

Employee Benefits & Executive Compensation Update

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This newsletter briefly discusses several recent developments in employee benefits and executive compensation that may be of interest to our clients. For more details on any item reported herein, please contact any member of Blank Rome's Employee Benefits and Executive Compensation Group.

Recent Developments In Employee Benefits And Executive Compensation

New Health Care Reform Guidance Issued

DOL and IRS have issued important guidance relating to the Patient Protection and Affordable Care Act ("Affordable Care Act" or "Health Care Reform"). The IRS issued Notice 2010-59 relating to the reimbursement of over the counter medicines under certain employer-provided plans, followed by IRS Notice 2010-63, which announced that the IRS is seeking comments on the application of nondiscrimination rules to insured arrangements.

The DOL website now includes a set of frequently asked questions ("FAQs"), providing guidance on certain Health Care Reform provisions. The DOL also issued DOL Technical Release 2010-02 addressing certain issues affecting the new internal appeals and external review requirements.

NOTICE 2010-59

Notice 2010-59 addresses Section 9003 of the Affordable Care Act, which revised the definition of medical expenses for employer-provided plans including health flexible spending arrangements (health FSA), health reimbursement arrangements, Health Savings Accounts, and Archer Medical Savings Accounts. The new definition provides that, effective January 1, 2011, expenses incurred for medicines or drugs may be paid or reimbursed only if the medicine or drug

(1) requires a prescription; (2) is an over-the-counter (OTC) medicine or drug for which the individual obtains a prescription; or (3) is insulin. Previously, OTC medicines were reimbursable without a prescription.

Notice 2010-59 clarifies that the new definition neither affects distributions nor reimbursements for medicines or drugs purchased before January 1, 2011. The restrictions also do not affect distributions or reimbursement of 2010 plan year claims submitted after December 31, 2010 for medicines or drugs purchased on or before that date. Notice 2010-59 provides for a transition rule for plan amendments to comply with the new definition, stating that retroactive amendments must be adopted no later than June 30, 2011, for expenses incurred after December 31, 2010.

Comment: Employers and FSA administrators must consider and adopt procedures to substantiate reimbursements for OTC drugs and medicines.

FAQS

The FAQs issued by the DOL are intended to assist plan sponsors, issuers and plans in making diligent, good-faith efforts to comply with the Affordable Care Act. The FAQs include guidance on specific topics as follows:

Grandfathered Health Plans

- Until final regulations are issued, an insured plan will not lose grandfathered status due to a change in the employer contribution rate, if (i) the insurer, upon renewal, required the plan sponsor to make a representation regarding its contribution rate for the new plan year and its rate as of March 23, 2010 **and** (ii) the insurance policy/certificate/contract prominently states that plan sponsors are required to notify the insurer of contribution rate changes during the plan year. These steps must be taken by January 1, 2011 for policies renewed prior to that date. Such a plan will lose grandfathered status once the insurer learns of a five percent reduction (or earlier if another change is made that would cause the loss of grandfathering).
- Similar guidance is provided for multiemployer plans, which, like insurers, often do not know of changes to employer contribution rates. Moreover, multiemployer plans with a fixed dollar contribution rate or no employee contribution will not lose grandfathered status solely as a result of a change in the employer contribution rate if there is no increase in the employee contribution toward coverage.

Claims, Appeals, and External Review Procedures (for non-grandfathered plans)

- In Technical Release 2010-01, the DOL articulated a safe harbor federal standard for external review procedures. Plans that do not follow the safe harbor may still be considered in compliance with the external review requirements based on the facts and circumstances.
- With respect to hiring independent review organizations ("IROs"), a self-insured plan need not contract directly with the IRO but can contract with a third-party administrator that in turn contracts with the IRO. In addition, a plan may contract with an IRO located in a different state from the plan.
- The interim final regulations governing claims procedures that shorten the time to make initial determinations with respect to urgent care claims do not change the time period for appeals of those claims.
- There is relief for compliance with the new standards for claims and internal appeals as described in DOL Technical Release 2010-02 (see below).

Emergency Services (for nongrandfathered plans)

- Where state law prohibits balance billing for emergency services or where a plan or insurer is contractually responsible for amounts balance billed by an out-of-network emergency services provider, plans and insurers need not satisfy the minimum payment requirements set forth in the interim final regulations (which would otherwise require that a plan reimburse emergency services at a minimum rate, based generally on its in-network allowance or other standards). However, patients must be provided with adequate and prominent notice of their lack of financial responsibility (and the plan or insurer is still subject to the prohibition against imposing a copayment or coinsurance requirement that is higher than the network requirement).

NOTICE 2010-63

IRS Notice 2010-63 provides general information regarding the provisions of the Affordable Care Act prohibiting insured plans from discriminating in favor of highly compensated employees. This IRS Notice requests comments for expected future regulatory guidance and also confirms that a nongrandfathered insured plan that does not comply with these requirements is subject to the taxes, remedies and penalties that would otherwise apply in the case of a violation of the mandates of the Affordable Care Act, including a \$100 excise tax/penalty per day per individual discriminated against, and other relief under ERISA (including an injunction to compel compliance). In contrast, under existing law, if a self-insured plan (whether or not grandfathered) violates Section 105(h), the only sanction is that highly compensated employees' health care benefits become taxable.

NOTICE 2010-02

DOL Technical Release 2010-02 provides a non-enforcement grace period (until July 1, 2011) to allow nongrandfathered plans to incorporate new content in notices of adverse benefit determination and notices of final adverse benefit determination and to afford them more time to implement procedures to comply with certain claim and appeals related provision of the Affordable Care Act. This grace period relates only to (i) changes in the time frame for making urgent care claims decisions, (ii) providing notices in a culturally and linguistically appropriate manner, (iii) certain additional content requirements in notices and (iv) the substantial compliance requirement.

Please see our prior newsletters regarding Health Care Reform (<http://www.blankrome.com/index.cfm?contentID=37&itemID=2318>) (<http://www.blankrome.com/index.cfm?contentID=37&itemID=2248>) for further information regarding the topics discussed in this new guidance.

Roth In-Plan Conversions Now Permitted Under the Small Business Jobs Act

On September 27, 2010, President Barack Obama signed The Small Business Jobs Act, permitting employees with amounts available for distribution and/or rollover to convert or transfer those amounts into Roth designated accounts within an employer-sponsored retirement plan. Prior to the Act, a participant seeking to convert regular plan funds to Roth funds was required to move money from the employer sponsored retirement plan into a separate Roth IRA account. Under the Act, participants possess the ability to convert existing 401(k) and 403(b) plan balances to a designated Roth account within the plan. The provision governing in-plan conversions is effective immediately. In addition, governmental 457(b) plans may add designated Roth accounts starting in 2011. Although employers are permitted to offer in-plan conversions, the provision is voluntary and plan sponsors are not required to offer Roth options. Employers who choose to offer the in-plan conversion should notify employees that such a conversion will constitute a taxable event to the plan participant.

Comment: Plan sponsors must act immediately to determine whether and how they should implement this new provision of the Act. Sponsors of plans that already offer a Roth contribution program may want to consider offering an in-service distribution option in order to allow participants to take immediate advantage of the Roth in-plan conversion. Participants converting to a Roth account in 2010 will be permitted to spread any amount required to be included in gross income in equal amounts to the 2011 and 2012 taxable years, unless the participant elects to have all of the income included only in the 2010 tax year. Participants converting to a Roth account after 2010 will have to recognize taxable income in the year of the conversion.

An employer that wants to afford employees the right to convert in 2010 should take immediate action to add Roth features to the plan and to address administrative issues.

Emerging Trend: Courts Permitting Employers to Equitably Reform Retirement Plans to Eliminate Drafting Error

Recent cases from several jurisdictions indicate that in some jurisdictions employers may be permitted to correct a drafting error—known as a scrivener’s error—in Employee Retirement Income Security Act (ERISA) plan documents under certain limited circumstances. In *Young v. Verizon’s Bell Atlantic Cash Balance Plan*, the U.S. Court of Appeals for the Seventh Circuit held that Verizon could correct its cash balance pension plan to remove a scrivener’s error. In *Young*, the ERISA plan document’s complex pension formula inadvertently included a multiplier provision in two places which could have greatly increased benefits. However, the employer intended to have the multiplier apply only once. Further, all plan communications, benefit statements, and subsequent versions of the plan showed an intent to use the multiplier only once and the plan was administered in operation accordingly. Nevertheless, a plan participant—who admitted that she never relied on the double multiplier—sued several years after starting to receive her pension benefits claiming that her pension should be doubled based on the plan document. The *Young* court considered the effect of reformation on ERISA’s plan document rule—that the benefits must be determined on the basis of the plan documents—and determined that it was permissible to correct a scrivener’s error. The court noted that only those employers who can meet a high standard of proof by offering “clear and convincing” evidence that the plan language was contrary to the parties’ expectations can maintain a viable claim for equitable reformation. Overall, reformation of the plan document permits Verizon to avoid disbursing nearly \$1 billion in unanticipated pension benefits. The *Young* court follows the Third Circuit’s ruling in *International Union v. Murata North America, Inc.*, 980 F.2d 889 (3d. Cir. 1992).

While the *Young* and *Murata* cases illustrate that some courts are willing to permit corrections of ERISA plan documents where the employer offers “clear and convincing” evidence that the error was unintended and where the Plaintiff cannot show reliance on the incorrect plan documents, other jurisdictions such as the Fourth, Fifth, and Ninth Circuit continue to prohibit retroactive correction of ERISA plan documents.

Comment: Although employers must remain diligent when drafting and amending ERISA plan documents, employers that uncover a scrivener's error should consult with an experienced employee benefits attorney to determine whether retroactive correction of the error is feasible.

Third Circuit Rules That Administrator of Welfare Benefit Plan Abused Discretion in Denying Claim for Benefits Under Program Following Sale of Business

In *Howley v. Mellon Financial Corporation*, the U.S. Court of Appeals for the Third Circuit held that an employer, which sold a subsidiary, must pay severance benefits under a welfare benefit plan, to a former employee who was terminated just one day after the change of ownership transaction was completed. Prior to the sale, Mellon provided a Displacement Program to employees. Mellon's Displacement Program is a welfare benefit plan subject to the requirements and protections of ERISA. The Displacement Program states that it is "intended to help displaced employees 'bridge the gap' between periods of employment or retirement income." The program provided a "sale of business exception," whereby an employee is ineligible for severance benefits if his/her employment with a Mellon subsidiary is terminated due to Mellon's sale of the subsidiary to a company that provides comparable employment. One day after Mellon sold the subsidiary, the acquirer—who committed to providing comparable employment to over 3,600 acquired employees—terminated 100 former Mellon employees. Shortly thereafter, one of the 100 terminated employees filed a claim for benefits under Mellon's Displacement Program.

The plan administrator determined that the "sale of business" exception applied and denied the claim. In denying the claim, the administrator relied upon a "snap shot" approach. Under the "snap shot" approach, the plan administrator concluded that the "sale of business" exemption applied because the former employee received comparable employment at the time the change of ownership transaction was completed.

While the court observed that the use of the "snap shot" approach is permitted, the court noted that use of such an approach does not relieve the Plan Administrator of its duty to ascertain whether the broader purpose of a particular welfare program is satisfied. Since the buyer did not continue the employment of the transferred employees for a reasonable period of time, the court concluded that such temporary employment did not satisfy the Displacement Program's intended purpose of "bridging the gap." As stated by the court, "[a]dministering benefits in a way that controverts a plan's stated purpose, renders plan language meaningless, and creates benefits that can exist only on paper, is unreasonable."

Comment: Plan Administrators evaluating welfare benefit plans subject to ERISA must be mindful of both the text and broader purpose of the plan. Employers conducting transactions implicating these types of plans should consult with an attorney prior to making a determination about whether a particular provision or exception applies to that specific transaction. ■

By: Kari K. Stevens

Employee Benefits and Executive Compensation Practice Group

Arthur Bachman	215.569.5715	Terry D. Johnson	609.750.2658	Virginia Escobar Neiswender	215.569.5439
Colleen A. Carolan	424.239.3430		215.569.5374	Jim D. Newman	424.239.3435
Paul A. Friedman	212.885.5411	Barry L. Klein*	215.569.5403	Mary Pierce	424.239.3433
Wilhelm L. Gruszecki	215.569.5477	Howard M. Knee	424.239.3439	Kari Knight Stevens	215.569.5705
Michael J. Hanlon	215.569.5652	Michael L. Ludwig	424.239.3438		
Cory G. Jacobs	215.569.5481	Anthony A. Mingione	212.885.5246		

* Editor