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### *Highlights*

1. SEC Report on Conflicts of Interest and Pension Consultants
2. IRS Allows Cafeteria Plan Sponsors to Modify Plan for 2 ½ Month Grace Period
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4. HHS Proposed Regulations on Civil Monetary Penalties under HIPAA
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### **SEC Report on Conflicts of Interest and Pension Consultants**

The Securities and Exchange Commission’s (SEC’s) Office of Compliance Inspections and Examinations issued a report on pension consultants on May 16, 2005. The SEC had investigated 24 pension consultants that are also registered investment advisers.

#### *Background*

The SEC report states that there are 1,742 SEC-registered investment advisers who indicate that they provide pension consulting services. These pension consultants provide advice to pension plans and their trustees with respect to the following matters:

1. identifying investment objectives and restrictions;
2. allocating plan assets to various objectives;
3. selecting money managers to manage plan assets in ways designed to achieve objectives;
4. selecting mutual funds that plan participants can choose as their funding vehicles;
5. monitoring performance of money managers and mutual funds and making recommendations for change; and
6. selecting other service providers, such as custodians, administrators and broker-dealers.

The report further states that the pension plans and their trustees rely heavily on the expertise and guidance of their pension consultants in helping them manage pension plan assets. Many of the pension consultants offer multiple lines of service and frequently seek to sell plan sponsors a “bundled” package of services.

Under the Investment Advisers Act of 1940 (the '40 Act), the adviser has a fiduciary duty to its clients and is required to provide disinterested advice and to ensure that this occurs



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the adviser is required to disclose material facts. Whether the adviser's relationship with other parties creates a material conflict of interest depends on facts and circumstances.

The investment advisers who are registered with the SEC typically make the required disclosures on their Form ADV. Part II of the ADV is typically offered to all advisory clients at the beginning of the advisory relationship and once each year thereafter. Relevant questions in Part II of the ADV (Items 8, 9, 12 and 13) ask the adviser to state affiliations, participation or interest in client transactions, brokerage transactions, and compensation for client referrals.

In addition to the ADV disclosures, all investment advisers as fiduciaries are expected to inform advisory clients of any material conflicts of interest that are specific to the client. This information is critical to the client since the pension plan and its trustees have to be able to assess the objectivity of the advice that is or may be provided by the pension consultant.

### *Findings*

The examination of the pension consultants covered the period from January 1, 2002 to November 30, 2003. The results of the examination raised concerns regarding the advice that pension consultants provide to pension plans and their trustees in light of the fact that many pension consulting firms provide services both to pension plans who are their advisory clients and to money managers. Providing services to both entities can create a conflict of interest, which has the potential to cloud the objectivity of the pension consultant's recommendations to advisory clients. This conflict could result in the pension consultant recommending a certain money manager or other vendor based on the pension consultant's other business relationships and/or the receipt of fees from these firms, rather than because the money manager is best-suited to the client's needs.

The results also raised questions regarding the extent to which pension consultants disclose these conflicts of interest to their clients. For example, more than a third of the pension consultants examined employed advisory representatives that were also registered representatives of a broker-dealer. In addition, many pension plan clients choose to utilize an affiliate of the pension consultant to provide various services, including investment management, brokerage execution, and transition management based on the pension consultant's advice.

Many pension consultants do not consider themselves to be fiduciaries to their clients. Several of the pension consultants believed that they had taken appropriate steps to insulate themselves from being considered a fiduciary under ERISA. Therefore, it appears that many consultants believe they do not have any fiduciary relationships with their advisory clients and ignore or are not aware of their fiduciary obligations under the '40s Act.



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Many of the pension consultants did not maintain procedures concerning how they prevent or manage conflicts of interest in their activities or governing disclosure of conflicts to clients.

### **Recommendations**

The SEC concluded that pension consultants that are registered investment advisers should be:

1. Formalizing “policies and procedures” to address their fiduciary and regulatory obligations under the ‘40s Act.
2. Identifying conflicts of interest and other compliance factors creating risk exposure for the firm and its clients in light of the firm’s particular operations and then designing policies and procedures that address that risk.

The SEC went on to note that such policies and procedures should ensure that the firm’s advisory activities are insulated from its other business activities, and that all disclosures required to fulfill fiduciary obligations are provided to prospective and existing clients, particularly regarding “material” conflicts of interest. The SEC also noted that policies and procedures should be designed to ensure adequate disclosure concerning the consultant’s compensation, including when the pension consultant receives compensation from brokerage transactions from advisory clients or money managers.

### **Conclusion**

In light of the SEC report, plan fiduciaries should make sure that their pension consultants have the policies and procedures in place that the SEC has recommended. The SEC report provides an outline for plan fiduciaries in examining their relationships with pension consultants to make sure that such relationships continue to meet the ERISA requirement that plan fiduciaries must act prudently in selecting and monitoring service providers. Proper disclosure of a services provider’s potential conflicts of interests is an important part of the selection and monitoring process.

## **IRS Allows Cafeteria Plan Sponsors to Modify Plan for 2 ½ Month Grace Period**

Everyone is familiar with the “use it or lose it” rule under cafeteria plans. Under this rule a plan participant must use the monies in his/her account by the end of the plan year for qualified benefits or lose those monies. Qualified benefits include employer-provided accident and health plans, group term life insurance, dependent care assistance programs,



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and adoption assistance programs. If the participant fails to use the monies in their account by the end of the plan year, then the money is forfeited.

In Notice 2005-42 the IRS has stated that an employer may amend its cafeteria plan to provide that participants will have a grace period of 2 ½ months after the close of the plan year to use the monies in their accounts for qualified benefits. Expenses for qualified benefits incurred during the grace period may be paid or reimbursed from monies remaining unused at the end of the immediately preceding plan year. If the employer amends its cafeteria plan, a participant who has unused monies relating to a particular qualified benefit from the immediately preceding plan year, who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused monies as if the expenses had been incurred in the immediately preceding plan year.

The extra 2 ½ months are referred to as a grace period under the IRS Notice. During the grace period, the unused monies cannot be cashed out or converted to any other taxable or non-taxable benefit. Unused amounts relating to a particular qualified benefit may only be used to pay or reimburse expenses incurred for that particular qualified benefit. For example, amounts unused in a health care flexible spending account can't be used or reimbursed for dependent care expenses incurred during the grace period.

In addition, the notice says that under current practice, employers may continue to provide a “run-out” period after the end of the grace period during which expenses for qualified benefits incurred during the cafeteria plan year and the grace period may be paid or reimbursed.

If an employer decides to amend its cafeteria plan to provide for the grace period, the amendment can be made as late as the last day of the current plan year. For example, if the plan year is the calendar year, then the plan sponsor would have until December 31, 2005 to amend the plan to provide a grace period for the 2005 plan year.

### **Continuation of Healthcare Coverage for Veterans is Changed by New Laws**

Two laws have changed the provisions relating to healthcare coverage for veterans. The new laws, the Veterans Benefits Improvement Act and the National Defense Authorization Act for Fiscal Year 2004, effective at various dates are discussed below.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) protects employees who leave for and return from any type of uniformed service in the United States Armed Forces. All employees who have held a civilian job



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for as little as one day have reemployment rights under USERRA. In addition, USERRA applies to all employers regardless of size.

As of March 10, 2005, employers are required to post a notice to employees describing employee rights, benefits and obligations under USERRA. The U.S. Department of Labor has published a sample notice on its web site at <http://www.dol.gov/vets/programs/userra/poster.pdf>.

USERRA provides that employees who are away from their jobs because of military service are entitled to purchase continued healthcare coverage under a group health plan for themselves and their families for up to 18 months. Under the Veterans Benefits Improvement Act this period is extended to 24 months with respect to elections to extend coverage made on or after December 10, 2004. This Act does not require extension of coverage with respect to employees who elected to continue coverage prior to December 10, 2004.

USERRA provides that if the military service related absence will be for less than 31 days, an employee cannot be charged more than active participants. If the military leave equals or exceeds 31 days, the plan sponsor can charge up to 102 percent of the plan cost for individual or family coverage.

Active duty military service members are covered by the military health program, TRICARE. Spouses and dependents are eligible for TRICARE if the employee is on active duty for at least 30 days. The National Defense Authorization Act established a program called TRICARE Reserve Select (TRS) effective April 26, 2005, to permit individuals to purchase standard TRICARE coverage. Specifically, reservists called after September 11, 2001, to serve for more than 30 days, who served or will continuously serve for 90 days or more, can purchase TRICARE Standard coverage for themselves and their family members after they demobilize. In order to purchase TRICARE coverage, the reservist must sign an agreement to continue serving for a period of one year or more in their reserve unit after their active duty ends.

The reservist and family members may purchase one year of TRICARE Standard coverage for each period of 90 days of consecutive active duty service. The coverage may be purchased on a self-only or self-and-family basis. The extended coverage begins after the reservist's eligibility for 180 days of transitional coverage ends.

TRS must be purchased by the reservist. Monthly premiums for 2005 are \$75.00 and \$233.00 for self-only and self-and-family coverage, respectively. The TRS premiums are adjusted annually on January 1<sup>st</sup> of each year.



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Plan sponsors need to be aware of TRS because participants may enroll in their healthcare plans as well as TRS. This dual coverage may raise coordination of benefit (COB) issues.

## **HHS Proposed Regulations on Civil Monetary Penalties under HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA) includes administrative simplification provisions that were designed to protect the privacy and security of certain health information and to promote efficiency in the healthcare industry through the use of standardized electronic transactions.

The Department of Health and Human Services (HHS) recently issued proposed regulations that modify and reorganize current enforcement provisions to make it clear that they apply not only to the privacy standards under HIPAA but also to the other administrative simplification requirements such as the security standards. These proposed regulations add a new subpart D, which sets out the rules governing the imposition of civil penalties for violations of the HIPAA administrative simplification rules.

HHS's proposed regulations contain extensive rules governing the imposition of civil penalties on a covered entity that has violated a HIPAA administrative simplification provision. For example, a covered entity is held liable for a violation committed by its agents, including workforce members, acting within the scope of their agency. However, a covered entity is not held liable for the acts of a business associate with which it has a business associate agreement, even if it is aware of the material violations, provided it takes reasonable steps to cure the violation and, if unsuccessful, either terminates the business associate agreement or reports the violation to HHS.

Penalties under HIPAA for violations of the administrative simplification rules are a maximum of \$100 for each violation subject to a maximum penalty of \$25,000 for identical violations in a calendar year. The proposed regulations clarify that an "identical violation" is a violation of the same HIPAA requirement and is not based on whether the violation involves the same individual's protected health information or the same transaction. For example, if a covered entity failed to provide its notice of privacy practices to 500 employees and the penalty was set at \$100 per violations, the total penalty would be \$50,000. However, because these violations relate to the same HIPAA requirement, the maximum penalty that could be imposed for a calendar year would be \$25,000.

The proposed regulations also provide a clarification that for purposes of calculating the civil penalties, a violation of a specific requirement will not be treated as a violation of a more general requirement in the same regulation. However, this rule does not apply



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where the act or omission results in the violation of different HIPAA requirements. For example, if a covered entity uses protected health information improperly because it has not implemented adequate safeguards; it has violated two separate requirements.

HIPAA sets out several affirmative defenses that a party who has violated a HIPAA requirement may raise to avoid imposition of a civil penalty. One of these defenses is lack of knowledge. The preamble to the proposed regulations indicates that the knowledge of facts underlying a violation will not negate an affirmative defense based on lack of knowledge. However, the lack of knowledge defense is not available if a covered entity's ignorance arises from its failure to inform itself about its compliance obligations or to investigate complaints or other information that would indicate possible noncompliance.

### **U.S. Court of Appeals Throws Out Workforce-Wide COLI Purchase**

The U.S. Court of Appeals for the 10<sup>th</sup> Circuit ruled that corporations cannot buy corporate-owned life insurance policies (COLIs) for all of their full-time workers because they don't have an insurable interest in their whole workforce. The Court stated that an employer must have a "substantial economic interest" in the employee in order to be an insurance beneficiary. The case is *Tillman v. Camelot Music, Inc.* 10<sup>th</sup> Cir, No. 03-5172, 5/11/05.

Camelot Music, Inc. purchased approximately 1,400 COLI policies in 1990 to insure the lives of all its full-time employees to ease its tax burden. One of employees covered by the COLI policies was Filipe Tillman who died in 1992. Camelot filed for bankruptcy protection in 1996 after it received \$340,000 from its COLI policy on Tillman. When the personal representative of Tillman's estate learned about the policy and the proceeds, the representative filed suit, arguing that Camelot did not have an insurable interest in Tillman's life and that Camelot had been unjustly enriched by the COLI policy proceeds. The U.S. District Court for the Northern District of Oklahoma ruled that Camelot did have an insurable interest in Tillman's life and was not unjustly enriched by the proceeds of the COLI proceeds. The representative appealed the District Court ruling.

In rendering its opinion, the Circuit Court wrote that "considerable expenditures in relation to a company's overall budget" constituted substantial economic interest. In that vein, "human resources' monies spent to attract and keep employees is a general cost of doing business and is not sufficient alone to support a finding of substantial interest in a specific employee's continued life."