014, and thus need not individually apply for waivers. The guidance applies to HRAs that were in effect before Sept. 23, 2010. The guidance also provides sample language to inform HRA-covered individuals.
- The IRS released *Notice 2011-28*, providing guidance on the reporting of the cost of health coverage on 2012 Forms W-2 that employers must provide to employees in Jan. 2013. The notice also excludes HRAs from the W-2 reporting beginning with the 2012 tax year and until further notice, and permits employers not to report the coverage if a worker terminates employment and requests the form before the end of the calendar year. Employers that issue fewer than 250 IRS Forms W-2 have a delayed implementation date. The reportable cost includes the value of the health benefits provided under the plans (rather than what the employer pays for the coverage).
- The IRS issued *Notice 2011-35*, requesting comments on PPACA's comparative effectiveness fee that insurers and self-funded plan spon-

sors must pay based on the average number of lives covered in plan or policy years beginning Sept. 30, 2012, and ending Sept. 30, 2019.
- The IRS released *Notice 2011-73*, seeking comments on a potential "safe harbor" that would allow an employer to determine the affordability of its coverage by considering wages paid rather than workers' household incomes. The safe harbor would apply only for PPACA's employer "shared responsibility" provision and would not affect employees' eligibility for health insurance premium tax credits, which would still be based on household income.

PPACA Provisions Repealed

In legislative developments, the president signed into law two bills that repeal specific PPACA provisions. First, P.L.112-9 repealed PPACA's requirement that businesses file Form 1099 tax documents on all cumulative purchases from a single vendor for more than $600 in a single year. To raise the revenues lost by the repeal, the law adjusts PPACA's premium assistance tax credits that will be available to low- and moderate-income recipients who purchase insurance through the exchanges so that they will repay a greater share of any overpayment of the tax credits. Second, P.L.112-10 repealed PPACA's "free choice voucher program." Under this provision, beginning in 2014 an employer would have been required to provide vouchers to workers if they opted out of the employer's plan because the premiums cost between 8% and 9.8% of their family incomes, where household income did not exceed 400% of FPL. It is not clear how the vouchers would have impacted multiemployer welfare plans.

Appeals Court Rulings on PPACA

On the judicial front, four of the five federal appellate courts that have heard challenges to PPACA have now weighed in, the most recent ruling coming in September from the Fourth Circuit. In its decision, the court ruled that the state of Virginia did not have standing to challenge the constitutionality of PPACA's individual mandate requirement (*Virginia ex rel. Cuccinelli v. Sebelius* (No. 11-1057, 9/9/11)) or the penalty the law imposes on individuals who do not obtain insurance or on employers if any of their employees obtained coverage through the health insurance exchange (*Liberty University Inc. v. Geithner* (No. 10-2347, 9/8/11)). In the latter case, the court concluded that, under the Anti-Injunction Act (AIA), it did not have jurisdiction to hear the challenge.

In the other cases:
- The Eleventh Circuit decided that the individual mandate is unconstitutional and that the mandate could be severed from the rest of PPACA (*Florida v. HHS* (No. 11-11021, 8/12/11)). The Department of Justice on Sept. 26 decided against asking the full court to hear the case, paving the way for the Administration to seek a review by the U.S. Supreme Court.
- The Ninth Circuit upheld a lower court's dismissal of a suit challenging the individual mandate, agreeing that the plaintiffs lacked legal standing to sue (*Baldwin v. Sebelius* (No. 10-56374, 8/12/11)).
- The Sixth Circuit upheld the individual mandate, saying that the Constitution's Commerce Clause gives Congress the power to require Americans to buy health insurance (*Thomas More Law Center v. Obama* (No. 10-2388, 6/29/11)).

The Supreme Court has been asked to review the Eleventh Circuit's ruling by the Justice Department and others. If review is granted, the court's decision is expected to be rendered in the term that ends next June.

Meanwhile, the U.S. Court of Appeals for the District of Columbia Circuit heard oral arguments on Sept. 22 in what might be the last case before the Supreme Court decides whether to review PPACA's individual mandate provision. In this particular case, the three-judge panel also raised the question of whether the AIA prohibits the court's consideration of the constitutionality of the mandate (*Seven-Sky v. Holder* (No. 11-5047)). By asking about an Internal Revenue Code clause that requires a taxpayer to first pay a tax before seeking a refund and challenging the assessment, the judges appeared willing to consider whether PPACA's penalties for individuals are exempt from or subject to the AIA. The court's decision may be issued after the Supreme Court decides to grant review of PPACA litigation from the other appellate courts.

Action

Employers that offer healthcare coverage should review the regulatory guidance from the IRS, DOL, and DHHS. Compliance with the IFRs is necessary for nongrandfathered plans; a grandfathered plan sponsor that is contemplating changes that will trigger nongrandfathered plan status should bear in mind the requirements of those IFRs. The agencies' proposed rule on benefit plan summaries should be reviewed for their effects by all plan sponsors. Self-insured plan sponsors in particular might want to focus on how communications and administrative processes may change if the rule is adopted as final. Group health plan sponsors also should review the other pieces of regulatory guidance and modify administrative systems (e.g., for HRAs) and/or submit comments on the open regulations, as appropriate. Employers should continue to anticipate more guidance in the coming months as the agencies develop other proposed rules or publish final regulations. Employers that participate in multiemployer welfare plans should anticipate having to coordinate with those plans to meet reporting and other requirements of PPACA. In addition, PPACA provisions that have been repealed should be reviewed and considered in planning strategies as additional provisions of PPACA are implemented over the next few years.

For additional information about the recent developments in healthcare reform regulations and legislation, as well as their potential impact to your program, please contact your Milliman consultant.

For additional information about these new regulations or for assistance with the requirements discussed in this Multiemployer Review, *please contact your Milliman consultant.*