



EMPLOYEE BENEFITS DEVELOPMENTS



RULINGS, OPINIONS, ETC.

EMPLOYER-PROVIDED CELL PHONES GENERALLY NON-TAXABLE

New guidance from the Internal Revenue Service (IRS) clarifies the tax treatment of cell phones that employers provide their employees. IRS Notice 2011-72 explains that if the employer-provided cell phones are given primarily for non-compensatory business purposes, both business and personal use of the phones is generally non-taxable to the employees. The Small Business Jobs Act of 2010 had previously removed cell phones from the definition of "listed property." Under the listed property rules, taxpayers were technically required to provide adequate records or other sufficient evidence supporting the business use of the employer-provided phones.

Under their new status, cell phones are no longer subject to the heightened substantiation rules applicable to listed property. As long as the phones are provided primarily for non-compensatory business reasons, the IRS will not require taxpayers to keep records of their business use of the phones to receive tax-free treatment on either the business or the personal use of the phones. Examples of non-compensatory business purposes include the employer's need to contact the employee at all times for work-related emergencies, the employer's requirement that the employee be available to speak with clients while away from the office, and the employee's need to speak with clients in other time zones outside of normal work hours. A related memorandum providing audit guidance to IRS examiners provides similar rules for arrangements under which employers reimburse employees for the business use of their personal cell phones. (SBSE-04-0911-083)

DOL POLICY ON ELECTRONIC DISCLOSURES

The Department of Labor (DOL) has been working on new disclosure rules for qualified retirement plans. The rules include expanded requirements, effective January 1, 2012 for calendar year plans, for service providers to disclose to plan sponsors the fees and service expenses for investments, recordkeeping, and other charges. A second set of rules, effective April 1, 2012 for calendar year plans, require plan administrators to disclose to plan participants the fees and expenses charged to plan accounts.

The DOL has now issued a new policy statement allowing plan administrators to provide these participant-level disclosures via electronic media in certain circumstances. The disclosure rules generally require written disclosures to be delivered to participants for such things as summary plan descriptions, account statements, and investment information. The DOL policy statement, issued September 13, 2011, allows for electronic delivery of disclosure materials in two circumstances:

1. For participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties.
2. For participants who affirmatively consent to receive disclosures through electronic media even where use of a computer is not an integral part of the job.

If electronic delivery of materials is appropriate, there are still six conditions that must be satisfied to meet the disclosure requirements:

1. The participant must voluntarily provide an e-mail address for receipt of disclosures.
2. An initial notice must be provided containing statements about the electronic delivery of materials, access information, the availability of free disclosures in paper form, the right to opt out of electronic delivery, and the procedure for updating an e-mail address.
3. An annual notice of the plan's electronic delivery procedures must be provided.
4. The plan administrator must have appropriate procedures in place to ensure that the electronic delivery system results in actual receipt of transmitted information.
5. The plan must have an appropriate system for confidentiality.
6. The notices must be provided in a manner calculated to be understood by the average plan participant.

As plans adapt to meet the additional disclosure requirements on fees, electronic delivery systems should be reviewed and utilized where appropriate. (DOL Technical Release 2011-03)

PBGC PROVIDES PREMIUM PENALTY AND ALTERNATIVE PREMIUM FUNDING ELECTION RELIEF

Under Executive Order 13563, the Pension Benefit Guaranty Corporation (PBGC) was directed to review and improve its regulatory processes. In accordance with this order, the PBGC recently issued a notice granting relief in several situations.

First, for plan years beginning after 2010, PBGC will waive premium penalties assessed solely because the payments are late by no more than seven days. In other words, the PBGC will assume that each premium payment was made seven days before it was actually made. All other rules will then be applied as usual.

Second, the PBGC is expanding relief related to variable rate premium alternative calculation elections. Since 2008, the PBGC has allowed plans to elect to use the alternative premium funding target to calculate its variable rate premium. To use this alternative method, plans are required to check box five of the comprehensive premium filing for the first plan year to which the election applies. Although the majority of plans that used the alternative method filed valid elections, some plans failed to check this box. To address these issues, the PBGC is modifying its online premium filing application to provide additional error check and alert notices. Relief is also provided if the plan inadvertently checked (or failed to check) the box for using the alternative method. For plan years after 2007, the PBGC will waive premium penalties in connection with these errors.

CASES

STOP-LOSS INSURANCE: CLOSING GAPS IN COVERAGE

A recent case out of Ohio reminds us of the limitations of stop-loss insurance and the need to obtain prior approval from the stop-loss carrier in situations where coverage is to be extended beyond the required COBRA coverage period. The plan sponsor in this case maintained a self-funded plan covering current and retired employees. In 2009, one of the plan's retirees underwent bypass surgery, incurring expenses of nearly \$500,000. At the time of his surgery, the retiree had been enrolled in the plan for 10 years in accordance with the terms of a separation agreement that provided continuation of coverage through age 65.

After the plan paid the claim, it applied to the stop-loss carrier for reimbursement. The stop-loss carrier denied the claim on the grounds that it was not aware of the extended coverage option contained in the retiree separation agreement and that, in any event, the stop-loss policy excluded coverage for "any . . . retiree whose continuation of coverage was not offered according to COBRA regulations." (*Bekaert v. Standard Security Life Insurance Company of New York*, N.D. Ohio, August, 2011)

A LESSON IN TIMELINESS

Anyone with a 401(k) account is aware of the volatility of investment markets, the significant losses that many investors experienced in the recent recession, and the equity losses that began in the fall of 2007.

The Court of Appeals for the Fifth Circuit recently gave a plan administrator a costly lesson in the importance of timeliness when it affirmed a trial court decision that awarded a plan participant the difference between his September 2007 plan account balance of \$490,000 and the value actually distributed at the end of 2008—\$306,000. The participant was awarded the \$184,000 difference, plus his attorney fees, because the plan administrator failed to provide the participant timely notice of the plan's procedures to request a distribution following separation from service. By failing to give the participant the appropriate distribution forms and information in a timely manner, the plan administrator ended up having to pay for the market losses that the participant might have suffered anyway, regardless of where he held his funds. Having to pay the participant's \$60,000 legal fees made the lesson especially bitter. This is a cautionary warning for all plan administrators to be diligent in handling routine plan distributions. (*Kujanek v. Houston Poly Bag I Ltd.*, 5th Cir. 2011)

SELF-INSURED MEDICAL PLAN'S CLAIM FOR RECOVERY OF MISTAKEN PAYMENT DISMISSED

The Court of Appeals for the Seventh Circuit held that a self-insured medical plan is not entitled to equitable relief in the recovery of payments it made for services rendered to a participant's child who was never enrolled in the plan. In this case, the plan made payments in the amount of approximately \$1.6 million to health care providers for medical services provided to the child. It was later determined that the child was not eligible for these benefits because the child was never properly enrolled in the plan.

In an attempt to recover the mistaken payments, the plan sued the health care providers by bringing several claims, including a claim under the Employee Retirement Income Security Act (ERISA). Under the ERISA claim, the plan sought to enforce its terms. Specifically, the plan contained a provision stating that it reserved the right to recover any payments that were in error and that the plan reserves "the right to recover against any covered persons if the plan has paid them or any other party on their behalf."

Because the child was never properly enrolled and therefore not a "covered person" as defined by the plan, the court ruled that this plan provision was not applicable and affirmed the district court's dismissal of the claim. This ruling highlights the importance of plan language. Although the plan contained a provision allowing for the recovery of mistaken payments, in this court's

view, that provision was drafted too narrowly to encompass the type of mistaken payment made in this case. (*Kolbe & Kolbe Health & Welfare Benefit Plan v. The Medical College of Wisconsin Inc.*, 7th Cir. 2011)

DISCLOSURE OBLIGATIONS REQUIRE CAREFUL ATTENTION

A recent case reminds us that clear communication of plan changes and a sound process for delivering those communications are critical elements of plan administration. In this case, an employee terminated employment with her employer by letter of resignation in May 1997, following a relatively short absence due to vacation and unpaid leave. The employee was covered by the employer's defined benefit pension plan. At the time of her termination, the employee was not eligible for either an unreduced or reduced early retirement benefit because she was not yet 55 years old and had fewer than 20 years of service with the employer.

Aware of the plan terms, the employee did not expect to be eligible for a pension benefit until she reached age 65. However, in August 1997, the employer adopted a special plan update that provided for an unreduced pension benefit at age 55 for participants who were actively employed after January 1, 1997. As the employee approached age 65, she learned that she had been eligible for an unreduced pension beginning at age 55. The employee's inquiries regarding her pension and her rights to begin her pension at age 55 were treated by the plan as a claim for additional, retroactive pension benefits. The plan administrator denied the claim, and on appeal, denied the claim again. At the heart of the employee's claims were her assertions that she did not receive any notices or other disclosures of her right to begin receiving her pension at age 55.

Following the rejection of her appeal, the employee commenced a lawsuit. The federal trial court that heard the case ruled that the plan abused its discretion in denying the employee's claim for additional, retroactive benefits because it did not engage in a reasonable and principled decision-making process, and because its determination was not supported by substantial evidence. The court seemed particularly concerned that the plan simply accepted the plan administrator's assertion that the documents had been provided to the employee and failed to affirmatively evaluate the mailing procedures. Consequently, the court awarded retroactive pension benefits. The court also ruled that the plan failed to comply with disclosure requirements of the Employee Retirement Income Security Act (ERISA) regarding the communication of material plan changes because it failed to employ a method of distribution that was reasonably calculated to ensure the employee's actual receipt of a 1998 summary plan description. Finally, the court ruled there was a breach of fiduciary duty when, despite her specific inquiries, the employee was not adequately informed that she could be eligible for early retirement benefits prior to age 65. The court declined, however,

to award monetary relief for the breach of fiduciary duty because the employee was awarded additional pension benefits; double recovery was determined not to be appropriate equitable relief. (*Helton v. AT&T, Inc.*, EDVA 2011)

COURT UPHOLDS PLAN'S DENIAL OF SEVERANCE BENEFITS TO FORMER EXECUTIVE

A senior managing director and vice president was a participant in an executive severance plan (ESP) maintained by his employer for a select group of highly compensated employees of the company's subsidiaries. The ESP provided that benefits were payable to vice presidents in the event of certain "covered terminations," a term that specifically excluded resignations, including resignations by reason of constructive discharge.

In 2009, the executive was informed that his unit was to be divided into three separate divisions, each of which would be run by a different individual. The executive was offered one of the three positions, but did not immediately accept or decline the position. Six days later, an email was sent to employees working under the executive stating that the executive had elected to leave the firm. The following day, the executive responded to the sender of the email, stating that he had neither resigned nor elected to leave the firm. The executive was then told that he could either accept or decline the job offer by the end of the following day. The next day, however, the executive requested an additional four days to decide whether to take the position. After passage of another five days, the executive was notified that the company would be processing his separation that day, and that he had to vacate the building and return all company property.

The former executive then submitted a claim for benefits under the ESP. The claim was denied on the basis that the executive had resigned from the company, and, on appeal, the claims administrator's determination was upheld by the compensation and management resources committee. When the former executive notified the plan that he intended to file an arbitration action before the Financial Industry Regulatory Authority, the plan commenced a declaratory judgment action that the former executive was ineligible for benefits under the ESP.

The ESP granted the plan administrator discretion to determine eligibility for benefits. Accordingly, the court applied an abuse of discretion standard of review to the denial of benefits under the ESP. In its analysis, the court noted that the former executive had repeatedly declined to accept the job offer. Despite the former executive's claim that he was in the midst of negotiations regarding the offered position, the court ruled that it was not an abuse of discretion to deny severance payments based on the resignation exclusion. The court reached this holding notwithstanding the fact that the company was operating under a conflict of interest because it was both responsible for paying benefits and determining eligibility for those benefits. (*Am. Int'l Group, Inc. v. Guterman*, SDNY Sept. 13, 2011)

WITNESS REQUIREMENT FOR WAIVER NOT REQUIRED WHERE “ABSURD” RESULT WOULD OCCUR

Richard was the principal shareholder, officer, and sole director of a corporation through which he conducted an orthodontics practice. Richard died and was survived by his second wife, Cheryl, and three sons from his first marriage. Prior to his death, Richard and Cheryl signed several documents relating to plan benefits. In these documents, Richard waived his right to a joint and survivor annuity and designated his three sons from his first marriage as beneficiaries, all with Cheryl’s written consent. After Richard’s death, Cheryl filed a claim for survivor annuity benefits with the plan. Cheryl argued that her consent was invalid because she did not remember signing the forms, the impact of the forms had not been explained to her, and her consent was not properly witnessed. On this third point, Cheryl claimed that the requirement under law that a proper waiver requires written spousal consent witnessed by a notary or plan representative was not satisfied, because the only plan representative who appears to have witnessed her signature was Richard, and Richard signed the forms the day before Cheryl signed. Cheryl claimed that Richard could not have witnessed her signature because he signed the forms before she did.

The plan found that Cheryl’s consent was valid based on the following facts: she never denied signing the consent, her signature and initials appeared in various places on the form, and the signatures were consistent with her verified signature on file with the plan. The plan also determined that the consent forms clearly explained their purpose and that Cheryl signed and initialed in relevant places indicating her understanding of the forms. Finally, the plan denied the claim that the witnessing requirement was not properly carried out. Because Richard clearly knew who Cheryl was, the witnessing had been satisfied or had been substantially complied with. Even though the consent form did not contain a true witness signature, the district court upheld the plan’s determination, finding that the forms, nonetheless, substantially complied with the requirements of the Employee Retirement Income Security Act (ERISA). Cheryl appealed to the Court of Appeals for the Seventh Circuit.

The Seventh Circuit affirmed the district court’s decision but on different grounds. The Seventh Circuit found that because ERISA explicitly requires a witness, there can be no “substantial compliance” interpretation. Nevertheless, the court found that it was undisputed that Richard signed the forms and then gave them to Cheryl, who also signed the forms, and that because the forms were in the plan files, Cheryl must have returned them to Richard. Finding that invalidating Cheryl’s consent in these circumstances would produce an absurd result, the court upheld the validity of the waiver.

This case demonstrates the importance of complying with the specific requirements of ERISA. To guard against the potential expense of litigation, plans accepting spousal waivers and consents should take steps to ensure that forms have been properly witnessed in accordance with those requirements. (*Burns v. Orthotek Inc. Employees’ Pension Plan and Trust*, 7th Cir., 2011)

WRAP DOCUMENTS: NOT JUST A PILE OF PAPER

Brokers and benefits attorneys have been promoting the use of so-called wrap documents as a cost-effective means of complying with the plan document and summary plan description requirements of the Employee Retirement Income Security Act (ERISA). While it is important to have these documents in place, it is equally important to understand that these documents impose various legal obligations on the sponsor and its benefits staff. Once in place, a document should not be put on a shelf to collect dust or be filed away and forgotten; the employer’s benefit staff should carefully review the document, consult it regularly in the course of plan administration, and comply with its terms.

In a recent instructive case, the court held that a health claimant did not need to exhaust the plan’s internal claims process as a condition of filing suit in federal court where the appropriate claims fiduciary failed to comply with its own administrative procedures for resolving disputes. Here, the plan document (which appears to have been a “wrap” document) stated that “for all component plans, the . . . Benefits Escalation Team is the claims administrator with respect to eligibility and enrollment claims, unless such a claim is being handled by the applicable third party administrator.” Without getting into the rather involved set of facts, the claim presented by the plaintiff in this case involved eligibility for benefits; therefore, the Benefits Escalation Team would have been the appropriate fiduciary to resolve such a claim. The court found, however, that the Benefits Escalation Team did not handle the claim in accordance with its internal ERISA claims procedure and, as a consequence, the plaintiff did not need to exhaust the plan’s internal claims procedure as a condition of filing suit. (*Emerson v. Bank of America N.A.*, NDCA August, 2011)

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