EMPLOYEE BENEFITS DEVELOPMENTS OCTOBER 2014

Hodgson Russ Newsletter
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2015 Benefit Limits Announced

The Internal Revenue Service and Social Security Administration have announced the cost of living adjusted dollar limits applicable to benefit plans. A listing of key limits is set out below:

2015 LIMIT

401(k)/403(b)/457 Plan Maximum Elective Deferral

$18,000

401(k)/403(b)/457 Catch-Up

$6,000

Defined Contribution Maximum Annual Addition

$53,000

Defined Benefit Maximum Annual Pension

$210,000

Qualified Plans Maximum Compensation Limit

$265,000

Highly Compensated Employee

$120,000

IRA Limit

$5,500

IRA Catch-up

$1,000

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Employee Benefits

SIMPLE Limit

$12,500

SIMPLE Catch-up

$3,000

Social Security Taxable Wage Base

$118,500

DOL Updates Missing Participants Guidance

When a defined contribution plan terminates, the plan administrator must distribute the plan's assets to participants and beneficiaries (collectively referred to as "participants" hereafter) as soon as administratively feasible after the plan termination. In connection with any distribution, the plan administrator is required to contact participants for directions on how to distribute their account balances. However, it is not uncommon that some participants fail to respond to notices sent by the plan administrator, creating a practical dilemma for plan administrators attempting to terminate the plan. While the decision to terminate a plan is considered a settlor decision that is not subject to fiduciary considerations under the Employee Retirement Income Security Act of 1974 (ERISA), the steps taken to locate missing participants and to distribute their benefits are viewed as fiduciary actions by the Department of Labor (DOL).

The DOL previously issued guidance on locating missing participants and distributing their benefits. Since this guidance was released, certain developments have occurred, such as both the Internal Revenue Service and Social Security Administration discontinuing their letter forwarding services for locating missing plan participants. In view of these changes, the DOL has issued updated guidance for locating missing participants and distributing their benefits.

Search Steps

Some search steps involve such little cost and such a high potential for success that the DOL requires these steps to be taken in all cases (i.e., without regard to the size of the participant's account balance). These steps include:

1. Using certified mail to notify the participant of the plan's termination. It should be noted that the DOL has issued a safe harbor model notice that may be used for purposes of notifying a participant of the plan's termination.
2. Checking related plan and employer records for more current contact information for the participant.
3. Attempting to contact any individual the missing participant has designated as a beneficiary under the plan or any related plan. If privacy concerns exists, the plan administrator may ask the administrator of a related plan to forward a letter on its behalf to the missing participant or his or her beneficiary.
4. Using free electronic search tools to search for the participant.

If the plan administrator is still unable to locate the missing participant after following these steps, the plan administrator should consider the size of the participant's account balance in comparison to the costs of further search efforts in deciding whether additional search steps are appropriate. The DOL has indicated that the additional steps taken will depend on the underlying facts and circumstances, but additional search steps might include commercial locator services, credit reporting agencies, and other services that may involve charges.

Distribution Options

The DOL's position is that, when a missing participant cannot be located after a reasonable search, a prudent fiduciary should generally transfer that portion of a participant's account balance that represents an eligible rollover distribution to an individual retirement plan established for the benefit of the participant. It should be noted that the choice of an individual retirement plan provider and the choice of the initial investment in the individual retirement plan are viewed as fiduciary decisions by the DOL. However, if the conditions set forth in the DOL's regulatory safe harbor are met with respect to the selection of the individual retirement plan and the initial investment in that plan, then the plan administrator will be considered to have discharged its fiduciary duties with respect to those actions.

If the plan administrator is unable to locate an individual retirement plan provider willing to accept a rollover on behalf of the missing participant, or some other compelling reason exists for the plan administrator not transferring amounts to an individual retirement plan, then the plan administrator may:

1. Open an interest-bearing, federally insured bank account in the name of the missing participant, or
2. Transfer the participant's account balance to a state unclaimed property fund.

In selecting among these options, the plan administrator must weigh the features of each option, such as whether the state's unclaimed property fund maintains a searchable database that would allow the participant to locate his or her retirement funds. [DOL Field Assistance Bulletin 2014-01]

Fourth Circuit Rules in Reverse Stock Drop Case: The "Would Haves" and "Could Haves" of Loss Causation

In 1999, RJR Nabisco spun off R.J. Reynolds Tobacco (RJR) from Nabisco, thus separating the company's food business from its tobacco businesses. Prior to the spin-off, RJR Nabisco sponsored a 401(k) plan, which included company stock funds as investment options. From that RJR Nabisco plan, a new plan sponsored by RJR was created, and the new RJR plan provided for the retention of Nabisco stock funds as "frozen" funds in the new plan that allowed covered participants to maintain existing investments in those Nabisco stock funds but prevented participants from purchasing additional shares of those funds. Notwithstanding the plan language that provided for the Nabisco stock funds to remain as frozen investment fund options, a working group of various corporate employees determined the Nabisco stock funds would be liquidated approximately six months after the spin-off. This working group decision was actually made *prior* to the spin-off because of the perceived risk and administrative burden of having a single, non-employer stock fund in the new RJR plan. Evidence presented at trial suggests that the fiduciary committees for the new RJR plan never "met, discussed, or voted on" the decision to eliminate the Nabisco stock funds. And in the months that followed the spin-off, RJR declined to hire financial

consultants, outside counsel, or independent fiduciaries to advise on the prudence of eliminating the Nabisco stock funds.

Immediately following the spin-off, but before the January 2000 divestment of the Nabisco stock funds, the value of Nabisco stock declined dramatically. Nevertheless, the RJR plan proceeded with the divestment as planned. Within months of the divestment, however, the value of the Nabisco stock began to rebound. By late 2000, the value of Nabisco stock was substantially more valuable than it was at the time of the January 2000 divestment.

In 2002, a class action suit was filed alleging the RJR plan committees breached their ERISA fiduciary duties by eliminating the Nabisco stock funds on an arbitrary timeline without conducting a thorough investigation, despite the likelihood that the Nabisco stock prices would rebound. After years of pre-trial motions and legal maneuvering, a federal district court listened to testimony and issued a final judgment in 2013. The court held that RJR's decision to eliminate the Nabisco stock funds was a fiduciary act and that RJR breached its fiduciary duties by proceeding with the divestment without undertaking a proper investigation. Despite the breach and evidence of losses suffered by the RJR plan, the court also held that RJR was not liable for the losses because RJR's decision to eliminate the Nabisco stock funds was "one which a reasonable and prudent fiduciary *could have* made after performing such an investigation."

Plaintiffs appealed, and the U.S. Court of Appeals for the Fourth Circuit affirmed the district court's ruling that RJR breached its duty of procedural prudence and bears the burden of proof as to whether that breach caused the losses suffered by the RJR plan. The Fourth Circuit, however, vacated the judgment in favor of RJR. In the majority opinion, the Fourth Circuit held that the district court erred in applying a *"could have"* standard in determining whether RJR was objectively prudent in its decision to divest the Nabisco stock funds. Instead, the court's majority held that that the defendants must show, by a preponderance of the evidence, that a prudent fiduciary *would have* made the same decision to divest the Nabisco stock funds had it undertaken a proper investigation. The majority noted that "the distinction between 'would' and 'could' is both real and legally significant." The majority also rejected RJR's argument that even if the district court erred by applying the "could have" standard rather than the "would have" standard, the error was harmless. The Fourth Circuit remanded the case to the district court for further proceedings consistent with the "would have" standard.

It is not entirely easy to reconcile some aspects of the majority opinion with existing case law, and whether the "would have" standard espoused by the Fourth Circuit stands up to further judicial scrutiny remains to be seen. But this case reminds us of the importance of adhering to a fiduciary process that protects the interests of plan participants. In this case, that fiduciary process broke down. If plan fiduciaries are not meeting and are not engaged in a proper investigation intended to determine whether a particular investment or divestment decision is prudent and in the best interest of participants, those fiduciaries may be vulnerable to breach of fiduciary duty claims. *Tatum v. RJR Pension Inv. Comm.*, 4th Cir. 2014.

Employers May Not Sue Multiemployer Plan Trustees for Mismanagement

A Teamsters Local pension plan (the fund) was terminated by a mass withdrawal of substantially all contributing employers. One of the employers liable to the fund for withdrawal liability brought an action against the fund trustees arguing that the trustees acted unreasonably in setting insufficient contribution rates and in the manner in which they invested fund assets. The trustees moved to dismiss the employers claim in district court. ERISA recognizes that beneficiaries could bring such an action, but ERISA does not provide for lawsuits by employers. The employer asked the district court to recognize a common

law action for claim of negligence against the trustees. The district court ruled in favor of the fund trustees. On appeal, the U.S. Court of Appeals for the Sixth Circuit ruled that a claim for mismanagement by the fund trustees was not a claim expressly provided for under ERISA, and there was no need to interpret ERISA to allow employers to have such a claim. Therefore, the Sixth Circuit upheld the dismissal of the action against the fund trustees. *DiGeronimo Aggregates, LLC v. Zemla*, 6th Cir., 2014

Deadline Fast Approaching for Large Health Plans to Obtain HPIDs

A health plan identifier (HPID) is a unique 10-digit number issued by the Centers for Medicare and Medicaid Services and is intended to streamline certain electronic transactions. This number will be used to identify group health plans that are part of an electronic HIPAA standard transaction, such as payment, claims, or enrollment functions. Self-insured group health plans with more than $5 million in annual receipts are required to obtain an HPID by November 5, 2014. Self-insured group health plans with $5 million or fewer annual receipts must obtain an HPID by November 5, 2015. Certain arrangements, such as health flexible spending accounts (health FSAs) and health savings accounts (HSAs) are not required to have HPIDs. Health reimbursement accounts (HRAs) that cover only deductibles or out-of-pocket costs are also not required to have HPIDs. However, HRAs that do not coordinate with other health coverage are likely to be required to obtain HPIDs. Although fully-insured group health plans will be required to have HPIDs, the insurance companies rather than employers are responsible for obtaining them. Employers may apply for an HPID directly through the CMS website. Once an HPID is obtained, the information should be shared with any third-party administrators that assist the plan with HIPAA standard transactions.

Sixth Circuit Rules Notice of Limitations Period for Review Must Be in Claims Denial Letter

In a split decision, the U.S. Court of Appeals for the Sixth Circuit ruled that a disability plan participant who had his lawsuit for disability benefits dismissed on grounds that the period of limitations had expired could pursue his case because the insurance company had failed to include notice of the three-year limitations period in its letter denying benefits to the participant.

When the participant in the disability plan applied for disability benefits in 2005, the insurance company originally approved his claim but reversed its decision in 2007 after determining that the participant was physically capable of performing work other than his former job. The participant's 2008 claims rejection letter included notice of his right to appeal but failed to include notice of a three-year time limit for review. When the participant sued in 2012, seeking recovery of unpaid disability benefits, the insurance company moved to dismiss, arguing that the plan's three-year period of limitations barred his claim. The district court agreed, noting the statement in the plan documents that a three-year limitations period applied for filing suit. On appeal, the Sixth Circuit disagreed, noting that the plan documents describing the limitations period were provided to participants only on request and that neither the claim rejection letter nor the summary plan description (SPD) referenced the limitations period for seeking judicial review. Focusing on the benefit denial letter, the court held that ERISA regulations require that benefit denial letters include a description of the plan's

review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action following a claim denial on review. Concluding that the benefit denial letter failed to ensure a fair opportunity for review because of its failure to include the time limits, the appeals court reversed and remanded the case to the district court for consideration of the participant's appeal. *Moyer v. Metro. Life Ins. Co* (6TH Cir. 2014)

When Must an SPD Be Written in a Language Other Than English?

According to a federal district court in Maryland, the answer may be "never" [*Melendez v. Hatfield's Equipment. and Dedication Services., Inc.*(D. Md., 2014)]. The plaintiffs in *Melendez* filed suit on behalf of nearly 40 Spanish-speaking employees and former employees alleging that the employer, as plan administrator, violated ERISA by failing to provide a summary plan document (SPD) calculated to be understood by the average plan participant. The plaintiffs alleged that the SPD, which was written only in English, failed this requirement because the average participant is a person who speaks and reads Spanish as his or her primary language. The plaintiff sought a court order requiring the plan administrator to issue plan documents and benefit statements in Spanish. In denying the plaintiff's request, the court correctly noted that ERISA contains no express requirement that an SPD be provided in multiple languages. However, the court went on to note that ERISA regulations require plan administrators to prominently publish an offer of assistance as part of the SPD if a specified number or percentage of the plan's participants are literate only in the same non-English language. The offer must be written in the applicable non-English language. For plans that cover fewer than 100 participants at the beginning of a plan year, the non-English offer of assistance must be prominently displayed in the SPD if 25 percent or more of all plan participants are literate only in the same non-English language. If a plan has 100 or more participants at the beginning of the plan year, the notice must be included in the SPD if at least 10 percent of the participants at the beginning of the plan year (or, if less, 500 participants) are literate only in the same non-English language. The court did not hold that the plan administrator breached the obligation to provide a foreign language notice because the complaint did not specify the number of total plan participants, the percentage of total plan participants who are literate in Spanish, or even that they are only literate in Spanish. Employers that have a significant number of employees who are literate only in the same non-English language should determine whether an offer of assistance is required and, if it is, ensure that all SPDs prominently display the requisite offer of assistance. As a risk management strategy, it may be prudent in some instances to offer foreign language assistance even when the regulation does not require the plan administrator to do so.