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# EMPLOYEE BENEFITS DEVELOPMENTS OCTOBER 2011

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**Practices & Industries**

Employee Benefits

## RULINGS, OPINIONS, ETC.

### 2012 Benefit Limits Announced

The Internal Revenue Service and Social Security Administration have announced the cost-of-living adjusted dollar limits applicable to benefit plans for 2012. A listing of key limits is set out below: **2012 Limit** 401(k)/403(b)/457 plan maximum elective deferral $17,000 401(k)/403(b)/457 catch-up $5,500 Defined contribution maximum annual addition $50,000 Defined benefit maximum annual pension $200,000 Qualified plans maximum compensation limit $250,000 Highly compensated employee $115,000 IRA limit $5,000 IRA catch-up $1,000 SIMPLE limit $11,500 SIMPLE catch-up $2,500 Social Security taxable wage base $110,100

### Agencies Issue Summary of Benefit Coverage Guidance

The Department of Labor (DOL), Department of the Treasury, and Department of Health and Human Services (HHS) jointly issued proposed regulations regarding the Summary of Benefit Coverage (SBC). The SBC is a new welfare benefit disclosure that insurers and group health plans must provide to participants and enrollees. The SBC is required by the Patient Protection and Affordable Care Act and must be issued by both grandfathered and non-grandfathered plans. The effective date for this new requirement is March 23, 2012.

The SBC is meant to enable participants to better understand the coverage they have and to compare other coverage options by providing welfare benefit information in a standardized and concise format. The proposed regulations provide that the SBC must be written in plain language, be no more than four double-sided pages, and not less than 12-point font.

The SBC will summarize key plan features, such as covered benefits, premiums, cost-sharing provisions, and coverage limitations and exceptions. The SBC must also include certain coverage examples. These coverage examples must illustrate plan coverage for common health scenarios, such as pregnancy, treating breast cancer, and managing diabetes.

To further help participants and enrollees understand the SBC, the SBC must also contain internet addresses to the DOL and HHS websites where participants and beneficiaries can access a uniform glossary of commonly used terms. Insurers and plans must also make this glossary of commonly used terms available on request.

The SBC must be provided (1) when any written materials are provided during open enrollment, (2) 30 days prior to reissuance or renewal of the participant's health coverage, (3) within seven days of a request for special enrollment, and (4) within seven days of a participant's or beneficiary's request. If there are any material changes to the SBC, the plan administrator must provide notice to participants and beneficiaries 60 days before the effective date of the change. The SBC can be provided in paper or electronic form. However, if provided electronically, plan administrators must satisfy the DOL's electronic disclosure safe harbor requirements.

The penalties are significant for failing to provide the SBC, the 60-day advance notice of material changes, or the uniform glossary of terms in a timely manner. Each willful failure is subject to a $1,000 penalty. Failures are also subject to an additional excise tax of $100 per day for each affected individual.

Plan sponsors should coordinate the responsibilities for the preparation and distribution of the SBC with the insurers and third party administrators that provide services for their plans.

## Interim Final Regulation for Women's Preventive Care Services Issued

Among its many provisions, the Patient Protection and Affordable Care Act requires that non-grandfathered group health plans must provide coverage for and are prohibited from imposing cost-sharing on certain women's preventive health services. The Department of Labor (DOL), Department of the Treasury, and Department of Health and Human Services (HHS) issued interim final regulations identifying a number of specific women's preventive care services subject to the coverage and no-cost sharing requirement. The required services identified by the recent guidance include: well-woman visits; screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling and screening for HIV; contraception and contraceptive counseling; breastfeeding support, supplies, and counseling; and screening and counseling for interpersonal and domestic violence. In recognition that the requirement to provide contraceptive services may conflict with the beliefs of some religious employers, plans established or maintained by religious employers are exempt from the requirement to provide contraceptive services.

Non-grandfathered health plans must provide coverage without cost-sharing consistent with these new regulations in the first plan year that begins on or after August 1, 2012.

CASES

## Employer Not Liable in Connection With Pension Benefit Miscalculation

When an employee was terminated from his position, he negotiated a severance package based, in part, on his belief that he would be receiving a pension in a certain amount from the employer's pension plan (the plan). Unfortunately, the administrator for the plan miscalculated some of the employee's projected pension numbers (the administrator correctly calculated the lump sum value of the pension benefit, but substantially overstated the benefits payable under the plan's four annuity payment options). After making an annuity election and signing off on the severance agreement, but before payment of the plan benefit commenced, the error was discovered and a new benefit election form was prepared for the employee. As a result of the error, the employee's actual benefit for the annuity option he selected was $450 per month less than his original benefit election form had indicated. The employee never returned the recalculated election form to the plan and consequently has not yet received any of his pension benefits. Instead, he filed suit against the plan.

The employee asserted that he relied on the written promise of pension benefits when he was negotiating the terms of his severance agreement. In particular, he asserted that he had relied on the amounts stated on the original election form when he made certain concessions in the severance agreement. His complaint asked the court to stop the plan from paying him anything other than the amount stated in the original election form because he had relied on the representation in the original election form to his detriment when negotiating his severance agreement.

The Court of Appeals for the Seventh Circuit held that the employee's claim fails for lack of evidence of intentional misrepresentation. The court concluded that none of the employee's evidence pointed to anything more than an inadvertent mistake or negligence by the plan, and opined that mistakes and negligence are not sufficient to meet the standard for a knowing misrepresentation. The Seventh Circuit also held that the employee's claim fails for lack of evidence of detrimental reliance. The Seventh Circuit noted that the employee's argument that he relied on the misstated pension numbers in deciding to sign the severance agreement was undermined by his admission that he did not wish to rescind the severance agreement. Accordingly, the Seventh Circuit affirmed the federal trial court's grant of summary judgment in favor of the plan. (*Pearson v. Voith Paper Rolls, Inc.*, 7th Cir. 2011)

## Plan Administrator Not Entitled to Rely Upon Per Se Intoxication Exclusion

A participant covered under an employer-sponsored life insurance plan was killed when the jet ski he was operating hit an underwater rock, causing him to be flung into another rock and drown. A boating accident report listed excessive speed, alcohol use, and operator inattention as contributing factors. The report identified alcohol use as the primary cause of the accident, with operator inattention being the second. The participant's blood alcohol content was 0.223.

The insurer, acting as plan administrator, denied the participant's beneficiaries' claim for benefits, citing two policy provisions. First, the plan administrator relied on an exclusion for intentionally self-inflicted injuries, reasoning that the participant's voluntary ingestion of alcohol was an intentional act that contributed to the jet ski crash and the participant's drowning. Second, the plan administrator denied the claim based on the policy's definition of "covered accident" to only include unforeseeable events. The plan administrator maintained that it was foreseeable that operating a jet ski while

intoxicated might result in death.

The court rejected outright the plan administrator's denial of benefits based on the exclusion for intentionally self-inflicted injuries. In doing so, the court pointed out that there was nothing to suggest that the participant became intoxicated with an eye toward harming himself.

The court remanded the issue of whether the participant's death came within the definition of "covered accident" for redetermination by the plan administrator. As a threshold matter, the court rejected a categorical approach to deaths occurring while a person was intoxicated, noting that statistics did not support such a per se finding of foreseeability of death. Moreover, the fact that the policy contained specific per se exclusions, but none for driving while intoxicated cut against finding an unwritten per se exclusion. In making its redetermination, the court ordered the plan administrator to evaluate all the facts and circumstances in determining whether the participant's death was foreseeable, including the additional factors of operator inattention, excessive speed, and the likelihood that a sober operator would have detected the underwater rock. (*Thies v. Life Ins. Co. of N. Am.*, WDKY August 17, 2011)

## Plan Not Required to Pay Estate Where No Liability Existed for Care Provided

The decedent had been eligible for benefits under a Medicare supplemental plan, which provided secondary insurance coverage to Medicare. The plan was to pay 80 percent of the difference between what was allowed but unpaid by Medicare, after a $250.00 annual deductible was paid, subject to a $300,000.00 per-person, per-lifetime limitation.

The decedent was hospitalized from December 31, 2008 until his death on February 17, 2009. The hospital submitted an invoice to Medicare for this period of $266,573.00. Medicare accepted the charges, but adjusted the claim to $58,770.28, which was paid to the hospital. After this payment, the outstanding balance due the hospital was $0.00 because the hospital had agreed to accept the amount paid by Medicare as payment in full.

The decedent's executor subsequently filed a claim with the plan for $165,992.18, representing 80 percent of the difference between $266,573.00 and $58,770.28, less the $250.00 deductible. The plan denied the claim, stating that the decedent's estate had no financial liability to the hospital. The decedent's estate agreed that no financial liability existed, but filed suit in district court, claiming that it was entitled to the amount of its claim because the $266,573.00 had been "allowed" by Medicare, but only $58,770.28 was paid.

The court found the estate's argument lacked merit. The court held that the plan's interpretation of plan language stating "your total benefits from all sources will be limited to 100% of reasonable and customary charges for the medical expenses incurred" as requiring an actual financial liability was reasonable. Since no such liability existed, the court granted summary judgment in favor of the plan. (*Griffin v. Corning Inc.*, WDNY August 16, 2011)

## One-Person Severance Agreement Not an ERISA Plan

Focusing on the definition of an "employee welfare benefit plan" in the Employee Retirement Income Security Act (ERISA), the U.S. Court of Appeals for the Eighth Circuit recently ruled that an employment agreement providing severance benefits for a single employee is not an ERISA welfare plan. The court noted that although severance benefits may be provided under an ERISA welfare benefit plan, the definition under the statute "strongly implies benefits that an employer provides to a class of employees," rather than to a single individual. References in the statute to "participants or their beneficiaries" reinforce the notion that Congress intended a covered plan to be one that provides benefits to more than one person.

Although it upheld the result of a district court finding that the agreement is not an ERISA employee benefit plan, the appeals court concluded that the lower court unnecessarily engaged in an analysis of whether the plan requires an ongoing administrative program to meet the employer's obligation to pay severance. The appeals court cut off the analysis at an earlier point, determining that a one-person plan simply cannot be an ERISA welfare benefit plan within the meaning of the statute. The court did not rule out the possibility, however, that federal jurisdiction may exist over portions of the complaint, to the extent that certain demands under the employment agreement relate to payment obligations provided under other plans governed by ERISA. (*Dakota, Minnesota & Eastern Railroad Corp. v. Schieffer*, 8th Cir. 2011)

## Beneficiary Designation Trumps Property Settlement in Award of Life Insurance Benefits

Finding that a divorce decree and property settlement requiring a plan participant to name his ex-wife as beneficiary of his employer-provided life insurance did not constitute a qualified domestic relations order (QDRO), a Virginia court held that a life insurance plan administrator properly paid benefits to the participant's second wife and children as named beneficiaries.

Under the property settlement, the participant agreed to make his ex-wife the beneficiary on all of his personal and group life insurance. Several years after his divorce, however, the participant changed the beneficiary designation on his life insurance, naming his second wife and his children the primary beneficiaries. On the participant's death in 2008, the insurance company paid the benefit to his widow and children. After the proceeds had been paid, the participant's first wife claimed the benefit, presenting the divorce decree and property settlement requiring the participant to maintain her as primary beneficiary. The insurance company filed suit, seeking a judgment as to the proper beneficiaries of the policy.

Because the insurance company did not take a position on the beneficiary issue, the participant's son asked the court to rule that the benefits had been properly paid. The court held that, absent a valid QDRO, the plan administrator must look solely at the plan document to determine the beneficiary of the benefits. Since the divorce decree and property settlement failed to specify the name of the plan and the amount of the benefit payable to the first wife, the court held it did not qualify as a QDRO. As a result, the benefits were properly paid to the widow and children as the designated beneficiaries.

In an interesting turn, the court imposed attorney's fees on the insurance company that brought suit because it refused to take a position in the complaint. The court noted that it was the insurance company that initiated the action, thereby compelling the son to seek counsel and incur legal fees. In the words of the court, had the insurance company "simply taken the position that it had distributed the benefits legally—a position that is clearly mandated by the facts and law of this case," the son would have had to spend little if any money defending the case. Instead, an unnecessary burden was placed on the widow and children to defend their receipt of benefits. Calling the insurance company's conduct "irresponsible" and bordering "on bad faith," the court awarded reasonable attorney's fees to the son who successfully defended the payments. (*Metropolitan Life Insurance Co. v. Leich-Brannen*, E.D. Va. 2011)

## Tenth Circuit Agrees That Cash Balance Plans Do Not Violate Age Discrimination Rules

The U.S. Court of Appeals for the Tenth Circuit has recently affirmed a lower court decision that a conversion of a traditionally defined benefit plan or cash balance plan did not violate provisions of the Age Discrimination in Employment Act. The Tenth Circuit now joins with the Second, Third, Sixth, Seventh, and Ninth Circuits in holding that cash balance plans do not violate age discrimination rules. (*Tomlinson v. El Paso Corp.*, 10th Cir. 2011)

## Whipsaw Claim in Cash Balance Plan May Continue

The District Court for the Southern District of New York has denied a motion for summary judgment on whether participants in PricewaterhouseCoopers cash balance plan properly used certain interest rates in computing lump sum payments. The so called "whipsaw" claim relates to the projection of a hypothetical cash balance account balance to age 65 and then payment of the present value of the projected benefit. Participants had claimed that the use of a 30-year Treasury rate did not accurately reflect the reasonable estimate of future interest credits. The district court refused to accept the opinion of a reputed expert in economics that the use of the risk-free Treasury rate was appropriate because the record had not yet developed and was not complete. (*Laurent v. PricewaterhouseCoopers LLP*, SDNY 2011)

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