Hodgson Russ LLP
ATTORNEYS

EMPLOYEE BENEFITS DEVELOPMENTS SEPTEMBER 2012

Hodgson Russ Newsletter
September 28, 2012

Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Department of Labor Updates 408b-2 Notice Procedures

Many service providers to plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) (with certain exceptions) were required to provide disclosures to responsible plan fiduciaries by July 1, 2012, regarding compensation they are receiving and potential conflicts of interest. A failure to meet these disclosure obligations results in a prohibited transaction under ERISA and the Internal Revenue Code of 1986 (IRC) by the service provider.

Even though a service provider fails to make adequate disclosure, a responsible plan fiduciary will not be considered to have engaged in a prohibited transaction, provided the responsible plan fiduciary did not know the service provider failed to make the required disclosure, and it reasonably believed that disclosure was made. A "responsible plan fiduciary" is a fiduciary with authority to cause the plan to enter into, extend, or renew the contract with the service provider.

The responsible plan fiduciary must review a service provider's 408b-2 disclosure for completeness, reasonableness of compensation, and any potential conflicts of interest. If the responsible plan fiduciary discovers deficiencies with respect to a service provider's disclosure, it must request in writing that the service provider correct the deficiency. In the event that the deficiency is not corrected within 90 days of the responsible plan fiduciary's written request (or the service provider refuses to furnish the requested information, if earlier), then the responsible plan fiduciary is obligated to notify the U.S. Department of Labor (DOL) of the service provider's failure within 30 days. The responsible plan fiduciary should also terminate the service provider as soon as possible, consistent with its fiduciary duty of care.

Previously, the notice to the DOL could be sent to an electronic or regular mailing address. While the notice may still be sent by regular mail, a new mailing address must be used:

U.S. Department of Labor
Employee Benefits Security Administration
Office of Enforcement
P.O. Box 75296
Washington, D.C. 20013

The notice may no longer be sent via e-mail. Instead, the notice may be submitted electronically by following the instructions on the "Fee Disclosure Failure Notice" page on the DOL website. Also available at the website is a model fee disclosure failure notice that may be completed and submitted to the DOL by regular mail. However, responsible plan fiduciaries choosing to utilize the model notice should take note that, as of the date of this publication, the model notice still uses the previous mailing address.

Guidance Issued on ERISA 101(j) Notice on Underfunded Defined Benefit Plans

As sponsors of defined benefit plans are well aware, certain limitations are imposed on a defined benefit plan when a plan's adjusted funding target attainment percentage (AFTAP) is below 80 percent. Additional limitations are imposed if the AFTAP is below 60 percent. When these limitations become applicable, a notice must be provided to participants and beneficiaries who are subject to the applicable benefit limitations. While the notice requirement has been in effect for several years, the Internal Revenue Service (IRS) recently issued Notice 2012-46 to provide guidance on the contents of the notice, the time and manner in which notices must be delivered, and which participants and beneficiaries are required to receive the notice. Notice 2012-46 also offers model language that can be used to provide the required notice.

Sponsors of defined benefit plans with AFTAPs below 80 percent should review with their advisors the form of notice suggested by the IRS to be certain that the notice that will be given complies with the guidance. Notice 2012-46 goes into effect November 1, 2012, and can be relied upon earlier. (IRS Notice 2012-46)

Health Care Reform Guidance on the Play-or-Pay Mandate

Late last month, the federal agencies responsible for the administration and enforcement of the Affordable Care Act (ACA) issued guidance in the form of Notices 2012-58 (issued by the IRS) and 2012-59 (issued by the Department of Labor, the Department of Health and Human Services, and the Treasury). Notice 2012-58 provides employers with safe harbor methods for determining whether an employee is a full-time employee for purposes of the employer shared responsibility provisions of Section 4980H of the Internal Revenue Code (i.e., the so-called "play-or-pay" mandate). Notice 2012-59 provides guidance on the prohibition against waiting periods in excess of 90 days. These requirements become effective January 1, 2014.

Notice 2012-58 – Play-or-Pay

Under Section 4980H of the Code, an "applicable large employer" (i.e., an employer with 50 or more full-time employees, including full-time equivalent employees) will pay a penalty for any month if at least one of its full-time employees is certified as having enrolled for that month in a qualified health plan through an exchange for which premium or cost-sharing assistance is allowed or paid and either (1) the employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage or (2) the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage but that coverage is not affordable or does not provide minimum value.

An employee is full time if he or she works an average of 30 or more hours per week.

Without administrative relief, the play-or-pay mandate would require employers to identify their full-time employees on a month-to-month basis. Under such a rule, employers with a significant number of hourly employees with irregular schedules (e.g., per diem employees) or seasonal employees (or both) would face significant administrative burdens.

In response to employer concerns, the IRS outlined an approach in Notice 2011-36 that would permit employers to determine full-time employees for any period, such as a plan year (referred to as a stability period), based on hours worked in some prior defined "look-back" period (referred to as a measurement period). Under this rule, if an employee is determined to be full time during the measurement period, the employee would be treated as full time during the subsequent stability period (e.g., the plan year) regardless of the employee's work schedule during the stability period. If an employee was not full time during the measurement period, the employee would not need to be treated as full time during the stability period even if the employee was, in fact, full time during the stability period.

In Notice 2012-17, the IRS described a similar approach (i.e., involving the use of a look-back measurement period) for determining the full-time status of new employees if, based on all of the facts and circumstances, the employer cannot reasonably determine whether the new employee will work full-time because the employee's hours are variable or otherwise uncertain.

Notice 2012-58 incorporates the concepts described in Notices 2011-36 and 2012-17 but modifies and expands them, permitting (but not requiring) employers to utilize a look-back measurement period for identifying full-time employees during a subsequent stability period.

The rules are flexible but somewhat complex and certainly novel in the context of health plan administration. A detailed summary of the rules is beyond the scope of this newsletter.

Consider the following example:

Acme Corp. maintains a health plan for full-time employees. The plan year is the calendar year. An employee is full time if he or she works an average of at least 30 hours per week. Acme has a significant number of per diem and part-time employees who work between 25 and 40 hours per week, depending on the availability of work. Acme chooses to use the safe harbor methods outlined in Notice 2012-58 and chooses the plan year as the stability period and the 12-month period ending on October 14 (which corresponds with the start of the open enrollment period) as the look-back measurement

period. Between October 14 and the beginning of the plan year, Acme determines which employees worked full-time during the measurement period, notifies employees of their eligibility for the upcoming plan year, and performs other tasks associated with the annual open enrollment process. Based on Acme's election, any employee who is determined to be full time during the measurement period will be treated as a full-time employee during the upcoming plan year for purposes of the play-or-pay mandate, regardless of the employee's work schedule during the plan year. An employee who was not full time during the measurement period would not need to be treated as full time during the stability period even if the employee was, in fact, working full time during the plan year.

Notice 2012-59 – 90 Day Waiting Period Limitation

For plan years beginning on or after January 1, 2014, a group health plan or health insurance issuer may not use a waiting period that exceeds 90 days. Under Notice 2012-59, a waiting period is the period of time that must pass before coverage of an employee or dependent who is otherwise eligible to enroll can become effective. An employee is eligible for coverage when he or she meets the plan's substantive eligibility conditions, such as, for example, employment within an eligible employment classification. Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days.

If a group health plan bases eligibility on the completion of a specific number of hours of service during a period (e.g., a weekly or biweekly period) and the employer is unable to reasonably determine whether a new hire will meet this requirement, Notice 2012-59 permits the employer to measure the employee's service over a measurement period that would be permitted under Notice 2012-58 (discussed above). To take advantage of this rule, coverage must become effective no later than 13 months from the employee's start date, plus the time remaining until the first day of the next calendar month.

Notice 2012-59 contains the following examples:

1. Facts. Employer X's group health plan limits eligibility for coverage to full-time employees. Coverage becomes effective on the first day of the calendar month following the date the employee becomes eligible. Employee B begins working full time for Employer X on April ll. Prior to this date, B worked part time for X. B enrolls in the plan and coverage is effective May 1.

Conclusion. In this example, the period from April 11 through April 30 is a waiting period. The period while B was working part time is not part of the waiting period because B was not in a class of employees eligible for coverage under the terms of the plan while working part time, and full-time versus part-time status is a bona fide employment-based condition that is not considered to be designed to avoid compliance with the 90-day waiting period limitation.

2. Facts. Under Employer Y's group health plan, only employees who work full time (defined under the plan as regularly working 30 hours per week) are eligible for coverage. Employee C begins work for Employer Y on November 26 of Year 1. C's hours are reasonably expected to vary, with an opportunity to work between 20 to 45 hours per week, depending on shift availability and C's availability. Therefore, it cannot be determined at C's start date that C is reasonably expected to work full time. Under the terms of the plan, variable-hour employees, such as C, are eligible to enroll in the plan if they are determined to be full time after a measurement period of 12 months. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. C's 12-month measurement period ends

November 25 of Year 2. C is determined to be full time and is notified of C's plan eligibility. If C then elects coverage, C's first day of coverage will be January 1 of Year 3.

Conclusion. In this example, the measurement period is not considered to be designed to avoid compliance with the 90-day waiting period limitation (and is, therefore, permissible) because the plan may use a reasonable period of time to determine whether a variable-hour employee is full time if the period of time is consistent with the timeframe permitted for such determinations under Code Section 4980H. In such circumstances, the time period for determining whether an employee is full time will not be considered to avoid the 90-day waiting period limitation if coverage can become effective no later than 13 months from C's start date, plus the time remaining until the first day of the next calendar month.

CASES

Eighth Circuit Denies Deference to Administrative Decision and Upholds $749,037 Award

A recent decision by the U.S. Court of Appeals for the Eight Circuit illustrates the importance of following the decision-making procedures of a plan's governing documents.

The case at hand involves two executives who had executed performance share and restricted stock agreements under their company's long-term incentive and equity compensation plans. Although the agreements required the executives to be employed for three years to receive the full number of shares awarded under the plans, if they retired or were involuntarily terminated without cause, they would be entitled to pro rata payments of their stock awards.

Following a company transaction and the executives' transfer to a new location, the two executives terminated employment with the company before the end of the performance period that would entitle them to full vesting of their shares. The executives claimed a pro rata share of their stock under the retirement provisions of the plans. Although the plans and agreements do not define the term "retirement," an administrative vice president determined that the executives were not entitled to pro rata payments because their terminations did not qualify as retirement. The executives sued the company for breach of contract, and a district court found for the executives, holding that their terminations qualified as retirement under the plans. The court awarded them damages equal to the value of their pro rata shares.

On appeal, the company argued that its determination was entitled to deferential review—that the vice president's determinations must stand "absent evidence of fraud, bad faith, or a gross mistake in judgment" because the company had discretion and decision-making authority with respect to the awards. The Eighth Circuit disagreed, noting that the agreements and the plan documents grant discretionary authority only to the executive compensation committee (ECC) of the board of directors, and that the ECC neither decided the claims nor delegated decision-making authority to the vice president. Finding that the decision of the vice president therefore was not entitled to deference, the Eighth Circuit upheld the lower court's award of $749,037 to the executives. (*Schaffart v. ONEOK Inc.*, 8th Cir. 2012)

Plan's Statute of Limitation Provision Bars Benefits Claim

The U.S. District Court for the Northern District of Ohio, Eastern Division recently held that a plaintiff's action to recover long-term disability benefits for a 2001 benefit claim was barred by the plan's three-year contractual statute of limitations clause. In this case, the plaintiff was denied long-term disability benefits in 2001, even though he was diagnosed with severe, steroid-dependent Crohn's Disease and anemia, among other disabling medical conditions. The plaintiff filed two administrative appeals, but the plan upheld its determination to deny benefits. If the plaintiff wanted to file a legal action in connection with the plan's denial of his 2001 claim for long-term disability benefits, the plan required him to do so within three years. The plaintiff did not file a legal action within the three-year period. However, the plaintiff asserts that he never received a copy of the plan, and the summary plan description (SPD) he did receive did not contain any language regarding the three-year statute of limitations provision.

In 2008, the plaintiff filed a second claim for long-term disability benefits. This time, the claim was approved by the plan. The plan's approval letter also indicated that the plaintiff could submit additional information to support a request for disability benefits based on an earlier date of disability. The plaintiff responded with a letter reflecting his belief that the plan's denial of his long-term disability claim in 2001 was incorrect, and that 2001, not the 2008 date, should be the disability date for the 2008 disability claim.

The Employee Retirement Income Security Act of 1974 (ERISA) does not contain a statute of limitations for claims for benefits, and courts normally apply the most analogous state statute of limitations. However, when a plan contains a reasonable contractual statute of limitations, courts generally apply the contractual statute of limitations. In this case, the court held that the plaintiff's legal action to recover benefits under the 2001 claim was barred by the plan's three-year statute of limitations provision. The court noted that even if the plaintiff received only the SPD (that did not contain a reference to the three-year statute of limitations), the SPD cannot change the terms of the plan itself, which does contain a three-year statute of limitations provision. Furthermore, the court stated that the plaintiff's ignorance of the three-year limitation is not sufficient, on its own, to render the plan's statute of limitations provision unenforceable.

This case illustrates how including a statute of limitations provision in an ERISA plan document can protect the plan from a lawsuit despite other administrative procedural errors that may have occurred. (*Engleson v. Unum Life Insurance Co. of America*, N.D. Ohio 2012)

Fourth Circuit Affirmed Decision Dismissing Claims on Definition of Normal Retirement Age

Bank of America established a cash balance defined benefit pension plan in 1998. In that plan, normal retirement age was defined as the earlier of attainment of age 65 or completion of 16 months of vesting service.

The purpose of this definition of normal retirement age was to avoid what is known as the "whipsaw effect" in a cash balance plan. The whipsaw effect could require that a lump-sum payment be distributed to a participant of an amount greater than what the cash balance plan's hypothetical account balance would be at the time of distribution. By defining normal retirement age to be equivalent to the time at which vesting occurs under the plan, any participant with a vested

interest would not have a whipsaw effect resulting from projecting the hypothetical account balance forward to normal retirement age using one rate of interest and bringing it back to time of distribution using a different interest rate established under rates published by the Internal Revenue Service (IRS).

A group of plaintiffs brought a class-action lawsuit challenging the validity of Bank of America's use of this definition of normal retirement age, arguing that it resulted in an impermissible backloading of benefit accruals The U.S. Court of Appeals for the Fourth Circuit affirmed the lower court's decision that calculation of a normal retirement age based on years of service met the requirements of Employee Retirement Income Security Act of 1974 (ERISA) Section 3(24) and rejected the backloading claim. (*McCorkle, et al. v. Bank of America Corp.*, 4th Cir. 2012)

Employee Benefits Practice Group

Peter K. Bradley
pbradley@hodgsonruss.com

Anita Costello Greer
agreer@hodgsonruss.com

Michael J. Flanagan
mflanagan@hodgsonruss.com

Richard W. Kaiser
rkaiser@hodgsonruss.com

Arthur A. Marrapese, III
art_marrapese@hodgsonruss.com

Ryan M. Murphy
rmurphy@hodgsonruss.com