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ERISA Risk Management and Action Items for Last Quarter of 2012: Disclosure-Driven Challenges

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Introduction

So far in 2012, there is a common disclosure thread to the demands facing employers and those responsible for administering their Employee Retirement Income Security Act plans. Generally, the greatest risks relate to monitoring the ERISA investment programs for 401(k) and other retirement plans, plus tending to upcoming requirements imposed by the Affordable Care Act now that the Supreme Court has upheld ACA's constitutionality. These, and some material court decisions are discussed below, providing details behind the items on the ERISA 2012 ''To Do'' list (below).

Pension Plan Developments

1. Fee Disclosure. In Field Assistance Bulletin 2012-02, the Department of Labor recently provided detailed guidance relating to its participant-level fee disclosure regulations for 401(k) and other defined contribution plans with self-directed investments that became effective Aug. 30 for calendar-year plans.[1] In so doing, FAB 2012-02 also provides insights into DOL's final Section 408(b)(2) regulations that required certain service providers to provide fee disclosures to employers in their capacity as retirement plan fiduciaries no later than July 1 to avoid prohibited transactions.[2]

Three items are worth singling out here:

- *First*, DOL has announced a good faith compliance standard in the sense that enforcement actions will not be taken against employers that make reasonable interpretations of the regulatory requirements. Employers should take limited solace in this relief because they must nonetheless implement the regulations in accordance with FAB 2012-02 and further guidance. Under Frequently Asked Question 37, an indicia of good-faith compliance is an employer's ''plan for complying with the requirements of this Bulletin in future disclosures.'' Employers may want to establish a basic plan at this juncture, in an effort to show procedural diligence directed toward substantive compliance.

- *Second*, Many of the FAQs in FAB 2012-02 require more detailed disclosures. For example, FAB 2012-02 requires specific information to be provided in disclosures of administrative expenses, including those that may be paid through revenue sharing, rather than being charged directly to participant accounts.

- *Third*, DOL has warned independent accountants that they have a duty to audit plans for their compliance with ERISA's fee disclosure requirements.[3] Employers should expect scrutiny for their compliance efforts and should build records to demonstrate proactive efforts.

Finally, it is important for employers to be aware that service providers have a vested interest in minimizing

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[1] For a summary of these regulations, please see our Client Alert *Adrift in a Sea of Disclosure: New DOL Rules Require Disclosure of Plan Fees to Participants* (October 2010).

[2] For a summary of these regulations, please see our Client Alert *DOL Issues Interim Final Rule on ERISA Plan Service Provider Fee Disclosures* (July 2010).

[3] *Plan Auditors Have Major Role in Enforcing Service Provider Disclosures, Official Says* (85 PBD, 5/3/12), quoting Ian Dingwall, chief accountant at DOL's Employee Benefits Security Administration as follows: Auditors, ''in large part, are going to be the enforcers of this service provider disclosure requirement.'').

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their fee disclosures, and this does not align with the employer's interest in assuring fulsome compliance with applicable DOL regulations. Employers should consequently be strategic in first pressuring service providers to take the lead with required disclosures and then being sure to have a second set of eyes review those disclosures for ERISA compliance. Employers that take this approach are finding material but correctable compliance gaps. For example, service providers have been found to underdisclose or to mistakenly disclose in regard to items such as redemption fees and other surrender charges associated with the sale or transfer of investment options.

To avoid exposure to prohibited transaction excise taxes, employers that have not received 408(b)(2) disclosures from their service providers that are required to furnish them should promptly contact those vendors in writing and request that they provide the requisite disclosures. If the provider refuses or fails to provide the information within 90 days of the date of the request, the employer should notify DOL within 30 days in the manner set forth in the regulations.

Equally important, employer-fiduciaries should review the fee disclosures provided by their plan service providers and make sure that they are comfortable that the fees disclosed are reasonable in relation to the service provided. Employers may wish to obtain benchmarking compensation data or conduct a request for information or request for proposal to confirm that the compensation received by the service provider is comparable to what other providers would require for a plan of similar type and size.

ERISA 2012 - "To Do" For Fall	
Retirement Plans	**1. Fee Disclosure.** Plan sponsors should be working with their vendors to update their participant-level fee disclosures in light of the Department of Labor's recent FAQs about the disclosure of investment and other plan expenses. In addition, plan sponsors should be contacting plan vendors from whom they have not received 408(b)(2) fee disclosures and evaluating the reasonableness of fees that have been disclosed.
	2. Fee Litigation. A recent $35 million damage award to plaintiffs in a class action lawsuit alleging fiduciary breaches for excess plan fees will likely embolden further class action litigation in this area. Employers should be sure their records demonstrate unambiguous attention to assuring to the monitoring of fees for reasonableness.
Health Plans	**3. Summary Benefit Coverage.** ACA requires employers and insurers to provide a summary of benefits and coverage for open enrollment periods beginning on or after Sept. 23.
	4. MLR Rebates. Employers that have been receiving medical loss ratio or MLR rebates from their insurance carriers pursuant to ACA should exercise caution in deciding how to use such proceeds as all or a portion of the rebates may constitute plan assets under ERISA.
	5. W-2 Reporting for Health Coverage. ACA requires employers to report the aggregate cost of employer-sponsored health coverage on Form W-2 for 2012 and later years (i.e., beginning with the 2012 W-2 that will be issued in January 2013).
	6. Brace for New ACA Fees. Employers that sponsor self-funded health plans must pay an annual fee to fund the Patient Centered Outcomes Research Institute beginning with the 2012 plan year (insurers pay the fee for fully insured plans).
	7. Health FSAs Are Capped in 2013. Health FSAs must limit salary contributions to $2,500 for plan years beginning on after Jan. 1, 2013.
	8. HIPAA Personal Liability. It is worth alerting administrators to a U.S. Court of Appeals for the Ninth Circuit decision holding that criminal liability arises from knowingly obtaining personal health information, even in the absence of knowledge of a HIPAA violation.

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ERISA 2012 - ''To Do'' For Fall	
	9. HIPAA Audit Protocols Released. The Office for Civil Rights (OCR) at the Department of Health and Human Services recently published its audit guidelines to monitor compliance with HIPAA's privacy and security standards.
ERISA Litigation	**10. Remedies.** Two recent U.S. Courts of Appeals decisions describe the types of harm participants must prove to recover equitable relief for fiduciary misrepresentations.
Mergers & Acquisitions	**11. Beware Inadvertent Plan Amendments.** The Court of Appeals for the Fifth Circuit's 2006 *Halliburton v. Graves* decision continues to warrant caution, given the Supreme Court's recent decision declining to review a split with other circuits regarding whether a merger or sale agreement may be deemed to amend an ERISA plan.
	12. Noncompetition Agreements. Several recent cases involve key employees of acquired companies who have had success in escaping or contesting the ability of a buyer to enforce sale-related restrictive covenants. Buyers should be sure to address key employee issues before or ASAP after closings occur.

2. Fee Litigation. Within the past few months, both court cases and settlements have resulted in multimillion-dollar recoveries in class action litigation alleging breaches of fiduciary duties in the monitoring of plan investment expenses. The U.S. District Court for the Western District of Missouri, for example, awarded $35.5 million in damages in *Tussey v. ABB Inc.*[4] based on a finding that the plan's fiduciaries had violated ERISA by:

- inadequately monitoring 401(k) recordkeeping costs that were paid through revenue sharing and hard dollars,
- failing to negotiate recordkeeping rebates for the ABB's 401(k) plans,
- using revenue sharing from the 401(k) plans to reduce employer costs for other plans,
- changing 401(k) investment alternatives without proper deliberation, and
- selecting more expensive share classes for 401(k) investment choices when less expense share classes were available.

There is little doubt that the *Tussey* decision will embolden further litigation of this kind. Plan sponsors and fiduciaries should accordingly assure careful attention to the monitoring of all facets of their plan investment programs – from fees, to investments, to the records inherent to demonstrating their diligence.[5] In addition, plan sponsors should review their investment policies and other governing plan documents to make sure they reflect best practices and the plan's actual operations.

Health Plan Developments

3. Health Plans – Summary Benefit Coverage. ACA requires administrators of health plans (usually the employer) and the insurers of group health plans to provide participants and beneficiaries with a summary of benefits and coverage (SBC) that must accurately describe the benefits and coverage of the plan/policy applicable to the participant or beneficiary in no more than four double-sided pages.[6] SBCs must be distributed for open enrollments commencing on or after Sept. 23 (a different effective date applies for enrollments occurring outside open enrollment such as new hires). Employers that fail to satisfy this requirement are subject to penalties of $1,000 per failure, per participant. Excise taxes of $100 per day for each participant apply, and employers that provide inaccurate or incomplete disclosures may be subject to fiduciary breach claims under ERISA. To comply with these requirements, employers should promptly coordinate with their insurers/TPAs and have legal counsel review the SBC before it is finalized and distributed to participants.

4. MLR Rebates. Employers that have been receiving MLR rebates from their insurance carriers pursuant to ACA should exercise caution in deciding how to use such proceeds as all or a portion of the rebates may constitute plan assets under ERISA. DOL has issued specific guidelines regarding how an employer may use MLR rebates that constitute ERISA plan assets.[7]

Permissible uses, depending on the facts, include paying rebates to participants who paid the premiums, paying rebates to current participants, or applying the

[4] *Tussey v. ABB Inc.*, No. 2:06-CV-04305, 2010 U.S. Dist. LEXIS 45240, 52 EBC 2826 (W.D. Mo. Mar. 31, 2012) (63 PBD, 4/3/12; (39 BPR 697, 4/10/12).

[5] See '' So You Think You are Safe: Board Members and Personal Liability under ERISA'' (Poerio and Keller, *Corporate Governance Advisor*, 2012 May-June).

[6] For a summary of this requirement and suggested action items, please see our Client Alert *Employers Must Provide Group Health Plan Participants with a New Summary of Benefits and Coverage (March 2012)*.

[7] DOL Tech. Release 2011-04 (Dec. 2, 2011), available at 232 PBD, 12/5/11

rebates to provide premium holidays or other benefit enhancements. In addition, IRS has issued on its website a set of Frequently Asked Questions addressing the taxation of rebates paid to participants either in the form of direct payments or premium holidays.[8]

5. W-2 Reporting for Health Coverage. ACA requires employers to report on Form W-2 the aggregate cost of employer sponsored health care coverage for 2012 and later years (i.e., the first required reporting will be in January 2013 for the 2012 Forms W-2 issued then).[9] This reporting is for informational purposes only and the reporting or failure to report this information will not cause the health coverage to become taxable to the employee. Employers should be updating their payroll systems to comply with this requirement.

6. New Affordable Care Act Fees. Employers that sponsor self-funded health plans that do not provide only Health Insurance Portability and Accountability Act-exempted benefits must pay an annual fee to fund the Patient Centered Outcomes Research Institute beginning with the 2012 plan year (insurers pay the fee for fully insured plans). The institute was established by ACA to conduct research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of medical treatments, services, procedures, drugs, and other strategies. The amount of the fee is $1 for each covered life for the 2012 plan year, $2 for each covered life for the 2013 plan year, and indexed thereafter. Lives include all persons covered, including employees, spouses and dependents, unless an exception applies.

There are three different methods that can be used by plan sponsors to count covered lives, as described below:

■ **Actual count method:** Plan sponsors may calculate the sum of the lives covered for each day in the plan year and then divide that sum by the number of days in the year.

■ **Snapshot method:** Plan sponsors may calculate the sum of the lives covered on one date in each quarter of the year (or an equal number of dates in each quarter) and then divide that number by the number of days on which a count was made. The number of lives covered on any one day may be determined by counting the actual number of lives covered on that day or by treating those with self-only coverage as one life and those with coverage other than self-only as 2.35 lives.

■ **Form 5500 method:** Sponsors of plans offering self-only coverage may add the number of employees covered at the beginning of the plan year to the number of employees covered at the end of the plan year, in each case as reported on Form 5500, and divide by two. For plans that offer more than self-only coverage, sponsors may simply add the number of employees covered at the beginning of the plan year to the number of employees covered at the end of the plan year, as reported on Form 5500.

For plan years beginning before July 16, and ending on or after Oct. 1 (i.e., for calendar-year plans, the 2012 plan year), self-insured plan sponsors are permitted to use any reasonable method to determine the average number of lives covered under the plans(s). There are special counting rules for health reimbursement arrangements (HRAs) and health flexible spending arrangements (FSAs) that are not HIPAA-exempted benefits.

Plan sponsors must report and pay these fees annually on IRS Form 720, which will be due by July 31 of each year. The first due date is July 31, 2013.

7. Health FSAs Capped in 2013. Salary contributions made to health FSAs for any plan year beginning in or after 2013 may not exceed $2,500 as indexed for cost-of-living adjustments. This limit applies only to employee salary contributions and does not apply to nonelective employer contributions (sometimes called flex credits) that may not be converted to cash. Health FSAs that permit a grace period up to two and one-half months following the end of the plan year do not have to count amounts that are carried over into the grace period for the next plan year. Plan documents must be amended to incorporate this requirement no later than Dec. 31, 2014. There is relief for contributions that exceed the limit due to a reasonable mistake and not due to willful neglect that are corrected.

8. HIPAA Criminal Liability. Misdemeanor penalties apply to those who wrongfully obtain personal health information (aka PHI) in violation of HIPAA, even if there is no proof of a knowing violation of law. The Ninth Circuit reached this conclusion in *United States v. Zhou*,[10] That decision merits a reminder to health plan administrators, because well-intentioned efforts could lead to criminal sanctions, such as could occur if PHI is obtained wrongfully in order to verify or to challenge questionable employee claims or conduct.

9. HIPAA Audit Protocols Released. OCR recently published its audit protocol for assessing compliance with HIPAA's privacy and security standards. OCR has increased its HIPAA enforcement efforts by implementing a new audit program. Employer-sponsored group health plans are among the HIPAA-covered entities that may be selected for audit by OCR in the initial stages of its audit program. The protocol covers 165 areas of performance evaluation, including 88 related to the privacy standards and 77 related to the security standards. Employers that sponsor group health plans subject to these standards should review their HIPAA policies and procedures and business associate agreements to verify that they comply with the guidelines.

ERISA Litigation

10. Equitable Relief. Last year, the Supreme Court in its *Cigna Corp. v. Amara*[11] opinion expanded the types of equitable remedies that are available for participants due to fiduciary breaches to include estoppel, reformation, and surcharge. Two recent lower court opinions

[8] Medical Loss Ratio (MLR) FAQs, available at http://subscript.bna.com/UTILS/lk.nsf/r/pkun8ykq75?opendocument.

[9] For a summary of this requirement and recommended action items, please see our Client Alert *Health Care Act W-2 Requirements: To Report or Not to Report – That is the Question* (April 2011).

[10] *United States v. Zhou*, No. 10-50231 (9th Cir. May 10, 2012).

[11] *Cigna Corp. v. Amara*, 131 S. Ct. 1866, 1878-1881, 50 EBC 2569 (2011) (95 PBD, 5/17/11; 38 BPR 990, 5/24/11).

have shed light on when these remedies may be available.

In *Skinner v. Northrop Grumman Retirement Plan B,*[12] the Ninth Circuit analyzed whether the plaintiffs could obtain equitable relief when the retirement plan's SPD promised better benefits than the plan document. The court held that the plaintiffs were not entitled to reformation or surcharge because the employer had not intentionally misled the plaintiffs and there was no evidence the plaintiffs actually relied to their detriment on the inaccurate SPD.

In *McCravy v. Metropolitan Life Ins. Co.*,[13] the Fourth Circuit analyzed whether a plaintiff could claim equitable relief under an estoppel or surcharge theory when she had paid premiums for life insurance on her daughter for many years only to have the carrier deny the claim following her death on the basis that her daughter was too old for coverage under the policy. The court held that the plaintiff could maintain such claims and remanded the case back to the district court for further proceedings.

Mergers and Acquisitions

11. Beware of Unintentional Amendments. The Supreme Court has declined to review a circuit court split arising because the Fifth Circuit has held that merger agreements and asset purchase agreements may be deemed to amend ERISA plans, while the First, Third, and Sixth circuits have disagreed when interpreting written agreements that were independent of plan documents.[14] Until this issue gets resolved, buyers should be careful to include what is known as a Halliburton provision in any merger, asset purchase, or other transaction documents. Such a provision generally affirms that nothing in the transaction document will be deemed to amend any ERISA or other benefit plan.

12. Beware of Challenges to Restrictive Covenants. In the heat of a merger or acquisition transaction, loose ends often arise in connection with assuring that key employees have agreed to post-closing restrictive covenants. Here are snapshots from a few cases that illustrate the high stakes involved:

■ **California Court Upholds M&A Noncompete, but not . . .** Beware in California if the noncompetition covenant in a sale of business agreement either differs from the one set forth in an employment agreement with the same person or has a term measured from termination of employment rather than the business sale date. Those are the main takeaways from *Fillpoint v. Maas*[15] in which a California court examined and applied the limited noncompete exemption set forth for business transactions in Cal. Bus. & Prof. Code § 16601. The decision invalidates not only the employment agreement's one year post-employment noncompete, but also its nonsolicitation covenant (the latter for being overly broad).

■ **Asset Purchase and Restrictive Covenants (New York and Connecticut Law, from Assignability to Torts).** In *Milso Industries v. Nazzaro*,[16] a Connecticut district court recently applied New York and Connecticut law to a dispute involving (1) an asset purchase that involved the seller's assignment of employment agreements that did not expressly allow for that; (2) the buyer's hiring of seller's key employees pursuant to offer letters that they did not sign; and (3) trade secret and noncompete issues arising when the key employees broke away to form a competing company. The court declined the buyer's motion for summary judgment because issues of fact existed under New York law regarding whether or not the seller and the key employees intended to allow the restrictive covenants to be assignable.

■ Note: Similar problems arose in *OfficeMax v. Levesque*, 658 F. 3d 94 (1st Cir. 2011), in which noncompete agreements were executed on the eve of closing and committed the employees to execute a post-closing noncompete with the buyer. When that did not occur due to refusal by the seller's key employees, the court took that as evidence that the noncompete was not intended to bind the buyer, and consequently declined to enforce it.

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[12] *Skinner v. Northrop Grumman Retirement Plan B,*, No. 10-55161, 52 EBC 2089 (9th Cir. March 16, 2012) (52 PBD, 3/19/12; 39 BPR 542, 3/20/12).

[13] *McCravy v. Metropolitan Life Ins. Co.*, No. 10-1074 (4th Cir. July 5, 2012) (130 PBD, 7/9/12;39 BPR 1339, 7/10/12).

[14] *Compare Halliburton Co. Benefits Committee v. Graves*, 463 F. 3d 360, 38 EBC 2249 (5th Cir. 2006), and *Evans v. Sterling Chemicals, Inc.*, 660 F. 3d 862, 49 EBC 2783 (5th Cir. 2011), *cert. denied* 3/19/12, to *Coffin v. Bowater*, 501 F. 3d 80, 41 EBC 1929 (1st Cir. 2007) (rejecting the argument ''that a document claiming to amend or terminate an ERISA plan need not be labeled as such''), *Shaver v. Siemens Corp.*, 2012 U.S. App. LEXIS 4081, 2012 WL 639269, 52 EBC 1806 (3d Cir. 2012) (concluding that ''Siemens did not obligate itself in the APA to provide PJS benefits to the legacy employees. Finding no ERISA provision that requires otherwise, we must enforce the Siemens Plans as written, and beyond any reasonable dispute those Plans do not entitle appellees to PJS benefits''), and *Sprague v. General Motors*, 133 F. 3d 388, 21 EBC 2267 (6th Cir. 1998) (stating in ¶ 104 that ''Neither can we accept the argument that the plan was modified or superseded either by the written 'statements of acceptance' signed by some of the named plaintiffs or by the written representations received by some from GM.'').

[15] *Fillpoint v. Maas*, No. G045057 (Cal. Ct. App. Aug. 24, 2012).

[16] *Milso Industries v. Nazzaro*, 2012 WL 3778978 (D. Conn. Sept. 9, 2012)