EMPLOYEE BENEFITS DEVELOPMENTS AUGUST 2012

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Employee Benefits

RULINGS, OPINIONS, ETC.

Basing Matching Contributions to Qualified Plan on Employee Salary Deferrals to 403(b) Plan Subjects 403(b) Plan to ERISA

In U.S. Department of Labor (DOL) advisory opinion 2012-02A, the DOL ruled that basing matching contributions to an Employee Retirement Income Security Act of 1974 (ERISA) covered money purchase plan upon employees' salary deferrals to a 403(b) plan prevented the 403(b) plan from qualifying for the exemption from ERISA under 29 C.F.R. § 2510.3-2(f). The ruling affects tax-exempt organizations with "linked" 403(b) arrangements.

With certain exceptions, ERISA generally applies to any pension plan "established or maintained" by an employer. A 403(b) arrangement is not treated as a pension plan "established or maintained" by an employer provided the safe harbor conditions in 29 C.F.R. § 2510.3-2(f) are met. Specifically:

1. The arrangement must be funded solely through salary reduction agreements or agreements to forego an increase in salary.

2. Participation by employees must be completely voluntary.

3. All rights under the 403(b) arrangement must be enforceable solely by the employee, an employee's beneficiary, or an employee's (or beneficiary's) authorized representative.

4. The employer's involvement is limited to certain specified activities.

5. The employer receives no direct or indirect compensation other than reasonable compensation to cover expenses incurred by the employer in performing its duties under a salary reduction agreement or agreement to forego salary increases.

By basing matching contributions to the money purchase plan on salary deferrals to a 403(b) plan, the DOL ruled that the safe harbor requirements that participation by employees in the 403(b) arrangement be completely voluntary and that employer involvement be extremely limited were not met. As a result, the 403(b) arrangements were deemed to be ERISA plans, subjecting them to ERISA's reporting and fiduciary regimes.

IRS Clarifies Treatment of Dividends and Dividend Equivalents Paid on Restricted Stock and Restricted Stock Units Under Section 162(m)

Internal Revenue Code (IRC) § 162(m) generally prohibits a publicly traded corporation from deducting compensation paid to "covered employees" in excess of $1 million per year. There are several exceptions to this limitation. One important exception is for amounts paid as qualified performance-based compensation, which become payable on account of the achievement of certain performance goals.

To preserve deductibility, many restricted stock or restricted stock unit plan arrangements are structured to provide that vesting occurs only on achievement of a permissible performance goal under IRC § 162(m). In Rev. Rul. 2012-19, the Internal Revenue Service (IRS), provides some clarity with respect to treatment of dividends or dividend equivalents paid on restricted stock or restricted stock units. The IRS indicates that the payment of the dividend or dividend equivalent is a separate grant from the underlying restricted stock or restricted stock unit. Therefore, the deductibility of the dividend or dividend equivalent is based on whether those amounts are payable only on achievement of the performance-based goal. For example, in a situation where the plan accumulates the dividends and dividend equivalents and only pays those amounts if the underlying shares or units become vested on satisfaction of the performance goal, the IRS held that the dividend or dividend equivalent qualifies for the performance-based compensation exception. However, where the dividend or dividend equivalent is paid at the same time that dividends are generally paid on the other shares and thus is not subject to the condition that the performance goal must be satisfied, those amounts are subject to the $1 million deduction limitation. (Rev. Rul. 2012-19)

CASES

Medical Plan Preauthorization Language Violates SPD Standards

In *Koehler v. AETNA Health Inc.*, the U.S. Court of Appeals for the Fifth Circuit held that Aetna's benefits decision was not, as a matter of law, entitled to deference where the same document, Aetna's certificate of coverage, served as both the plan document and summary plan description (SPD).

In *Koehler*, Aetna refused to reimburse a participant for care she received from a specialist who was not in the plan's participating provider network. Exercising its right to construe the plan, a right conferred upon Aetna under the terms of the certificate, Aetna determined that the certificate required preauthorization of out-of-network claims, and because the participant had not obtained preauthorization, Aetna denied the claim.

Shortly thereafter, the participant filed suit in federal district court. The court ruled against the participant, finding that Aetna did not abuse its discretion in construing the terms of the plan. The participant appealed. On appeal, the Fifth Circuit ruled that the need for pre-authorization was not clearly stated in the certificate; that Aetna's interpretation of the ambiguous preauthorization provision was legally incorrect; and that the failure to clearly state the plan's preauthorization rules was a violation of the legal standards that apply to SPDs. The Fifth Circuit ruled that where an SPD and plan document are identical, ambiguities in the document will be resolved in favor of participants and beneficiaries, even if the document gives the administrator the discretion to resolve ambiguities in the plan language.

As this case illustrates, the standards that apply to the interpretation of a plan may differ depending on how a plan is documented. Where the plan document and SPD are separate and distinct documents, the plan administrator is likely to be afforded greater latitude in construing the terms of the plan. This case also illuminates one of the most important standards impacting the content of SPDs, which is that SPDs must completely and accurately document the circumstances under which benefits can be lost or forfeited. (*Koehler v. AETNA Health Inc.*, 5th Cir. May 2012)

Sixth Circuit Holds Employer Did Not Breach Fiduciary Duties in Transferring Investments From Stable Value Fund to New Qualified Default Investment Alternative

Following the issuance of regulations by the U.S. Department of Labor (DOL) relating to Qualified Default Investment Alternatives (QDIAs), University Medical Center, Inc. (UMC) decided to change its default fund from the Lincoln Retirement Services Company Stable Value Fund to Lincoln's Lifespan Fund. UMC did not maintain records that would allow it to determine which participants had elected to invest in the Stable Value Fund versus those participants who had been invested in that fund by default. As a result, UMC mailed notices to any participant with one hundred percent of their investment in the Stable Value Fund, advising that all existing investments in the Stable Value Fund would be transferred to the Lifespan Fund unless the participant directed otherwise by July 16, 2008.

The plaintiffs in the case failed to respond to the notice and therefore had their investments transferred to the Lifespan Fund. The plaintiffs claimed that they never received the notice—that it was only upon receiving their quarterly benefit statements they learned of the transfer. At that time, the plaintiffs returned their investments to the Stable Value Fund, but not before sustaining losses during the interim. While UMC could demonstrate that all notices had been mailed and that the addresses it had for the plaintiffs were correct, there was no evidence that the notice was received by the plaintiffs.

The U.S. Court of Appeals for the Sixth Circuit upheld the lower court's ruling that the DOL's QDIA regulation shielded UMC from liability to the plaintiffs. In relevant part, that regulation provides that, with certain exceptions:

[A] fiduciary of an individual account plan that permits participants or beneficiaries to direct the investment of assets in their accounts and that [satisfies certain conditions] shall not be liable for any loss, or by reason of any breach under part 4 of title I of ERISA, that is the direct and necessary result of [] investing all or part of a participant's or beneficiary's account in any [QDIA].

Two of the specified conditions are that 1) participants and beneficiaries have been given an opportunity to provide investment instruction but have not done so, and 2) a notice generally must be furnished to participants and beneficiaries in advance of the first investment in the QDIA and annually thereafter.

The plaintiffs did not argue that UMC failed to satisfy the required conditions set forth in the DOL regulation; they instead argued that that the DOL regulation did not apply in the first instance because they had elected to invest in the Stable Value Fund. Reviewing the DOL's commentary to the regulation, the court made quick work of plaintiffs' argument. It noted that the "DOL stated explicitly that 'the final regulation applies to situations beyond automatic enrollment,'" and that it extends to any "failure of a participant or beneficiary to provide investment instruction," "without regard to whether the participant or beneficiary was defaulted into or elected to invest in the original default investment vehicle of the plan." Since the plaintiffs failed to provide investment instructions in response to UMC's notice regarding the plan's new default investment, the Sixth Circuit held that UMC was entitled to the regulation's protections in transferring the plaintiffs' investments. The Sixth Circuit also noted that although the plaintiffs failed to address whether proper notice was provided, UMC's actions were "reasonably calculated to ensure actual receipt of the material by plan participants," which is all that is required by ERISA. (*Bidwell v. Univ. Med. Ctr.*, Docket No. 11-5493, 6th Cir. June 29, 2012)

No Fiduciary Breach Where ESOP Trustee Was Not Acting in His Fiduciary Capacity

Pursuing a claim for breach of fiduciary duty against an individual necessarily involves the claimant establishing that the individual's breach was committed while acting in his or her fiduciary capacity. In a recent case against an employee stock ownership plan (ESOP) trustee, the plaintiffs failed to make that case.

In 2003, the defendant in the aforementioned case incorporated a new company, National Financial Systems Management, Inc. (NFSM), and the NFSM board of simultaneously created an ESOP. All of NFSM's stock was held by the ESOP, and the defendant was designated as the ESOP trustee. NFSM's revenue came in the form of "management fees" paid by two other companies owned by defendant. In 2007 and 2008, NFSM purchased those two other companies from the defendant. The purchase price for the two companies was paid in part by the issuance of promissory notes. In 2009, the defendant entered into "default agreements" with NFSM, under which NFSM acknowledged it was in default on the outstanding promissory notes. NFSM then transferred the stock of the two companies back to defendant. The defendant did not refund any payments made by NFSM for the two companies and subsequently sold those two companies to a third party.

The plaintiffs commenced a lawsuit alleging, among other things, that the defendant breached his fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA). The court dismissed the fiduciary duty claim. First, the court noted that the plaintiffs alleged that the defendant took part in or sanctioned in some way NFSM's purchase of the two companies as CEO of NFSM. To whatever extent the defendant was involved in the transaction as a buyer on the NFSM side, the court concluded that the defendant participated as an agent for NFSM, and *was thus acting as an employer*. Second, ERISA fiduciary duties attach only to transactions that involve investing the ESOP's assets or administering the ESOP. The defendant, in his role as seller, did not make any decision with respect to the ESOP; he merely offered up assets for sale to NFSM and received the purchase price.

Therefore, to the extent that the plaintiffs challenge the defendant's involvement as seller of the two companies purchased by NFSM, the court ruled that the transaction is not governed by ERISA. The same reasoning applies to the defendant's alleged participation in NFSM's decision to transfer the two companies back to defendant via default agreement. (*Middleton v. Stephenson*, D. Utah 2012)

Faulty Denial Letters Result in Ruling Favorable to Plaintiff

The U.S. Court of Appeals for the Tenth Circuit ruled in favor of a plaintiff where a disability plan's benefit denial letters cited the wrong sections of the summary plan description (SPD). In this case, the plaintiff worked for his employer for approximately 37 years before a disability caused him to take an early retirement. After he retired, the plaintiff submitted a written claim to the plan administrator stating that the Social Security Administration had found him to be permanently and totally disabled as of a date prior to the date he retired. The plaintiff then asserted a claim for the plan's permanent and total disability life insurance benefit. The plan administrator subsequently denied his claim both initially and on administrative appeal.

The Employee Retirement Income Security Act of 1974 (ERISA) requires plan administrators to provide claimants with specific reasons for a claim denial. The U.S. Department of Labor's (DOL) regulations explain that the notice of a claim denial must contain "[t]he specific reason or reasons for the adverse determination" and "[r]eference to the specific plan provisions on which the determination is based." In this situation, the plan's denial letters cited specific sections of the SPD, but they were the wrong sections. The benefit plan's SPD was organized into five sections: "Healthcare Benefits," "Life and Accident Insurance Benefits," "Disability Benefits," "Retirement Benefits," and "Other Important Information." A subsection within the "Disability Benefits" section provides for permanent and total disability life insurance benefits. However, both the initial and appeal denial letters cited the "Healthcare Benefits" section of the SPD to support the decision to deny the plaintiff's disability benefit. Relying on the administrative record, the court held that the plan administrator's decision to deny disability benefits based on the "Healthcare Benefits" section of the SPD was arbitrary and capricious. Furthermore, the court concluded that the appropriate remedy was to remand the case to the district court with directions for the district court to modify its order and enter judgment in favor of the plaintiff. The Tenth Circuit also instructed the lower court to consider on remand whether the plaintiff is entitled to attorney fees and prejudgment interest.

This case provides an example of the importance of establishing and following claim denial procedures. As noted above, the procedures should cite specific plan language supporting the reason for a denial. Plan administrators should review their claim denial procedures and monitor the claim denial letters to confirm that the proper process is being followed. (*Spradley v. Owens-Illinois Hourly Employees Welfare Benefit* Plan, 10th Cir. 2012)

First Circuit Rules DOMA Unconstitutional

The U.S. Court of Appeals for the First Circuit weighed in on the validity of the federal Defense of Marriage Act (DOMA), finding unconstitutional the denial of federal benefits to same-sex couples lawfully married in Massachusetts. The First Circuit noted that although DOMA does not prohibit same-sex marriages under state law, it imposes financial and other burdens on same-sex couples, preventing them from enjoying certain benefits of marriage afforded opposite-sex couples.

Unlike their opposite-sex counterparts, for example, same-sex couples may not file joint tax returns, with the resultant tax savings, or receive Social Security survivor benefits upon a spouse's death. Finding that the denial of federal benefits to legally married same-sex couples "has not been adequately supported by any permissible federal interest," the First Circuit upheld a lower court decision that the law is unconstitutional. Nevertheless, the First Circuit stayed its decision, anticipating a review of DOMA by the U.S. Supreme Court. (*Massachusetts v. HHS*, 1st Cir. 2012)

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