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EMPLOYEE BENEFITS DEVELOPMENTS
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Employee Benefits

RULINGS, OPINIONS, ETC.

New Grandfathered Plan Regulations Permit Insurance Contract Changes

Under the Affordable Care Act, group health plans are required to comply with a number of new insurance market reform requirements. Grandfathered plans are not subject to certain of these requirements—most notably, the new rules pertaining to first dollar coverage of preventive care, and the new standards that apply to internal claim and external review procedures.

The Initial Regulation. In June, the Departments of the Treasury, Health and Human Resources, and Labor issued a regulation pertaining to grandfathered health plans, detailing (among other things) the types of changes that would cause a plan to lose grandfathered status. Under the initial regulation, if a plan sponsor changed insurance carriers, changed from one group insurance contract to another with the same insurer, or converted from self-funded to insured status, the grandfather status of the plan would be lost.

The Regulation as Amended. In November 2010, the initial regulation was amended to provide that a benefit option under a group health plan will not lose its grandfathered status if a plan sponsor enters into a new insurance policy, as long as the plan does not make any other changes that would cause a loss of grandfather status (e.g., a reduction in benefits or a change in co-pays, employer contributions, deductibles, out-of-pocket maximums, or co-insurance).

Effective Date of the Regulation, as Amended. The recent amendment to the grandfather plan regulation applies to changes in group health insurance coverage that are effective on or after November 15, 2010. The amended regulation emphasizes that the new rule does not apply retroactively to changes to group health insurance coverage that were effective before this date. For this purpose, the date the new coverage becomes effective is the operative date, not the date the contract for a new policy, certificate, or contract of insurance is entered into. The following examples are provided in the regulation, as amended:

Example. A plan enters into a new insurance contract on September 28, 2010. The new contract will become effective on January 1, 2011. Therefore, January 1, 2011 is the relevant date for determining the application of the new rule.

Example. A plan enters into a new contract with an insurer on July 1, 2010, for a new policy to be effective on September 1, 2010. The plan would cease to be a grandfathered plan because the new contract is effective before November 15, 2010.

Importantly, to maintain status as a grandfathered health plan, a group health plan that enters into a new contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether there were any other changes to the coverage that would cause it to cease to be a grandfathered health plan. (75 Fed. Reg. 70114)

IRS Extends Deadlines for Adopting Certain Amendments

In IRS Notice 2010-77, the Internal Revenue Service (IRS) extended the deadline for adopting certain amendments to defined benefit plans until the last day of the first plan year that begins on or after January 1, 2011. Under the Notice, the deadline for amending defined benefit plans to reflect the funding based restrictions contained in Internal Revenue Code of 1986 (IRC) § 436 has been extended. Also extended is the deadline for amending cash balance and other hybrid-type defined benefit plans to reflect the special vesting provisions and other rules relating to age discrimination under IRC § 411 (a)(13) and IRC § 411(b)(5).

IRS Provides Guidance on Funding Relief Rules

The Preservation of Access to Care for Medicare Beneficiaries and Pension Act of 2010 provided much-requested funding relief for single and multiple employer defined benefit pension plans. Generally, a defined benefit plan must establish a shortfall amortization base with respect to a plan year for which the value of a plan's assets is less than the amount of the plan's funding target. The period for amortization of a shortfall is seven years. Under the relief provisions of the act, a plan sponsor may elect, for certain plan years, to amortize the shortfall amortization base for the plan year under one of two alternative amortization schedules: the "2 plus 7-year" amortization schedule; or the "15-year" amortization schedule. In Notice 2011-3, the IRS provided general guidance describing the relief available. Sponsors of defined benefit plan could have elected relief for the 2008, 2009, or 2010 plan year or may elect relief for the 2011 plan year. Those plan sponsors electing relief should review with the plan's actuary the impact of the guidance issued by the IRS to be certain that their funding relief is properly calculated.

CASES

Full-Time Medical Residents Subject to FICA

The U.S. Supreme Court recently affirmed a decision of the Court of Appeals for Eighth Circuit upholding the IRS's position that remuneration paid to medical residents working full-time is subject to FICA tax. The IRC exempts from FICA remuneration paid to students for services performed in the employ of a school, college, or university. At issue in this case was whether the IRS regulations, drawing a bright-line distinction between student and employee for purposes of the student exemption, was a valid interpretation of the IRC. The IRS regulations provide that the student exemption is only available if the service is incidental to the course of study. Furthermore, if an individual is normally scheduled to work at least 40 hours per week, the service is not considered incidental, and the remuneration is considered wages subject to FICA tax. In 2007, rather than rely on the 40 hour per week work schedule standard, a federal trial court held that the IRS would need to determine whether FICA tax was applicable to stipends paid to medical residents on a case-by-case basis. The Eighth Circuit reversed the federal trial court's decision, concluding that limiting the student exemption to students who were not full-time employees was a valid interpretation of the IRC. The Supreme Court unanimously upheld the Eighth Circuit decision by stating that where a statute is silent or ambiguous, courts should defer to the regulatory agency's interpretation of the statute, unless the regulation is arbitrary, capricious, and manifestly contrary to the statute. In this case, the Supreme Court held that the IRS position that residents working over 40 hours per week did not qualify for the student exemption was a reasonable interpretation of the statute. Although the specific application of this case is somewhat narrow, the principle that a court should give deference to a regulatory agency's interpretation of an ambiguous statute has a much broader application. Health care reform, anyone? (*Mayo Foundation for Medical Education and Research v. United States*, US Sup. Ct. 2011)

Insurer Not a Fiduciary When Negotiating Rates

The Court of Appeals for the Sixth Circuit ruled that an insurer was not acting as a fiduciary when it negotiated rates with hospitals that favored its health maintenance organization clients over its self-funded plan clients. Under Employee Retirement Income Security Act of 1974 (ERISA), a fiduciary is obligated to discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries. In this case, the plaintiff claimed that the insurer's fiduciary status should have prevented it from engaging in contract negotiations that resulted in higher rates to the self-insured plan in which he participated. However, in a divided decision, the court held that although the insurer acted as a fiduciary in its capacity as a claims processing agent for the plan, the insurer was not acting as a fiduciary to the plan when it negotiated rates with hospitals. A factor that the court considered when ruling that the insurer was not acting as a fiduciary was that the insurer's rate negotiation was generally appliacable to a broad range of health care customers and not directly associated with the benefit plan at issue. (*DeLuca v. Blue Cross Blue Shield of Michigan*, 6th Cir. 2010)

Teachers' Efforts to Bring 403(b) Plan Lawsuits Fall Short

In two different cases from two different regions of the country, teachers brought lawsuits to challenge alleged endorsement and kickback arrangements involving IRC § 403(b) plans on the basis of fiduciary breaches. Thus far, the courts have derailed those lawsuits. The first case is actually an update on a case we first reported in November 2009. The case involved two teachers from the Long Beach School District who alleged the fiduciary provisions of ERISA were violated in connection with a 403(b) plan sponsored by the school district. The plaintiffs claimed there was a breach of fiduciary duty under ERISA because the New York State United Teachers (NYSUT), an organization representing the employees, reportedly paid kickbacks to ING Life Insurance and Annuity Co. in connection with the program.
The District Court for the Southern District of New York dismissed the action, finding that the 403(b) plan was a governmental plan exempt from ERISA. Undeterred, those same teachers commenced another lawsuit against NYSUT in which they made claims for breach of fiduciary duty and unjust enrichment under state law rather than ERISA. Again, the courts dismissed the teachers' lawsuit. After the case was removed to federal court, a judge ruled the federal Securities Litigation Uniform Standards Act (SLUSA) bars the pursuit of the teacher' class-action lawsuit under state law. SLUSA generally prohibits plaintiffs from pursuing securities law violations as state law class actions in state courts, and the judge concluded that the teachers' claims in this case fell within SLUSA's purview. (*Montoya v. New York State United Tea*chers, EDNY 2010)

In a second, similar case, the Court of Appeals for the Ninth Circuit ruled that the National Education Association (NEA) cannot be held liable under ERISA for a fiduciary breach because of its endorsement and marketing of annuities in 403(b) plans offered to NEA members. A lawsuit was brought by public school teachers who alleged that the NEA violated ERISA in connection with the selection and monitoring of mutual funds available to participants in a 403(b) plan. The Ninth Circuit upheld the decision of a federal trial court to grant the NEA's motion to dismiss. The Ninth Circuit ruled that neither the 403(b) annuities nor the NEA program of endorsing the annuities constitutes an ERISA benefit plan, and that the school district 403(b) plans that offered the NEA-endorsed annuities as investment options are exempt from ERISA because they are governmental plans. (*Jerre Daniels-Hall, et al. v. National Education Association, et al.*, 9th Cir. 2010)

Owner-Employer Cannot Obtain Refund of Plan Contributions

The Court of Appeals for the Third Circuit recently ruled that an owner-employer could not recover contributions made to a multi-employer pension fund on his behalf. The contributions were made during a period when the owner-employer knew that he did not qualify to participate in the plan, and when he retired, he applied for a pension based on the contributions. The fund subsequently denied his application on the grounds that he was not a participant when the contributions were made. He and the company then sued for a refund of the contributions, arguing that it was inequitable for the fund to keep the contributions without paying him a pension. The owner-employer and company obtained a favorable ruling on general equity grounds at the district court level, but the Third Circuit reversed the decision. According to the Third Circuit, ERISA places "strict limits" on circumstances permitting refunds of employer contributions from multi-employer plans "in order to further ERISA's primary purpose of protecting and stabilizing the assets of employee pension plans, thereby safeguarding the interests of plan participants and their beneficiaries." Thus, as the Third Circuit explained in detail, refunds from multi-employer plans are permitted by ERISA only when contributions are made mistakenly, **and** only if the

employer submits a refund claim to the plan within six months of the plan administrator's determination that the contributions were made in error. Here, the facts of the case established that the contributions were deliberately made with the knowledge that the owner-employer did not qualify as a participant, and the company did not seek a refund within the applicable six-month period after receiving notification from the fund that the contributions were made in error. As a result, the Third Circuit determined that the fund was not permitted to refund the contributions under ERISA and concluded that an order of restitution under the circumstances would not serve ERISA's purposes. This case demonstrates the importance of ensuring that plan contributions are made only for eligible participants and ensuring that refund claims are made promptly in the event of a legitimate mistake. (*Mazza v. Sheet metal Workers' National Pension Fund*, 3rd Cir. 2010)

401(k) Plan Unreasonably Refused to Distribute Participant's Non-Employer Benefits

The District Court for the Eastern District of California recently ruled that a frozen 401(k) plan unreasonably refused to distribute the portion of a participant's account attributable to his own contributions while he was facing various misconduct-related claims by his employer after termination. The participant sued the plan in district court after several unsuccessful requests for a distribution and motioned for summary judgment on his benefits claim. As justification for its refusal to distribute the participant's benefits, the plan argued that the employer was entitled to rescind contributions it made to the participant's account because of a "mistake of fact." The assertion was that if the employer had known about the participant's alleged misconduct, it would have terminated the participant and not made contributions to his account. The district court determined that the mistake-of-fact argument could not justify withholding distribution of the portion of the account attributable to the participant's own contributions because distribution of that portion of the account was controlled by the plan's anti-alienation provisions. The protections afforded by those provisions, which are required by ERISA, made the plan administrator's decision unreasonable and an abuse of discretion, according to the district court. With regard to the portion of the account attributable to employer contributions, however, the district court determined the participant failed to demonstrate that the plan's mistake-of-fact argument was unreasonable. The plan contained a provision that, in accordance with ERISA, provided for the return of **employer** contributions that were made as a result of a mistake of fact. Additionally, the court noted that the Court of Appeals for the Ninth Circuit, where the district court was located, recognizes the right of employers to rescind contributions because of a mistake of fact and to bring actions under ERISA to recover those mistaken contributions. As a result, the district court granted the participant's summary judgment motion only with regard to the portion of his account attributable to his own contributions. This case demonstrates that mistake of fact arguments may provide a basis for refusing to distribute employer benefits but should not be used as a basis to withhold distribution of non-employer benefits. (*Anderson v. Strauss Neibauer & Anderson APC Profit Sharing 401(k) Plan*, ED Cal. 2010)

Profit-Sharing Contribution Required for Employee on FMLA Leave

The District Court for the District of Columbia ruled that a legal secretary's employer violated the ERISA when it refused to make a year-end contribution to her account in the firm's profit-sharing plan while she was on medical leave under the Family Medical Leave Act (FMLA). Suffering from carpal tunnel syndrome, the employee took leave from her position in

September 2007 to have surgery on her wrists. Unable to return to work after the surgery, the employee applied for, and was granted, disability benefits in 2008, retroactive to December 2007. Her employer refused to make a contribution to her profit-sharing account for 2007, claiming she was not an employee during the period she was on leave. The plan requires a participant to be employed by the firm on the last day of the year to receive a profit-sharing contribution. The district court disagreed with the employer, ruling that the secretary was indeed an employee on December 31, 2007. Because she was on sick leave under the FMLA at the time, "her job could not be taken away." The court also noted that her employer did not consider her a non-employee, given their careful efforts to get her to "resign" from her position in February 2008. Given her protected status under the FMLA, the employee should have been treated as an active employee at the end of the year, and her employer should have made a contribution for her to the firm's profit-sharing plan. (*Dorsey v. Jacobson Holman PLLC*, DDC 2010)

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