

Benefits and Employment Briefing



“Before anything else, preparation is the key to success.”

- Alexander Graham Bell

A quarterly newsletter about employee benefits and current issues

Fourth Quarter 2011

▶ HEALTH CARE REFORM: WHAT'S GONE AWAY? AND WHAT'S COMING IN 2012?

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▶ LOSS OF PRIVILEGE: ANOTHER REASON NOT TO GIVE THE “COMPANY” A FIDUCIARY ROLE

In our efforts to help plan sponsors minimize their fiduciary risk, we consistently advise against giving the sponsoring employer a fiduciary role. Designating the “company” or “employer” as an ERISA fiduciary can unintentionally subject the employer’s executive officers and board of directors to ERISA’s fiduciary standards, and potentially to personal liability.

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HEALTH CARE REFORM: WHAT'S GONE AWAY? AND WHAT'S COMING IN 2012?

The tide of regulations interpreting the 2010 Patient Protection and Affordable Care Act (“PPACA”) began to ebb in 2011, and portions of the law have even been repealed or put on hold. Nonetheless, health plan sponsors will still face new compliance burdens in 2012. This article briefly addresses these aspects of the PPACA.

Legal Challenges to Individual Mandate

Foremost on the mind of many plan sponsors is the constitutionality of the PPACA’s “individual mandate.” Starting in 2014, this would require that virtually all U. S. citizens either have health insurance or pay a monetary penalty. Several lower federal courts have examined this issue during the past year, with varying outcomes. On November 14, the United States Supreme Court agreed to review three lower court decisions addressing this and other PPACA-related questions – scheduling an extraordinary 5 ½ hours of oral arguments. Those arguments will likely take place in March, with a decision possible by the end of the Court’s term in June.

If the Supreme Court declares the individual mandate unconstitutional, Republicans could gain some momentum toward repealing the entire PPACA. On the other hand, Democrats believe the remainder of the law would still be viable. They also see a silver lining; if the least popular provision of the PPACA is repealed, what remains may become stronger and more popular with the public. Nevertheless, if the individual mandate – which would require millions of young,

healthy people to buy coverage – is struck down, but the rules compelling insurers to cover sick people remain intact, the cost of coverage could skyrocket. Plan sponsors will surely be anxious to see how this situation unfolds.

Repeal of Form 1099 Reporting Requirement

As predicted in our [February 2011 article](#), Congress and the President eventually agreed on legislation repealing the PPACA’s expanded Form 1099 reporting requirements. Those requirements were described in our [April 2011 article](#), along with a summary of the changes that were made to the PPACA as a way of offsetting the cost of this repeal.

Repeal of Free-Choice Voucher Requirement

Somewhat more surprisingly, Congress and the President also agreed to repeal the PPACA provision that would have required employers to issue “free-choice vouchers.” The coalition backing that repeal included both large employers and unions. The “adverse selection” concerns underlying this repeal were outlined in a second [April 2011 article](#).

Shelving of CLASS Act

Most recently, in October, the Obama Administration tabled the Community Living Assistance Services and Supports program (“CLASS Act”), after determining that this long-term care insurance program is not financially sustainable. This national, government-run program was designed to allow certain individuals the option of buying insurance for benefits that would largely supplement, but not replace,

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existing public programs or insurance. The President opposes efforts to permanently repeal the program, however, and he may veto any attempt to do so.

Uniform Summary of Benefits and Coverage

The PPACA will require that each employer health plan provide a four-page summary of the plan's benefits to all individuals who are eligible for coverage. This requirement was scheduled to take effect on March 23, 2012 (two years after the PPACA's enactment).

The agencies charged with implementing the PPACA proposed regulations on this topic in August, along with templates of proposed formats under which a plan may furnish this new "summary of benefits and coverage" ("SBC"). See our [August 2011 article](#) for more details. In a recent FAQ, the agencies repeated their intention to issue final regulations as quickly as possible. The agencies also noted, however, that plans and insurers need not issue SBCs until those final regulations are issued. Moreover, those regulations will give plans and insurers "sufficient time to comply." It therefore seems highly unlikely that SBCs will be required before 2013.

Women's Preventive Services

The PPACA also requires that group health plans (other than plans that are "grandfathered") cover a list of "preventive health services." In August, the agencies charged with administering the PPACA issued additional rules describing *women's* preventive services that must be covered. Like the services listed in earlier agency guidance, these women's preventive services must be covered on a first-dollar basis, and with no cost-sharing requirement.

Our [August 2011 article](#) briefly summarized the new rules. Generally speaking, the new services must be covered during plan years beginning on or after August 1, 2012. Thus, although calendar-year plans need not cover these services until January 1, 2013, the requirement will take effect during 2012 for plans with plan years beginning during the last five months of the calendar year.

Form W-2 Reporting of Health Coverage

As a result of the PPACA, employees' Forms W-2 must provide useful and comparable consumer information on the cost of their employer-sponsored health coverage. On March 29, 2011, the IRS issued Notice 2011-28, providing interim guidance on this new reporting requirement.

As we discussed in [our October 2010 article](#), this W-2 reporting is *optional* for 2011, but *required* for the 2012 Forms W-2 (to be given to employees in January of 2013). As we also noted, such reporting will not affect the tax treatment of employer-sponsored coverage. See our [April 2011 article](#) for more information on this topic.

Clearly, plan sponsors have much to do to prepare for this new reporting requirement. At a minimum, they will want to make sure they have systems in place to track this additional information. Sponsors may also want to prepare a special communication to be provided with their employees' 2012 Forms W-2. This would not only explain the new tax-reporting number, but also emphasize that the reporting is mandated by the PPACA for informational purposes only, and that it will not affect the employees' tax withholding or liability.

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Nondiscrimination Requirements for Insured Health Plans

As we reported in our [December 2010 article](#), the Internal Revenue Service announced (in Notice 2011-1) that insured group health plans will not be required to comply with the PPACA's income-based nondiscrimination requirements until sometime after the IRS issues regulatory guidance on those requirements. That guidance has yet to be issued. Therefore, sponsors of fully insured plans continue to enjoy a temporary reprieve from these nondiscrimination requirements – and the onerous penalties associated with noncompliance.

Absent a statutory repeal of the PPACA provision mandating that insured plans comply with these nondiscrimination rules, however, *non-grandfathered* insured plans will eventually be subject to nondiscrimination requirements that are similar to the “nondiscriminatory eligibility” and “nondiscriminatory benefits” tests currently applicable to self-funded plans under Code Section 105(h). Employers sponsoring fully insured plans should therefore consider the steps they would need to take to comply with these requirements. [Return to Top](#)

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DEADLINES APPROACHING FOR RETIREMENT PLAN AMENDMENTS

Once again, amendment season is upon us. Sponsors of tax-favored retirement plans should keep in mind the many required amendments for which a year-end deadline is fast approaching. This article highlights some of the more

important changes that sponsors must address before the curtain closes on 2011.

Defined Contribution Plans: Waiver of 2009 RMDs

Most retirement plans must begin distributing benefits to retirees who have attained age 70½. The distributions necessary to satisfy this requirement are called required minimum distributions (or “RMDs”). As we reported in a [February 2009 article](#), the Worker, Retiree and Employer Recovery Act of 2008 (“WREERA”) eliminated the requirement that many defined contribution plans make RMDs for the 2009 calendar year.

In a [November 2009 article](#), we reported on [Notice 2009-82](#), in which the IRS explained how plan sponsors should implement that one-time waiver. Although plan sponsors had to decide by November 30, 2009, how to handle 2009 RMDs *operationally*, the amendment deadline is only now approaching for calendar-year plans. Affected plans must be amended no later than the last day of the first plan year beginning on or after January 1, 2011.

Defined Contribution Plans: In-Plan Roth Conversions

Ordinarily, the only way participants may make Roth contributions to a retirement plan is to designate a salary deferral as a “qualified Roth contribution” when it is made. As we reported in our [February 2011 article](#), however, the Small Business Jobs Act of 2010 established a mechanism whereby participants may convert their *pre-tax* retirement savings into Roth accounts.

In [Notice 2010-84](#), the IRS issued guidance on implementing such “in-plan

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Roth conversions.” Among other things, the Notice extended the amendment deadline for adding an in-plan conversion feature. This relief extended not only to the conversion component, but also to the addition of the underlying Roth contribution arrangement and the distribution provisions necessary to trigger the conversion. The extended amendment deadlines are as follows:

- For **401(k) plans**, the later of: (i) the last day of the first plan year in which the amendment is effective, or (ii) December 31, 2011.
- For **safe-harbor 401(k) plans**, the later of: (i) the day before the first day of the first plan year in which the amendment is effective, or (ii) December 31, 2011.
- For **403(b) plans**, the later of: (i) the last day of the first plan year in which the amendment is effective, or (ii) the last day of the plan’s “remedial amendment period,” if any. (In general, a 403(b) plan will have a remedial amendment period if it was adopted in writing by December 31, 2009, and the plan’s sponsor either adopts a pre-approved 403(b) plan that has received a favorable opinion letter [once those letters are issued] or submits an application for an individual determination letter [once that option becomes available to 403(b) plans].)
- For **457(b) plans**, we are still awaiting IRS guidance.

Governmental Plans: PPA Amendment Deadline

As we reported in our [August 2009 article](#), Congress gave *governmental* employers an additional two years to amend their retirement plans to reflect the mandatory changes enacted as part of the Pension Protection Act of 2006. That deadline is the last day of the first plan year beginning on or after January 1, 2011 (i.e., December 31, 2011, for calendar-year plans). This deadline applies to both defined benefit and defined contribution plans.

Discretionary Amendments

In General. In most cases, the deadline for adopting a plan-design amendment (at least, one that does not reduce the rate of benefit accruals) is the end of the plan year in which it takes effect. In other words, such changes may usually be made retroactive to the first day of the plan year. Thus, for most purposes, calendar-year plans must be amended to reflect 2011 design changes by no later than December 31, 2011.

Special Changes. Some design changes must be adopted *before* the plan year in which they take effect. These include certain changes to safe-harbor 401(k) contributions, as well as certain reductions in the rate of pension accruals. For such design changes to be effective for the 2012 plan year, they must therefore be adopted by the end of the 2011 plan year. (These changes may also require the sponsor to issue participant notices before the amendment is effective.) Thus, calendar-year plans must be amended for this type of change by the same date—December 31, 2011.

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Cycle A Filing Deadline

In addition to the changes discussed above, individually designed Section 401(a) qualified plans falling within Cycle A of the IRS's determination-letter program should be amended and restated—and have a determination letter application filed with the IRS—by January 31, 2012. This deadline is unrelated to the plan year on which a plan operates.

A plan falls within Cycle A if the sponsoring employer's tax identification number ends with either "1" or "6." The many changes that must be incorporated into a Cycle A plan are listed on the IRS's 2010 cumulative list of retirement plan changes, which was issued in [Notice 2010-90](#). Accordingly, the sponsor of any Cycle A plan that has not already begun this review and amendment process should do so without further delay.

What Should Plan Sponsors Do?

The consequences of missing any of the amendment deadlines discussed above could be quite severe: the plan would lose its tax-favored status. The consequence for Cycle A plans that are not timely restated and submitted to the IRS is also severe: they will not be covered by a favorable determination letter until—at the earliest—their next on-cycle year (2017).

Sponsors should therefore carefully review their documents to determine whether they have adopted conforming amendments and restatements by the applicable deadlines. Spencer Fane's Employee Benefits Group is ready to assist sponsors in this review, as well as in drafting any necessary documents. [Return to Top](#)

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HEALTH PLAN ASSESSED DOUBLE DAMAGES FOR MSP VIOLATION

A federal appeals court has held that the Medicare Secondary Payer ("MSP") Act authorizes a medical provider to sue an employer health plan for *double damages* when the plan fails to comply with the MSP Act, thereby forcing the provider to accept the lower level of reimbursement available under Medicare. This Sixth Circuit decision, in [Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast and Southwest Areas Health and Welfare Fund](#), definitely raises the stakes for health plans that fail to comply with the MSP rules.

In its lengthy opinion, the Sixth Circuit was essentially required to make sense of nonsense. This is because the relevant provisions of the MSP Act have been amended over the years in ways that allow for multiple interpretations. Ultimately, this *Bio-Medical* court adopted a different interpretation than a sister appellate court (the Eleventh Circuit) in a case it decided back in 2006.

Factual Background

The facts at issue in the *Bio-Medical* decision were as follows. In August of 2005, an individual who had coverage under the Central States Plan was diagnosed with end-stage renal disease ("ESRD") and began receiving kidney dialysis treatment at a Bio-Medical facility. Pursuant to the patient's assignment of her right to benefits, the Plan began paying Bio-Medical for that treatment. Three months later, on November 1, 2005, the patient became entitled to Medicare (presumably, on the basis of her ESRD).

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The Central States Plan contained the following provision: “Coverage under this Plan shall terminate on the earliest of the following dates: ... the date [the insured] first becomes entitled to Medicare benefits ...” On learning of the patient’s Medicare entitlement, the Plan retroactively terminated her coverage as of November 1, 2005. It also recouped most of the benefits it had paid since that date, by offsetting the alleged overpayments against amounts otherwise payable to Bio-Medical for the treatment of other Plan participants.

Bio-Medical continued to treat the patient until her death on May 18, 2006. The total charges from November 1, 2005, through that date were approximately \$210,000. Although Medicare eventually paid a portion of this amount (not disclosed in the opinion), Bio-Medical sued the Plan for the remainder.

Bio-Medical’s Lawsuit

Bio-Medical’s lawsuit was based on two different statutes: (1) under ERISA, for unpaid benefits (as the patient’s assignee), and (2) under the MSP Act (and particularly that Act’s provision of a “private cause of action” for “double damages”). The trial court held for Bio-Medical on its ERISA claim, but it dismissed the MSP claim. That dismissal was based on a 2006 Eleventh Circuit decision (subsequently followed by several other lower courts) holding that such a private cause of action could be brought only if the defendant’s responsibility for the payment had been “previously demonstrated.”

The Sixth Circuit’s Analysis

On appeal, the Sixth Circuit affirmed the trial court’s ERISA ruling, but it reversed as to the MSP Act. The analysis under ERISA was fairly straightforward. Although ERISA requires that fiduciaries administer a plan in accordance with its terms, and although a plan administrator’s interpretation of a plan will be upheld unless it is arbitrary and capricious, any denial of benefits is *deemed* to be arbitrary and capricious if it results in a violation of federal law.

Here, it was clear that, for the first 30 months of the patient’s Medicare entitlement due to ESRD, the Plan could not “take into account” that entitlement. But that is exactly what the Plan did by terminating the patient’s coverage as of her Medicare entitlement date. To cure that MSP violation, the Plan was required to reinstate her coverage – and to pay the patient’s claims on a basis that was primary to Medicare.

Bio-Medical wanted more than this, however; it wanted to force the Plan to pay *double* damages for this MSP violation. This double damages claim was based on a provision added to the MSP Act in 1986 (six years after the law was enacted). This provision grants a private party (i.e., other than Medicare) the right to sue a “primary plan” that fails to honor its obligations under the MSP Act, thereby forcing Medicare to make a “conditional payment” (which is what Medicare did in this case).

This is where the legal thicket becomes virtually impenetrable. Around the turn of this century, individuals (later followed by Medicare) began suing tobacco

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companies to recover the expenses Medicare was required to pay for the treatment of diseases attributable to cigarette smoking. Those private lawsuits were based on this double damages provision. The courts' reactions to those lawsuits – which were almost uniformly negative – led Congress to amend the MSP Act in various respects.

For instance, those amendments made clear that *tortfeasors* (as the tobacco companies were alleged to be) could be considered “primary plans” for this purpose. At the same time, however, the Act was amended to condition liability for double damages on a defendant's responsibility for the expenses at issue having already been demonstrated before the suit was filed. Presumably, that liability would be demonstrated in a “products liability” or similar lawsuit.

Relying on this “demonstrated responsibility” provision, the Eleventh Circuit had dismissed the earlier claims against the tobacco companies. In reaching this result, the Eleventh Circuit read this requirement quite broadly, in a way that would apply to an insurer or health plan, and not simply a tortfeasor. The *Bio-Medical* court held that this was an improper reading of the statutory language.

According to the Sixth Circuit, the “demonstrated responsibility” requirement applies only when the target of a double damages lawsuit is a tortfeasor. Citing regulations issued by the Centers for Medicare and Medicaid Services, the Sixth Circuit held that an insurer or other health plan with *contractual* liability for the payment of medical benefits could be sued on the basis of *that* liability – with no need to obtain a determination of legal

responsibility *before* seeking the double damages.

It is this holding that may expose employer health plans to liability for double damages when they violate the MSP Act. Although the *Bio-Medical* decision arose in the relatively narrow context of ESRD benefits, the MSP rules also apply to individuals who are entitled to Medicare on account of their age or total disability. The implications of this decision are therefore far broader than the ESRD context.

Recommended Next Steps

Given this Sixth Circuit decision, sponsors and administrators of employer health plans will want to proceed as follows:

- Review their plan provisions to determine whether they comply in all respects with the MSP Act. If they do not, immediately adopt appropriate corrective amendments.
- Assuming the plan provisions are in compliance, verify that claims have always been processed and paid in accordance with those provisions.
- If claims have not been processed and paid in accordance with the MSP rules, consider correcting that failure before either Medicare or a private payer files a lawsuit seeking to obtain double damages. [Return to Top](#)

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EXTENSION OF TRADE ADJUSTMENT ASSISTANCE AFFECTS CERTAIN COBRA COVERAGE

The Trade Act of 2002 created a health care tax credit (“HCTC”) for certain individuals who become eligible for trade adjustment assistance (“TAA eligible individuals”), as well as for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (“PBGC recipients”). Under the original HCTC provisions, eligible individuals could either claim a tax credit or receive advance payment of 65% of the premiums they pay for qualified health insurance, including COBRA continuation coverage. Special COBRA rights, including a second opportunity to elect COBRA coverage, also apply to TAA-eligible individuals and PBGC recipients.

The American Recovery and Reinvestment Act of 2009 (“ARRA”) made several amendments to these provisions, including a temporary increase in the amount of the credit (to 80% of the premiums) and a temporary extension of the maximum period of COBRA continuation coverage for both TAA-eligible individuals and PBGC recipients. Due to an impasse in Congress, however, the ARRA extension expired as of February 13, 2011, and the credit reverted back to the original 65%.

On October 21, 2011, the President signed into law the Trade Adjustment Assistance Extension Act of 2011 (the “Extension Act”). The Extension Act temporarily extends the HCTC provisions applicable to TAA-eligible individuals and PBGC recipients through December 31, 2013. It also retroactively reinstated the

tax credit – effective for coverage months beginning after February 12, 2011 – and increased it from 65% to 72.5%. Note, however, that the ability to receive advance payment of this increased percentage appears to be available only *prospectively* (for coverage months beginning on or after November 20, 2011). Both the special COBRA election opportunity and the extension of the maximum period of COBRA coverage were also reinstated.

Although many employers may have no employees directly affected by the Extension Act, they should still review their COBRA notices and plan documents to ensure that any description of the HCTC provisions remains accurate. [Return to Top](#)

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FAILING TO NOTIFY PARTICIPANTS OF PLAN CHANGES CAN BE COSTLY

Among ERISA’s many notice and disclosure obligations, the requirement to timely inform participants of important plan changes is one that is too often overlooked. Although there is no monetary penalty for failing to distribute a summary of material modifications (“SMM”) or an updated summary plan description (“SPD”) within the time periods set by the regulations, such a failure can still have severe consequences. AT&T recently learned that lesson – to the tune of a six-figure judgment awarded to a deferred vested participant in its defined benefit pension plan. ([Helton v. AT&T, Inc.](#) Sept. 16, 2011).

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Following a three-day trial, a United States District Court in Virginia ruled that the fiduciaries of the AT&T Pension Benefit Plan had abused their discretion by failing to timely notify Francine Helton of a change in the Plan's terms. That change was significant because it would have entitled Ms. Helton to retire at age 55 with no reduction in her monthly benefit. The court also found that the Plan's fiduciaries had erred when they failed to correct Ms. Helton's misunderstanding as to her eligibility to retire.

Change in Early Retirement Eligibility

Ms. Helton terminated her employment from AT&T in May of 1997, at age 50, following an extended leave of absence. At that time, she was not eligible for an unreduced benefit under the Plan. Just three months later, however, AT&T amended the Plan in a way that would have allowed her to begin receiving distributions at age 55 with no reduction for early retirement. AT&T claimed that it had notified employees of this change in a letter sent in late April of 1997, and then again in 1998 when it distributed a revised SPD. Ms. Helton contended that she received neither the letter nor the revised SPD.

Further complicating the case for AT&T, Ms. Helton also testified that, in 2001, she had specifically asked a Plan representative to verify that she was not entitled to a benefit until she reached age 65. Although Ms. Helton obviously misunderstood her rights at this point, the court found no evidence that the Plan representative attempted to correct Ms. Helton's misunderstanding. Only when Ms. Helton inquired again in 2009, as she neared age 65, did she learn that she had been eligible to receive a benefit for nearly eight years.

Ms. Helton asked the Plan to make retroactive benefit payments to her from the date she attained age 55. That request was denied, as was her administrative appeal. The Plan's fiduciaries based their denial on a finding that she had received notice of the change in the Plan's rules through both the April 1997 letter and the 1998 SPD. Ms. Helton filed suit shortly thereafter.

Defective Notice and Abuse of Discretion

The court reviewed Ms. Helton's claim under the "abuse of discretion" standard, giving deference to the Plan fiduciaries' findings. Even under that forgiving standard, however, the court concluded that the fiduciaries' evaluation was woefully deficient. The fiduciaries could point to no evidence that either the April 1997 letter or the 1998 SPD had actually been delivered to Ms. Helton. Moreover, they could not demonstrate that they even *considered* the possibility that those notices had *not* been delivered. Instead, they merely relied on vague statements from the Plan administrator about the standard process for distributing such notices.

The fiduciaries' defense was hampered by the fact that Ms. Helton's employment records had been destroyed years before the trial. Thus, there was no way to prove that the notices had actually been sent to her. The fiduciaries were also unable to produce mailing lists used for these notices that included Ms. Helton's name.

Perhaps most damaging to the AT&T defendants, however, was the fact that the 1997 letter and the 1998 SPD were addressed only to active management employees. Ms. Helton was neither

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actively employed during those times, nor a management employee. Instead, she had terminated her employment after a leave of absence, and she was then classified as a deferred vested participant.

Because the defendants could not prove that they took appropriate measures to notify Ms. Helton of the change in the Plan's early retirement rules, the court held that they had acted arbitrarily and capriciously in denying her claim, and that they had violated ERISA's disclosure rules. It pointed to ERISA's regulatory requirement that plans notify affected participants – including deferred vested participants – of material changes within 210 days after the end of the plan year in which the changes are adopted. Those regulations require administrators to “use measures reasonably calculated to ensure actual receipt of the material by plan participants.” By failing to mail an SMM or revised SPD to deferred vested participants, the Plan's fiduciaries violated that requirement.

Fiduciary Breach for Failing to Correct Misunderstanding

The court also concluded that the AT&T defendants had breached their fiduciary duties by failing to correct Ms. Helton's misunderstanding of her rights under the Plan. According to the court, fiduciaries have an obligation “not to misinform employees through material misrepresentations and incomplete, inconsistent or contradictory disclosures.” When Plan representatives became aware in 2001 that Ms. Helton did not understand that she was entitled to retire with unreduced benefits at age 55, rather than age 65, they had an affirmative fiduciary duty to correct that misunderstanding.

Ultimately, the court awarded Ms. Helton nearly \$125,000 in retroactive benefits, and it also ordered AT&T to pay her attorneys' fees.

Lessons for Fiduciaries

Although the process of sending timely SMMs to affected participants is obviously more complicated for plans with thousands of participants scattered all across the country, errors such as those addressed in the *Helton* case can happen to *any* plan, with equally drastic consequences. To avoid such a costly mistake, plan fiduciaries should:

- Prepare and distribute SMMs as soon as material modifications are made to the plan;
- Carefully evaluate *how* notices of such changes are being distributed, and to *whom*;
- Maintain contemporaneous records of the process used to distribute those notices, such as mailing lists; and
- Instruct benefits administrators to correct participants when they express an obvious misunderstanding of their rights under the plan.

In the end, adopting a plan amendment is merely the tip of the iceberg; the real danger lies in failing to communicate the amendment's changes to affected participants.

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INVESTMENT PROVIDERS AND ADVISORS MAY NOW PROVIDE “CONFLICTED” ADVICE TO PLAN PARTICIPANTS

Both the Employee Retirement Income Security Act (“ERISA”) and the Internal Revenue Code (the “Code”) generally prohibit fiduciary investment advisers from receiving compensation from the investment vehicles that they recommend to plan participants and IRA holders. However, the Pension Protection Act of 2006 amended ERISA to create a new statutory exemption from the prohibited transaction rules that is designed to expand the availability of fiduciary investment advice to participants in individual account plans and IRAs, subject to specific safeguards and conditions.

Although this statutory exemption has been in effect since 2007, it has taken several years for the Department of Labor (“DOL”) to draft appropriate regulatory guidance. Final regulations implementing the statutory exemption were published in January of 2009, but they were delayed several times and then eventually withdrawn. Significantly revised regulations were re-proposed in March of 2010, and they were finalized, with minor modifications, on October 24, 2011. These final regulations will become effective on December 27, 2011 – applying to transactions occurring on or after that date.

What is “Conflicted” Investment Advice?

Under ERISA, a “fiduciary” includes any entity or individual who renders investment advice for a fee (or other direct or indirect compensation) with respect to the assets of an ERISA-covered plan, or that has any authority or responsibility to do so.

A fiduciary is then prohibited from dealing with the assets of a plan in its own interest or for its own account, and from receiving any consideration for its own personal account from any party dealing with the plan in connection with a transaction involving the assets of a plan.

These “self-dealing” prohibitions have been interpreted as barring a fiduciary from using the authority, control, or responsibility that makes it a fiduciary to cause itself (or a party in which it has an interest that may affect its best judgment as a fiduciary) to receive additional fees. Consequently, fiduciaries are generally prohibited from rendering investment advice to participants with respect to investments that result in the payment of additional advisory or other fees to the fiduciary or its affiliates. Similar rules apply under the Code to the rendering of investment advice to IRA holders.

What Transactions are Covered by the Statutory Exemption?

Section 408(b)(14) of ERISA lists the transactions that are exempt from the prohibited transaction rules if certain requirements (described below) are met. These transactions include:

- The provision of investment advice to a participant or beneficiary with respect to an investment option that is available under the plan;
- The acquisition, holding, or sale of an investment (i.e., an available investment option under the plan) pursuant to that investment advice; and

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- The direct or indirect receipt of compensation by a fiduciary adviser or affiliate in connection with the provision of that investment advice or the acquisition, holding, or sale of the investment.

What is an “Eligible Investment Advice Arrangement”?

Section 408(g) of ERISA provides that potentially conflicted advice will be exempt from the prohibited transaction rules only if it is provided by a fiduciary adviser under an “eligible investment advice arrangement.” There are two general types of eligible arrangements: a “fee-leveling” arrangement (where the fees do not vary based on the investments selected by the participant); and a “computer model” arrangement (requiring the use of certified computer-generated asset allocation models). Both types of arrangements must also satisfy several other requirements.

To qualify as a “fee leveling” arrangement, the fiduciary adviser must:

- Base the advice on generally accepted investment theories that take into account several types of data/information;
- Take into account investment management and other fees and expenses of the investments;
- Request, and take into account to the extent furnished, individual information about the participant (such as age, risk tolerance, etc.); and

- Not receive compensation that varies on the basis of the participant’s selection of a particular investment option.

Obviously, the last of these four conditions is the key; the advisor must not have a financial bias in recommending any particular investment option. This includes any direct or indirect compensation that the *advisor* may receive in connection with the participant’s selection of that investment. However, it does *not* include compensation payable to an *affiliate* of the advisor. Therefore, an advisor may in fact recommend funds sponsored by (or that share revenue with) an affiliate of the advisor, so long as the advisor does not receive any greater compensation with respect to those funds than it does with respect to any other investment option offered under the plan. (This should be compared to the more restrictive rule for “computer model” arrangements, as discussed below.)

To qualify as a “computer model” arrangement, the following requirements must be met:

- The model must apply generally accepted investment theories that take into account several listed types of data/information;
- The model must take into account the investment management and other fees and expenses associated with the recommended investments;
- The model must appropriately weight the factors used in estimating future returns;

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- The arrangement must request, and take into account to the extent furnished, certain information about the participant (age, risk tolerance, etc.);
 - The model must utilize appropriate objective criteria to provide asset allocation portfolios composed of the investment options available under the plan;
 - The recommended portfolios must not inappropriately favor the options offered by, or options that may generate greater income for, the fiduciary advisor or any entity with a “material affiliation” or “material contractual relationship” with the advisor (as those terms are defined in the regulations); and
 - The model must take into account all designated investment options under the plan, without giving inappropriate weight to any particular option.
- Provide certain written disclosures to the authorizing fiduciary;
 - Provide appropriate disclosures in accordance with all applicable securities laws;
 - Ensure that any sale or acquisition occurs solely at the direction of the recipient of the advice;
 - Receive no more than “reasonable” compensation;
 - Ensure that the terms of any sale or acquisition are at least as favorable to the plan as an arm’s-length transaction would be; and
 - Maintain records, for not less than six years, sufficient to demonstrate compliance with the regulations.

Do the Regulations Make Prior DOL Guidance on Investment Advice Obsolete?

Under *either* a “fee leveling” or a “computer model” arrangement, the advisor must (in addition to the above requirements):

- Obtain a plan fiduciary’s prior authorization of the arrangement;
- Arrange for an annual audit of the arrangement;
- Provide certain written disclosures to participants;

No. The final regulations specifically provide that nothing in Section 408(g) of ERISA, Section 4975 of the Code, or the final regulations invalidates or otherwise affects prior regulations, exemptions, or interpretive or other guidance issued by the DOL pertaining to the provision of investment advice and the circumstances under which that advice may or may not constitute a prohibited transaction under ERISA or the Code. Such prior guidance includes Advisory Opinion 2001-09A (the “SunAmerica” opinion), which allows potentially conflicted advisors to provide

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advice that is based on investment-specific asset allocation portfolios created by an independent third-party fiduciary advisor.

Are Plan Sponsors Required to Provide Investment Advice?

No. Neither a plan sponsor nor an investment provider is *required* to provide fiduciary investment advice. The DOL has issued guidance (in [Interpretive Bulletin 96-1](#)) setting forth the types of “investment education” that employers and/or service providers may provide without that education being treated as fiduciary investment advice. That guidance – which allows a plan’s broker or investment provider to provide asset allocation assistance, so long as the recommendations are limited to *categories* of investments (such as large-cap growth or international funds) rather than specific investment options – is not affected by these new regulations.

However, if a plan’s investment provider (or any other service provider or advisor with a financial interest in the investment options available under the plan) provides advice to plan participants that involves the recommendation of specific investment options, that advice *must* be provided under an “eligible investment advice arrangement” meeting the requirements of these new regulations. [Return to Top](#)

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LOSS OF PRIVILEGE: ANOTHER REASON NOT TO GIVE THE “COMPANY” A FIDUCIARY ROLE

In our efforts to help plan sponsors minimize their fiduciary risk, we consistently advise against giving the sponsoring employer a fiduciary role. Designating the “company” or “employer” as an ERISA fiduciary can unintentionally subject the employer’s executive officers and board of directors to ERISA’s fiduciary standards, and potentially to personal liability. The United States Supreme Court recently reminded us of another reason to avoid this plan governance mistake: the potential loss of the attorney-client privilege.

Although the Court’s June 13, 2011, decision in [United States v. Jicarilla Apache Nation](#) did not directly involve ERISA, it has important implications for the relationship between plan sponsors and their lawyers. In this case, the Court recognized the “fiduciary exception” to the attorney-client communications privilege. Under ordinary circumstances, that privilege shields the lawyer’s client from having to disclose confidential communications between the two. But when a *fiduciary* of a trust seeks advice from a lawyer concerning the administration of the trust, the fiduciary cannot assert the privilege against the trust’s beneficiaries. This is because, in these circumstances, the lawyer’s advice is being obtained for the benefit of the beneficiaries. In a sense, the advice – and thus the privilege – *belongs* to the beneficiaries, and not the fiduciary.

The Court’s analysis in *Jicarilla Apache Nation* is not inconsistent with lower court rulings over the years, but it highlights a

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key tenet of sound ERISA plan governance. If the sponsoring employer is also an ERISA fiduciary with respect to the plan, or if the employer pays for legal advice out of the plan's assets, it is much more difficult to protect against the disclosure of confidential communications involving the plan. Many benefit plan documents – especially prototype documents – automatically designate the “company” or “employer” as the plan's administrator and/or named fiduciary. Unless the sponsor takes affirmative steps to shift that fiduciary status to someone else – such as an administrative committee or individual – the sponsor puts its communications with legal counsel at risk of disclosure in a participant lawsuit or Department of Labor audit. [Return to Top](#)

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