EMPLOYEE BENEFITS DEVELOPMENTS FEBRUARY 2007

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Practices & Industries

Employee Benefits

RULINGS, OPINIONS, ETC.

Guidance issued for post-PPA pension benefit statement requirements
The Pension Protection Act of 2006 (PPA) enacted rules designed to improve the individual benefit statements required to be provided to participants and beneficiaries under the Employee Retirement Income Security Act (ERISA). Among the new requirements are more frequent periodic pension benefit statements and new notices regarding participant diversification rights. These new requirements generally are effective for plan years beginning after 2006.

On December 20, 2006, the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) published Field Assistance Bulletin 2006-03 which provides guidance relating to the new individual benefit statement requirements. According to the bulletin, until formal regulations are issued with respect to the post-PPA benefit statement requirements, the DOL will, as an enforcement matter, treat a plan administrator as satisfying ERISA if the administrator acts in good faith. The bulletin provides EBSA's views as to what constitutes good faith compliance with certain post-PPA benefit statement requirements, including guidance on the form, manner, content, and timing for delivering individual benefit statements. For individual account plans that permit participant-directed investments, the bulletin also offers model language for satisfying the requirement that the pension benefit statement provide information concerning the importance of a diversified portfolio. Finally, the bulletin provides guidance on the extent to which furnishing the first individual benefit statement can satisfy diversification notice requirements.

A copy of the bulletin is available at www.dol.gov/ebsa/pdf/fab2006-3.pdf.

Final regulations on HIPAA nondiscrimination and wellness programs
On December 13, 2006, the Departments of Health and Human Services, Labor, and Treasury jointly issued final regulations governing wellness programs and nondiscrimination requirements under the Health Insurance Portability and Accountability Act (HIPAA). The final regulations clarify the application of HIPAA nondiscrimination rules and detail the wellness program exception to those nondiscrimination rules. The final regulations replace interim final nondiscrimination rules and proposed regulations issued in 2001. The final regulations apply to group health plans for plan years beginning after June 2007.

Generally, HIPAA's nondiscrimination rules prohibit a group health plan from conditioning eligibility or charging similarly situated individuals different premiums based on a health factor. The final regulations, while consistent with the interim rules and proposed regulations, clarify certain situations that might otherwise be considered violations of the nondiscrimination rules. Among the clarifications, the final regulations state that:

Health reimbursement accounts are not considered discriminatory even though, over time, healthier individuals will generally accumulate a greater balance.

"Actively-at-work" clauses are generally prohibited as a condition of initial or continued eligibility if an individual is absent due to a health issue.

Group health plans may not exclude an individual who participates in hazardous activities, although plans may be designed to deny coverage for injuries resulting from participation in specific hazardous activities. Group health plans, however, may not deny coverage for an otherwise covered injury that results from domestic violence or a medical condition. As an example, the regulations explain that a plan containing an exclusion for self-inflicted injuries must nonetheless cover those injuries if they result from a medical condition (such as depression). This exception applies even if the medical condition was not previously diagnosed.

The remainder of the final regulations are devoted to defining the criteria for the wellness program exception to the HIPAA nondiscrimination rules. Although, as previously stated, the general HIPAA nondiscrimination rules do not allow for similarly situated individuals to be charged different premiums based on a health factor, an exception is made for wellness programs. Wellness programs are arrangements that condition a reward (or avoidance of a penalty) on the adherence to a program designed to promote health or prevent disease. While wellness programs are permitted under the HIPAA nondiscrimination rules, some wellness program designs are subject to additional standards.

The final regulations categorize wellness program designs into two groups. The first group conditions a reward based only on participation (e.g., providing premium discounts for filling out a health survey). The second group conditions a reward based on the attainment of a health standard (e.g., providing premium discounts if cholesterol is maintained below 200). Wellness programs that require the satisfaction of a standard related to a health factor must additionally meet the following five criteria:

1. The reward for all wellness programs related to a health plan may not exceed 20 percent of the total cost of coverage under the plan. The 20 percent cap on the reward applies separately to each type of coverage offered under the plan. Therefore, if an employer offers both single and family coverage and an employee's spouse and dependents are allowed to participate in a wellness program, the limit applies to the cost of family coverage. On the other hand, an employee under the same plan with single coverage could only receive a reward of up to 20 percent of the cost of single coverage.

2. The program must be reasonably designed to promote good health or prevent disease.

3. The program must give individuals an opportunity to qualify for the reward at least once per year.

4. The wellness program must make available a reasonable alternative standard for the achievement of the reward for individuals who, for medical reasons find it unreasonably difficult or medically inadvisable to achieve the applicable health standard. This reasonable alternative standard does not have to be determined in advance, but must be available upon

request. The alternative standard may be individually designed for each participant (i.e., in consultation with the participant's doctor).

5. The wellness program must disclose the availability of the reasonable alternative standard in all materials that describe the wellness program, although the specifics of the alternative standard do not need to be disclosed.

On a cautionary note, compliance with the new HIPAA final regulations does not automatically constitute compliance with other laws that impose nondiscrim-ination requirements, including the IRC, ERISA, Americans with Disabilities Act, civil rights laws, and the Public Health Service Act. (71 Fed. Reg. 75014)

IRS ends cash balance moratorium

In Notice 2007-6, the IRS announced that it is lifting the moratorium on issuance of determination letters for conversions of traditional defined benefit pension plans to cash balance plans that were put in place in 1999. Clarifications regarding cash balance plans enacted under the PPA allowed the IRS to provide for similar rules in processing pending determination letter applications. Notice 2007-6 describes a type of plan referred to as a "statutory hybrid plan" which, under new IRC § 411(a)(13), would not violate the IRC's vesting provisions. A statutory hybrid plan is a plan that is either a lump-sum-based plan or a plan that has a similar effect to a lump-sum-based plan. A lump-sum-based plan is a defined benefit plan where the benefit of a participant is expressed as the hypothetical account balance maintained for the participants or as a current value of the accumulated percentage of a participant's final average compensation. The fact that a plan provides a lump sum distribution option does not in itself make a plan a lump-sum-based plan. The notice also provides certain guidance on safe harbor market rates of return that can be used by statutory hybrid plans pending the issuance of further guidance. Under this guidance, different rules will apply for cash balance plan conversions that occurred prior to June 30, 2005 and those occurring after June 29, 2005 (i.e., those that are subject to the new PPA provisions). The notice requests comments on several remaining issues and indicates that further guidance will be issued in the near future. (IRS Notice 2007-6)

IRS provides transitional relief for health FSA and HRA debit card reimbursements

On December 14, 2006, the Internal Revenue Service (IRS) issued Notice 2007-2 providing transitional relief for the use of debit cards at non-healthcare related merchants (e.g., grocery stores, supermarkets, discount and wholesale clubs) for medical expense reimbursements under health flexible spending or health reimbursement arrangements. Originally, in Revenue Ruling 2003-43, the IRS limited the use of debit cards to merchants identified with specific healthcare-related merchant category codes.

In July 2006, the IRS followed up with Notice 2006-69, which provides that debit cards may be used at merchants with non-healthcare-related merchant category codes as long as the merchant has an inventory information approval system. The inventory information approval system, as described in Notice 2006-69, allows debit cards to be used for eligible medical expenses at the point of sale without the need for any additional substantiation.

Under Notice 2007-2, the IRS provides transitional relief until December 31, 2007 under which merchants that do not have specified healthcare-related merchant category codes (including mail order and web-based vendors), and do not yet have an inventory information approval system, will be permitted to accept debit cards. During the transition period, participants will be required to provide proper documentation for debit card transactions that cannot be automatically

substantiated. After 2007, non-healthcare-related merchants will need to have an inventory information approval system in order to accept debit cards.

After December 31, 2008, to be able to accept debit cards, merchants with the Drugstores and Pharmacies merchant category codes must either have an inventory information approval system in place or 90 percent of the store's gross receipts during the prior taxable year must have consisted of items which qualify as expenses for medical care under Internal Revenue Code (IRC)
§ 213(d). (IRS Notice 2007-2)

IRS issues final ESOP regulations on S corporation allocations
IRC § 409(p) contains a complex rule designed to prohibit the concentration of S corporation ownership within a group of significant shareholders and their family members (defined as "disqualified persons") through the operation of an employee stock ownership plan (ESOP). The rule prohibits allocations under an S corporation ESOP for the benefit of the disqualified persons in a "nonallocation year." Whether these rules will apply in any year of an S corporation ESOP depends on a projection of stock ownership through the ESOP to identify the group of disqualified persons. In addition, stock options, warrants, or other rights, referred to as "synthetic equity" in the statute, are taken into account in determining the group of disqualified persons and whether there is a nonallocation year. The final regulations must be reviewed by any S corporation that has or is contemplating an ESOP. Areas covered in the final regulations include the treatment of family members as disqualified persons, methods for determining the number of shares represented by synthetic equity arrangements, and the definition of prohibited allocations. Compliance with the regulations for S corporation ESOPs is critical because noncompliance means that the plan ceases to qualify as an ESOP, and the related share purchase agreements used to acquire the corporate stock will likely be prohibited transactions. The regulations describe methods that are effective in preventing the occurrence of a nonallocation year. These methods include a sale of the S corporation stock held in a participant's account before a nonallocation year occurs, a transfer of S corporation securities to a separate portion of the plan that is not an ESOP or to another qualified plan of the employer, or a reduction in outstanding synthetic equity. These methods must comply with the nondiscrimination rules applicable to qualified plans. Careful plan design, with attention to these final regulations, is important to avoid problems with the operation of an S corporation ESOP. (Treasury Decision 9302, issued December 20, 2006)

CASES

More mutual fund 401(k) plan fee litigation
A recent decision by the United States District Court for the Southern District of Illinois highlights the critical importance of prudently exercising the fiduciary duties associated with the selection (and monitoring) of IRC § 401(k) plan investments. The plaintiff in this case was a former employee who sued his former employer, claiming the employer had breached its fiduciary duties with respect to the company 401(k) plan by selecting "retail" mutual funds as plan investments. Given the size of the plan's assets ($2 billion), the plaintiff alleged the employer could have negotiated lower fees in one of two ways:

The employer could have privately retained the same professional money managers used by the mutual funds, thereby avoiding a host of fees associated with mutual fund transactions, including shareholder service fees, transfer agent fees, state and local taxes, and 12b-1 fees; or

The employer could have purchased less expensive "institutional shares" in the funds instead of the more expensive "retail shares" commonly sold to individuals or small investors.

The lawsuit seeks to have the employer pay to the plan the difference between the mutual fund expenses actually paid by the plan (for the "retail" shares) and the expenses the plan would have incurred if one of the two more prudent investment approaches had been employed. The case came to public view in the context of a motion by the employer to dismiss the case on the grounds that the plaintiff had signed a release of his ERISA claims in return for a severance pay package. In a ruling that is likely to generate some controversy, the federal district court held that the plaintiff's claim was not barred by the release because it was, in fact, a claim for vested benefits. The court reasoned that if the plaintiff's claim for fiduciary breach were to prevail, he could become entitled to additional benefits under the plan. (*Boeckman's v. A.G. Edwards Inc.* (S.D. Ill., Sept. 2006))

Failure to follow COBRA rules is costly

A decision by the United States District Court for the Southern District of Illinois sounds another warning about the costly consequences of failing to provide proper notices about the continuation of health benefit coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and to comply with the Family and Medical Leave Act's (FMLA) requirements.

An employee of Mid-Illinois Concrete (Mid-Illinois) was no longer able to work after August 2003 due to terminal cancer. Mid-Illinois continued to pay the employer share of the employee's health coverage for 16 weeks. Mid-Illinois did not properly follow any of the FMLA's rules or notice requirements or comply with COBRA health care continuation coverage, even though its policies were generally favorable to employees. After the 16-week period of shared coverage costs, Mid-Illinois sent a letter to the employee indicating he would have to pay the full premium, which he did. The employee died in June 2004. By then, the insurance carrier had paid $94,000 in medical bills after the employee stopped working and had refused to pay another $50,000 in medical bills. After the employee had first taken leave due to his cancer, the health plan carrier changed, further complicating matters. After discovering all the facts, the health insurer maintained it should not have paid the $94,000 in bills because the employee was not eligible to enroll in the coverage. Mid-Illinois tried to argue that enrollment was permissible under the FMLA rules and that continued coverage was authorized by COBRA. Because Mid-Illinois never followed these statutory rules, however, the employee was not properly enrolled and did not elect COBRA coverage. A lawsuit brought by the employee's widow sought to recover all unpaid medical expenses from either the insurer or Mid-Illinois. The insurer counterclaimed to recover the $94,000 it had paid. In its judgment, the federal district court ruled in favor of the widow and the insurer, leaving Mid-Illinois responsible for the full $144,000 of medical expenses and an expensive lesson in the need to follow federal mandates. (*Uthell v. Mid-Illinois Concrete, Inc.*, et al. (S.D. Ill., Dec. 2006))

Top hat plan for surgeons exempt from ERISA vesting rules

The United States District Court for Massachusetts recently held that a surgical group did not violate ERISA's vesting and fiduciary requirements when it reduced the deferred compensation benefits of a surgeon after his employment was

terminated. The plaintiff surgeon was a participant in two nonqualified deferred compensation plans maintained by the Brigham Surgical Group Foundation (BSG) for its highly compensated surgeons who were on the Harvard Medical School faculty. The medical school maintained an annual cap on the maximum compensation that could be received by a faculty member, and BSG adhered to that cap. The deferred compensation plans were established in part to aid in the recruitment and retention of excellent surgeons who would be adversely affected by that cap. If a surgeon generated a net practice income in excess of the salary cap for any given year, BSG would reduce the surgeon's salary and credit an amount to the plans. The plans also provided that a surgeon's account would be reduced to offset any "practice deficit" the surgeon experienced in a subsequent year.

When his plan accounts were reduced by over $400,000 to offset his accumulated practice deficit, the plaintiff sued BSG following his termination, claiming that his contributions were vested and thus protected from reduction by ERISA. The federal district court disagreed, holding that the plans were "top hat" plans and thus were exempt from the vesting and fiduciary responsibility provisions of ERISA. By definition, top hat plans are unfunded plans maintained primarily to provide deferred compensation for a select group of management or highly compensated employees. The plaintiff argued that the plans were not top hat plans because they were designed to create recruitment and retention incentives rather than to provide deferred compensation. The court rejected this argument, noting that top hat plans commonly have recruitment and retention as related, subsidiary goals. The plaintiff also argued that participation was not limited to a select group of highly compensated employees because approximately 30 percent of BSG's employees were theoretically eligible to contribute to the plans. Noting that participation of about 15 percent of employees is generally considered the upper limit of the acceptable size in determining whether a group is a "select" group, the court nevertheless found that the group of BSG participants was "select." In practice, only highly compensated surgeons who earned more than the faculty salary cap could receive a contribution to the plans, and that group consisted of no more than 8.7 percent of BSG employees for the relevant years, thus making it a "select" group in the eyes of the court. Finally, in response to the plaintiff's claim that he had no individual power to negotiate the terms of the plans, the court held it was not statutorily necessary for highly compensated employees to individually have substantial bargaining power for a plan to achieve top hat status. (*Alexander v. Brigham and Women's Physicians Organization Inc.* (D. Mass., 2006))