Proskauer

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in this issue

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A report to clients and friends of the firm

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Editor's Overview

In this month's newsletter we address ten important issues to consider when drafting and amending a summary plan description. You will not find any of these issues directly addressed in ERISA's regulations. Rather, they all have been derived largely by case law. As always, the Newsletter also addresses a multitude of topics under Rulings, Filings and Settlement of Interest, including PPACA Penalties, liability for underfunded pension liabilities; the *Moench* presumption of prudence; fiduciary breach cases and the DOL's new field assistance bulleting providing relief from required annual fee disclosures.

Top 10 Summary Plan Description Issues Not Addressed in the ERISA Regulations

By Heather Stone

The Employee Retirement Income Security Act of 1974 (ERISA) requires employee benefit plans to provide a summary plan description (SPD) to participants and beneficiaries and also sets forth the minimum required information that must be disclosed in an SPD. The following 10 items are what we consider to be the most important issues to consider when drafting and amending an SPD that are not directly addressed in ERISA's regulations.

1. Firestone Language

SPDs, in addition to plan documents, should give the plan administrator discretionary authority to interpret and administer, in its sole discretion, the terms of the plan, and to make factual determinations. If a plan grants a plan administrator discretionary authority to determine eligibility for benefits, courts are required to defer to the plan administrator's interpretation of the plan unless the interpretation is arbitrary and capricious. In the absence of a grant of discretion to the plan administrator, a court may engage in de novo review and substitute its

own view of reasonableness for that of the plan administrator.[1] The importance of including *Firestone* language in the plan document and SPD cannot be overstated. While *Firestone* language is routinely included in new plan documents and SPDs, older SPDs should be reviewed to ensure it is included.

2. Exhaustion Requirements

ERISA's regulations require that SPDs provide a description of the procedures that participants must follow to make a claim and/or appeal for benefits under a plan. The description should specify that the procedures be "exhausted" before a participant can file a lawsuit against the plan. Exhaustion requirements encourage a resolution without resorting to a costly lawsuit and also ensure that the plan administrator's decision is given deference if a lawsuit is filed.

Recently, the Second Circuit held in *Kirkendall v. Halliburton Inc.*[2] that, despite the plan's inclusion of an exhaustion requirement, a participant did not need to exhaust the plan's claims procedures when filing a claim to clarify a right to a *future* benefit because the exhaustion language referred only to actions to recover benefits. One possible way to avoid a similar problem is to make sure that the exhaustion language references all three types of benefit claims available under Section 502(a)(1)(B) of ERISA: (i) recovery of benefits under the plan, (ii) enforcement of the participant's rights under the terms of the plan, and (iii) clarification of the participant's right to future benefits under the terms of the plan.

3. Forum Selection Clause

Generally, ERISA allows a lawsuit to be filed in any venue where the plan is administered, where the breach took place, or where the defendant resides or may be found. By allowing a participant to select any of these venues, ERISA gives participants substantial control over the venue of a lawsuit. In light of the fact that the circuit courts have not reached uniform rulings on many ERISA issues, the broad venue provision also provides an opportunity for plaintiffs to forum shop.

Plan fiduciaries can regain control over the venue in which suits are brought by including a clause in the plan document and SPD that preselects a venue that is convenient for litigation (also known as a forum selection clause). Courts generally will enforce such clauses unless a plaintiff can prove that: (i) the forum selection clause was the result of fraud, undue influence, or overwhelming bargaining power; (ii) the selected forum was so inconvenient that injustice will result or the party will be deprived of its day in court; or (iii) enforcement of the clause would contravene a strong public policy of the forum in which the suit is brought, declared by statute or judicial decision. Courts have declined to uphold such clauses due to inadequate notice of the provision. Plans should therefore consider inclusion of the forum selection clause in the SPD.

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[1] *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 10 EBC 1873 (1989).

[2] *Kirkendall v. Halliburton Inc.*, 707 F.3d 173, 54 EBC 2797 (2d Cir. 2013).

4. Modification of the ERISA Rights Statement

The U.S. Department of Labor (DOL) provides model language for use in SPDs that describes a participant's rights under ERISA, including the right to file a lawsuit when a claim for benefits is denied. While it is generally advisable to use the model language created by the DOL verbatim, in some cases it may be appropriate to modify it. One such instance is the model language that states a participant "may file suit in a state or Federal court" when a benefit claim is denied. At least one court held that the use of this phrase permitted a participant to file a lawsuit without exhausting the claims procedures.[3] Therefore, plan sponsors and fiduciaries should consider modifying the model language to refer to the plan's claims procedures and to require participants and beneficiaries to exhaust the plan's claims procedures before filing a lawsuit.

5. Time Limit for Filing a Lawsuit

ERISA does not provide a statute of limitations for benefit claims. As a result, courts generally apply the most analogous state law statute of limitations. The length of such statutes of limitations varies (sometimes significantly) from state to state. In order to avoid being subject to varying statutes of limitations, plan sponsors and fiduciaries should consider including in their plan documents and SPDs a limitation on the time that a participant may file a lawsuit for benefits after exhausting the claims and appeals procedures. Many courts have enforced these plan-imposed limitations as long as they are published (e.g., in the SPD) and reasonable. Courts have upheld time limits as short as 90 days, although the lengthier the time limit, the more likely that a court will be to uphold it.

6. Subrogation and Reimbursement Language

ERISA regulations require SPDs to clearly identify any circumstances that may result in recovery of benefits by the plan, including the plan's subrogation and reimbursement rights. In the employee benefit plan context, subrogation is the plan's assumption of the legal rights of a plan participant for purposes of recovering a loss from a third party. Reimbursement is the recovery of payment from a plan participant who has recovered amounts from a third party. It is particularly important for self-funded health plans to include specific language regarding subrogation and reimbursement to maximize the protection of the plan's rights. If a plan has an insured benefit, the insurer, and not the plan, will likely look for recovery under these principles.

Plan sponsors and fiduciaries should consider drafting the plan's subrogation and reimbursement rights: (i) as broadly as possible, i.e., to cover all possible types of recovery and claims; (ii) to require first dollar reimbursement from any recovery; and (iii) to make clear that the "make-whole" and the "common fund" doctrines do not apply. The "make-whole" doctrine prevents a plan from claiming a right of subrogation or reimbursement if the plan participant recovers some, but not all, damages, and the "common fund" doctrine requires a contribution to the attorney's fees associated with collecting from the third party.

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[3] *See Watts v. Bellsouth Telecomms, Inc.*, 316 F.3d 1203, 29 EBC 2195 (11th Cir. 2003).

A careful review of a plan's subrogation and reimbursement rights is in order in light of the U.S. Supreme Court's recent decision in *U.S. Airways v. McCutchen*,[4] There, the Court found that the common fund doctrine applied because the plan did not specify that the doctrine did not apply, and thus, limited the plan's reimbursement right.

7. Incorporation of Securities Filings

Retirement plans that offer publicly traded employer stock as an investment option under the plan must provide participants with a prospectus, as required by the Securities Act of 1933. The prospectus must include a summary of certain plan provisions. For convenience purposes, many SPDs incorporate certain Securities and Exchange Commission filings into the SPD/prospectus, and vice versa. This practice, however, has recently come under attack.

Several courts have concluded that a plan fiduciary that incorporates by reference securities filings into a Form S-8 or prospectus is not acting in a fiduciary capacity and, as a result, cannot be liable for a breach of fiduciary duty associated with misrepresentations in those filings simply because of the incorporation.[5] The law is less clear, however, on the viability of an ERISA fiduciary breach claim resulting from a plan fiduciary's decision to incorporate by reference allegedly false or misleading securities filings into an SPD.[6]

In some jurisdictions, employers may be at risk of having to defend fiduciary breach claims based on the incorporation by reference of securities filings into an SPD. It is thus appropriate to consider whether to continue using the SPD as the vehicle for satisfying the prospectus requirements associated with the plan's offering of the company stock fund as an investment option. Plan sponsors should consider instead the feasibility of separating its securities filings from plan communications.

8. SPD Disclaimer

In light of *Cigna v. Amara*,[7] there is no doubt that it is the plan document that controls participants' rights to benefits under the plan. Many SPDs contain language that alerts readers that the SPD is only a summary of plan benefits, and that the underlying plan document (or insurance contract) controls if there are any inconsistencies between the SPD and the plan document. Plan fiduciaries should continue this practice even after Amara to avoid any misunderstanding on the participants' behalf about what document controls in the event of a conflict in the documents, or an omission in the SPD.

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[4] *U.S. Airways v. McCutchen*, 569 U.S. __, 133 S. Ct. 1537 (2013).

[5] See, e.g., *Kirschbaum v. Reliant Energy Inc.*, 526 F.3d 243, 257, 43 EBC 2281 (5th Cir. 2008); *Lanfear v. Home Depot, Inc.*, 679 F.3d 1267, 1283-84, 53 EBC 1261 (11th Cir. 2012).

[6] Compare *In re Wachovia Corp. ERISA Litig.*, 2010 WL 3081359, at *16 (W.D.N.C. Aug. 6, 2010) (dismissing fiduciary breach claim) *with Dudenhoefer v. Fifth Third Bancorp*, 692 F.3d 410, 422-23, 53 EBC 2842 (6th Cir. 2012) (allowing fiduciary breach claim to withstand motion to dismiss), *petition for cert. filed*, 133 S. Ct. 1656 (Dec. 14, 2012).

[7] *Cigna v. Amara*, 131 S. Ct. 1866, 50 EBC 2569 (2011).

9. Allocation of Fees

ERISA does not mandate how fees and expenses associated with, among other things, loans, investments, distributions, and qualified domestic relations orders are allocated to participants and beneficiaries. The regulations only require that SPDs include a summary of any plan provisions that may result in a participant fee. Therefore, plan sponsors and fiduciaries have considerable discretion to determine how the fees are allocated. Plan sponsors should decide on the allocation method and describe it in the plan document as part of the plan design. This ensures that the decision regarding the allocation method is a settlor, as opposed to a fiduciary, function. If the plan documents are silent on the allocation method, the plan fiduciaries would need to choose the allocation, and their choice will be subject to fiduciary standards. Any allocation of fees to participants set forth in the plan document should also be described in the SPD.

10. Circular 230

"Circular 230" are regulations governing practice before the Internal Revenue Service. The regulations contain specific rules regarding the standards for written tax advice. Recent changes to those rules have led to the use of a "Circular 230 Disclaimer" which states that, to the extent the communication contains federal tax advice, that advice cannot be used to avoid federal tax penalties. While including such a disclaimer is not common practice in SPDs, the ramifications for violation of the Circular 230 regulations are so severe that plan fiduciaries may want to consider with their tax professionals whether it is appropriate to do so, or to take other steps to ensure that the SPD cannot be construed as giving tax advice.

Proskauer's Perspective

The 10 tips identified above are derived largely from case law developments on issues not resolved by the regulations. Accordingly, in addition to including the information required by the regulations, plan sponsors and fiduciaries should monitor case law developments and consider amending their SPDs to take those developments into account where appropriate.

Rulings, Filings, and Settlements of Interest

Private Investment Funds May Be Liable For Portfolio Company's Underfunded Pension Liabilities Under First Circuit Ruling

By Ira G. Bogner, Ira Golub, Adam Scoll and Justin Alex

> On July 24, 2013, the U.S. Court of Appeals for the First Circuit ruled in *Sun Capital Partners III, LP v. New England Teamsters and Trucking Industry Pension Fund* (No. 12-2312, 2013 WL 3814984) that a private equity investment fund was engaged in a "trade or business" under ERISA, and, therefore, could be part of a "controlled group" with one of its portfolio companies and potentially liable for its underfunded pension liabilities. This is the first appellate decision to address this question. If an entity (such as a private equity investment fund) is determined to be engaged in a trade or

business and meets certain ownership thresholds, it could be a member of another entity's (such as a portfolio company's) "controlled group." Members of "controlled groups" are jointly and severally liable for certain liabilities of defined benefit pension plans maintained or contributed to by their members, including single employer plan termination liability and multiemployer plan withdrawal liability. In addition, being a member of a "controlled group" may create other administrative issues, such as nondiscrimination testing on a controlled group basis for tax-qualified retirement plans and certain welfare plans. Controlled group members also have to consider the implications of being in a controlled group for purposes of COBRA, health care reform, and Section 409A of the Internal Revenue Code, among other legal requirements. Pending future guidance from the government agencies (in particular, the IRS), the broader implications of this decision for employers and their employee benefit plans remains uncertain. For additional information about this case and its impact, please see our client alert at http://www.proskauer.com/publications/client-alert/investment-funds-potentially-liable-for-portfolio-companys-underfunded-pension-liabilities-under-first-circuit-ruling/

PPACA Penalties Delayed One Year

By James Napoli

> On July 9th, the IRS issued Notice 2013-45 announcing that certain reporting requirements under the Patient Protection and Affordable Care Act ("PPACA") would be delayed for one year. Specifically, Notice 2013-45 states that certain tax Code reporting requirements will not apply for 2014 and, instead, are delayed for one year (presumably meaning that the first reports required to be filed will have to be submitted in January 2016). In addition, because the information otherwise required to be reported is vital to the IRS's ability to assess and collect the employer "play or pay" penalties under PPACA, imposition of the penalties are likewise delayed and will not apply until 2015. Finally, Notice 2013-45 clarifies that additional guidance will be issued later this summer regarding these employer reporting requirements under PPACA.

Specifically there are two reporting requirements that are delayed for one year: (1) Code section 6055 reporting, which requires insurers and self-funded employer plan sponsors to report to the IRS and plan participants whether plan coverage offers minimum essential health coverage in compliance with the employer mandate; and (2) Code section 6056, which requires applicable large employers of 50 or more employees to report to the IRS and plan participants specific information regarding its employer-provided coverage and the employees covered thereunder.

It should be stressed that the IRS transition relief is limited to a delay in the effective date of the Code section 6055 and 6056 employer reporting obligations and delayed imposition of the penalties under the employer mandate. The Notice specifically states that this delay has no effect on other PPACA requirements. Absent guidance to the contrary, therefore, the various

coverage mandates under PPACA continue to apply or will otherwise become effective in 2014. For example, the 90-day waiting period rule is still scheduled to become effective in 2014. Under that rule, a plan cannot enforce a waiting period beyond 90 days of the date an employee otherwise meets the plan eligibility provisions. Likewise, the requirement that an employer must notify its employees of the existence of the public health insurance exchanges (a/k/a "marketplaces") prior to October 1, 2103 remains effective.

What the Delay Means for Employer and Plan Sponsors

Notice 2013-45 is welcome news to many employers who have been struggling with implementing measures aimed at meeting PPACA's employer mandate in an environment where guidance is noticeably lacking. The one-year extension provides employers and plan sponsors a better opportunity to develop the information and administrative systems necessary to comply with the reporting requirements that are being delayed. Significantly, the delay will also give the IRS additional time to develop the guidance that is needed to develop those systems. This one-year delay means that employers should consider the following issues as they consider their compliance strategies:

- Employers will now have time to determine which of its workers will or will not be treated as an employee for purposes of complying with the play or pay mandate in 2015. This is significant, because employers have been struggling to identify and understand how various worker classifications fit within the PPACA standard for being "common law" employees. Many companies retain the services of individuals who are not considered "W-2 employees," but who might be considered "employees" under the common law standard of the proposed pay-or-play regulations. This is a time-consuming and technical analysis and requires a review of various employment agreements and arrangements. The challenges posed by having to potentially re-classify workers due to PPACA requirements has been the topic of many comments filed with the regulatory agencies and is expected to be addressed in final regulations anticipated later this year.

- Employers will not have to go through the exercise of identifying full-time "equivalent" employees nor will they have to deal with the complex rules for determining whether to treat variable hour employees as part-time or full-time for 2014. The pay-or-play proposed regulations include a number of very complicated rules that address the manner with which hours must be counted and the length of coverage that must be offered to individuals who are determined to be "full-time employees." Numerous comment letters were filed with the IRS explaining various issues that need further clarification under the proposed rules and it is anticipated that the final regulations will provide additional guidance.

- Due to the delay, an employer will not need to determine whether its health coverage is affordable or meets minimum value in 2014 for purposes of determining whether the employer is subject to penalty.

Nevertheless, an employer may still wish to have that information available to answer questions from employees seeking information to assist them in making coverage decisions (i.e., whether to elect the employer-provided coverage or coverage through an exchange). As stated in the Notice, an employee who meets certain income requirements will still be eligible for a federal premium subsidy to assist the employee in purchasing coverage through a public exchange, but only if the employer either does not offer coverage or only offers coverage that does not meet the affordability and/or minimum value standards under PPACA. Although it is not clear that an employer is required to provide this information, employers may nonetheless wish to determine whether their health plans are affordable and meet minimum value.

> Many employers who are contributing to multiemployer plans were in the process of contacting those plans to obtain information regarding affordability, minimum value and dependent coverage in order to ensure that under the special 2014 transition rule no penalty would apply with respect to union employees on whose behalf contributions were made to the multiemployer plans. As a result of the delay, there is significantly less urgency associated with those inquiries unless the employer wishes to have such information to answer employee questions regarding whether the coverage offered under the multiemployer plan is affordable and meets minimum value. As the transition rule governing multiemployer plans only applies to 2014, it remains to be seen how the employer mandate will apply to employers contributing to these plans once the employer mandate does take effect in 2015.

A Final Word on the Matter

Employers and plan sponsors now have an opportunity to take their time as they work through the guidance and develop their compliance strategies. At the same time, the PPACA mandate has now attracted a high degree of Congressional scrutiny. There are Congressional hearings on the reasons for the delay and there are also various legislative initiatives working their way through Congress. For example, legislation was introduced in the U.S. Senate that would modify the definition of a "full-time employee" from a 30 hour per week standard to a 40 hour per week standard. If that legislation is ultimately passed and signed into law, employers would have another form of relief from the pay-or-plan mandate.

This is just another way to say that things are changing and developing on nearly a daily basis. Employers and plan sponsors should use the remainder of 2013 and a good part of 2014 to evaluate the new regulatory and any legislative developments and then renew their intense efforts to fully implementing their compliance strategies as we move toward 2015.

Fifth Circuit Applies Moench Presumption of Prudence at Motion to Dismiss Stage

By Michael Spencer

> The Fifth Circuit recently joined four other circuits (the Second, Third, Seventh and Eleventh Circuits) in holding that the presumption of prudence applicable in employer stock fund cases is appropriately applied at the motion to dismiss stage of a litigation. *Kopp v. Klein*, 2013 WL 3449866 (5th Cir. July 9, 2013). Applying the presumption, the Court upheld the dismissal of a claim for fiduciary breach alleging that defendants – various members of Idearc's board of directors and Idearc's officers, the Plan Benefits Committee, and the Human Resources Committee – should not have permitted the continued investment in an employer stock fund and also should have liquidated the plan's employer stock holdings prior to the corporate sponsor's bankruptcy filing. The Court determined that, although plaintiffs had alleged sufficient facts that, if proven, would demonstrate that defendants should have been concerned about the company's financial condition, the allegations were insufficient to create awareness that the company stock was in danger of becoming worthless. To the contrary, the court found that in "the months following the Idearc Defendants' decision to stop offering Idearc stock as an investment option under the Plan and prior to Idearc filing for bankruptcy, there [was] a near total dearth of facts asserted in the complaint indicating the Idearc Defendants had any reason to believe, based on public or nonpublic information that Idearc was on the brink of collapse." The Court also found that the defendants had no duty to liquidate the employer stock based on nonpublic information because doing so could have amounted to a securities law violation.

Second Circuit Dismisses Lehman Brother's ERISA Stock-Drop Action

By Russell Hirschhorn and Joseph Clark

> The Second Circuit recently affirmed the dismissal of former Lehman Brothers employees' fiduciary breach claims relating to their investment in the Lehman Brothers stock fund through their 401(k) plan. *Rinehart v. Akers*, 2013 WL 3491281 (2d Cir. July 15, 2013). As is typical for cases of this type, the complaint included both a claim for imprudence in maintaining the company stock fund and a claim for misrepresentation/material nondisclosure insofar as the plan fiduciaries allegedly failed to communicate the risks associated with investment in the stock fund. With respect to the first claim, consistent with its prior rulings, the Court applied the presumption of prudence and found the presumption could not be rebutted here. The Court stated that, although Lehman's share price exhibited a downward trend overall, the daily stock price fluctuated widely and, in its final hours, the market arguably viewed it as a "going concern." The Court also held that plan fiduciaries did not have a duty to investigate whether there was material, nonpublic information showing that Lehman was in a "dire situation." With respect to plaintiffs' disclosure claim, the Court agreed with the Sixth Circuit and held that incorporation by reference of securities filings into a summary

plan description is a fiduciary communication. The Court nevertheless dismissed the disclosure claim because it found that plaintiffs had failed to identify specific portions of the securities filings that the plan fiduciaries allegedly knew were false or misleading, or that even were false or misleading.

Department of Labor Provides Relief From Required Annual Fee Disclosure

By Steven Weinstein

> The U.S. Department of Labor (DOL) announced today in Field Assistance Bulletin (FAB) No. 2013-02 that it was adopting a temporary enforcement policy that would offer plan administrators temporary relief from certain of the participant disclosure requirements in the form of a one-time "re-set."

Under DOL regulations issued in October of 2010, administrators of calendar year plans were required to disclose to participants for the first time detailed comparative charts of plan investment options by no later than August 30, 2012. The regulations also required that plans had to again furnish these comparative charts "at least annually thereafter," which was defined as at least once in any 12-month period, without regard to whether the plan operates on a calendar or fiscal year basis. Therefore, if a plan administrator provided the comparative chart in August of 2012, it had to again provide the comparative chart by the same day in August of 2013.

The DOL indicated in the FAB that some plan administrators expressed concerns about this timing, in that the comparative charts could not be combined with other annual participant disclosures (e.g., those required at the end of the plan year). This would result in additional costs, and perhaps be less likely to get the attention of plan participants. Under the current DOL regulations, this could only be avoided by plan administrators if they "re-set" the deadline by providing two comparative charts within the same 12-month period (for example, if a plan administrator provided a second chart in January of 2013 and each subsequent January thereafter). However, this would result in additional plan costs that could be passed along to participants.

In response to these concerns, the FAB provides additional flexibility to plan administrators by allowing them to align the comparative chart deadline with other plan disclosure and notice deadlines in a cost efficient manner. Specifically, if the plan administrator reasonably determines that doing so will benefit plan participants and beneficiaries, it may provide the 2013 comparative chart no later than 18 months after the first comparative chart was provided (i.e., the one provided no later than August 30, 2012). Thus, for example, if the first comparative chart was furnished on August 9, 2012, the DOL will take no enforcement action regarding the timeliness of the next comparative chart (which would otherwise have been due by August 9, 2013) if it is furnished by February 9, 2014.

For plan administrators that already furnished the 2013 comparative chart, the FAB permits such plan administrators to furnish the 2014 comparative chart using the same re-set rule that is available for the 2013 comparative chart.

The DOL noted that the relief provided by the FAB would not relieve plan administrators from other obligations under the DOL regulations relating to participant access to updated investment-related information. However, it did note that it is considering permanently revising the current requirement of a fixed deadline for furnishing the comparative charts to give plan administrators more flexibility. Specifically, it is considering replacing the hard deadline at the end of the 12-month "at least annually" period with a 30-day or 45-day window during which such charts could be provided.

No Fiduciary Status For 401(k) Plan Service Provider

By Page W. Griffin

> John Hancock Life Insurance Company is the most recent 401(k) plan service provider to prevail in a case by the plaintiffs' bar asserting ERISA fiduciary breach claims based on allegations that it charged excessive 401(k) plan fees and received excessive revenue sharing payments. *Santomenno v. John Hancock Life Ins. Co.*, No. 2:10-cv-01655 (WJM), 2013 WL 3864395 (D.N.J. July 24, 2013). A federal district court in New Jersey concluded that JHLIC was not acting as a fiduciary in connection with the service provider fees it charged to various 401(k) plans because a service provider "owes no fiduciary duty with respect to the negotiation of its fee compensation." The fees were negotiated at arms' length and fully disclosed. The court similarly concluded that JHLIC was not a fiduciary with respect to the revenue sharing payments because service providers "do not become fiduciaries merely by receiving shared revenue," especially when such payments are, as in this case, fully disclosed. Lastly, the court concluded that JHLIC was not a fiduciary by virtue of having offered a menu of investment options from which plan trustees could select and make available for investment by plan participants.

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits, Executive Compensation & ERISA Litigation Practice Center. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

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