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Highlights of the Month

- 1. President Signs Pension Protection Act of 2006 and Legislation Blocking State Taxation of Retirement Income of Non-Resident Partners**
- 2. Internal Revenue Service Issues Final Anti-Cutback Regulations for Defined Benefit Plans**
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- 7. Ninth Circuit Sets New Rules for Standard Review in ERISA Benefits Litigation**

President Signs Pension Protection Act of 2006 and Legislation Blocking State Taxation of Retirement Income of Non-Resident Partners

President Bush signed the Pension Protection Act of 2006 on August 17, 2006. Among its numerous provisions, the Act overhauls the funding and disclosure rules for defined benefit plans, revises the deduction limits for qualified plans, addresses conversions of pension plans to cash balance plans, makes permanent EGTRRA pension provisions which were scheduled to expire in 2010, and modifies investment diversification and participant education rules for defined contribution plans, as well as minimum vesting schedules for employer contributions to defined contribution plans.

H.R. 4019 was also signed into law by President Bush in August. The bill requires states to treat the retirement income of all retirees, whether they were employees or partners prior to retirement, in the same manner for state tax purposes. In 1996, P.L. 104-95 was enacted and prohibited state taxation of certain retirement income of non-residents of the taxing state. Qualified plans, SEPs, IRAs and other similar arrangements were all included in the definition of retirement income as was nonqualified deferred compensation plans as defined in Internal Revenue Code ("Code") Section 3121(v)(2)(C). The state of New York took the position that this did not prevent it from

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taxing nonqualified retirement benefits paid by a partnership to its retired non-resident partners. They based this decision on the language of the Code which applied only to employees, not to partners. H.R. 4019 retroactively (amounts received after December 31, 1995) amends P.L. 104-95 to prohibit states from taxing nonqualified deferred compensation plans as defined in the aforementioned Code section and nonqualified retirement benefits paid to its retired non-resident partners by a partnership.

Internal Revenue Service Issues Final Anti-Cutback Regulations for Defined Benefit Plans

The Internal Revenue Service has issued final regulations creating a third exception to the IRC Section 411(d)(6) anti-cutback rules for eliminating optional forms of benefit from defined benefit plans. These final regulations also codify the Supreme Court decision in *Central Laborers' Pension Fund v. Heinz* (541 U.S. 739 (2004)).

In applying the holding in *Heinz*, the final regulations retain the rule in the proposed regulations that a plan amendment that decreases accrued benefits or places greater restrictions or conditions on protected benefits violates Code Sec. 411(d)(6) even if the amendment only adds a restriction that is otherwise permitted by vesting rules. The final regulations added a limited exception that applies to certain changes in a plan's vesting computation period. The rules in these regulations apply to plan amendments adopted after August 9, 2006.

The final regulations create a "utilization" exception to the anti-cutback rules which joins the "redundancy" and "core option" exceptions which were included in the 2005 final regulations issued by the IRS. This utilization exception applies only if (1) the generalized optional form of benefit was available to at least 50 participants during the "look-back period", and (2) no participant has elected that optional form of benefit with an annuity start date within the look-back period. Core options – straight-life annuity, 75% joint and survivor annuity, ten-year term certain and life annuity, and the most valuable distribution option for a participant with a short life expectancy - may not be eliminated under the utilization exception. A generalized optional form of benefit is considered "available" to a participant only if the participant was eligible to elect to begin payment of an optional form of benefit with an annuity start date within the look-back period. The look-back period is defined as the two plan years immediately preceding the year of adoption, plus the period preceding the date of adoption. For the year of adoption, plan sponsors may exclude the month of adoption and the preceding one or two calendar months (if within the year of adoption) from the look-back period. To meet the 50 participant threshold, sponsors may extend the look-back period to as many as five years preceding the year of adoption. In addition, at least one of the years in the look-



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back period must be a 12-month plan year. The rules provided in the utilization test are applicable for plan amendments after December 31, 2006.

Court Cases Involving COBRA Election Notices End with Mixed Results

In the first case (*Piercefield v. Int'l Truck & Engine Corp.*, S.D. Ind. 2006), an employee in Indiana made a claim that after his employment terminated, his former employer failed to provide him with a COBRA election notice. His claim for statutory penalties was filed two years and three months after his termination. Both parties to the claim agreed that the two-year Indiana statute of limitations for statutory penalties applied to the claim. The dispute came over the start date for the two-year period, i.e., when the claim accrued. The court's decision was that the claim accrued when the statutory deadline for providing the COBRA election notice expired. COBRA requires an employer to notify the plan of a termination of employment within 30 days, and then to provide the COBRA election notice to the qualified beneficiary within 14 days. Therefore, the court concluded that the notice period ended 44 days after the termination of the employee. The court rejected the employee's argument that a new violation of the statutory deadline occurred with each day that notice was not provided, thus keeping the two statute of limitations running. Since the lawsuit was filed more than two years and 44 days after the date of termination, the court held that the claim was time-barred and entered judgment for the employer.

In the second case (*Mershon v. Woodbourne Family Practice, LLC*, E.D. Pa. 2006), a woman sued for both pregnancy discrimination and violation of COBRA. The employee was sent a notice in the form of an acknowledgement, to be signed and returned by the employee, indicating whether or not she wished to elect COBRA benefits. The notice only stated that the employee had been offered COBRA coverage, that the premium in a specified amount was due by a certain date, and that coverage would otherwise expire as of the end of the month. There were no other details provided within the notice. The employer asked for dismissal based on the fact that it had fulfilled its duty by mailing the notice – sent by certified mail but returned unclaimed after two weeks. The court focused, not on the adequacy of the notice itself, but on the length of the COBRA election period. The court rejected the employer's position on the basis of failing to provide the employee at least 60 days to elect COBRA, as required under the language of the statute.

Finally, in *Crotty v. Dakotacare Admin. Servs. Inc.*, 2006 U.S. App, 8th Circuit, a former employee sued her employer's health plan administrator for failure to provide COBRA



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notification when she was terminated. The administrator provided the courts with an audit report showing that its computer system had generated a notice to the former employee and presented testimony from one of its employees regarding its procedures and process for generating, printing, sorting and mailing the notices. The Eighth Circuit held that the administrator did not present any evidence that the notice for this particular employee had followed this process, stating that no evidence was presented that this particular notice “was printed out, placed in a properly addressed envelope, or sent through the mail.” While COBRA does not require any specific approach to delivering notices, plan administrators must be able to prove what was mailed and to whom it was mailed.

Distress Terminations Involving Multiple Plans Must Consider All Plans in the Aggregate, Not Independently

The U.S. Court of Appeals, Third Circuit has ruled (*In re Kaiser Aluminum Corporation, Debtor. Pension Benefit Guaranty Corporation, Appellant.*, 2006 WL 2061337), that when an employer in a bankruptcy reorganization is seeking to terminate more than one pension plan simultaneously through a distress termination proceeding, all of the plans in the aggregate are required to be considered by the bankruptcy court.

A single-employer pension plan can be terminated in one of two ways: a standard termination (ERISA Section 4041(b)), or a distress termination (ERISA Section 4041(c). Under ERISA Section 4041(c)(2)(B)(ii), certain criteria must be met to terminate a plan under distress during a reorganization in bankruptcy. However, ERISA does not specifically address situations where the employer is attempting to terminate more than one plan simultaneously. In the Kaiser Aluminum Corporation case, the company was seeking the termination of six of its single-employer, collectively bargained pension plans in a voluntary distress termination under ERISA Section 4041(c)(2)(B)(ii). The bankruptcy court applied the reorganization test to all six plans in the aggregate and reached the conclusion that the termination of the plans was necessary for Kaiser to emerge from Chapter 11. The ruling was appealed by the Pension Benefit Guaranty Corporation (PBGC) on the grounds that the reorganization test should have been applied to each of the six plans on an independent basis. Under this methodology, not all of the plans would have satisfied the test and thereby could not be terminated. A district court sided with the bankruptcy court, and the PBGC appealed, citing ERISA Section 4041(c) which refers to “plan” rather than “plans” in the reorganization test language. The Third Circuit disputed the “linguistic argument” made by the PBGC and further stated that a reorganization test cannot be rationally applied on a plan-by-plan basis, as there is no equitable manner in which to decide the order in which the plans should be considered.



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Therefore, the court concluded that the bankruptcy court correctly applied the reorganization test in the aggregate to the six plans that Kaiser was seeking to terminate.

IBM's Cash Balance Plan Found to Be Non-Discriminatory With Respect to Age

The Seventh Circuit of the U.S. Court of Appeals has ruled that IBM did not violate the ERISA provisions prohibiting age discrimination when it amended its defined benefit pension plan to establish a hybrid plan, known as a cash balance plan. In their amended plan, each employee would not have a separately funded account but would have a value imputed to an account in the form of credits – a 5% pay credit and annual interest credits. Every employee received the same pay and interest credits. Under ERISA Section 204(b)(1)(H)(i), a defined benefit plan may not cease an employee's benefit accrual and may not reduce the rate of such accrual because the employee has reached a certain age. Selected employees of IBM filed suit against the company alleging it had violated these provisions because it reduced a participant's rate of benefit accrual based on age. The district court granted partial summary judgment to the plaintiffs, which was appealed by IBM. In its ruling on the appeal, the Seventh Circuit looked at the aforementioned ERISA section, as well as the corresponding section in ERISA relating to defined contribution plans, Section 204(b)(2)(A). The court found that both these sections prohibit the same thing – an employer may not stop making allocations or accruals to the plan or change the rate of allocation/accrual based on age. According to the ruling by the Seventh Circuit, the district court erred in treating the "time value of money" as age discrimination; this is not what was intended as a "benefit accrual" under ERISA. The Court stated that benefit accrual refers to what is imputed to the account by the employer, and since interest is not treated as age discrimination in a defined contribution plan, neither should it be treated as such in a defined benefit plan. The Seventh Circuit's conclusion is that the term "benefit accrual" for a defined benefit plan has the same meaning as the term "allocation" for a defined contribution plan.

While the recently signed Pension Protection Act of 2006 establishes a simple age discrimination standard for all defined benefit plans and thereby clarifies the law regarding age discrimination requirements under ERISA, it only does so on a prospective basis. This court decision by the Seventh Circuit clarifies the law for existing cash balance plans.



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Delay by Employer in Forwarding Employee Contributions to Health Plan Administrator Did Not Breach Fiduciary Duty

In an appeals case heard by the Fourth Circuit Court of Appeals (*Phelps v. CT Enterprises, Inc.*, 2006 U.S. App. (4th Circuit 2006)), the Court affirmed the trial court's opinion in favor of the employer stating that the employer's delay in forwarding employee contributions to their health plan administrator did not constitute a breach in fiduciary duty by the employer.

In this case, the employee contributions were made under the terms of a cafeteria plan. Under Technical Release 92-01, the employer was not required to place the contributions in trust and their normal practice was to forward administrative fees to the health plan administrator, which included the employee contributions to the plan. However, the employer began experiencing financial difficulties and fell behind in paying the administrative fees to the administrator. The employer held meetings to inform the employees of its financial difficulties, including their shortcoming in funding claims. Employees were told that the company was doing everything it could to pay outstanding claims, but they were never told that employer contributions were not being made to the administrator. Several months later, the employees were informed that the health plan was being terminated, but were not told the status of claims payments for claims incurred prior to the termination date or the status in the funding of these claims. The employees later filed suit against the employer and others to recover payment for approved but unpaid claims and alleging that the employer(s) breached their fiduciary duties in two ways: they misused employee contributions and failed to remit employee contributions to the plan administrator as soon as practicable; and they failed to disclose material information about the plan to the employees.

For cafeteria plans, the Department of Labor does not assert a violation "solely because of a failure to hold participant contributions in trust." (*ERISA Technical Release 92-01*, 57 Fed. Reg. 23272 (June 2, 1992)). However, this allowance does not relieve fiduciaries "of an obligation to ensure that participant contributions are applied only to the payment of benefits and reasonable administrative expenses of the plan." (*Id.*) The date on which employee contributions become plan assets is no later than 90 days from the date on which they are withheld, but not to exceed the date on which such contributions can reasonably be segregated from the general assets of the employer. In this case, until July of 2000, employee contributions were submitted to the administrator on a weekly basis. After this date, the employer withheld employee contributions on a weekly basis, but stopped making submissions to the plan administrator on a weekly basis. However, within 90 days of each weekly paycheck, the employer forwarded amounts greater than



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the sum of the employee contributions to the administrator. While these amounts were not sufficient to pay all the claims, all employee contributions were remitted to the administrator within 90 days of receipt. The Court concluded that there was no evidence that the employer “used the contributions inappropriately, as general assets of the company, during the intervening time. The Court addressed the plaintiffs’ argument that the change in the timing of payment of employee contributions to the administrator constituted a breach of fiduciary duty, by concluding “that *CT Enterprises, Inc.* forwarded contributions to Kanawha as soon as practicable, in light of the extenuating financial situation of the company.”

As to the plaintiffs’ claim of breach of duty related to failure to disclose material information to the employees, the Court also found in favor of the employer. The Court identified two situations in which an ERISA administrator has a fiduciary duty to advise beneficiaries. First, a fiduciary must give complete and accurate information to a beneficiary, if the beneficiary requests information, and second, a fiduciary must provide “material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection.” (*Griggs v. E.I. DuPont De Nemours & Co.*, 237 F.3d 371, 381 (4th Cir. 2001)). The Court relied on the meetings that the employer held, and the fact that all employee contributions to the plan were forwarded to the plan as evidence that there was no loss to the employees resulting from a failure to disclose information.

Ninth Circuit Sets New Rules for Standard of Review in ERISA Benefits Litigation

The Ninth Circuit Court of Appeals has significantly revised how the “abuse of discretion” standard of review is to be applied in that Circuit when a plan decision maker has a conflict of interest or has failed to observe the procedural requirements in the claims process. The case (*Abatie v. Alta Health & Life Ins. Co.*, 2006 U.S. App., (9th Cir., 2006)) involved an employee covered under an ERISA life insurance plan who became disabled, and then retired. In order to continue his coverage under the plan, the employee could pay premiums on his own or file a waiver of premium request. Such a waiver, if granted, would keep coverage in effect as long as the employee remained disabled. When the employee died, the insurer refused to pay on the beneficiary’s claim, contending that no waiver of premiums had been requested. This decision was appealed by the beneficiary but the denial was upheld. At the end of the appeals process, the insurer added an additional reason for the denial - the employee had not remained continuously disabled until his death. The beneficiary sued and the trial court found in favor of the insurer determining that, in spite of the contradictory evidence as to whether a premium waiver was ever requested, there was no abuse of discretion by the insurer in



finding that no waiver request had been made. The court also refused to consider additional evidence from the beneficiary regarding the disabled status of the employee.

The case was heard by the Ninth Circuit Court of Appeals who took this case “en banc to reconsider our approach to ERISA cases in which a plan administrator denies benefits and (1) the wording of the plan confers discretion on the plan administrator and (2) the plan administrator has a conflict of interest.”

In reversing the trial court’s decision, the Ninth Circuit went back to the initial decision by the U.S. Supreme Court (*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)) that established the abuse of discretion standard of review. In *Firestone*, the Supreme Court concluded, among other things, that general trust principles apply when considering how district courts should review ERISA denial of benefits cases because the plan administrator stands in a fiduciary relationship to the plan participants. To assess the applicable standard of review, the starting point is the wording of the plan. *Firestone* appears to provide for only two alternatives. When a plan confers discretion, abuse of discretion review applies; when it does not, de novo review applies. The essential first step of the analysis is to examine whether the terms of the ERISA plan unambiguously grant discretion to the administrator. Abuse of discretion review applies to a discretion-granting plan, even if the administrator has a conflict of interest. But *Firestone* also states that the existence of a conflict of interest is relevant to how a court conducts abuse of discretion review. In discussing abuse of discretion review, the Supreme Court cautioned that, “if a benefit plan gives discretion to an administrator or fiduciary that is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r] in determining whether there is an abuse of discretion.’” The Ninth Circuit Court has previously held that an insurer that acts as both the plan administrator and the funding source for benefits operates under what may be termed a structural conflict of interest. (*Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999))

In reviewing its standards, the Ninth Circuit Court announced that its own precedent, *Atwood v. Newmont Gold Co.*, 45 F.3d1317 (9th Cir. 1995), must be overruled because it misinterpreted *Firestone* and placed an unreasonable burden on plaintiffs. The Court concluded “that when a decision by an administrator utterly fails to follow applicable procedures, the administrator is not, in fact, exercising discretionary powers under the plan, and its decision should be subject to de novo review. Lesser irregularities, like the one in this case, do not remove the decision from abuse of discretion review, but rather should be factored into the calculus of whether the administrator abused its discretion.” The Court’s decision cites a new review approach in following the *Firestone* decision: “a review is to be informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record. This standard applies to the kind



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of inherent conflict that exists when a plan administrator both administers the plan and funds it, as well as to other forms of conflict.” Under this ruling, a district court must decide in each case how much or how little to credit the plan administrator’s reason for denying insurance coverage. An egregious conflict may weigh more heavily than a minor, technical conflict might. But in any given case, all the facts and circumstances must be considered. In general, a district court may review only the administrative record when considering whether the plan administrator abused its discretion, but may admit additional evidence on de novo review.

In this case and using the new standards, the Ninth Circuit Court determined that the plan administrator exercised discretion but, in doing so, made procedural errors. A procedural error, like a conflict of interest, is a matter to be weighed in deciding whether an administrator’s decision was an abuse of discretion. When a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record. Even when procedural irregularities are smaller, and abuse of discretion review applies, the court may take additional evidence when the irregularities have prevented full development of the administrative record to virtually recreate what the administrative record would have been had the procedure been correct.

The Ninth Circuit sent this case back to the trial court for it to reconsider the insurer’s conflict of interest, to revisit the dispute about whether a waiver of premiums had been requested and to consider additional evidence regarding the employee’s continued disability.