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Highlights of the Month

- 1. Pension Benefit Guaranty Corporation) Updates Regulation §4011 Regarding Notices to Participants of Funding for Defined Benefit Pension Plans**
- 2. Fourth Circuit Court of Appeals Rules ERISA Preempts Maryland's "Play or Pay" Health Mandate Law**
- 3. Senate Version of Minimum Wage Bill Passes with Major Changes to Tax Treatment of Executive Compensation Arrangements**
- 4. First Circuit Court of Appeals Outlines Service Requirements for an Employee's Eligibility for Leave Under the Family Medical Leave Act**
- 5. Third Circuit Court of Appeals Rules on the Accrual Date of Cause of Action for Incorrect Disability Payments**
- 6. Employee Benefits Security Administration Announces Fiscal Year Enforcement Results**
- 7. Internal Revenue Service Releases Bulletin 2007-7 Containing Guidance on Pension Protection Act of 2006 Issues**

Pension Benefit Guaranty Corporation Updates ERISA § 4011 Regarding Notices to Participants of Funding for Defined Benefit Pension Plans

The Pension Protection Act of 2006 (PPA) repealed § 4011 of the Employee Retirement Income Security Act (ERISA) for plan years beginning after December 31, 2006 and replaced the disclosure requirement under §4011 with a disclosure requirement under Title I of ERISA [§ 101(f)]. As a result, the PBGC has issued an amendment to its regulation implementing § 4011 of ERISA to cover only plan years beginning on or after January 1, 1995 and before January 1, 2007. For plan years beginning on or after January 1, 2007, defined benefit pension plans will be required to provide the annual funding notice to the PBGC, to each plan participant and beneficiary, and to each labor organization representing the plan's participants or beneficiaries. Additionally, multiemployer plans will be required to provide the annual funding notice to each employer that is required to contribute to the plan. The administrator of a plan must provide the notice, in writing or electronically, no more than 120 days after the end of each plan year. Small plans (generally, plans with 100 or fewer participants) do not have to provide the notice until they file their Form 5500 annual reports.



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The annual funding notice must include the following information:

- ❖ Information identifying the plan
- ❖ Funding Status for Single Employer Plans – information regarding whether the plan's funding target attainment percentage (FTAP) is at least 100% for the current plan year and for each of the past two plan years. If the FTAP is not at least 100%, the actual FTAP must be provided. In addition, the notice must include the amount of the plan's assets and liabilities as reported on the three most recent Form 5500 filings made by the plan, as well as the value of the assets and liabilities measured as of the last day of the plan year for which the notice is being provided.
- ❖ Funding Status for Multiemployer Plans – information regarding whether the plan's funded percentage is at least 100% for the current plan year and for each of the past two plan years. If the funded percentage is not 100% for any of these years, the actual funded percentage must be provided. In addition, the notice must include the values of the plan's assets and liabilities measured as of the last day of the plan year to which the notice relates and as of the last day of each of the last two plan years. If the plan was in critical or endangered status for the plan year, disclosure of that fact must be made as well as disclosure of any funding improvement or rehabilitation plan that has been adopted. Information regarding how to obtain a copy of the plan's funding improvement or rehabilitation plan, along with the actuarial and financial data demonstrating action the plan has taken towards fiscal improvement, must be included in the notice.
- ❖ Projected Changes to Assets or Liability Values – any plan amendments, scheduled benefit increases or reductions, or other known events taking place in the current plan year must be disclosed if they will have a material effect on plan assets or liabilities for the plan year. Such disclosure must include a projection of the effect on plan liabilities to the end of the year.
- ❖ Funding Policy – a statement of the plan's funding policy and asset allocation as of the end of the plan year must be included in the notice.
- ❖ Number of Participants – the number of participants must be disclosed and broken out by active participants; the number of participants who are retired or separated from service and receiving benefits; and the number of participants who are retired or separated from service and are entitled to future benefits.
- ❖ Plan Termination and PBGC Guarantees – a description of the plan's benefits that are eligible for PBGC guarantee, an explanation of the limits on the PBGC guarantee and the circumstances under which these guarantees apply must be included in the notice. For single employer plans, a summary of the rules regarding plan terminations must be included in the notice. For multiemployer plans, the rules governing reorganization or insolvency, including any limitations on benefit payments must be disclosed.



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- ❖ Form 5500 Annual Report – the notice must include a disclosure of the availability of the plan's Form 5500 filing, i.e., that the Form 5500 is available upon request, on the Department of Labor's website and the plan's website (required by the PPA beginning in 2008). A multiemployer plan must indicate in the notice that the plan administrator will provide, upon written request, a copy of the Form 5500 to any labor organization representing participants and beneficiaries and to any employer obligated to contribute to the plan.

Fourth Circuit Court of Appeals Rules ERISA Preempts Maryland's "Play or Pay" Health Mandate Law

On January 17, 2007, the Fourth Circuit Court of Appeals affirmed an earlier U.S. District Court's ruling that Maryland's Fair Share Health Care Fund Act (Fair Share Act) is preempted by ERISA. [*Retail Industry Leaders Association v. Fielder*, No. 06-1840 (4th Cir., 2007)] In January 2006, the Maryland legislature enacted the Fair Share Act which generally requires private employers in Maryland with at least 10,000 employees to provide a required level of health benefits to those employees or make a contribution to a trust fund which would be used to pay the costs of Maryland's Medicaid and children's healthcare plans. Under the Fair Share Act, those employers would be required to spend at least eight percent of the total wages paid to their Maryland employees on health benefits for those employees. (For a nonprofit organization, the requirement is six percent of total wages.) If an employer did not meet this threshold, they would be required to deposit the difference into the trust fund. A \$250,000 civil penalty would be imposed against any employer who did not make the required payment to the trust fund. The Fair Share Act was scheduled to become effective January 1, 2007.

The legislation effectively only applied to four employers in Maryland. Two of those employers already met the threshold for spending on health benefits. A third employer was carved out by adding an exemption to the calculation of total wages which allows the employer to exclude compensation paid to employees in excess of the median household income in Maryland. This left only Wal-Mart Stores, Inc. (Wal-Mart) as an affected employer. The Retail Industry Leaders Association (RILA), of which Wal-Mart is a member, brought suit against James D. Fielder, Jr., the Maryland Secretary of Labor, Licensing, and Regulation (the Secretary), to declare that the Act is preempted by ERISA and to prevent the enforcement of the Fair Share Act. The district court rejected the Secretary's jurisdictional arguments and concluded that ERISA preempted the Fair Share Act because the Act effectively mandated that employers spend a minimum amount on healthcare benefit plans. The District Court also found that the Fair Share Act did not violate the Equal Protection Clause because the Act's classifications were not irrational. An appeal was then filed.



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ERISA establishes comprehensive federal regulation of employers' provision of benefits to their employees. It does not mandate that employers provide specific employee benefits but leaves them free, "for any reason at any time, to adopt, modify, or terminate welfare plans" [*Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)]. Instead, ERISA regulates the employee benefit plans that an employer chooses to establish, setting "various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility" [*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983)]. The vast majority of healthcare benefits that an employer extends to its employees qualify as an "employee welfare benefit plan," which ERISA defines broadly as any *plan, fund, or program* which . . . was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . *medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability...* While an employer's one-time grant of some benefit that does not require an administrative scheme does not constitute an ERISA "plan", a grant of a benefit that occurs periodically and requires the employer to maintain some ongoing administrative support generally constitutes a "plan". The primary objective of ERISA was to "provide a uniform regulatory regime over employee benefit plans." [*Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); see also *Shaw*, 463 U.S. at 98-100]. To accomplish this objective, § 514(a) of ERISA broadly preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA [29 U.S.C. § 1144(a)]. Unlike laws that regulate healthcare providers and insurance companies, "state laws that mandate employee benefit structures or their administration" are preempted by ERISA. [*N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658-59 (1999)].

Courts have regularly found preemption of state laws that act directly upon an employee benefit plan or effectively require it to establish a particular ERISA-governed benefit. A state law that directly regulates the structuring or administration of an ERISA plan does not avoid preemption by including a means for opting out of its requirements [*Egelhoff v. Egelhoff*, 532 U.S. 141, 150-51 (2001)]. A state law has an impermissible "connection with" an ERISA plan if it directly regulates or effectively mandates some element of the structure or administration of employers' ERISA plans. On the other hand, a state law that creates only indirect economic incentives that affect but do not bind the choices of employers or their ERISA plans is generally not preempted [*Travelers*, 514 U.S. at 658]. The Court of Appeals concluded that "in effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans to meet the minimum spending threshold. The Fair Share Act therefore falls under *Shaw's* prohibition of state mandates on how employers structure their ERISA plans. [*Shaw*, 463 U.S. at 96-97]. Because the Fair Share Act effectively mandates that employers structure



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their employee healthcare plans to provide a certain level of benefits, the Fair Share Act has an obvious "connection with" employee benefit plans and so is preempted by ERISA.

Senate Version of Minimum Wage Bill Passes with Major Changes to Tax Treatment of Executive Compensation Arrangements

On February 1, 2007, the Senate passed legislation to increase the minimum wage and attached to it was the Small Business and Work Opportunity Act of 2007 (SBWOA) containing two provisions that would significantly change the tax treatment of executive compensation arrangements. The executive compensation provisions are part of the revenue raisers that will be used to offset the costs of the small business tax relief included in the SBWOA.

The changes to the Internal Revenue Code (IRC) § 409A would limit deferrals to an individual's taxable compensation for the following types of deferrals:

- employee and employer contributions to classic deferred compensation plans made after 2006 and earnings thereon;
- accruals under supplemental retirement plans ("SERPS") and "mirror" 401(k) plans;
- amounts payable under certain equity compensation awards, such as restricted stock units; and
- amounts payable under certain executive severance arrangements

The current § 409A rules do not limit the amount that may be deferred under plans subject to § 409A. The SBWOA would revise § 409A to limit an individual's annual deferrals under such arrangements to the lesser of \$1 million, or the five-year average of the individual's annual taxable compensation. If an individual's annual deferrals exceeded the limit, all of the individual's deferred compensation would be immediately taxable and subject to the additional 20 percent tax and interest under § 409A. In general, any plan which provides for payment in a later year of compensation to which an individual has a legally binding right could be a deferred compensation plan subject to § 409A. Statutory exceptions include qualified retirement plans and bona fide vacation, sick leave, compensatory time, disability pay and death benefit plans. Other exemptions from § 409A include amounts which are payable within 2½ months after the end of the year in which the amounts were vested (the "short term deferral rule"), and stock options and stock appreciation rights that were granted with an exercise price at least equal to the fair market value of the stock at date of grant. Grants of restricted stock are also not considered nonqualified deferred compensation.



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Changes to IRC § 162(m) are also included in the SBWOA. IRC § 162(m) caps the annual amount of compensation paid to a "covered employee" that a publicly-held corporation can deduct at \$1 million. Current IRS guidance on § 162(m) provides that a covered employee includes a corporation's chief executive officer ("CEO") and the four other most highly compensated officers as reported in the corporation's proxy statement. Such an individual is not considered as a covered employee for a year unless he is employed by the corporation on the last day of the year. The SBWOA proposes to effectively remove this "last day" rule and provides that any individual treated as a covered employee at any time after 2006 be considered a covered employee in all later years, as would his beneficiaries. By expanding the definition of "covered employee" to include officers after they terminate employment, the bill would subject post-termination benefits, including nonqualified retirement payments and severance payments to the annual \$1 million deduction limit under § 162(m).

First Circuit Court of Appeals Outlines Service Requirements for an Employee's Eligibility for Leave Under the Family Medical Leave Act

The United States First Circuit Court of Appeals has held that an employee may count periods of past employment with an employer in order to satisfy the twelve-month eligibility requirement for leave under the Family Medical Leave Act (FMLA). [*Rucker v. Lee Holding Co.*, No. 06-1633, 2006 WL 3704457 (1st Cir., Dec. 18, 2006)] FMLA requires covered employers to grant eligible employees up to twelve weeks of unpaid leave during any twelve-month period for a variety of reasons, including birth of a child, serious health condition, or to care for an immediate family member. Eligibility requirements for leave under the FMLA include having worked for the employer for at least twelve months and for at least 1,250 hours during the previous twelve-month period. (29 C.F.R. 825.110) Kenneth Rucker worked for five years as a salesman for Lee Auto Malls. Rucker left the employer for a period of approximately five years and then returned to work. Seven months after his return, Rucker injured his back and took periodic medical leave, during which time he was terminated by the employer for excessive absenteeism. Rucker sued the employer, claiming wrongful termination in violation of the FMLA. The U.S. District Court for the District of Maine granted the employer's motion to dismiss on the basis of Rucker's failure to satisfy the twelve-month employment requirement as his most recent employment term was only seven months.

Rucker appealed, and on appeal, the Court of Appeals reversed the District Court's ruling, stating that Rucker could combine his two employment terms for purposes of meeting the twelve-month eligibility requirement for leave under the FMLA. The Court of Appeals found that there was no legislative history or statutory constructions to eliminate the



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ambiguity surrounding the FMLA's defining of an "eligible employee" as one employed "for at least twelve months by the employer." The Court of Appeals relied on the Department of Labor's (DOL) interpretation of the FMLA provisions in both the preamble to the FMLA regulations and in an amicus brief filed by the DOL. The DOL interpreted the provisions as not barring employees from counting previous periods of employment towards the twelve-month service requirement. The DOL's amicus brief encouraged the Court to establish a rule limiting the break-in-service to five years for purposes of counting prior employment. The Court found that the DOL's interpretation of eligible employment was reasonable and therefore ruled that the five year break in employment did not preclude the five years of employment from being counted as eligible service for leave under the FMLA. However, it did not set a limit on the period of break-in-service.

Third Circuit Court of Appeals Rules on the Accrual Date of Cause of Action for Incorrect Disability Payments

In a recent ruling, the U.S. Court of Appeals for the Third Circuit affirmed the ruling of a District Court which determined that the date for cause of action with respect to the underpayment of disability benefits is the date that the payments first began. [*Miller v. Fortis Benefits Ins. Co. and Resorts International Hotels*, 2007 WL 210370 (3rd Cir., Jan. 29, 2007)]

Paul Miller became disabled on October 6, 1986 after undergoing surgery. Months before the surgery, Miller was employed by Resorts International Hotel (Resorts) as a casino floor worker making \$690 per week. However, immediately before becoming disabled, he worked as an outside marketing salesman earning \$768 per week. In April 1987, he filed a claim for employee disability benefits under a long term disability policy issued by Mutual Benefit Life Insurance Company (Mutual Benefit). Under the disability plan, Miller was entitled to ongoing disability payments of sixty percent of his current salary until he reached the age of sixty-five. Miller's complaint alleged that when Resorts reported his salary to Mutual Benefit, it mistakenly reported that he still held his old position as a casino floor worker earning \$690. In April 1987, Miller began receiving disability payments based on this former salary. It was not until 2002 that Miller realized the calculation was incorrect. On November 12, 2002, Miller sent a letter to Fortis Benefits Insurance Company (Fortis), which had acquired Mutual Benefit, seeking an upward adjustment to reflect his 1987 salary. Fortis agreed to investigate the matter, but subsequently informed Miller by letter that the relevant pay records were no longer available. According to Fortis, since Resorts kept pay information for only seven years, it no longer had the information needed to determine the merits of Miller's claim. In August 2003, Miller filed a complaint in New Jersey Superior Court which was removed



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to the District of New Jersey. In his amended complaint, Miller alleged, under 29 U.S.C. § 1132(a)(1)(B), that Fortis and Resorts unlawfully denied him disability benefits, and, under 29U.S.C. § 1132(a)(3), that they breached a fiduciary duty to him by misrepresenting his proper salary and failing to investigate thoroughly his claim for adjustment. Resorts and Fortis moved to dismiss Miller's complaint for failure to state a claim upon which relief could be granted; specifically they contended that Miller's claims were barred by a six-year statute of limitations which began to run in 1987. Miller conceded that the six-year limitations period applied, but disagreed with Fortis as to the appropriate date of accrual. The District Court ruled that the six-year statute of limitations began to run in July 1987, based on the language in the disability plan.

In its ruling, the Court of Appeals relied on the premise that the accrual date for federal claims is governed by federal law, irrespective of the source of the limitations period. To determine the accrual date of a federal claim, the federal "discovery rule" is utilized when there is no controlling federal statute. Under this rule, a statute of limitations begins to run when a plaintiff discovers or should have discovered the injury that forms the basis of his claim. [*Romero v. Allstate Corp.*, 404 F.3d 212, 220 (3rd Cir., 2005)] In *Romero*, the Court of Appeals noted that in the ERISA context, this discovery rule has been developed into the more specific "repudiation" rule – a claim with a non-fiduciary cause of action accrues when a claim for benefits has been denied. A formal denial is not required if there has already been a repudiation of the benefits by the fiduciary, which was clear and made known to the beneficiary. [*Id.* at 222-23] Meaning, some event other than a denial of a claim may trigger the statute of limitations by alerting the plaintiff that his entitlement to benefits has been repudiated.

Following that logic, the Court of Appeals determined that in this case, the underpayment of a benefit is in effect a denial of a portion of the claim. The payments were a simple calculation of 60% of pay and should have been identified as being incorrect by the plaintiff at the time payments began. The Court of Appeals then concluded that the accrual date in this case was July 1987, when the plaintiff first began receiving the disability payments, and thus affirmed the District Court's ruling.

Employee Benefits Security Administration Announces Fiscal Year Enforcement Results

The Employee Benefits Security Administration (EBSA) is responsible for ensuring the integrity of the private employee benefit plan system through its enforcement of ERISA. The EBSA announced that in fiscal year 2006, it restored \$829 million in plan assets and benefits for participants through its enforcement efforts. Over 3,400 civil investigations were closed in fiscal year 2006, with almost 75% of those investigations resulting in



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monetary results for plans or other corrective actions. According to the EBSA, this has been accomplished mainly through improved targeting of plans for investigation.

The EBSA's Voluntary Fiduciary Correction Program (VFCP) and Delinquent Filer Voluntary Compliance Program (DFVCP) provide incentives to fiduciaries and others to self-correct. In fiscal year 2006, the EBSA received almost 1,500 applications for the VFCP and over 15,000 filings under the DFVCP. The EBSA stated that in 2006, applicants restored \$24.2 million in assets to employee benefit plans under the VFCP.

Internal Revenue Service Releases Bulletin 2007-7 Containing Guidance on Pension Protection Act of 2006 Issues

In January 2007, the Internal Revenue Service (IRS) released Bulletin 2007-7 which provides guidance on provisions of the PPA which are effective in 2007 or earlier. The guidance is provided in the form of questions and answers, a portion of which is excerpted below.

An employee's elective contributions under a cash or deferred arrangement can only be distributed upon the occurrence of certain events, one of which is the employee's hardship. A distribution is made on account of hardship only if the distribution both is made on account of an immediate and heavy financial need of the employee and is necessary to satisfy the financial need. A distribution made for any of the expenses listed in Regulation § 1.401(k)-1(d)(3)(iii)(B) is deemed to be on account of an immediate and heavy financial need of the employee. Several of these listed expenses can be expenses of the employee's spouse or dependents.

PPA § 826 directs the Secretary of the Treasury to modify the rules relating to distributions from § 401(k) § 403(b), § 409A, and § 457(b) plans on account of a participant's hardship or unforeseeable financial emergency to permit such plans to treat a participant's beneficiary under the plan the same as the participant's spouse or dependent in determining whether the participant has incurred a hardship or unforeseeable financial emergency.

Q5: What changes are being made pursuant to PPA § 826 in the rules relating to hardship distributions from 401(k) plans and 403(b) plans and relating to distributions on account of an unforeseeable financial emergency from a plan as described in § 457(b) or § 409A?



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A5: (a) A 401(k) plan that permits hardship distributions of elective contributions to a participant only for expenses described in § 1.401(k)-1(d)(3)(iii)(B) may, beginning August 17, 2006, permit distributions for expenses described in § 1.401(k)-1(d)(3)(iii)(B)(1), (3), or (5) (relating to medical, tuition, and funeral expenses, respectively) for a primary beneficiary under the plan. For this purpose, a "primary beneficiary under the plan" is an individual who is named as a beneficiary under the plan and has an unconditional right to all or a portion of the participant's account balance under the plan upon the death of the participant. A plan that adopts these expanded hardship provisions must still satisfy all the other requirements applicable to hardship distributions, such as the requirement that the distribution be necessary to satisfy the financial need. These rules also apply to 403(b) plans.

(b) In applying § 457(d)(1)(A)(iii), § 1.457-6(c)(2)(i), § 409A(a)(2)(A)(vi), and Proposed Regulation § 1.409A-3(g)(3)(i), a plan described in § 457(b) or § 409A may treat a participant's beneficiary under the plan the same as the participant's spouse or dependent in determining whether the participant has incurred an unforeseeable financial emergency. This will be reflected in the upcoming final regulations under § 409A.

Prior to the effective date of PPA § 904, a defined contribution plan satisfied the minimum vesting requirements of Code § 411(a) with respect to employer non-elective contributions if it maintained a 5-year vesting schedule or a 3 to 7 year vesting schedule. PPA § 904 amended the minimum vesting requirements to require faster vesting of employer non-elective contributions to a defined contribution plan. Under Code § 411(a)(2)(B) as amended by PPA § 904, a defined contribution plan satisfies the minimum vesting requirements with respect to employer non-elective contributions if it has a 3-year vesting schedule, or a 2 to 6 year vesting schedule. Code § 411(a)(2)(B) as amended by PPA § 904 generally applies to contributions for plan years beginning after December 31, 2006.

Q29. Can a plan have separate vesting schedules for employer non-elective contributions that are and are not subject to Code § 411(a)(2)(B), as amended by PPA § 904?

A29. Yes. A plan can have a vesting schedule for employer non-elective contributions for plan years beginning after December 31, 2006, and another vesting schedule for other employer non-elective contributions under the plan, provided that the plan separately accounts for the contributions made under the vesting schedule in effect prior to the first



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day of the first plan year beginning after December 31, 2006, and the vesting schedule for employer non-elective contributions for plan years beginning after December 31, 2006, satisfies Code § 411(a)(2)(B), as amended by PPA § 904.