Hodgson Russ LLP
ATTORNEYS

EMPLOYEE BENEFITS DEVELOPMENTS FEBRUARY 2012

Hodgson Russ Newsletter
February 28, 2012

Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Participant Fee Disclosures: DOL Revises Interim Enforcement Policy on Use of Electronic Media

In the November 2011 edition of Employee Benefits Developments, we reported on the Department of Labor's (DOL) interim enforcement policy (as set forth in Technical Release 2011-03) regarding the use of electronic media to satisfy required disclosures under the new participant fee disclosure regulations. The interim policy generally states that the DOL will not take enforcement action based solely on a plan administrator's use of electronic media to make the required participant fee disclosures if the administrator complies with certain conditions described in the technical release. The technical release, however, triggered additional questions as to 1) whether the technical release is intended to apply to continuous-access websites, and 2) whether and under what circumstances certain investment-related information, including comparative chart information, may be furnished as part of a pension benefit statement.

In response, the DOL fully revised and restated Technical Release 2011-03 (published as Technical Release 2011-03R). The revised technical release is identical to the original, except that it has been modified to make clear that 1) continuous access websites are permissible if the administrator complies with the conditions in the technical release; and 2) investment-related information may be furnished as part of or along with a pension benefit statement, either electronically (under the conditions set forth in the technical release) or in paper form.

Summary of Benefits and Coverage: Final Rules Issued

Group health plans and health insurance issuers offering group health insurance coverage are required to provide a written summary of benefits and coverage (SBC) for each benefit package that is offered. On February 9, 2012, the Department of

Health and Human Services, Department of Labor, and Department of the Treasury released final regulations detailing the form, content, and delivery requirements pertaining to SBCs. The regulations include a template SBC document, instructions for completing the template, and a uniform glossary of medical and insurance terms.

Insured Group Health Plans

Health insurance issuers must provide SBCs to group health plans at the following times: 1) no later than seven days following the date the group health plan submits an application for health coverage; 2) prior to renewal of the insurance contract (at least 30 days prior to the beginning of the new year in some cases); and 3) as soon as practicable but in no event later than seven business days following receipt of a request. If there are changes in benefits or coverage after the initial SBC is furnished but before the first day of coverage, a revised SBC must be furnished by the first day of coverage.

Health insurance issuers and group health plans must, in turn, provide the SBC to participants and beneficiaries at the following times: 1) as part of the plan's enrollment material; 2) by the first day of coverage, if there are changes in the benefits or coverage after the enrollment SBC is provided; 3) upon renewal, if the employer requires participants to renew in order to maintain coverage (at least 30 days prior to the new year in some cases); and 4) as soon as practicable but no later than seven business days following receipt of a request. In the case of special enrollment, an SBC must be provided within 90 days of enrollment.

Important: Under the final rule, both the insurer and the plan (acting through the administrator) have the obligation to provide the SBC. To prevent duplication of effort, the plan administrator is relieved of this responsibility provided the issuer provides a timely and complete SBC. Plan administrators that intend to rely upon an issuer for compliance should ensure that the issuer's obligations are set forth in writing and that the written agreement contains appropriate hold-harmless provisions.

Self-Insured Group Health Plans

The plan administrator of a self-insured group health plan must provide the SBC to participants and beneficiaries at the same times described above for insured plans.

Important: Under the final rule, the plan administrator has the obligation to provide the SBC. A plan administrator may assign this responsibility to a third-party administrator and is relieved of the responsibility to comply provided the third-party administrator provides a timely and complete SBC. Plan administrators that intend to rely upon a third-party administrator for compliance should ensure that the tpa's obligations are set forth in writing and that the written agreement contains appropriate hold-harmless provisions.

Effective Date

For participants and beneficiaries who enroll or reenroll through an open enrollment period, the rules apply as of the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (e.g., individuals who are newly eligible for coverage and special enrollees), the rules apply on the first day of the first plan year that begins on or after September 23, 2012.

Exempt Plans

SBCs are not required for plans or benefit packages that qualify as excepted benefits (e.g., stand-alone dental or vision plans or exempt health flexible spending accounts [FSAs]). SBCs are required for non-exempt FSAs and health reimbursement accounts (HRAs), although FSA and HRA information can be combined with the SBC for a major medical plan if the FSA or HRA is integrated with the major medical plan. Stand-alone HRAs and FSAs that are not exempt must satisfy the SBC requirements independently. If a health savings account (HSA) is not a group health plan (most are not), an SBC is not required for the HSA, although details concerning the HSA can be included with the SBC for the high-deductible plan benefit package.

Consequences for Failing to Comply

A group health plan or health insurance issuer that fails to comply can be liable for a fine of up to $1,000 for each "willful" failure. A failure with respect to each participant or beneficiary constitutes a separate offense. In addition, a group health plan maintained by an entity (other than a governmental entity) can be liable for an excise tax of $100 per day per individual.

Group Health Plan Action Steps

Group health plans and issuers should proceed as follows:

1. Identify the plans for which an SBC will be required.

2. Identify the effective date.

3. Reach out to insurers and third party administrators to determine the extent to which they will be providing assistance in the preparation and distribution of the SBC and enter into written agreements with appropriate indemnification provisions.

4. Develop a distribution strategy.

CASES

Short-Term Second Spouse Prevails as Beneficiary Over Children From Prior Marriage

This dispute stems from a common scenario: a 401(k) plan participant names his children from a prior marriage as his beneficiaries, remarries without changing his beneficiary designation, then dies, resulting in a predictable battle between the second wife and the deceased participant's children over entitlement to the participant's plan benefits. In this case, the participant had been married to his second wife for only about six weeks before his death.

The Louisiana district court that originally heard the case upheld the plan administrator's decision to award the benefits to the second wife, finding that the terms of the plan are clear: the plan provides that a participant's spouse will be the beneficiary of the participant's entire vested interest in the plan unless an election is made to waive the spouse as a beneficiary. No waiver of the surviving spouse's beneficiary status was ever executed; nevertheless, the children argued that the second wife should not be considered a "spouse" because she had been married to their father for less than one year. They based their argument on Section 205 of the Employee Retirement Income Security Act of 1974 (ERISA), which states that a plan may provide that a survivor annuity will not be provided unless a participant and spouse had been married throughout the one-year period ending on the earlier of the participant's annuity starting date or the date of the participant's death. In finding for the second wife, the lower court determined that the one-year requirement is permissive rather than mandatory, and that ERISA contemplates that some plans may vest rights in participants' spouses immediately upon marriage. The lower court's determination that the administrator thus properly awarded the benefit to the second wife in accordance with clear plan terms was recently affirmed by the Court of Appeals for the Fifth Circuit. (*Cajun Industries LLC 401(k) Plan v. Kidder*, 5th Cir. 2011)

'Full and Fair' ERISA Review Required for Top-Hat Plan Claim

An executive who was denied severance and incentive award benefits after she resigned for "good reason" following a company merger may pursue her claim for benefits under a Massachusetts district court ruling that the plan administrator failed to provide a full and fair review of her claim, as required by the Employee Retirement Income Security Act of 1974 (ERISA). Under her employment and incentive award agreements, the executive was entitled to receive more than $4 million in payments if she resigned for "good reason," as defined under her employment agreement. Immediately following a company merger, the executive gave written notice of her intention to resign her position for good reason, stating that as a result of the change in control, the nature, status, and prestige of her responsibilities, duties, and position were substantially and adversely altered.

As plan administrator, the post-merger compensation committee was charged with evaluating the validity of the executive's good-reason claim. Following its review, the committee denied payment of benefits to the executive, finding that she had not demonstrated "good reason" for her resignation. The committee gave no reasons for the denial, provided no information regarding the executive's appeal rights, and ignored requests from the executive's attorney for the information the committee had relied on in coming to its decision. The executive sued, alleging violation of her ERISA rights to adequate notice and a full and fair review of her claim.

Determining that the agreements constitute "top-hat" plans under ERISA, as they are unfunded plans maintained primarily for the purpose of providing deferred compensation benefits to a select group of management or highly compensated employees, the court focused on ERISA's claims requirements for top-hat plans. The court found no top-hat exception to the statutory notice provisions of ERISA and rejected the administrator's argument that the plan is not subject to ERISA's full-and-fair-review requirements because the reference in the statute to review by an "appropriate named fiduciary" could not apply to top-hat plans, which are exempt from the fiduciary responsibilities of ERISA. Focusing on the abbreviated committee debate held on the merits of the executive's claim and other shortcomings in the committee's decision-making process, the court found that the committee failed to conduct a full and fair review of the executive's claim. The court also

found deficiencies in the committee's procedures relating to adequate notice, information on the appeals process, and access to documents. Finally, the court found that the committee operated under a conflict of interest in denying the executive's claim because some committee members had a personal financial stake in the outcome. The court remanded the claim to the plan administrator and awarded reasonable attorneys' fees to the executive. (*McCarthy v. Commerce Group Inc.*, D. Mass., 2011)

Court Holds That Plan May Recoup Overpayment of Pension Benefits

The district court for the District of Massachusetts held that a multiemployer pension plan may recoup the overpayment of benefits, notwithstanding the participant's intervening bankruptcy.

The participant began receiving a disability pension under the plan in 1992. Disability pensioners were notified that disability pension payments would be discontinued if they returned to work or had sufficiently recovered so as to be able to return to gainful employment, and that they should notify the plan if they became employed.

Subsequently, the participant began work as a real estate agent without notifying the plan of his return to gainful employment. When the plan learned of the participant's new employment, it terminated his disability pension. The participant brought suit, claiming that the termination of his disability pension violated the plan's terms. The plan trustees counterclaimed for restitution of the overpayment of disability benefits for the period during which the participant was employed but failed to notify the plan of his employment. The court awarded judgment to the plan trustees.

Five months later, the participant filed for bankruptcy. The plan filed a proof of claim, asserting a right of recoupment for the overpayments made. In response to the participant's objection to the proof of claim, the bankruptcy court abstained from further consideration, as the participant's vested interest in the plan was not an asset of the bankruptcy estate.

More than ten years later, the participant applied for a normal retirement pension from the plan. The plan notified the participant that his normal retirement pension would be reduced by 20 percent each month until the overpayment was recouped. The participant filed suit, challenging the plan trustee's reduction of his monthly pension benefits.

Citing explicit plan provisions authorizing the plan trustees to recoup overpayment of pension benefits through a reduction in future benefit payments, the district court held that the trustees were entitled to reduce the participant's pension benefits until the overpayment was recouped. The participant's bankruptcy did nothing to alter this result. In accordance with controlling precedent and because the debt the participant owed to the fund (i.e., the overpaid disability amounts) and the debt the fund owed to the participant (i.e., pension benefits) arose out of the same contract (i.e., the plan), the plan trustees' right to recoupment survived the participant's bankruptcy. (*Celi v. Trustees of Pipefitters Local 537 Pension Plan*, D. Mass. Nov. 28, 2011)

Time Limitation for Claims in Summary Plan Description Held Applicable

The summary plan description for a long-term disability plan provided that the forms to receive benefits must be completed and returned to the claims administrator within one year of a participant's last day of work. The plan document did not make reference to any time limitation for filing claims; however, the plan document cited certain "operative documents," including plan summaries, as being part of the plan.

The participant's last day of work had been no later than August 30, 2003, but she failed to file her application for benefits under the plan until December 25, 2007. In denying the participant's claim for benefits, the issue that the participant's claim was untimely was raised for the first time at the administrative appeals stage. The court initially held for the plan based upon the one-year limitation set forth in the summary plan description.

The participant then filed a motion for reconsideration, where the participant argued that 1) *Cigna Corp. v. Amara* prevented the terms of a summary plan description from becoming part of a plan, and 2) the plan had waived the time limitation when the limitation was not raised in the initial claim denial.

The court held that *Amara* did not stand for the blanket proposition that the terms of a summary plan description could never become part of a plan. Instead, Amara stands for the general proposition that a summary plan description does not alter the terms of a plan. However, since the plan document here incorporated the terms set forth in plan summaries, the summary plan description terms were also terms for the plan document. Thus, the time limitation for filing claims was part of the plan document.

Having disposed of the issue of whether the time limitation was a part of the plan document, the court remanded the issue of whether the plan had waived the limitation by failing to assert the limitation in its initial denial of benefits. Following the court's decision, the question potentially arises as to what should happen when a plan document incorporates the terms of a summary plan description but the summary plan description's terms conflict with the plan document. The court strongly hinted that the terms of the plan document would preempt the summary plan description in such a situation, stating: "[t]his court does not read Amara as holding that the terms of a summary plan description cannot be part of a benefit plan, at least where, as here, the terms of the plan summary at issue do not conflict with the language of the formal plan document, and the plan document authorizes the creation of the terms in the summary plan description." (*Grant v. Eaton Disability Long-Term Disability Plan*, S.D. Miss. Dec. 13, 2011).

'Silent' Plan Document Allows Plaintiff to Appeal Claim Denied Two and a Half Years Earlier

The district court for the District of Massachusetts recently held that a plan could not dismiss the appeal of a denied benefit, even though the denial occurred more than two years earlier.

The district court reasoned that the appeal is not time-barred because the plan document did not contain any time limit within which an appeal must be made. In this case, the plaintiff was a participant in his employer's long-term disability plan. The employer utilized the certificate of insurance as the plan document and a summary plan description drafted by the long-

term disability insurer. Due to a disability, the plaintiff's last day of work was November 29, 2003. The plaintiff began receiving long-term disability benefits in February 2004. In March 2006, the plaintiff was notified that, based on medical and occupational information, he no longer was entitled to benefits. The plaintiff did not appeal the denial of benefits until February 2009. The plan refused to consider the appeal because it was not made within 180 days of the benefit denial. Although the summary plan description contained a provision requiring that an appeal of a denied claim must occur within 180 days, such a provision was not part of the plan document.

The district court, citing the recent *Amara* Supreme Court decision, held that the terms of the plan govern, and that the terms of the summary plan description are not the terms of the plan. Because the plan document did not contain any time limit within which an appeal must be made, the plan acted improperly in refusing to consider the plaintiff's appeal on the grounds that the appeal was untimely.

This case is significant because it illustrates the heightened importance of the plan document following the Amara decision. Employers should review their plan documents to confirm that important provisions are included in the plan document and not just disclosed as part of the summary plan description. (*Merigan v. Liberty Life Assurance Co. of Boston*, D. Mass. 2011)

Bankruptcy Estate Does Not Avoid Control Group Status for Withdrawal Liability

In 1999, Michael Cappy filed for bankruptcy protection. Prior to the bankruptcy filing, Mr. Cappy transferred his interest in two real estate leasing companies to two family trusts. Mr. Cappy also owned a lumber milling company that went out of business in October 2001. As a result of the closure of the business, the lumber milling company incurred withdrawal liability from a multiemployer pension plan. Within the bankruptcy proceeding, the bankruptcy court found that the transfers of the two real estate entities were fraudulent and ordered that the interests transferred to the trusts be returned to the bankruptcy estate. As a consequence, 100 percent of the interests in the lumber milling company and the two real estate leasing businesses were effectively owned by Mr. Cappy. The multiemployer plan sought to impose control group liability for the withdrawal on the two real estate leasing businesses. Affirming the decision of a lower court, the Court of Appeals for the Seventh Circuit held that the real estate leasing companies were trades or businesses because they were formed to generate income or profit, and that the ownership interest of Mr. Cappy in the three entities remained in place even though ownership of the entities was in the bankruptcy estate. (*Central States Southeast & Southwest Areas Pension Fund v. SCOFBP LLC*, 7th Cir., 2011)

Release Invalid When Given Without Full Knowledge of Facts

In 2008, Optimus Corp. terminated a non-qualified deferred compensation plan. At that time, the calculated value of the benefits under the plan was approximately $6.4 million. Optimus informed participants in the plan that it did not have sufficient funds to pay the entire amount of the benefits. The participants were given the offer of receiving an amount equal to half of the benefit in 2008 or waiting until the year 2017 for payment of the full amount. The participants signed releases accepting payment in half.

Shortly thereafter, the majority owner of Optimus died and Optimus's assets were appraised for estate tax purposes. It was then discovered that Optimus owned unencumbered artwork with an appraised value of approximately $26.8 million. The artwork was shown on Optimus' financial statements with a book value of $2.2 million. The participants sued to collect the full value of the benefit owing under the plan. Optimus claimed that the participants were barred from bringing the action because they executed releases. The district court for the District of Nebraska ruled that these releases were invalid because the participants were induced to sign the release by improperly omitting the value of Optimus' artwork. (*Edelstein v. Optimus Corp.*, D. Neb., 2011)

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