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Employee Benefits

RULINGS, OPINIONS, ETC.

HEALTH CARE REFORM UPDATE

Enforcement of Insured Plan Nondiscrimination Rules Delayed

As many employers are by now well aware, the Affordable Care Act imposes nondiscrimination rules on insured non-grandfathered group health plans. The new rules apply to plan years beginning on or after September 23, 2010. These nondiscrimination rules are to be applied in a manner that is "similar to" the rules that apply to self-insured group health plans. In Notice 2010-63, issued on September 20, 2010, the IRS requested public comments on guidance needed to implement the new rules. One message that came through loud and clear is that the IRS should not require compliance in the absence of detailed guidance. In Notice 2011-1, the Treasury Department and the Internal Revenue Service (IRS), as well as the Departments of Labor (DOL) and Health and Human Services (HHS) (collectively, the Agencies), stated that compliance with the new rules should not be required (and thus, any sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability has been issued. In order to provide insured group health plan sponsors time to implement any changes required as a result of the regulations or other guidance, the Agencies anticipate that the guidance will not apply until plan years beginning after the guidance is issued.

More Health Care Reform FAQs Issued

Over the past several months DOL, HHS, and the IRS (collectively, the Agencies) have issued a series of frequently asked questions (FAQs) regarding the implementation of the Affordable Care Act. This guidance generally reflects the Agencies' view of emphasizing compliance assistance rather than the imposition of penalties on plans working diligently and in good faith to understand and comply with the new law. Although this article highlights only a few important FAQs, all FAQs can be viewed at the following links:

PART I: www.dol.gov/ebsa/faqs/faq-aca.html
PART II: www.dol.gov/ebsa/faqs/faq-aca2.html
PART III: www.dol.gov/ebsa/faqs/faq-aca3.html
PART IV: www.dol.gov/ebsa/faqs/faq-aca4.html
PART V: www.dol.gov/ebsa/faqs/faq-aca5.html

- Effective Date of Automatic Enrollment Requirements

The Affordable Care Act requires employers with at least 200 full-time employees to automatically enroll employees for coverage under their group health plans. The Affordable Care Act did not specify an effective date, but most commentators surmised that compliance with the automatic enrollment provisions would not be required until regulations are issued. In recent guidance issued in the form of FAQs, the Agencies confirmed that, until regulations are issued, employers are not required to comply with the automatic enrollment elections. The Agencies intend to complete this rulemaking by 2014; therefore, compliance with this requirement is not expected anytime soon.

- 60-Day Advance Notice of Material Modifications

When a group health plan is modified in a material manner, the Affordable Care Act requires employers to notify employees of the modification at least 60 days in advance of the effective date of the modification. As with the automatic enrollment requirement, the Affordable Care Act did not specify an effective date. In recent guidance issued in the form of FAQs, the Agencies stated that group health plans are not required to comply with this 60-day prior notice requirement until such time as they are required to comply with the act's requirement to maintain and provide uniform benefit summaries. The act requires employers to begin furnishing these summaries by March 23, 2012; therefore, compliance with the notice requirement pertaining to material modifications will not be required before then.

- Grandfathered Plans

The interim final regulations on grandfathered status require certain participant communications to include a statement that the benefit package is believed to be grandfathered. The FAQs provide that this disclosure statement does not have to be included in every participant communication regarding benefits, but should be included in materials used to inform participants about their benefits so that they can make informed choices regarding health coverage. For example, the disclosure statement should be included in a summary plan description provided to participants when they first become eligible for coverage, or during the annual open enrollment period. Although this FAQ appears to provide some relief from this disclosure requirement, plan administrators should review their participant communications and confirm that the disclosure statement is included with all benefit descriptions provided when participants are making decisions regarding their health care options.

- Dependent Coverage of Children

One of the better-known provisions of the Affordable Care Act is the requirement that group health plans that offer dependent coverage must continue to provide that coverage until the dependent turns age 26. The FAQs address situations where a plan could require additional conditions (such as residency or support) in order to provide coverage to individuals

under age 26. The guidance provides that a plan would not fail to satisfy the new law by limiting health coverage for children until the child turns 26 to only those children described in Code Section 152(f)(1) (this includes biological children, adopted children, children placed for adoption, step children, and eligible foster children). However, if a plan provides coverage to children outside this "safe harbor" group, the plan could impose additional conditions on the extended coverage. For example, a plan offering coverage to grandchildren could require that the grandchild be a tax dependent of the participant employee in order to receive coverage under the plan. Plan sponsors should review their plan's definition of dependent to confirm that the plan's coverage complies with the new law.

New Guidance Regarding Debit Card Use for OTC Expenses

Under the Affordable Care Act, expenses incurred for a medicine or a drug would be treated as a reimbursement for a medical expense only if the medicine or drug is a prescribed medicine or drug or is insulin. IRS Notice 2010-59 provides that, except with respect to "90 percent pharmacies," health FSA and HRA debit cards may not be used to purchase over-the-counter medicines or drugs after January 15, 2011. See our October 2010 Client Alert "Health Care Reform Update: Changes Impacting Account-Based Health Plans" for more information.

In Notice 2011-5, the IRS modified Notice 2010-59 with respect to the use of debit cards for the purchase of over-the-counter medicines or drugs. The new guidance provides that after January 15, 2011, health FSA and HRA debit cards may continue to be used to purchase over-the-counter medicines or drugs if:

- Prior to purchase, the prescription (as defined in Notice 2010-59) for the over-the-counter medicine or drug is presented (in any format) to the pharmacist; the over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and an Rx number is assigned;
- The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements;
- All of these records are available to the employer or its agent upon request;
- The debit card system will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned; and
- The requirements of the guidance provided in Notice 2010-59 are satisfied.

If these requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale.

Vendors that maintain health care–related Merchant Codes, as described in Rev. Rul. 2003-43, must also meet the above requirements, other than the requirements specified in the first and fourth bullet points, and the requirement in the second bullet point that a record of the Rx number be retained.

If these requirements are satisfied, debit card transactions involving over-the-counter medicines or drugs will be considered fully substantiated at the time and point-of-sale.

Health FSA and HRA debit cards may be used to purchase over-the-counter medicines and drugs at "90 percent pharmacies" but only as provided in Notice 2010-59.

This notice is effective for health FSA and HRA debit card purchases of over-the-counter medicines or drugs made after January 15, 2011.

Reporting Deadline for ISO or ESPP Plans Approaching

Employers that have incentive stock option (ISO) plans under Internal Revenue Code §422 or employee stock purchase plans (ESPP) under Code §423 are subject to new tax reporting obligations for 2010. The IRS has released final versions of Form 3921, relating to the exercise of an incentive stock option under Code §422(b) and IRS Form 3922, relating to the transfer of title of stock acquired through an employee stock purchase plan under Code §423(c). The deadline for paper filing of these forms with the IRS is February 28, 2011. The filing deadline for electronic filing of these forms is March 31, 2011. Electronic filing of these forms is required if more than 250 or more forms are being filed. Note that because the information reported on Form 3921 is unique to a particular exercise of an ISO or on Form 3922 to a transfer of title of shares acquired under the ESPP, more than one filing may need to be made with respect to an employee if there are multiple exercises or multiple dates of transfer. In connection with issuance of these final Forms, the IRS has also specified the information that must be provided to the employees. A copy of the Form 3921 or Form 3922 that is filed with the IRS is now the information statement required to be provided to employees. The deadline for providing these information statements to employees is January 31, 2011. The penalties for failure to timely file, or to file electronically if required, is $50 per return.

New Relief Under §409A Correction Programs

The IRS recently issued new guidance for nonqualified deferred compensation plans, providing clarifications and additional relief for correcting inadvertent errors under §409A of the Internal Revenue Code (§409A). Prior guidance issued in 2008 provided self-correction methods for certain "operational failures" in nonqualified arrangements subject to §409A (Notice 2008-113). That notice was followed in early 2010 by guidance on correction methods for certain §409A "documentary failures" (Notice 2010-6). The new guidance, Notice 2010-80, modifies both prior notices to provide extended correction relief:

- Linked Plans and Stock Rights. The types of plans eligiblefor relief under the document correction procedures of Notice 2010-6 now include (i) certain linked plans — nonqualified plans with benefits linked to benefits under other plans — with plan document failures if the linkage does not affect the time and form of payment of amounts under the plans; and (ii) plans granting stock options and stock appreciation rights that are intended to be subject to (and comply with) §409A, if the document failure is otherwise covered by the correction procedures. The relief still does not extend to stock rights, such as options, that are intended to be exempt from §409A.
- Payments Contingent on a Release. Notice 2010-80 provides an additional method for handling payments made on separation from service where recipients are required to sign a release of claims or other agreement (such as a noncompete or nonsolicitation agreement) before receiving payment. The IRS maintains that a §409A agreement that conditions

payment on the signing of a release without specifying a time period during which the release must be signed, or that specifies a time period that may span two taxable years, violates §409A, because a recipient may be able to affect the year of payment by timing the signing of the release. Notice 2010-6 provided limited ways to correct this documentary violation. The new notice now permits payment to be made within a specified period of time, not longer than 90 days, provided that if the payment period spans two years, the payment must be made in the second year.

- Expanded Transition Relief for Payments Contingent on a Release. For arrangements containing impermissible contingent payment provisions on or before December 31, 2010, new transitional relief provides that there is no §409A violation if the payment is triggered on or before March 31, 2011. Relief is also provided for these plans if payment is triggered on or before December 31, 2012, provided payment is made in the later year if the payment period spans two years, and provided that if any amounts remain deferred under the plan, the document is corrected to be §409A compliant by the end of 2012. Payments triggered by March 31, 2011 do not require document correction. As before, agreements that are exempt from §409A (e.g., under the short-term deferral or separation pay exception) are not required to adopt §409A-compliant language
- Information and Reporting Relief for Certain Corrections. Notice 2010-80 modifies the information and reporting requirements specified in Notices 2008-113 and 2010-6 by waiving the employee notification requirements for (i) most documentary corrections made before the end of 2010, (ii) operational corrections made in the same year of the error; and (iii) certain documentary errors related to releases during the transition period. Employees are also relieved of the requirement to attach an information statement to their personal tax returns under the same circumstances. The requirement that an employer include with its own tax returns certain information related to a plan correction still applies.

EBSA Proposes Rule Broadening Definition of "Fiduciary" in Investment Advice Context

On October 22, the DOL's Employee Benefits Security Administration (EBSA) published a proposed rule to broaden and clarify the circumstances under which an individual is considered a "fiduciary" under the Employee Retirement Income Security Act of 1974 (ERISA) by virtue of rendering investment advice for a fee. The current rule addressing fiduciary status for investment advice providers is 35 years old and has not been updated. The proposed rule is intended to provide increased protection to plans and plan participants from conflicts of interest and self-dealing, taking into account changes in the financial industry and expectations of investment advice recipients.

The proposed rule would broaden the circumstances under which investment advice providers are considered fiduciaries, by removing the current requirement that advice be given on a "regular basis," along with the requirement that the parties mutually understand that the advice will be the "primary basis" for investment decisions. The proposed rule would also expand and outline the forms of "advice" that would be covered by the rule, and would clarify that advice or recommendations made to plan participants or beneficiaries can also result in fiduciary status. Under the proposed rule, an investment advice provider would have to satisfy one of four conditions (in addition to providing one of the forms of advice covered by the rule) in order to be considered a fiduciary, such as having represented or acknowledged that it is a fiduciary. Certain activities in and of themselves, such as providing educational materials and information, would not be considered

giving investment advice if the proposed rule were adopted. The proposed rule would also provide a definition for "fee or other compensation." If adopted, the proposed rule would also apply for purposes of the prohibited transaction provisions in the Internal Revenue Code.

As indicated by EBSA, the proposed rule would affect sponsors, fiduciaries, participants, and beneficiaries of pension plans and individual retirement accounts, and would also affect providers of investment and investment advice–related services to those plans and accounts. The DOL is accepting comments on the proposed rule until January 20, 2011. (Department of Labor Proposed Regulation Section 2510.3-21, published October 22, 2010)

CASES

Court Upholds ESOP's Use of Year-Old Valuation to Process Distributions

A federal trial court in New York recently ruled that the sponsor of an employee stock ownership plan (ESOP) did not breach its ERISA fiduciary duties when it used a June 30, 2008 valuation of the company stock to process a distribution in June 2009 to participants whose account values were under $1,000. The participants asserted that the valuation did not reflect the fair market value at the time of the distribution.

The affected participants argued the plan sponsor breached its ERISA fiduciary duty on the grounds that a prudent ERISA fiduciary would not have terminated the participants' interest in the ESOP in June 2009 without first determining the fair market value of the company as of the termination date. The plan sponsor responded that it complied with its ERISA obligations because it acted "in accordance with the documents and instruments governing the plan" and for the permissible purpose of reducing administrative costs associated with the ESOP. The court found the ESOP not only condoned, but explicitly required, the plan sponsor's use of the June 30, 2008 valuation to establish the fair market value of company stock at the time of the distribution.

The affected participants also argued the plan sponsor also breached its duty of loyalty under ERISA by undervaluing the participants' ESOP accounts, and depriving them of the full distribution to which they were entitled (in other words, a new appraisal of the stock value would have yielded higher returns). The court found, however, that so long as defendants used the June 30, 2008 valuation for the distribution because it reasonably appeared to maximize returns for Plan participants under then-prevailing circumstances, they were justified in doing so. The court also concluded that there "can be no question that reliance on the June 30, 2008 valuation seemed to best serve Participant interests." A new valuation was expected to cost at least $20,000 — practically a third of the plan sponsor's total value at the time. The court asserted that incurring over $20,000 in expenses for a new valuation, only a short time before the regularly scheduled valuation was set to take place, would run counter to defendants' statutory duty to defray administrative expenses. Accordingly, the court held that the plan sponsor acted in manner consistent with its fiduciary duty of loyalty by using the June 30, 2008 valuation as the basis for the distribution.

The court granted summary judgment to the plan sponsor. (*McCabe v. Capital Mercury Apparel*, S.D.N.Y. 2010)

409A Provisions Create Uncertainty in Plan Document

As our readers are probably very aware, Internal Revenue Code § 409A requires that payments to "specified employees" which are triggered by a separation from service must be delayed for a period of six months from the date of separation. As a recent case demonstrates, this delay can raise questions of interpretation under a plan document. In the case, an individual was awarded restricted stock units (RSUs) which were to be paid partly in cash. The plan contained the six-month-delay rule for specified employees. However, the plan did not specify when the RSUs were to be valued for determining the amount of the payment. In the case, the employee retired on December 31, 2007. On June 30, the company paid approximately $1.2 million to the employee for the cash portion of his RSUs using a December 31, 2007 valuation date. Subsequently, the employer concluded that the valuation date should have been June 30, 2008, the date of distribution. During that six-month period the value of the RSUs decreased by approximately $540,000. After the executive refused to return the money, the employer sued. Both the District Court and the Eleventh Circuit Court of Appeals upheld the position of the executive finding that there was a notable omission from the position taken by the employer; the employer could not point to any plan language mandating when the RSUs were to be valued. The Eleventh Circuit noted that there is nothing in Code § 409A that would determine when the valuation date is to be and, because the company was suing to recover the amounts, the burden of proof as to demonstrating the proper valuation date shifted to the company. Employers who have amended deferred compensation agreements to provide for required six-month delay also should review whether the agreements provide for administrative procedures that will specify the desired valuation date to avoid disputes with executives. (*Graphic Packaging Holding Co. v. Humphrey*, 11th Cir., 2010)

Third Circuit Rules No Fiduciary Breach Related to Non-Employee Spouse's Decision to Retire

A former Avaya, Inc. employee and his wife sued Avaya under ERISA, alleging that the company breached its fiduciary duty to the couple as participant and beneficiary under the company's pension plan. The claim was based on several letters the employee received from Avaya regarding his benefits under the company's pension plan from which he calculated his expected monthly pension amount. Without confirming the accuracy of his calculations with Avaya, the employee and his wife evaluated their current and expected financial situation and decided that the wife should retire from her job with a different employer. The pension benefit turned out to be much less than they calculated. The couple then sued Avaya, claiming that the letters were misleading and were the basis for the wife's retirement. The couple was unsuccessful at the district court level. On appeal, the Third Circuit found in Avaya's favor on the basis that the couple could not show sufficient detrimental reliance to establish their breach of fiduciary claim. As explained by the Third Circuit, the decision the couple made did not relate to benefits or retirement under the employee-husband's plan. Rather, the decision affected the non-employee wife in her wholly separate benefits and retirement with another employer. Thus, Avaya's fiduciary obligations under the plan were not implicated. Furthermore, Avaya had no knowledge of the wife's decision, and the Third Circuit concluded that a fiduciary could not reasonably foresee that a non-employee would decide to retire based on representations the fiduciary makes to an employee regarding the employee's own benefits. The Third Circuit's decision is

an encouraging one for plan fiduciaries because it limits the potential scope of fiduciary liability based on communications with plan participants. (*Shook v. Avaya Inc.*, 3rd Cir. 2010)

District Court Rules Unambiguous Plan Language Not Trumped by SPD Language

A participant's widow sued Diebold, Inc. after the company denied her claim for death benefits under a supplemental executive retirement plan (SERP) set up for her deceased husband. The dispute between the widow and Diebold centered around differing definitions of "spouse" contained in the SERP's plan document and summary plan description (SPD). The actual plan document defined "spouse" as a surviving spouse that was married to the participant for at least one year prior "to the earlier of" the date of the participant's death or retirement. The SPD only stated that for a surviving spouse to be eligible for a post-retirement death benefit, the participant and the spouse had to be married for the one-year period leading up to the participant's date of death. The widow in this case was married to the participant for more than a year prior to his death, but she was not married to him when he retired, making her ineligible for benefits under the language of the plan document. The widow argued that she was still entitled to benefits, basing her claim on SPD's failure to include the "to the earlier of" language in its "spouse" definition.

The U.S. District Court for the Northern District of Ohio disagreed with the widow's argument, concluding that ambiguous language in an SPD does not trump unambiguous plan language where a party has access to the plan and SPD. Although the court acknowledged that omission of the "to the earlier of" language could "create potential for misrepresentation," the court determined that the omission did not "alter" the plan's terms. The court explained that the controlling law applicable in the Sixth Circuit (where the court is located) requires a "direct conflict," rather than mere inconsistency, for SPD language to control. Furthermore, according to the court, the Sixth Circuit standard only applies where a plaintiff received the SPD but not the plan document, which was not alleged in this case.

The court concluded that on the facts of the case, the widow could not base her claim for benefits solely on the SPD language because the participant, who the court emphasized was involved in drafting and implementing the SERP, knew about and had access to the unambiguous plan language. The court also noted that reliance on the SPD language was not warranted because the SPD indicated that it provided only a "summary" of the SERP and that the plan document would control the final determinations on claims. The court concluded that the widow was not entitled to benefits anyway, because the plan administrator's determination to deny the widow's claim was correct and entitled to deference. Although the determination in this case was largely based on the facts, it demonstrates that ensuring that plan language is unambiguous and that participants have access to both the SPD and the plan document, while also including language in the SPD emphasizing that the plan document controls, may support a plan administrator's claim determinations in situations where an SPD and plan document differ. (*Parr v. Diebold, Inc.*, ND Oh. 2010)

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