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EMPLOYEE BENEFITS DEVELOPMENTS APRIL 2012

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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Agencies Issue New FAQs Regarding Summary of Benefits and Coverage

The U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury have issued a set of frequently asked questions (FAQs) regarding the implementation of the Patient Protection and Affordable Care Act. This guidance, the eighth in a series of FAQs that the agencies have published, focuses on the Summary of Benefits and Coverage (SBC). The SBC is a new document that group health plans and insurance issuers will be required to provide to plan participants regarding their benefits. Below are some of the issues addressed by this recent guidance.

Plans must provide SBCs during the first open enrollment period on or after September 23, 2012. Group health plans must provide an SBC to participants and beneficiaries who enroll or re-enroll through an open enrollment period, beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll outside the open enrollment period (e.g., special enrollees or newly eligible individuals), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

No penalties during first year for plans working in good faith to comply. The guidance reiterates the agencies' position of emphasizing compliance assistance rather than the imposition of penalties. Consistent with this approach, the guidance provide that during the first year of applicability, the agencies will not impose penalties on plans that are working diligently and in good faith to provide the required SBC content in a manner consistent with the regulations.

No separate SBC for each tier of coverage. If a group health plan offers different coverage tiers (e.g., employee-only, employee-plus-one, and family coverage), the plan may combine the information in a single SBC. In such circumstances, the coverage examples in the SBC should be completed using cost sharing for the

employee-only tier, and the coverage examples should note this assumption.

Under certain circumstances, the SBC may be provided electronically. For participants and beneficiaries *who are eligible but not enrolled for coverage*, an SBC may be provided electronically, if:

- The format is readily accessible (i.e., html, MS Word, or pdf format);
- Upon request, the SBC is provided in paper form free of charge; and
- If the SBC is provided through the Internet, the plan or issuer must provide the Internet address and, in a timely manner, must advise participants and beneficiaries that the SBC is available. Plans and issuers may make this disclosure by mail. The guidance provides sample language for this disclosure (referred to as an e-card or postcard).

For participants and beneficiaries *who are covered under a plan*, an SBC may be provided electronically, so long as the disclosure complies with DOL regulations. The DOL regulations contain a safe harbor for electronic disclosures for participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and, with respect to whom, access to the employer's electronic information system is an integral part of those duties. Other individuals may also opt into electronic delivery under the safe harbor.

The entire set of FAQs on the new health care law can be found by clicking on the "FAQs" tab on the left side of the DOL Employee Benefit Security Administration website at www.dol.gov/ebsa.

Retirement Annuities: New IRS Guidance

There is a growing interest in making annuities available to retirees under defined contribution retirement plans, including 401(k) plans. At some point in the near future, it is possible that we will see the government mandate the availability of annuities in all defined contribution retirement plans. With that in mind, it is worth noting that two rulings were recently published that have a bearing on retirement annuities in qualified retirement plans.

In Revenue Ruling 2012-3, the Internal Revenue Service attempts to clarify how the qualified joint and survivor annuity (QJSA) rules, as well as the qualified preretirement survivor annuity (QPSA) rules, apply when employees purchase deferred annuity contracts under a profit-sharing plan that does not make other annuity options available to participants. The ruling considers three scenarios in which the plan offers a deferred annuity contract with varying election options, and analyzes whether each
of the scenarios allows the plan to remain exempt from the application of the QJSA and QPSA requirements. In broad terms, the ruling holds that the survivor annuity rules do not apply if, under the plan's deferred annuity investment option, the participant is able to transfer assets out of the deferred annuity contract at any time before annuitization.

Revenue Ruling 2012-4 provides a roadmap for how employees may be permitted to receive lump-sum cash payments from a defined contribution plan and can then roll over some or all of those amounts to a defined benefit pension plan sponsored by the same employer (assuming the pension plan accepts rollover contributions) as a means of annuitizing the defined contribution plan benefit. This ruling holds Internal Revenue Code (IRC) Sections 411 and 415 are not violated by the

defined benefit pension plan if it provides an annuity resulting from the rollover that is determined by converting the amount rolled over into an actuarially equivalent immediate annuity using the applicable interest rate and the applicable mortality table under IRC Section 417(e). The holdings of this ruling do not apply with respect to rollovers made before January 1, 2013. However, employers may rely on the ruling with respect to any rollovers made prior to that date.

Supreme Court Considers Constitutionality of Individual Mandate

At the end of March, the U.S. Supreme Court heard arguments on the constitutionality of a provision in the Patient Protection and Affordable Care Act (ACA) that requires most U.S. residents to maintain health care coverage for themselves and their dependents. Individuals who fail to do so pay a penalty to the Internal Revenue Service (IRS) when they file their federal tax returns. This requirement becomes effective January 1, 2014, and is referred to as the "individual mandate." The Supreme Court is expected to hand down a decision this June. Below is a summary of the main questions before the Supreme Court, the arguments made on behalf of the respective parties—the federal government on one hand, 26 states and private petitioners on the other—and what employers should do in this uncertain legal environment.

Questions Before the Supreme Court

With respect to the individual mandate, there are three questions before the Supreme Court:

1. Does the Supreme Court have the right to rule on the constitutionality of the individual mandate?

2. Does Congress have the power under Article I of the Constitution to enact the individual mandate?

3. If the individual mandate is an unconstitutional exercise of Congress's enumerated powers, to what extent, if any, should other provisions of the ACA go down with it?

Does the Supreme Court have the right to rule on the constitutionality of the individual mandate? As a general rule, individuals who wish to challenge a tax or penalty must pay first and litigate later. Certain provisions of U.S. tax law are designed to prevent courts from interfering with the federal government's right to assess and collect taxes, and compel taxpayers to raise their objections in suits for refunds. If these provisions apply to the individual mandate, no court, including the Supreme Court, could restrain the assessment or collection of the penalty before it is due and before the exhaustion of the procedures that apply to the assessment and collection of a tax. No person will be liable for the penalty until the due date for the 2014 federal income tax return (April 2015). The U.S. Court of Appeals for the Fourth Circuit held last year that the courts, at this juncture, cannot rule on the constitutionality of the individual mandate. Some experts believe the Supreme Court will disagree.

Is the individual mandate constitutional? The states and private litigants argue that the requirement to purchase insurance or pay a penalty is not a permissible regulation of interstate commerce. They argue that while Congress has the power to regulate commerce, the power to regulate commerce does not include the power to compel individuals to enter into commerce. Such a requirement, the states argue, is an unprecedented use of Congress's power. A decision to not purchase health insurance constitutes inactivity, which is not connected to interstate commerce. The states and private litigants argue that there is no way to uphold the individual mandate without doing irreparable damage to our basic constitutional system of governance. If this is to remain a system of limited and enumerated federal powers that respects individual liberty,

accountability, and the residual dignity and sovereignty of the states, the individual mandate cannot stand.

On the other hand, the federal government maintains that it is clearly within Congress's power to regulate activities that substantially affect interstate commerce. In the government's view, the individual mandate regulates an economic activity—the manner in which individuals finance participation in the health care market. In other words, the economic activity that is being regulated is the individual's decision whether to self-insure health care expenses or purchase insurance. The government pointed out that, in enacting the law, Congress found that an individual's decision to self-insure results in the shifting of substantial costs and risks to other market participants, and that the individual mandate is a reasonable means to prevent this.

If the individual mandate is unconstitutional, what about the rest of the ACA? According to the states and private litigants, the entire ACA should be struck down if the individual mandate is found to be unconstitutional because, without the mandate, the remainder of the law will not function as Congress intended. If the states' position is correct, this means that a number of the provisions that are already in effect (e.g., the age 26 coverage mandate, first dollar coverage of preventive care services for non-grandfathered plans, no preexisting condition exclusions, no lifetime or annual dollar limits with respect to essential health benefits, etc.) will no longer be in effect.

On the other hand, the federal government's position is that most of the ACA can remain in effect if the individual mandate is declared unconstitutional. According to the federal government, only the guaranteed issue and community rating provisions would fall with it. According to the government, the remainder of the ACA is unrelated to the individual mandate and should remain law if the individual mandate is declared unconstitutional.

What Should Employers Do?

Until the Supreme Court rules on the constitutionality of the individual mandate, employers should postpone any serious consideration of changes to health plans based on the provisions of the ACA that will become effective January 1, 2014. However, employers should make every effort to ensure compliance with the provisions of the ACA that are currently in effect. We understand the U.S. Department of Labor is beginning to actively investigate plans and employers for compliance with the provisions of the ACA. The good news is that the agencies responsible for the ACA's administration and enforcement (i.e., the U.S. Departments of Health and Human Services, Labor, and Treasury), have stated in guidance that their efforts will emphasize assisting rather than imposing penalties on plans, issuers, and employers that are working diligently and in good faith to understand and come into compliance with the ACA.

CASES

District Court Holds That Insurer Breached Fiduciary Duty When Crediting Below Market Interest to Retained Asset Accounts

Unum Life Insurance Company of America issued group life insurance policies to two employers. Those policies provided that if a claim for benefits was at least $10,000, then a retained asset account would be made available to the beneficiary. The retained asset account was an interest-bearing account established in the beneficiary's name. How interest was to be

credited to the account was unstated. A beneficiary could draw down the account by writing checks against the amounts credited to the retained asset account. The retained asset account was a bookkeeping device, with Unum retaining those assets until the beneficiary drew down the account.

A committee at Unum would periodically meet to determine what amount of interest should be credited to retained asset accounts. Among the considerations used to determine a rate of interest were the rate at which beneficiaries would draw down the accounts to place the funds into higher yielding accounts (thereby depriving Unum of the use of those funds), and whether higher interest rates on retained asset accounts offered by other insurers would cause Unum to lose business. For the period at issue, Unum settled on a one percent interest rate. Unum's peers offered an average rate of two percent during the same period, with some insurers providing rates as high as four percent.

The U.S. District Court for the District of Maine first held that Unum was not a fiduciary by virtue of exercising control over plan assets. It was the insurance policy itself, the district court noted, that was a plan asset, not the proceeds due under that policy. Thus, by investing the amounts credited to the retained asset accounts on its own behalf, Unum was not self-dealing in plan assets.

The district court next analyzed whether Unum was a fiduciary as a result of exercising discretionary authority in the administration of the plan. The district court answered this inquiry in the affirmative. In so holding, the district court explained that Unum's retention of discretion to set interest rates under the policy made it a fiduciary. Had Unum removed this discretion by setting forth the interest rate in the plan (even one tied to an index rate), it would have escaped status as a fiduciary.

Finding that Unum was a fiduciary when setting interest rates under the plan, the district court also found that Unum had breached its fiduciary duties. The considerations used by Unum's committee in setting interest rates, together with the average rates provided by Unum's peers, established that Unum was not acting solely in the interest of beneficiaries, a breach of its fiduciary duties.

As to damages, plaintiffs sought equitable relief in the form of disgorgement of Unum's investment spread (i.e., the difference between the one percent interest rate credited to the retained asset accounts and the amount earned by Unum on the retained funds). The district court rejected such an approach. Since Unum's breach related to crediting the retained asset accounts with a below market rate of interest, not self-dealing in plan assets, the appropriate remedy was to award plaintiffs the difference between the actual amount paid by Unum and the amount that would have been paid had a market rate of interest been paid. (*Merrimon v. Unum Life Ins. Co. of Am.*, D. Me. 2012)

District Court Holds That Insurer Was Not Acting as a Fiduciary When Investing Amounts Credited to Retained Asset Accounts

The U.S. District Court for the Eastern District of Pennsylvania held that Lincoln National Life Insurance Company was not acting as a fiduciary when it invested amounts backing retained asset accounts for its own benefit.

Lincoln issued a group life insurance policy, the terms of which did not specify the method in which any life insurance proceeds would be paid. However, the claim form explained that if the amount payable was at least $5,000, then a retained asset account would be established. The retained asset account bore interest at a rate equal to the national average for interest-bearing checking accounts as published by Bloomberg, plus one percent. A beneficiary could draw down the retained asset account by writing a check.

Lincoln did not actually fund the retained asset account, which served as a bookkeeping device. The funds backing the retained asset account remained within Lincoln's general assets, and Lincoln would only transfer the funds when a check was drawn on the account and presented for payment.

The district court's analysis centered on whether Lincoln was acting as a fiduciary by virtue of exercising authority or control over plan assets. The district court first looked to whether Lincoln violated any terms of the plan in creating the retained asset accounts. As the plan document was silent on the method of payment, the district court found that Lincoln had not acted contrary to the plan's terms.

Next, the district court found that once Lincoln established the retained asset account, credited the account with the proper amount, and provided the beneficiary with the checkbook, practical control of the funds backing the retained asset account shifted to the beneficiary. As a result, Lincoln was not only not acting as a fiduciary when it invested those funds on its own behalf, but those funds were not plan assets under the terms of the plan.

Seemingly overlooked was whether Lincoln's decision to pay death benefit proceeds of at least $5,000 through retained asset accounts could serve as the foundation for a breach of fiduciary duty claim. In other words, the district court did not appear to consider the issue of whether Lincoln was exercising discretion in the administration of the plan by selecting the method of payment (i.e., creating retained asset accounts), and, in exercising that discretion, whether Lincoln acted solely in the interest of beneficiaries under the plan. Although the district court briefly addressed Lincoln's management and administration of the plan in several footnotes, and noted that the selection of a mode of payment is a discretionary function in one of those footnotes, the analysis largely misses the point. No mention is made in the opinion of whether the interest credited to retained asset accounts by Lincoln was competitive with other insurers in the market, or what considerations were used in setting the interest rate. (*Edmonson v. Lincoln Nat'l Life Ins. Co.*, EDPA 2012)

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