Contemporary Compliance Issues

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NO SURPRISES ACT – IDR PROCESS

No Surprises Act – IDR Process

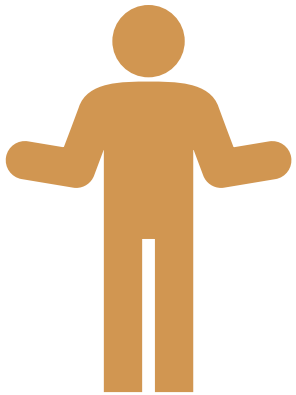
- No Surprises Act (NSA) passed in 2020
- Aimed at curbing “surprise billing” for patients, specifically:
  - Out-of-network emergency services;
  - Out-of-network services in an in-network facility; and
  - Air ambulances.
- NSA introduced new concept: Independent Dispute Resolution (IDR) which occurs when provider and plan cannot agree to a price for services

No Surprises Act – IDR Process Continued

- NSA provides steps leading up to IDR, including:
  - The provider billing the Plan
  - The Plan sending payment or denial based on Qualified Payment Amount (QPA)
  - Negotiation period
- IDR can be initiated by either part if negotiation fails after 30 business days
- Each entity submits its “offer” and IDR entity chooses the best offer. It *cannot* pick a number in the middle of the two offers on the table.

No Surprises Act – IDR Process Continued

- **So far? Not so good.** Confusion, litigation, and some use of IDR by providers that did not seem to be in line with the intent.
- **What's next?**
- November 3, 2023: Proposed Rule published by DOL, Treasury and HHS
- Primary Goals:
  - Encourage better pre-IDR negotiations;
  - Facilitate information sharing between providers and plans; and
  - Establish eligibility reviews to prevent unnecessary use of IDR
- Proposed rule was mostly positive and productive
- Comments were due January 2, 2024, but comment period was reopened from January 22, 2024 through February 5, 2024
- Waiting for final rule with additional guidance



PBM LITIGATION

PBM Litigation

- Pharmacy Benefit Manager
  - Manages pharmacy benefits on behalf of a health plan, insurer, or plan sponsor.
  - Negotiates prices with drug manufacturers.
  - Designed to influence the behaviors of providers and patients who can affect the outcomes and cost of pharmacy benefit plans.

PBM Litigation

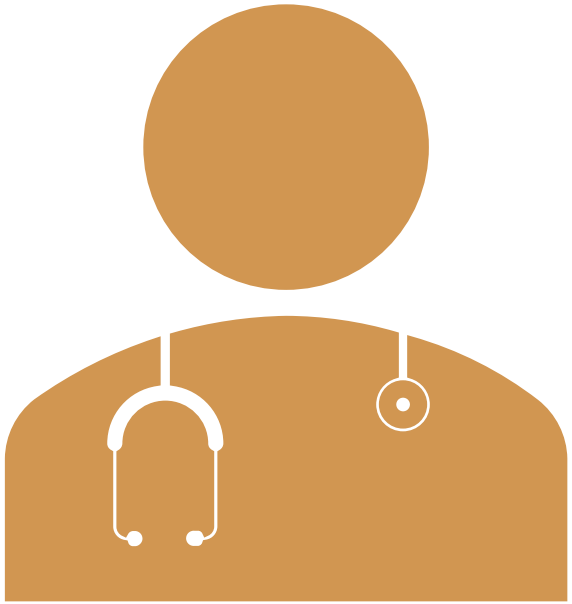
LITIGATION BY EMPLOYERS AND BENEFIT FUNDS

ERISA PREEMPTION

FIDUCIARY BREACH LITIGATION RELATED TO DRUG PRICING

PBM Litigation – Lawsuits by Employers and Benefit Funds

- Fiduciary Debate
  - Outcome of these cases often hinge on whether PBMs are considered “fiduciaries,” responsible for ensuring employee health funds are spent prudently



PBM Litigation – ERISA Preemption

- State legislatures have recently focused heavily on the role of PBMs in the context of health care benefits
- Initially focused largely on PBM services offered to health insurers and Medicaid
- More recently had material impacts on self-insured group health plans, involving fundamental aspects of plan costs, design, and administration

PBM Litigation – ERISA Preemption

- Rutledge v. PCMA
  - 2020 Supreme Court case
  - Held that regulation of the amount that a PBM pays a retail pharmacy was not preempted even though ERISA-covered plans experienced indirect non-acute economic burdens as a result of the state regulation
  - Held that the Arkansas statute that set rates with respect to PBMs did not have an impermissible reference to or connection with ERISA-covered plan
- PCMA v. Mulready
  - 2023 10th Circuit case
  - Reversed the district court and held that all four provisions of an Oklahoma law that regulated PBMs were preempted by ERISA

Fiduciary Breach Litigation- Employee Drug Price Lawsuits

- Lewandowski v. Johnson & Johnson
  - First case brought by an employee against a major company alleging breach of ERISA fiduciary duty over mismanagement of health plan funds
  - Alleges J&J mismanaged its prescription drug benefits program, costing employees millions of dollars in higher payments for drugs, as well as higher premiums, deductibles, coinsurance, copays, and lower wages or limited wage growth
  - Express Scripts, which is one of the nation’s largest PBMs, was not named as a defendant in the lawsuit

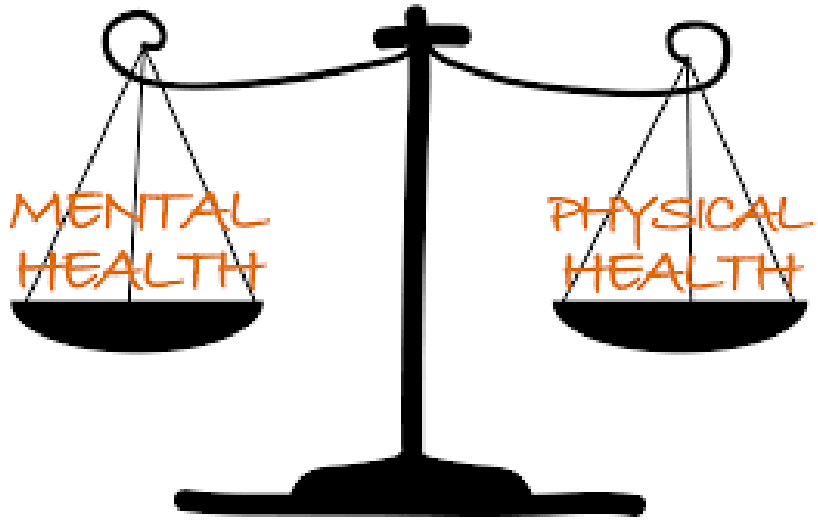
Fiduciary Breach Litigation- Employee Drug Price Lawsuits

- Johnson & Johnson (continued)
  - Suit cites a charge of more than $10,000 for a 90-day prescription of generic drug used to treat MS
  - The same drug would have cost as little as $28 from online pharmacy Cost Plus Drugs
  - “No prudent fiduciary would agree to make its plan and beneficiaries pay a price that is two-hundred-and-fifty times higher than the price available to any individual who just walked into a pharmacy and pays out-of-pocket”
  - Case will focus on whether the plan had a reasonable process for selecting and monitoring its drug benefits

MHPAEA – PROPOSED ANALYSIS AND REPORTING REQUIRMENTS

MHPAEA Proposed Analysis and Reporting Requirements

- Mental Health Parity and Addiction Equity Act – requires that group health plans cannot impose limits on mental health/substance use disorder benefits that are *less favorable* than any such limits imposed on medical/surgical benefits
- Requires plans to conduct a nonquantitative treatment limitations ("NQTLs") analysis to demonstrate compliance
- Plans have been seeking guidance on what exactly the NQTL analysis should include



MHPAEA Proposed Analysis and Reporting Requirements – Continued

July 23, 2023:

DOL, Treasury and HHS ("Tri-Agencies") released a proposed rule, providing some long-awaited guidance on the requirements for the NQTL analysis.

Proposed rule:

Data analysis is *mandatory* for NQTL analysis to demonstrate "comparability and stringency in operation".

Comment period initially set to close on October 2, 2023, but was extended through October 17, 2023.

MHPAEA Proposed Analysis and Reporting Requirements – Continued

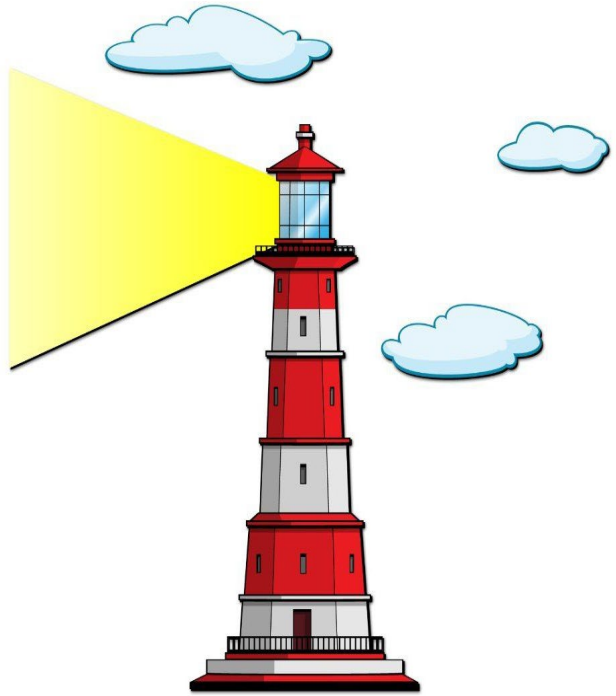
- **What data should plans be looking at?**
- Proposed rule does not define “relevant data” although it does provide some hints
  - Number and percentage of claims denials of MH/SUD vs. M/S benefits
  - Other data required by state law standards
  - Out-of-network utilization rates
  - Network adequacy metrics
  - Provider reimbursement rates
- If a “material difference” is found, it will be considered a “strong indicator” of a violation and the plan will be required to take “reasonable action to address to differences as necessary” and to document actions taken.
- Proposed rule solicited comments on what could “properly mitigate materially different access.”

MHPAEA Proposed Analysis and Reporting Requirements - Continued

- Problems with Proposed Rule:
  - Timing
  - Infrastructure
  - Costs
  - Plans don’t hold requested data
  - Unclear definition of NQTLs
  - Fiduciary certification
  - Could result in loss of MH/SUD provided benefits

MHPAEA Proposed Analysis and Reporting Requirements - Continued

- **Safe Harbor?**
- Departments intend to create an enforcement safe harbor for plans and issuers that “meet or exceed” specific data-based standards identified in future guidance.
- Plans that satisfy the terms of the safe harbor would not be subject to an enforcement action by the Departments under MHPAEA with respect to NQTLs related to network composition for a period of time, that will be specified in the future guidance.



REQUEST FOR INFORMATION ON OVER-THE-COUNTER PREVENTIVE SERVICES

RFI OTC Preventive Services

- Section 2713 of the Public Health Service Act (PHSA), which is incorporated by reference into ERISA and the Code, requires non-grandfathered group health plans and insurers to provide coverage for certain preventative services without cost-sharing
- The regulations implementing the ACA's preventative services coverage requirements ensure plan participants receive required preventative services without cost sharing while also allowing flexibility for plans to monitor and control costs and administer plans

RFI OTC Preventive Services

- Department of Treasury, Department of Labor, and the Department of Health and Human Services requested information on application of preventative services requirements under Section 2713
- Specifically requested information regarding:
  - Potential benefits on cost of requiring non-grandfathered group or individual health insurance coverage to cover OTC preventative items and services without cost sharing and without prescription by a health care provider;
  - Any potential challenges associated with providing such coverage;
  - Whether and how providing such coverage would benefit consumers; and
  - Any potential burden that plans and insures would face if required to provide such coverage

RFI OTC Preventive Services – Concerns for Multiemployer Plans

Flexibility: the ability to continue to be able to use cost containment measures

- Current structure allows for cost management techniques that benefit participants and plans. For example,
  - Many required preventative services do not include frequency. Allows plan to establish a process under which the service is available within certain time frames
  - Plans may provide preventative services through “carveout” or “point solution” benefit, where the plan has a separate contract with a service provider
  - Some items (e.g. breast pumps) are covered without cost-sharing if received from an in-network provider

RFI OTC Preventive Services – Concerns for Multiemployer Plans

Maintaining controls to assure proper use of services

- Plans use a variety of fraud, waste, and abuse protections to assure plan costs are appropriately paid for qualified medical expenses, and that costs were incurred by plan participants
- If OTC preventative services are required to be covered without a prescription, plans need to be able to create substantial fraud, waste, and abuse protections to assure that benefits are properly paid
    - A system to verify the purchase and assure it was purchased by a participant or dependent for their own use
    - Implement a system that is consistent with their plan administration, such as mandatory network provider, or mandatory mail order program
    - Impose quantity and frequency limitations on OTC products
    - Impose cost limits

RFI OTC Preventive Services – Concerns for Multiemployer Plans

Consideration of Reimbursement Process

- Plans and participants benefit from a process that allows plans to verify that a medical expense is a permissible payment under the IRC and the plan's medical management rules, and allows participants to obtain the service without cost sharing
- Multiemployer plans prefer not to make participants pre-pay
- Multiemployer plans do not operate health flexible spending arrangements (FSAs)
- Health reimbursement arrangements (HRAs) often offset patient cost-sharing based on provider bills and do not require participants to submit a separate claim (these are rare in multiemployer world)
- A reimbursement process that relies on payment card reimbursement would be difficult and costly for multiemployer plans

PROPOSED SECURE 2.0 ISSUES, GUIDANCE, AND PROPOSED TECHNICAL CORRECTIONS

SECURE 2.0 Issues

- SECURE 2.0 passed in 2022: aimed to encourage retirement savings
- Included a few fairly significant technical errors:
  - RMD age
  - Catch-up Contributions
  - Mandatory Roth Rollovers for High Earners
  - Automatic Enrollment
  - Collection of Overpayments
- On December 6, 2023, the House and Senate released a draft bipartisan technical correction bill – aptly called the SECURE 2.0 Technical Corrections Act of 2023
- Congress now looking for must-pass legislation, such as omnibus, to get these corrections through which would effectively update SECURE 2.0 so the new language would act as it was always there

Proposed SECURE 2.0 Technical Corrections - Continued

RMD Age:

- Current Language:
  - RMD age increased to 73 for participants who attain age 72 after December 31, 2022, and increased to age 75 for participants who attain age 74 after December 31, 2032.
- What's the issue?
  - People born in 1959 and 1960 fall into both categories, so what is their RMD age?
- IRS Guidance
  - Not necessary – issue does not arise until 2033.
- Proposed Technical Correction:
  - RMD age increased to 73 for participants who attain age 72 on or after January 1, 2023 and to 75 for those who attained age 73 on or after January 1, 2033.
- Takeaway:
  - RMD would be 73 for those born in 1951-1959 and 75 for those born in or after 1960.

Proposed SECURE 2.0 Technical Corrections - Continued

Catch-up Contributions:

- Current Language:
  - SECURE 2.0 accidentally eliminated the provision enabling participants to elect catch-up contributions.
- What's the issue?
  - That's not what they meant to do.
- IRS Guidance:
  - Deleted language was surplusage and does not eliminate ability of eligible participants to elect catch-up contributions (Notice 2023-62).
- Proposed Technical Correction:
  - Reinstates deleted language.

Proposed SECURE 2.0 Technical Corrections - Continued

Mandatory Roth Rollovers for High Earners:

- Current Language:
  - SECURE 2.0 requires plans to treat all catch-up contributions as Roth contributions for high income participants.
- What's the issue?
  - This requirement would be administratively difficult for multiemployer 401(k) plans to implement. Plans would have to rely on employers for salary information.
- IRS Guidance:
  - Added two year "administrative transition period" to create effective date of 2026 rather than 2024 to allow time for legislative fix.
  - IRS suggests it may agree to consider wages on employer-by-employer basis, not in the aggregate. However, IRS has not indicated willingness to accept that contributing employers are not "sponsors" of multiemployer plans for purposes of application of rule.
- Proposed Technical Correction:
  - None. This issue was not addressed.
- Takeaway:
  - If this is not fixed, Trustees may remove catch-up contributions from multiemployer plans.

Proposed SECURE 2.0 Technical Corrections - Continued

Automatic Enrollment:

- Current Language:
  - Automatic enrollment for new plans and new contributing employers to existing “multiple employer plans” (according to title of the provisions) or “plan[s] maintained by more than one employer” (according to text).
- What’s the issue?
  - Unclear whether language applicable to “new employers” applies only to multiple employer plans or also to multiemployer plans.
- IRS Guidance:
  - Nothing formal, but informally suggests that multiemployer plans will be treated the same as multiple employer plans.
- Proposed Technical Correction:
  - “New employer” requirement only applies to “plan[s] described in 413(c)”, which excludes multiemployer plans.
- Takeaways:
  - If enacted, only new multiemployer plans will be subject to the automatic enrollment requirement.

Proposed SECURE 2.0 Technical Corrections - Continued

Collection of Overpayments:

- Current Language:
  - Recovery allowed for participants or beneficiaries who are “culpable” including those who received benefits based on “fraud or misrepresentation.”
- What’s the issue?
  - What does that mean?
- Proposed Technical Correction:
  - “Culpable” language remains, but “fraud or misrepresentation” language was removed.
- Takeaway:
  - Well, what does that mean?

WITHDRAWAL LIABILITY DISCOUNT RATE (UPDATE)

Withdrawal Liability - Background

- Established in 1980 with Multiemployer Pension Plan Amendments Act (MPPAA)
- Plans charge employers **withdrawal liability** upon complete or partial withdrawal
- Represents employer's share of the plan's **unfunded vested benefits** (UVBs)
  - UVBs determined annually by plan's actuary
  - Equal to shortfall, if any, between plan assets and value of vested benefits
  - Measured based on **actuarial assumptions** and methods
- UVB allocated under one of a few **allocation methods**, chosen by the plan
- Withdrawal liability paid according to a **payment schedule**, defined in statute

Withdrawal Liability – Actuarial Assumptions

ERISA Section 4213(a) – Actuarial Assumptions

The **corporation may prescribe by regulation** actuarial assumptions which may be used by a plan actuary in determining the unfunded vested benefits of a plan for purposes of determining an employer's withdrawal liability under this part. Withdrawal liability under this part shall be determined by each plan on the basis of –

(1) actuarial assumptions and methods which, **in the aggregate**, are reasonable (taking into account the experience of the plan and reasonable expectations) and which, in combination, offer the **actuary's best estimate of anticipated experience under the plan**, or

(2) actuarial assumptions and methods set forth in the corporation's regulations for purposes of determining an employer's withdrawal liability.

Withdrawal Liability –Interest Assumption

Funding

- Interest rate is based on expected return on plan assets
- Generally, the same as for minimum funding purposes
- No implied risk transfer

Settlement

- Interest rate is based on settlement (annuity purchase) rates
- Common proxy: PBGC interest rate for plan terminations
- Full risk transfer

Something Else

- Could be a blend of expected return on plan assets and settlement rates
- Example: Segal Blend
- Could also include a margin for adverse experience
- Partial risk transfer

Withdrawal Liability – Appellate Court Decisions

Second Circuit

Sixth Circuit

D.C. Circuit

Ninth Circuit

Withdrawal Liability – Selection of Rate

- **Sofco Erectors, Inc. v. Ohio Operating Engineers Pension Fund 15 F.4th 407 (6th Cir. 2021)**
  - "Segal Blend" violated ERISA
  - Interpreted "best estimate of anticipated experience under the plan" refers to "unique characteristics of the plan" such as plan investment asset mix and expected rate of return on such assets
  - Actuaries can be conservative, but factoring in a discount for conservatism after the actuary has arrived at his best estimate of anticipated experience is contrary to the statute
- **UMWA 1974 Pension Plan v. Energy West Mining Co. 39 F.4th 730 (D.C. Cir. 2022)**
  - PBGC rates violated ERISA
  - PBGC rates approximate annuity purchase rates
  - Assumptions must reflect characteristics of the plan
  - The actuary must estimate how much interest the plan's assets will earn based on their anticipated rate of return
- **GCIU-Employer Ret. Fund v. MNG Enterprises, Inc. 51 4th 1092 (9th Cir. 2022)**
  - PBGC rates violate ERISA
  - Assumptions must reflect plan characteristics
  - Discount rate assumption cannot be divorced from the plan's anticipated investment return

Withdrawal Liability – Measurement Date

National Retirement Fund v. Metz Culinary Management, Inc. 946 F.3d 146 (2d Cir. 2020)

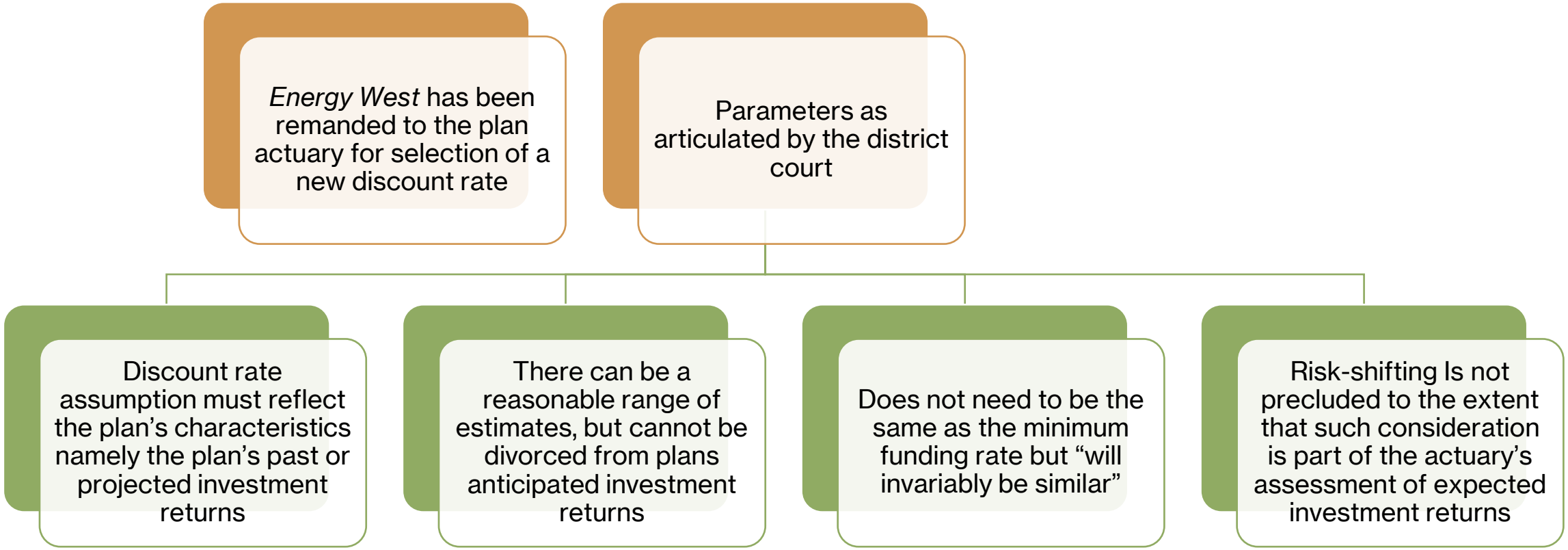
- Held that ERISA requires actuaries to use the rate assumption in effect as of the measurement date
- Funds may not select an interest rate assumption after such date and retroactively apply that assumption to withdrawal liability calculations

Withdrawal Liability –Measurement Date

Trustees of IAM Nat'l Pension Fund v. M&K Emp. Sols, No. 22-7157 (D.C. Cir. 2024)

- IAM Fund assessed withdrawal liability against two employers for a 2018 withdrawal
- As of December 31, 2017 (measurement date), the plan was using a discount rate of 7.5%
- Late January 2018, the actuary selected a new discount rate assumption of 6.5% - to be used retroactively
- D.C. Circuit upheld district court decision, which found ERISA allows for "later adoptions of actuarial assumptions, so long as those assumptions are 'as of' the measurement date – that is, the assumptions must be based on the body of knowledge available up to the measurement date."
- Calculation of the plan's experience, reasonable expectations, and the best estimate of anticipated experience must be "as of" the measurement date, not the date of the calculation.
- Expressly rejected the reasoning in Metz, finding that it was "counter to the text of the MPPAA…"

Withdrawal Liability – What's Next?



NEW PRE-EXAMINATION COMPLIANCE PILOT (“2.0”)

New Pre-Examination Compliance Pilot (“2.0”)

- February 7, 2024: IRS announced phase two of its expansion of the Pre-Examination Compliance Pilot Program.
- Under the pilot program, a plan may limit or entirely avoid an impending IRS audit if they promptly correct any identified errors via the IRS’s Self Correction Program (SCP).
- This follows phase 1 from June 3, 2022 - 100 letters sent, 72% responded which IRS says shows interest in the program.

New Pre-Examination Compliance Pilot ("2.0") – Continued

What does Pilot 2.0 look like?

- IRS will notify each plan by letter that it was selected for upcoming examination. Letters will be sent 90 days before examination would otherwise begin.
- The plan then has 90 days to review their plan's documents and operations to determine if current requirements are met.
- If the errors are identified, plan may self-correct the errors under the SCP.
  - Errors that aren't eligible for correction under the SCP can be corrected by requesting a closing agreement, and the IRS will use the favorable Voluntary Correction Program (VCP) fee structure to determine the sanction amount payable.
- At the end of pilot program, the IRS will evaluate the program's effectiveness and determine if it should continue to be part of its overall compliance strategy.

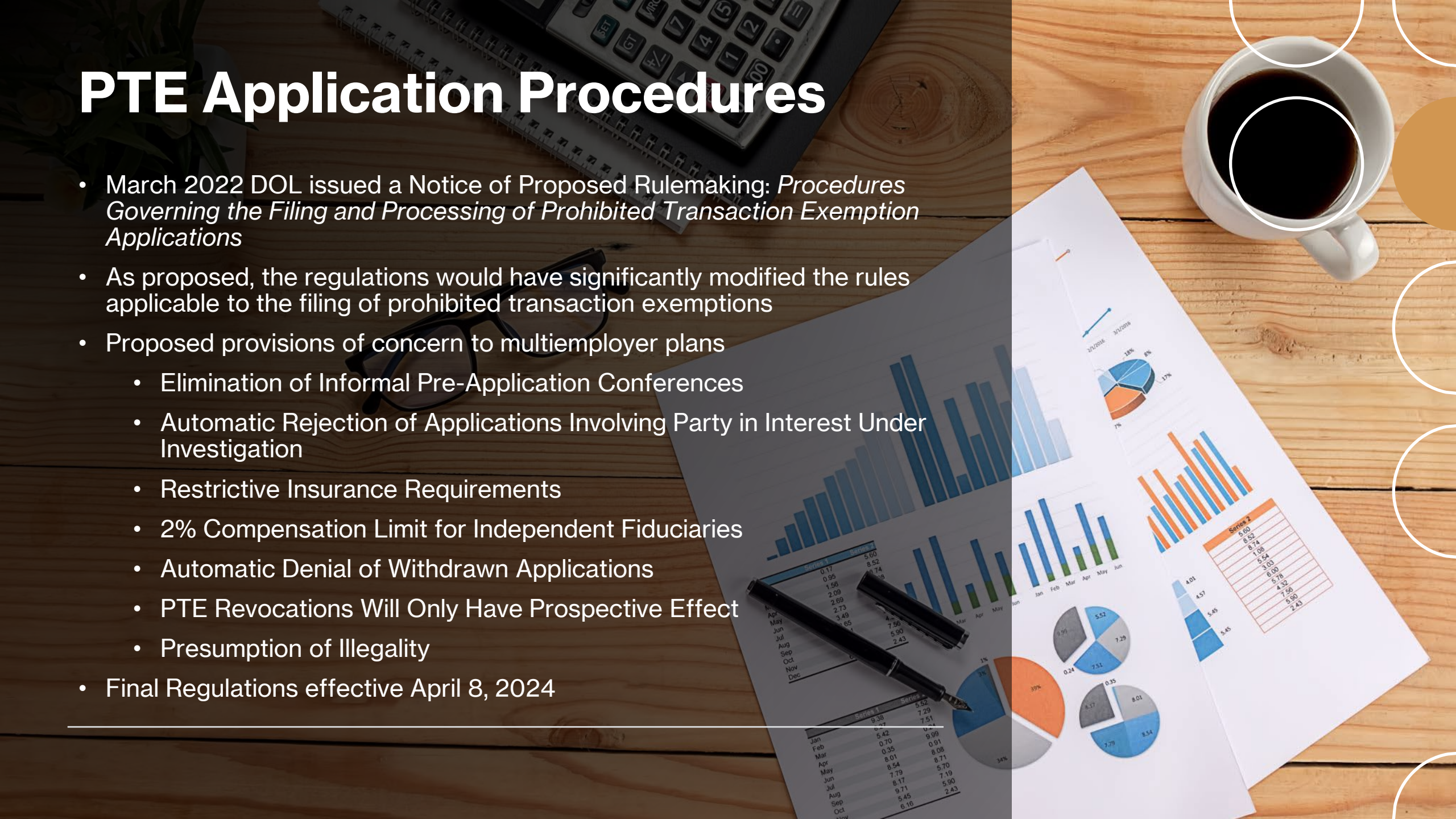
DOL PROHIBITED TRANSACTION EXEMPTION APPLICATION PROCEDURES

Prohibited Transaction Exemptions ("PTE")

- ERISA and the IRC prohibit a wide array of transactions involving employee benefit plans, which are necessary or advantageous for the operation of plans.
- As a result, Congress established a prohibited transaction exemption framework
  - Statutory PTEs, such as those that allow the payment of reasonable compensation to service providers; and
  - DOL has the authority to grant PTE on a class or individual basis, provided the exemption is:
    - Administratively feasible;
    - In the interest of participants and beneficiaries; and
    - Protective of the rights of participants and beneficiaries

PTE Application Procedures

- March 2022 DOL issued a Notice of Proposed Rulemaking: *Procedures Governing the Filing and Processing of Prohibited Transaction Exemption Applications*
- As proposed, the regulations would have significantly modified the rules applicable to the filing of prohibited transaction exemptions
- Proposed provisions of concern to multiemployer plans
  - Elimination of Informal Pre-Application Conferences
  - Automatic Rejection of Applications Involving Party in Interest Under Investigation
  - Restrictive Insurance Requirements
  - 2% Compensation Limit for Independent Fiduciaries
  - Automatic Denial of Withdrawn Applications
  - PTE Revocations Will Only Have Prospective Effect
  - Presumption of Illegality
- Final Regulations effective April 8, 2024



PTE Application Procedures – Pre-Application Communications

Proposal: All fact-specific communications with the Department that could lead to a PTE application would become part of the administrative record and would immediately be open to public inspection, without regard to whether the PTE application was filed.

Concern: This would have a chilling effect and discourage informal communications that are beneficial to both the parties involved in a proposed transaction and the Department, and could lead to streamlined and more efficient process.

Final Rule: Although pre-submission, fact specific communications would become part of the administrative record, they would not become available for public inspection until and unless a formal application is filed.

PTE Application Procedures – Party-in Interest Under Investigation

Proposal: An application will be automatically rejected if any party in interest involved in the proposed transaction is under investigation by, or engaged in any litigation with, any U.S. federal or state authority for any reason involving the enforcement of any domestic law.

Concern: Overreach, which would prohibit potentially valuable transactions having nothing to do with the investigation or litigation. For example, plans are often under audit for years for issues such as inability to located missing retirees, which would likely have nothing to od with a proposed transaction.

Final Rule: Substantially narrows the types of litigation or investigations that would be considered relevant to the PTE application to those that involve violations of ERISA or FERSA or that involve actual dishonesty. More importantly, the final rule eliminates the automatic disqualification, replacing it with an obligation to report any such relevant litigation or investigation to the Department.

PTE Application Procedures – Independent Fiduciary Insurance

Proposal: Independent fiduciaries chosen to oversee transactions contemplated by an individual PTE application would be required to have their own fiduciary insurance in an amount sufficient to reimburse the plan for any breach of contract or fiduciary duty by independent fiduciary.

Concern: Requiring independent fiduciaries to provide their own insurance in all cases could drive smaller independent fiduciaries out of the business, limiting the field to the large, institutional independent fiduciaries. Also, it would likely increase cost of obtaining and administering a PTE exemption.

Final Rule: The specific requirement that the independent fiduciary have his or her own insurance was eliminated. The PTE application is, however, required to include a description of any insurance maintained by the independent fiduciary, and insurance is a consideration in determining whether to grant the application.

PTE Application Procedures – 2% Compensation Limit for Independent Fiduciaries

Proposal: Independent fiduciary would be automatically rejected if he or she was projected to receive more than 2% of the fiduciary's annual revenues from parties associated with the transaction (including controlled group members), unless the Department determines otherwise in its sole discretion.

Concern: The reduction in the percentage threshold is likely to drive smaller, truly independent fiduciaries out of the marketplace, with no discernable benefit.

Final Rule: The Department eliminated the change in the threshold and has retained the existing percentages. Only subject to automatic rejection if revenues from interested parties and their affiliates exceed 5% of total annual revenues.

PTE Application Procedures – Automatic Denial of Withdrawn Applications

Proposal: Applications that are withdrawn would be formally denied.

Concern: Applications may be withdrawn for various reasons. Formally denying applications that may be withdrawn leaves an impression of wrongdoing.

Final Rule: The Department adopted its proposal.

PTE Application Procedures – Retroactive Effect of PTE Revocations

Proposal: Any revocation of a PTE would have prospective effect only. The Department would cease to have the authority to revoke PTEs retroactively.

Concern: None. This is a positive change that reenforces settled expectations.

Final Rule: The proposal was adopted.

PTE Application Procedures – Presumption of Illegality

Proposal: The proposal embodied a bias against individual PTEs. The presumption was that they were illegal transactions that should be avoided in favor of transactions that were not illegal.

Concern: Unlike single employer plans, multiemployer plans are separate entities that are at the center of a myriad of relationships and that do not have access to the resources of their contributing employers.

Final Rule: The most onerous provisions of the proposal were either eliminated or significantly ameliorated.

SFA LEGISLATION CONCERNS

SFA Legislation Concerns

- SFA Program - enacted as part of the American Rescue Plan Act (ARPA) of 2021, to provide funding to the most underfunded multiemployer pension plans, to provide funding with a goal of getting plans through 2051
- So far, over $52 billion in SFA has gone out, covering over 71,000 participants
- Recently Virginia Foxx, Chairwoman of the House Committee on Education and Workforce and Bob Good, Chairman of the House Subcommittee on Health, Employment, Labor, and Pensions have voiced “concerns” about misuse of taxpayer money

SFA Legislation Concerns - Continued

- Important to follow - we don't know where politics will go and we need to protect SFA assets and the process
- **What can we do?**
- Implement internal controls:
  - Demonstrate how amounts were calculated, who are the participants and beneficiaries?
  - Tracking SFA assets into investments and benefit payments
- Concerns regarding return of SFA:
  - Does PBGC have authority to recoup overpayments?
  - Is returning overpaid funds a fiduciary breach?

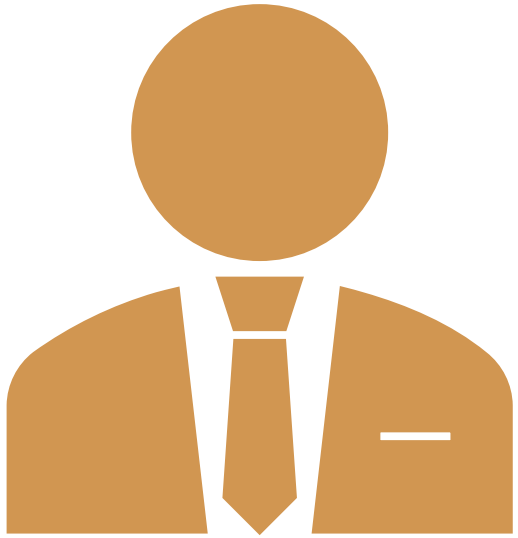
REQUEST FOR INFORMATION ON ZONE CERTIFICATION FORM

RFI Zone Certification

- Section 432(b)(3) requires an actuarial certification of whether a multiemployer plan is in endangered status, and whether a multiemployer plan is or will be in critical status, for each plan year
- Must be completed by the 90th day of the plan year
- If certification is within the plan's funding improvement period or rehabilitation period, actuary must also certify whether the plan is making scheduled progress in meeting the requirements of its funding improvement plan or rehabilitation plan

RFI Zone Certification

- IRS requested comments on Form 15315, *Annual Certification for Multiemployer Defined Benefit Plans*
- Comments were invited on:
  - Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility;
  - The accuracy of the agency's estimate of the burden of the collection of information;
  - Ways to enhance the quality, utility, and clarity of the information collected;
  - Ways to minimize the burden of the collection of information on respondents, including through automated collection techniques; and
  - Estimates of capital or start-up costs of operation, maintenance, and purchase of service to provide information



RFI Zone Certification

- Consistency in information provided to the IRS and other ERISA agencies is critical to them and other multiemployer plan stakeholders (including participants, plans, unions, and employers) in monitoring and evaluating the vitality of plans and the multiemployer system as a whole
- Current form only requires basic zone status information, which may limit its utility

RFI Zone Certification

- Push for More Information
  - Actuaries have to make projections and do analysis in order to complete the annual certification
  - If plan is in endangered or critical status, that fact, along with other relevant information must be disclosed on Schedule MB, form 5500, but much later
  - Requiring available actuarial information to be attached to the Form ensures the current data is used in evaluating the health of plans and multiemployer system and stakeholders can analyze the well-being of plans and the multiemployer system on a near rea;-time basis
  - Because actuaries already prepare projections and analysis to complete the annual certification, attaching the documentation is not overly burdensome

Questions??