September 2006 Employee Benefits Update

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SELECT COMPLIANCE DEADLINES

401(k) and Roth 401(k) Deadlines

Plan sponsors who have implemented changes to their 401(k) plans under the 2006 final 401(k) regulations or added Roth 401(k) features to their plans must adopt amendments documenting the changes by the end of the plan year in which the amendments are effective. For calendar year plans that adopted such changes in 2006, the amendments must be adopted by December 31, 2006.

Deadlines Under the New Determination Letter Program

As we previously reported, the Internal Revenue Service ("IRS") has implemented a new determination letter program, for employers to file determination letter requests for qualified retirement plans. Under the new program, a plan's filing deadline is based on its filing cycle, which is determined by the last digit of the plan sponsor's employer identification number ("EIN"). Individually designed plans sponsored by employers with an EIN ending in 1 or 6 are in Cycle A and must file no later than January 31, 2007. Pre-approved plans are on a six year cycle and are not required to have to file before 2010.

There are special rules for certain types of individually designed plans, as well as plans sponsored by controlled group members. Multiple employer plans are in Cycle B and must file on or before January 31, 2008. Government employers, which are in Cycle C, must file no later than January 31, 2009. Multi-employer plans fall in Cycle D and have a filing deadline of January 31, 2010. A controlled group may either file on a plan-by-plan basis, or may make an election that results in all plans of the controlled group using Cycle A. In addition, parent subsidiary controlled groups that maintain more than one plan may elect to use the cycle that is based on the parent's EIN.

PBGC Releases 2006 Participant Notice

Plan administrators of certain underfunded, defined benefit plans must annually notify participants and beneficiaries of the plans funding status and the limits of the PBGC's guarantee of benefits. The PBGC has issued an updated model notice that plan administrators can use to provide the notice, which includes the most recent information on maximum guaranteed benefits. The 2006 participant notice

is due two months after the due date (including extensions) for the 2005 Form 5500. Note that the Pension Protection Act of 2006 replaces this notice requirement with a new funding notice that will need to be provided within 120 days after the end of each plan year beginning with the 2008 plan year.

RETIREMENT PLAN DEVELOPMENTS

Pension Protection Act of 2006 Becomes Law

On August 17, 2006, President Bush signed into law the Pension Protection Act of 2006. Reinhart's August 2006 Employee Benefits Update outlined significant provisions of the Act. More detailed topic summaries of the Act are, or will soon be, available on our website in an e-alert.

IRS Delays Effective Date for Section 403(b) Regulations

The IRS has announced that the general effective date for the regulations regarding 403(b) arrangements will not be earlier than January 1, 2008. These regulations were proposed in 2004 and include the related controlled group regulations under Internal Revenue Code (the "Code") section 414(c). The extension is designed to provide employers, employees, insurance carriers and mutual funds involved in 403(b) arrangements a reasonable advance period before the regulations go into effect.

IRS Issues Final Anti-Cutback Regulations for Defined Benefit Plans

The IRS has issued final regulations relating to the anti-cutback rule in Code section 411(d)(6) applicable to defined benefit pension plans. The regulations create a utilization exception to the anti-cutback rule for eliminating optional forms of benefit and codify the Supreme Court's decision in *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004).

In general, Code section 411(d)(6) provides that a plan sponsor may not amend its plan to eliminate optional forms of benefit with respect to previously accrued benefits. In 2005, the IRS issued final regulations providing two exceptions to the general rule: the "redundancy" and "core option" exceptions, which provide that participants must continue to have certain distribution options available after a plan eliminates one or more optional forms of benefit. The 2006 regulations create a third exception, the "utilization" exception, which permits defined benefit plan sponsors to eliminate certain optional forms of benefit that have not been used for two or more years.

The utilization exception applies if the generalized optional form was available to at least 50 participants during a "look back period" and no participant has elected any optional form of benefit that is part of the generalized optional form with an annuity start date that is within the look back period. The utilization exception cannot be used to eliminate "core" options, which include a straight life annuity, a 75% joint and survivor annuity, a ten-year term certain and life annuity and the most valuable distribution option for a participant with a short life expectancy. The utilization exception is effective for amendments adopted after December 31, 2006.

In *Heinz*, the Supreme Court ruled that a Multi-employer plan sponsor had violated the anti-cutback rule when it expanded a suspension of benefit requirement for early retirees. The plan amendment had expanded the definition of "covered employment" that would trigger a suspension of benefits. The 2006 regulations apply the Court's ruling to any amendment that adds a restriction or condition that is otherwise permitted under the vesting rules of Code section 411(a)(3) (11), not just an amendment regarding a suspension of benefits. The regulations do not, however, prohibit changing a plan's vesting computation period in accordance with Department of Labor ("DOL") regulations. The rule regarding changes to suspension of benefits provisions is effective June 27, 2004 (the date of the *Heinz* decision) and the rule regarding other plan amendments is effective for amendments adopted after August 9, 2006.

Plan Fiduciaries Removed from Plan

The Fourth Circuit recently upheld the removal of a defined contribution plan's fiduciaries and an award of $720,000 in favor of the plan in *Chao v. Malkani, et al.*, 452 F.3d 290 (4th Cir. 2006). The employer, Information Systems and Networks Corporation ("ISN") established a defined contribution plan in 1982, which required ISN to make an annual contribution. In 1995, ISN stopped making required contributions to the plan.

The DOL filed suit against Roma Malkani, the president and plan administrative committee chairwoman, for failing to make required contributions for 1995 through 2003. Several times after that, Malkani and ISN requested that the plan's third party administrator ("TPA") pay ISN amounts ranging from $62,000 to $706,000 from plan assets for reimbursement of administrative expenses. The TPA denied the larger requests but did pay ISN $62,800. ISN also attempted to have the TPA transfer approximately $1.86 million from plan assets on the grounds that ISN had excessively contributed to the plan. The district court held

that Malkani and ISN had breached their fiduciary duties and ordered ISN to return the $62,800 it had received as reimbursement for administrative expenses. The court also removed Malkani and ISN as the plan's fiduciaries and barred them from ever again serving as employee benefit plan fiduciaries.

The district court determined that Malkani and ISN had to pay $720,000 (including interest) for the failure to contribute to the plan. The Fourth Circuit rejected Malkani and ISN's arguments that their actions were permitted and affirmed the district court's decision.

Note: The plan sponsor failed to take any action to formally suspend or terminate contributions.

Claims Procedure Violations Did Not Affect Statute of Limitations

The Ninth Circuit recently held that flawed claims procedures did not prevent the statute of limitations from starting. *Chuck v. Hewlett Packard Co.*, 2006 U.S. App. LEXIS 18579 (9th Cir. 2006). The employee in this case resigned and received a distribution from his retirement plan. More than ten years later, he sued for additional benefits, claiming that a gap in his employment should have been included in calculating his benefit. The employee argued that the statute of limitations had not begun to run because the plan had failed to comply with the claims regulations when it did not inform him of his appeal rights or give him an adequate explanation of the reasons for its denial.

The court found in favor of the plan, holding that the statute of limitations had expired and the claim was time barred. The court explained that the statute of limitations begins to run when the cause of action accrues, which was when the plan actually denies a claim or when the claimant has reason to know that his or her claim has finally been denied. The court found that the participant had reason to know that his claim was denied when he received a letter from the plan stating that no further retirement benefits were payable.

WELFARE AND FRINGE BENEFIT PLAN DEVELOPMENTS

IRS Rejects HRA that Reimburses Expenses of Nonspouse and Nondependent Beneficiaries

The IRS recently issued Revenue Ruling 2006 36, which addressed a health reimbursement arrangement ("HRA") that continued to pay benefits to a designated nonspouse, nondependent beneficiary, either upon the death of a deceased employee's surviving spouse and last dependent, or upon the death of

an employee with no spouse or dependents. The value of the reimbursements was never included in the employee's income, but was treated as taxable income to the designated beneficiary.

The IRS concluded that all reimbursements paid from the arrangement were taxable because of the reimbursements to nonspouse, nondependent beneficiaries. The IRS based its decision on regulations under Code section 105, which provide that only amounts paid to reimburse expenses incurred by an employee, spouse or dependents are excluded from the employee's gross income. It also cited a 2005 revenue ruling, which specifically disapproved payment of a cash benefit to a deceased person's beneficiary or estate, and concluded that the holding in that ruling broadly applied to the situation at issue.

"Reg. E" Does Not Apply to Electronic Payment Cards

Regulation E ("Reg. E") is a federal banking regulation that covers electronic funds transfers authorizing a financial institution to debit or credit a consumer's account. Reg. E. includes extensive disclosure and authorization requirements designed to protect and limit the liability of consumers. In response to questions regarding whether Reg. E applies to electronic payment cards used with health flexible savings accounts ("FSAs"), health savings accounts ("HSAs") or health reimbursement accounts ("HRAs"), the Federal Reserve System ("FRS") indicated in regulations that Reg. E does not apply to these cards. FRS specifically stated that cards used solely for health related expenses are not covered by the regulation, whether funded by the employer or employee. However, FRS has said that it will continue to monitor the prepaid card market and may reconsider its conclusion in the future.

ERISA Does Not Preempt Assignment of Benefits Statutes

The Fifth Circuit recently held that ERISA does not preempt a Louisiana law requiring health plans to honor assignments of benefits by patients, to health care providers. *Louisiana Health Services & Indemnity Co. v. Rapides Health Care System*, No. 04 31114 (5th Cir. 2006). The state statute provides that insurance companies and employee benefits plans may not pay hospital benefits to an insured person when the claim clearly indicates that the person has assigned the right to benefits to a hospital. Under the law, misdirected payments to the insured do not release the insurer or plan from liability to the hospital and payment to the insured is not a defense to an action by a hospital to collect the benefits.

The plaintiff (d/b/a Blue Cross and Blue Shield of Louisiana) argued that state law was preempted because it conflicts with ERISA's civil enforcement scheme for regulation of employee benefit plans. The Fifth Circuit disagreed, concluding that the Louisiana law was not "conflict preempted" because ERISA does not address assignability of employee welfare benefits. The court also noted that the state law did not create an additional means to enforce payment of benefits, but passed the right to seek enforcement from the patient to the hospital.

Audit Report Did Not Prove Mailing of COBRA Notice

In *Crotty v. Dakotacare Admin. Servs. Inc.*, the Eighth Circuit rejected a plan administrator's assertions that it had mailed a COBRA election notice to a terminated employee. 2006 U.S. App. LEXIS 19289 (8th Cir. 2006). The employee sued the plan administrator, claiming that she had never received the notice. The administrator presented evidence that the notice had been sent, including an audit report that its computerized tracking system had generated a notice to the former employee and testimony from an employee that its procedure for mailing notifications is that notices are automatically generated and then printed, sorted, placed by hand into an addressed envelope and mailed with necessary postage.

The district court found that the administrator presented sufficient evidence that it had mailed the notice and ruled in favor of the administrator. The Eighth Circuit disagreed on appeal, concluding that the administrator had not presented evidence that its procedure had been followed for this particular employee's notice.

Mailbox Rule Sufficient to Prove Notice of Plan Amendment

In this case, a participant's employment was terminated after he did not return to work after more than six months of disability leave. *Custer v. Murphy Oil, USA, Inc.*, 2006 U.S. Dist. LEXIS 49976 (E.D. La. 2006). Prior to his injury, the company's health plan had been amended to provide that disabled terminated employees were no longer covered under the plan until age 65, but would instead be offered COBRA coverage at active employee rates. The employee claimed that he had not received notice of the amendment and the company claimed that it had sent him both a notice of the change and an updated SPD via first class mail.

The court rejected the participant's claim and applied the "mailbox rule." Under the mailbox rule, evidence of the proper and timely mailing of a document raises a presumption that the document was received by the addressee. The court stated that a presumption of receipt is created by evidence of a mailing sent

pursuant to office procedures followed in the regular course of business. In this case, the company's benefits manager testified regarding the company's mailing procedures, confirmed that the procedures were followed with respect to the plan amendment notice and presented the company's mailing list with the participant's current address. This testimony was confirmed by other employees. The court held that the participant did not overcome the mailbox presumption with the evidence he presented.

Plan Document Language Controls Reimbursement

In *Popowski v. Parrott*, the Eleventh Circuit addressed two separate reimbursement cases. See 2006 U.S. App. LEXIS 21587 (11th Cir. 2006). Participants in two separate group health plans were involved in accidents, had their medical expenses paid by the plans and then received settlements relating to the accidents. The plans sought reimbursement, but the participants argued that the claims were not for appropriate equitable relief. The participants prevailed at the trial court level.

The appeals court issued a single opinion regarding both cases, holding that one plan could continue with its reimbursement claim, but the other could not. The court of appeals based its decision on the reasoning of the Supreme Court in the *Sereboff* case and each plan's reimbursement language. The court outlined that appropriate equitable relief, as defined by *Sereboff*, includes a plan's claim for breach of contract that seeks reimbursement through a constructive trust or equitable lien on a particular share of a specifically defined fund that is in the defendant's possession and control.

One plan document provided that a participant had to repay the plan, out of any recovery from a third party, the amount of benefits paid on the participant's behalf. The plan also stated that it had a lien on any amount recovered by a participant from a third party. The court of appeals held that this plan met *Sereboff's* requirement of seeking "appropriate equitable relief" because of the plan's language and the fact that a significant portion of the recovery was in the participant's possession.

The other plan documents were not drafted as carefully. They provided that, upon receipt of a settlement, judgment or other payment relating to an accident, the plan had a right to reimbursement in full for any medical expenses paid by the plan relating to the accident. The court of appeals held that this language did not meet *Sereboff's* requirements because the documents failed to limit recovery

to a specific portion of a particular fund and used the receipt of the settlement merely as a trigger for a general reimbursement obligation.

No Deferential Review Where Not Granted by Policy

The Seventh Circuit recently addressed a standard of review issue in *Sperandeo v. Lorillard Tobacco Co.*, 2006 U.S. App. LEXIS 21216 (7th Cir. 2006). An ERISA plan participant's claim for long term disability benefits was denied. The participant challenged the insurer's denial, which was upheld by the trial court. The court of appeals reversed the trial court's decision in part and affirmed it in part regarding the participant's eligibility for benefits.

The court of appeals also reviewed the standard of review that should be applied and concluded that the de novo standard of review was correct. The court based its decision on the insurance policy, which it recognized as an ERISA plan document for purposes of the standard of review. Although the insurance certificate and SPD granted the insurer discretionary authority to determine plan benefits, the insurance policy did not. Therefore, the insurer was not entitled to the more deferential standard of review. The insurance certificate and SPD explicitly stated that they were not part of the policy.

ESOP DEVELOPMENTS

IRS Issues Regulations Limiting Deduction for ESOP Dividends

The IRS has issued final regulations limiting the Code section 404(k) deduction for dividends paid to an ESOP by precluding a deduction for payments in redemption of stock held by an ESOP. T.D. 9282 (August 29, 2006).

In general, a corporation cannot deduct for income tax purposes dividends paid to its shareholders. However, Code section 404(k) permits corporations to deduct the amount of certain dividends that it pays to an ESOP. Under Code section 162(k)(1), a corporation cannot take an otherwise allowable deduction for any amount that is paid by a corporation for the reacquisition of stock.

The IRS had previously ruled in Revenue Ruling 2001-6 that corporations cannot deduct payments in redemption of stock held by its ESOP because allowing the deduction would permit employers to claim deductions for payments that do not represent true costs. This ruling was questioned by the Ninth Circuit in Boise Cascade *Corp. v. U.S.*, 329 F.3d 751 (9th Cir. 2003).

The final regulations confirm the IRS's position that allowing a deduction for

amounts paid to reacquire stock is improper because permitting the deduction would allow a corporation to claim two deductions for the same cost-one deduction for the value of stock originally contributed to the ESOP and another for the amount paid to redeem the stock. The final regulations do not address the issue in the proposed regulations regarding which corporation is entitled to the Code section 404(k) deduction when the ESOP benefits employees of more than one corporation. However, the preamble to the final regulations indicates that the issue will be addressed in future regulations.

GENERAL TOPICS

IRS Releases Priority Guidance Plan

The IRS has issued its 2006-2007 Priority Guidance Plan, which is a list of regulatory projects that may be issued from July 2006 through June 2007. The list includes 37 pension and benefits projects. Highlights include:

- Final regulations on electronic transmission of notices to participants regarding distributions from qualified retirement plans;
- Guidance on benefits not permitted in a defined benefit plan;
- Guidance on notices to employees participating in 401(k) safe harbor plans;
- Final regulations on designated Roth contributions;
- Guidance under Code section 411 regarding accrual and vesting of benefits provided under qualified retirement plans;
- Final regulations regarding the limitations, benefits and contributions under Code section 415;
- Revenue ruling on taxable health benefits for beneficiaries;
- Proposed regulations on cafeteria plans under Code section 125;
- Guidance on health savings accounts; and
- Final regulations under Code section 409A on nonqualified deferred compensation.

Court Rules ERISA Claim Time Barred

The Seventh Circuit recently addressed questions regarding how long participants

have to bring an ERISA claim in *Berger v. AXA Network LLC*, (7th Cir. 2006). Two insurance salesmen, Terrance Berger and Donald Laxton, filed an ERISA claim against their employer, AXA Network LLC. The plaintiffs claimed that AXA impermissibly altered their employment status for the purpose of interfering with their rights under AXA's benefit plans, in violation of ERISA section 510. Their claim was based on a change in how AXA determined whether the salesmen were qualified as full time agents eligible to participate in the benefit plans. After the change was implemented, Berger and Laxton did not meet the requirements to be considered full time agents and lost eligibility under the plans.

The court of appeals first decided that the law of New York (where AXA is located) should apply to the dispute instead of the law of Illinois (where Berger and Laxton worked and brought suit) because New York was significantly related to the claim. The court found that New York law required the claim to be filed within two years after AXA changed its method of determining full time status in 1998. Because the plaintiffs waited to bring suit until after they lost eligibility, more than two years later, their claim was dismissed.

Ninth Circuit Updates Rules for Standard of Review

The Ninth Circuit has significantly changed its approach to determining the appropriate standard of review. In this case, an employee covered by an ERISA life insurance plan became disabled and retired. *Abatie v. Alta Health & Life Ins. Co.*, 2006 U.S. App. LEXIS 20829 (9th Cir. 2006). After the employee died, his widow filed a claim for life insurance benefits. The insurer denied her claim and she filed suit.

On appeal, the Ninth Circuit reversed the trial court and significantly revised the rules on how courts review cases when the plan decision maker has a conflict of interest or has failed to observe claims procedures. Under the new rules, a court must consider the nature, extent and effect of a conflict of interest and any failure to follow procedural requirements. The court's decision might be affected by evidence of malice, inconsistent reasons for denial, failure to investigate claims adequately or repeated denials of benefits by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record. The court should consider all relevant evidence and should not require the participant to prove that the claim was denied because the insurer had a conflict of interest.