COBRA Subsidy Update and Court Rulings on Beneficiary Designation Conflict and Revenue-sharing Disclosure

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MORE ON THE NEW COBRA SUBSIDY

While the new COBRA provisions contained in the American Recovery and Reinvestment Act of 2009 (ARRA) were touched on briefly in the last column, they can be discussed more substantively now that important guidance from both the Department of Labor and the IRS has been issued. To briefly summarize the new COBRA provisions, if an employee is involuntarily terminated between September 1, 2008, and December 31, 2009, and loss of coverage under the employer group health insurance plan occurs within this period, the individual is entitled to pay only 35% of the COBRA premium he or she would otherwise pay for 9 months unless he or she earlier becomes eligible to enroll in a another group health plan or Medicare. The employer initially pays the other 65% of the premium but then is reimbursed by the federal government by means of a credit against payroll taxes.

While it appeared when ARRA was passed that the main concern of Congress was to protect employees who were laid off due to lack of work in a slowing economy, the definition of *involuntary termination* as determined by the IRS in Notice 2009-27 encompasses many more types of situations. The IRS broadly defines *involuntary termination* as any termination of an employee other than at the employee's request where the employee was willing to continue to perform services. Thus it includes a lay-off, furlough, or other suspension of employment; an employee whose contract is not renewed if he or she is otherwise willing to continue; an employee who chooses to terminate his or her employment following a material negative change in working conditions; a retirement if the employee had knowledge that he or she would be terminated but for the retirement; a lockout by the employer; and a buy-out by the employer if the employer indicates that after the buy-out period ends some remaining employees will be terminated.

Involuntary termination does not include an involuntary termination due to death or an absence (but not termination) from work due to illness or disability or a work stoppage as a result of a strike. It also does not include termination on account of "gross misconduct," which has always prevented COBRA rights.

The IRS Notice also discusses topics such as who is an assistance-eligible individual, how to calculate the new reduced COBRA premium, coverage eligible for premium reduction, the beginning of the premium reduction period, the end of the premium reduction period, the recapture of premium assistance (by highly paid former employees), and the extended election period (i.e., a second chance to elect COBRA even though it was initially rejected or dropped after election).

Employers must notify affected former employees of these new rights. Model election forms have been drafted by the Department of Labor and can be found on its Web site.

It is important to note for smaller medical practices that even though COBRA may not apply (it only applies to employers with 20 or more employees), this premium subsidy does apply to continuation rights extended under state insurance law. For example, in Illinois an employee of a small employer who is exempt from COBRA may still elect nine months of continuation coverage under a commercially insured group health plan pursuant to state insurance law. Many other states have similar continuation privileges.

There is a major difference between COBRA and state continuation rights with regard to the subsidy. While ARRA specifically provides that an employee who never elected COBRA or dropped it after election has a new second opportunity to elect COBRA, a similar right does not apply at the state level. Hence, unless a state amends its insurance laws to provide for this new election, the ARRA subsidy would only apply at the state level to those former employ-

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ees meeting the parameters of ARRA who actually elected continuation under state insurance law. Smaller medical practices with fully insured group health plans should check with their carriers on developments at the state level.

SUPREME COURT DECISION ON DIVORCE DECREE AND BENEFICIARY DESIGNATION CONFLICT

For many years, there has been a provision under the Employee Retirement Income Security Act of 1974 (ERISA) that permits a retirement plan to recognize a division of plan benefits pursuant to a divorce decree and property settlement. A special court order called a qualified domestic relations order (QDRO) can be issued by a court to a plan administrator specifying how the plan benefits are to be paid to the affected parties. The QDRO must meet specific requirements set forth in Department of Labor regulations on QDROs.

The U.S. Supreme Court in the case of *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan,* decided January 26, 2009, addressed the unfortunately rather common situation where the divorce decree specifies benefits are to be divided in a certain way but a separate QDRO is not obtained and filed with the plan. The court accepted the case to resolve a split among lower courts on both the issues of: (1) whether a spouse can waive benefits through a divorce decree that is not a QDRO; and (2) whether a waiver of benefits is effective when that waiver is inconsistent with plan documents.

Under the facts in the case, an employee and wife divorced in 1994. The wife agreed to waive all rights under the retirement plans of the husband. A domestic relations order was drafted to reflect this agreed upon division of benefits but it was never submitted to the plan. The employee died in 2001, and his estate demanded from the retirement plans all the benefits. DuPont, however, said it still had a beneficiary designation form signed by the deceased employee naming his former wife as the beneficiary under the retirement plans. Therefore, DuPont distributed all plan benefits to the former spouse, and the estate sued.

The Supreme Court said first of all that a QDRO cannot be used to serve merely as a waiver of the former spouse's rights. Instead the QDRO must designate an alternate payee. As the court said: "In fact, a beneficiary seeking only to relinquish her right to benefits cannot do this by a QDRO, for a QDRO by definition requires that it be the 'creation or recognition of the existence of an alternate payee's right to, or assignment to an alternate payee of the right to, receive all or a portion of the benefits payable with respect to a participant under a plan.' 29 U. S. C. §1056(d)(3)(B)(i)(I). There is no QDRO for a simple waiver; there must be some succeeding designation of an alternate payee."

Even though the court concluded a waiver of benefits would not constitute a QDRO, it went on to say that a waiver of benefits was not a violation of ERISA so a waiver could be recognized in certain circumstances. The court said the plan had no obligation under ERISA to look at documents outside the plan. ". . . [T]he question remains whether the plan administrator was required to honor Liv's waiver with the consequence of distributing the SIP balance to the Estate. We hold that it was not, and that the plan administrator did its statutory ERISA duty by paying the benefits to Liv in conformity with the plan documents."

The Court said ERISA mandates that the plan pay out benefits to the named beneficiary since ERISA requires that payments be made in accordance with plan documents including the beneficiary designation form ". . . [T]his case does as well as any other in pointing out the wisdom of protecting the plan documents rule. Under the terms of the [retirement plan] Liv was William's designated beneficiary. The plan provided an easy way for William to change the designation, but for whatever reason he did not. The plan provided a way to disclaim an interest in the [retirement plan] but Liv did not purport to follow it. The plan administrator therefore did what ERISA 1104(a)(1)(D) required: the documents control and those name the ex-wife."

There are two important principles to be derived from this case. First of all, a division of benefits in a divorce that involves just a waiver (and not the assignment of benefits) cannot be accomplished through a QDRO but in certain circumstances the waiver can be recognized by a plan. Second, to be recognized by a plan the waiver would have to occur in the form of a plan document. Under the facts in the case, DuPont had a procedure included in the document where the spouse could have waived her interest under the plan, but failed to do so. Most plan documents do not contain language permitting a waiver of an interest under the plan but adding such language would appear to be beneficial to plan sponsors since the Supreme Court said its conclusion in this case was based in part on the fact that the plan had a provision allowing waiver that was not utilized.

FIRST IMPRESSION COURT RULING ON PLAN SPONSOR OBLIGATION TO DISCLOSE REVENUE-SHARING AGREEMENTS TO PLAN PARTICIPANTS

The Seventh Circuit Court of Appeals on February 12, 2009, issued the first appellate decision on the issue of whether a plan sponsor has to disclose revenue sharing between the plan's trustee and investment manager. The decision is *Hecker v. Deere & Co.* Under the facts in the case, the John Deere Company named Fidelity Management

Trust Co. (Fidelity Trust) as the trustee under the 401(k) plan. Fidelity Trust also performed recordkeeping services. The parties agreed that the investments made available under the plan would be limited to those offered by Fidelity Management and Research Co. (Fidelity Management), which acted as the investment adviser. Most of the funds were Fidelity mutual funds but a brokerage link permitted investment in 2500 mutual funds outside Fidelity. Revenue was shared between the Fidelity Management and Fidelity Trust. The revenue sharing was not disclosed to plan participants.

Plan participants in a class action sued both Deere and Fidelity arguing that the investments offered charged excessive fees and ERISA was violated because the fees and the revenue sharing was not disclosed to plan participants.

The Seventh Circuit rejected the plan participants' argument that Fidelity became a fiduciary under ERISA. The court pointed out that Deere had negotiated the terms of the arrangement so Fidelity Management as a service provider did not automatically become a fiduciary. In addition, Fidelity Management merely provided professional advice as to investment funds but the ultimate decision remained with Deere.

On a second and equally important point, the Seventh Circuit said under ERISA as currently written there is no obligation to disclose revenue sharing to plan participants: "How Fidelity Research decided to allocate the monies it collected (and about which the participants were fully informed) was not, at the time of the events here, something that had to be disclosed. It follows, therefore, that the Hecker group failed to state a claim against Deere based on the revenue-sharing arrangement and the lack of disclosure about it." The court went on to say likewise Deere did not breach a fiduciary duty to participants because a breach would occur only if a statement was intentionally misleading or a material omission. "The only question is thus whether the omission of information about the revenue-sharing arrangement is material. Deere disclosed to the participants the total fees for the funds and directed the participants to the fund prospectuses for information about the fund-level expenses. That was enough. The total fee, not the internal, post-collection distribution of the fee, is the critical figure for someone interested in the cost of including a certain investment in her portfolio and the net value of that investment."

Third, the court said there was no fiduciary breach by Deere in selecting only a single mutual fund family, Fidelity. "As for the allegation that Deere improperly limited the investment options to Fidelity mutual funds, we find no statute or regulation prohibiting a fiduciary from selecting funds from one management company. A fiduciary must behave like a prudent investor under similar circumstances; many prudent investors limit themselves to funds offered by one company and diversify within the available investment options. As we have noted several times already, the Plans here directly offered 26 investment options, including 23 retail mutual funds, and offered through BrokerageLink 2,500 non-Fidelity funds."

Finally, the court said compliance with ERISA section 404(c) was a sufficient defense even if some of the offered funds charged high administrative fees. Section 404(c) of ERISA (also referred to as 29 USC section 1104(c)) permits a transfer of liability from the plan sponsor to individual participants for investment results as long as the plan sponsor offers a sufficiently broad array of investment choices, information about those choices is made available, and other technical requirements of the 404(c) regulations issued by the Department of Labor are met. "The central question is thus whether the alleged misconduct—the imprudent selection of mutual funds with excessively high fees—falls within the safe harbor. . . . Even if § 1104(c) does not always shield a fiduciary from an imprudent selection of funds under every circumstance that can be imagined, it does protect a fiduciary that satisfies the criteria of § 1104(c) and includes a sufficient range of options so that the participants have control over the risk of loss."

This decision has become extremely controversial and not just among attorneys for plan participants. The Department of Labor, which filed an amicus brief on behalf of the plan participants, has expressed concern that the Seventh Circuit did not recognize a duty by the plan fiduciary to reduce allegedly high management fees. It also took issue with the Seventh Circuit's conclusion that as long as a plan complies with ERISA 404(c) that is a defense to an argument that fees were excessive.

Even though this decision may provide some comfort to plan sponsors, it is likely short lived. The Department of Labor has for many years encouraged greater and greater disclosure of various types of fees assessed to plan participants. In fact, the annual report (Form 5500) for the 2009 plan year will require disclosure of the following types of fees as stated in official Department of Labor guidance:

> "fees and expense reimbursement payments received by a person from mutual funds, bank commingled trusts, insurance company pooled separate accounts, and other separately managed accounts and pooled investment funds in which the plan invests that are charged against the fund or account and reflected in the value of the plan's investment (such as management fees paid by a mutual fund to its investment adviser, sub-transfer agency fees, shareholder servicing fees, account maintenance fees, and 12b–1 distribution fees). Other examples of reportable indirect compensation are finder's fees, float revenue, brokerage commissions (regardless of whether the broker is granted discretion), research or other products or services, other than execution, received from a broker-dealer or other third party in connection with securities

> transactions (soft dollars), and other transaction based fees received in connection with transactions or services involving the plan whether or not they are capitalized as investment costs."

While these requirements were issued by the Department of Labor under the Bush administration, it is expected the Department under the Obama administration will be even more aggressive in ferreting out administrative fees that usually cannot be readily detected by participants or even plan sponsors but which can have a substantial impact on a plan participant's account over the course of many years.

PLAN DOCUMENT REMINDER

Medical practices that utilize retirement plan documents that have been pre-approved by the IRS, known as prototype or volume submitter plans, should contact their benefits advisers on required plan amendments. In general, a version of these pre-approved plans updated for EGTRRA (Economic Growth and Tax Relief Reconciliation Act of 2001) must be adopted by individual employers by April 30, 2010. In addition, a separate plan amendment is required to incorporate the requirements of the Pension Protection Act of 2006. This separate amendment must be adopted by the last date of the 2009 plan year. ■

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.