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Briefly on Benefits (August 2009)

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IRS Scores Another Win in 419A Case
by Ben Wells

On July 21st, the U.S. Court of Appeals for the 2nd Circuit affirmed the Tax Court's decision in *B.R. DeAngelis M.D. P.C. v. Commissioner*, (2nd Cir., Case No. 08-1143-AG). The case involved payments to a "Severance Trust Executive Program Multiple Employer Supplemental Benefit Plan and Trust." This plan was promoted as a welfare benefits fund that was part of a 10-or-more employer plan described in Code Section 419A(f)(6).

These plans provide "severance" payments which are (according to the IRS) in actuality intended to be a subterfuge to pay excess cash to the owner -- after funding it through life insurance policies. The arrangement purportedly qualifies for a deduction under Code Section 419A(f)(6) because it consists of ten or more separate employers.

The IRS has for many years viewed these arrangements as a scam and aggressively pursues enforcement against them. However, we continue to find instances where clients have had such plans promoted to them. If you are approached by a promoter about such an arrangement -- be very cautious!

DOL Issues 403(b) Plan Form 5500 Reprieve
by David Whaley

While the march to make 403(b) Plans look and act more like 401(k) Plans continues, the DOL issued guidance on the Form 5500 requirements to make this move easier. On January 1, 2009, new Final Treasury Regulations became effective which detailed multiple requirements imposed on 403(b) Plans. In concert with those Treasury Regulations, the Department of Labor indicated that the limited reporting exemption for 403(b) plans would disappear for the 2009 Plan Year - requiring, among other matters, 403(b) plans with more than 100 participants to file audited financial statements with their 2009 Form 5500.

Since, historically, there has been very little (if any) tracking of what investment vendors held a 403(b) plan's contributions, there was a concern about how to complete the Form 5500 and perform an audit of the plan's assets. The DOL issued a reprieve in Field Assistance Bulletin 2009-02 and stated that only contracts or accounts that are currently offered under the 403(b) plan are considered "plan assets" subject to the reporting and audit requirements. The DOL stated that a contract or account is not currently offered under a 403(b) plan - and is therefore exempt from the reporting and audit requirement - if:

1. It was issued to a current or former employee before Jan. 1, 2009;

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2. The employer ceased to have any obligation to make (and in fact did not make) contributions to the contract or account before Jan. 1, 2009 (Note: This includes salary reduction contributions made at the election of an employee);

3. All of the rights and benefits under the contract or account are legally enforceable against the insurer or custodian by the individual owner of the contract or account without employer involvement; and

4. The account or contract is non-forfeitable/fully vested.

As a result of the Final Treasury Regulations, many employers reduced the number of their 403(b) investments vendors. Thus, those vendors who were removed as a current investment option before January 1, 2009 will likely satisfy the requirements of this exemption test - meaning these vendors will not need to be listed on Form 5500 and auditors will not need to take these investments into account in preparing their 403(b) audit. In addition, if an individual's only investments are within these excepted accounts or contracts, the employer may not need to count that individual as a participant. This will have the affect of reducing the number of plan participants and, therefore, may enable an employer to file as a small plan instead of a large plan - keeping from the need to perform an audit.
More changes are coming for 403(b) plans - including a prototype plan program and a favorable determination letter program. Thus, this will be a changing area of benefits law which we - and all 403(b) plan sponsors - will be watching in the months and years to come.

A Benefit Claim Denial Must Be More Than a Mere Conclusion - a Reminder from the 7th Circuit
by Mark Bongard

Have you ever had a benefit claim denied? If so, was the explanation thorough and well reasoned or did it state conclusions without explanation? A case from the 7th Circuit decided July 23, 2009 (*Love v. National City Corporation Welfare Benefits Plan*, No. 07 C 50048) reminds us that ERISA requires a claim denial to explain why the claim is denied.

Nancy Love worked for National City Corporation for 20 years before experiencing medical problems. She was diagnosed with multiple sclerosis and obtained short term disability and then long term disability benefits.

The plan had a two part definition of disability that is fairly typical. For the first two years, you only have to be disabled from performing your own job or another job with the company having equivalent duties. After two years, the plan required that the disability:

makes you unable to perform the duties of any other occupation for which you are, or could become, qualified by education, training or experience.

Ms. Love survived the application of this more stringent second prong of the disability definition, but not for long. After she received the disability benefit for three years, a doctor working for the claims administrator, Liberty Mutual, determined that she did not satisfy the plan's definition of disability. The first denial letter concluded there was no objective evidence showing that Ms. Love had a functional limitation. However, the Court noted that there was other evidence in the file, but that the denial letter failed to explain why that evidence was not probative.

Ms. Love filed an administrative appeal with the claims appeal committee. She also submitted additional evidence from three different doctors each asserting she had functional limitations. The claims appeal

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committee referred the claim and the additional evidence to a different doctor, whose conclusion agreed with the first doctor. The second denial again failed to explain why the appeal was denied and why the additional medical evidence submitted by Ms. Love was not convincing.

Ms. Love went to court and lost on summary judgment. She appealed to the 7th Circuit and received a better outcome, but still did not get complete satisfaction.

Ms. Love tried to convince the Court that the recent Supreme Court case of *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343 (2008) changed the standard of review applicable to denied benefit claims. The Court explained that *Glenn* merely provided that when the identity of the claim payer and the claim decider is the same then that is a factor to consider. But the Court went on to indicate that:

We continue to apply an arbitrary-and-capricious standard to denial-of-benefits claims after Glenn.

Ms. Love also tried to use her approved Social Security Disability claim as leverage in her claim for her employer's long term disability benefits. The Court noted that the definition of disability in the plan was different from the definition of disability under Social Security. Therefore, Social Security Disability was not dispositive relative to her claim under the plan.

The Court did, however, rule that both claim denials failed to meet the ERISA standard under the statute and Department of Labor regulations to provide specific reasons for the denial. Therefore, the plan's decision to deny benefits was arbitrary.

Ms. Love still did not get full satisfaction. The Court determined that the evidence showed there was a possibility that the denial could be supported. Therefore, the Court remanded the case to the claims administrator for a more complete investigation of whether Ms. Love meets the plan definition of disability.

The moral of this tale is that a little exposition can save some time and effort in the long run - and result in compliance with ERISA.

IRS Letter Clarifies "Medical Expenses" - Demonstrates Problems for HSA Auditors
by David Whaley

In response to a request, the IRS detailed the rules relating to what Over-the-Counter (OTC) expenses qualify as "medical expenses" under Section 213(d) of the Code. While the contents of the IRS opinion are not surprising (it concluded that food is never a medical expense, personal items such a compression socks may be a medical expense, and items that no have other purpose than to treat a disease, illness or medical or physical defect are a medical expense), the application utilized in reaching its conclusion details a "pandora's box" of problems for IRS auditors reviewing the expenses claimed as reimbursable from a Health Savings Account (HSAs).

Commentators have suggested that fiduciaries and other plan administrators of Flex Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) should understand the rationale behind the IRS' decision so as to determine whether "dual-purpose" expenses are in fact medical expenses under Code section 213(d) entitled to reimbursement. Some of these decisions can be challenging for a disinterested fiduciary (Sunglasses with "blank" non-prescription lenses are generally not reimbursable but this expense could be reimbursable for an individual who has and eye condition - such as glaucoma - and must have protection from the sun's UV rays). However, if an individual who maintains their own HSA is asked to make the same decision - there is little likelihood that any claim for reimbursement will not be paid. This fact will

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likely lead IRS auditors of an individual's HSA to challenge reimbursements and apply the terms of this IRS opinion. This shifting of the responsibility from fiduciaries to IRS agents will likely result in tax-preferences for some very questionable expenses.

Senator Blanche Lincoln Introduces ESOP Liberalization Bill
by Ben Wells

On August 7th, Senator Blanche Lincoln (D-AR) introduced S.1612, the "ESOP Promotion and Improvement Act of 2009."

This Act would make several changes to the laws regarding employee stock ownership plans.

- It repeals the 10% penalty tax on distributions by S corporations to participants from current earnings;
- It clarifies that dividends paid by C corporations on ESOP stock are not a preference item in calculating corporate alternative minimum tax;
- It permits sellers of stock to an ESOP maintained by an S corporation to make use of tax deferred re-investment under Section 1042 of the Code;
- It clarifies ownership rules for determining who is a 25% or more owner for purposes of Section 1042;
- It allows the proceeds of a 1042 transaction to be invested in mutual funds consisting of U.S. operating company securities; and
- It clarifies that an entity is eligible for certification as a small business by the SBA if it is acquired by an ESOP.

Although this bill is a long way from passage, its introduction by an influential Senator from the majority party (in addition, the bill is co-sponsored by Senator Mary Landrieu (D-LA)) shows that the ESOP community continues to have influence in Washington. We will keep you posted on the progress of this bill.

Code Section 414(x)
by Ben Wells

IRS and Treasury have issued an announcement (Notice 2009-71) that they will soon issue guidance on "eligible combined plans" under Section 414(x) of the Internal Revenue Code. This section allows an employer to maintain both a defined contribution plan and a defined benefit plan on a combined basis, thus potentially reducing the administrative burdens and costs of maintaining two separate plans.

Section 414(x) was added by the Pension Protection Act of 2006 and revised by the Worker, Retiree and Employer Recovery Act of 2008.

To meet the requirements of Section 414(x), an "eligible combined plan" must be established by "a small

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employer." For this purpose, a small employer generally means an employer who employed an average of fewer than 500 employees during the preceding calendar year.

Code Section 414(x) becomes effective for plan years beginning after December 31, 2009. More details will be provided as they become available.

Blue Plate Special - Ohio Joins States Mandating Cafeteria Plans
by Mark Bongard

With the passages of H.B.1 on July 17, 2009, Ohio joined a growing number of states using cafeteria plans as a means for expanding health insurance coverage. The new law will go into effect in stages, based on the size of the employer. Its implementation is contingent on receiving certain favorable determinations from the Internal Revenue Service ("IRS") and the Department of Labor ("DOL") regarding the application of federal law to the actions required under the statute.

First: What is a Cafeteria Plan?

A cafeteria plan is a creature of Internal Revenue Code (IRC) § 125. It allows an employee to elect between current taxable cash and non-taxable qualified benefits, like health insurance. There is panoply of requirements that must be met to obtain this tax benefit. Among them are:

- There must be a written plan document;
- Employee elections must be made before the period to which the elections apply, which is generally a 12 month plan year (most often a calendar year); and
- Employees' elections must be irrevocable for the period to which they relate, except under very limited circumstances.

A cafeteria plan itself is not necessarily an ERISA covered plan. A cafeteria plan is a funding mechanism through which qualified benefits may be purchased with pre-tax dollars.

Second: What Does the New Law Require?

The new Ohio law will apply to employers of 10 or more employees who do not otherwise offer health insurance coverage in a permitted manner to their employees. A covered employer will have to adopt a cafeteria plan under IRC § 125 to allow its employees to pay for health insurance coverage through a salary reduction agreement. This does not, however, mean that the covered employer must obtain group health insurance. Instead, the new law contemplates that the employees could obtain their own individual health insurance policies and make premium payments for them on a pre-tax basis through the mandated cafeteria plan. Such a paradigm raises questions under federal law governing benefit plan arrangements, but more on that later.

The new law will apply in stages as follows:

- For employers with more than 500 employees, by the later of January 1, 2011 or 6 months after the superintendent of insurance adopts rules.
- For employers with 150-500 employees, by the later of July 1, 2011 or 12 months after the superintendent of insurance adopts rules.

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- For employers with 10-149 employees, by the later of January 1, 2012 or 18 months after the superintendent of insurance adopts rules.

Third: What are the Legal Issues Anticipated by the Statute?

Provisions in the new law itself anticipate there could be federal legal issues associated with its implementation. In fact, implementation of the new statutory rules is contingent upon the superintendent of insurance receiving a written confirmation from relevant government authorities (like the IRS and DOL) that employers will be able to establish cafeteria plans in accordance with federal law consistent with the requirements of the Ohio statute and that individual policies purchased by employees through the cafeteria plans will not have to comply with the group market rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The authors of this new Ohio law may have read the preamble to final and temporary Treasury regulations on HIPAA that provide:

If an employer provides coverage to its employees through two or more individual policies, the coverage may be considered coverage offered in connection with a group health plan and, therefore, subject to the group market provisions under HIPAA. A determination of whether there is a group health plan depends on the particular facts and circumstances surrounding the extent of the employer's involvement.

There could also be issues regarding coverage under ERISA, other tax code provisions affecting group health plans and the HIPAA privacy and security rules. It is beyond the scope of an article such as this to provide detailed analysis regarding the issues raised. Suffice it to say that the drafters of this legislation were aware there were issues and wanted to get them settled from the relevant federal authorities before implementation of the new cafeteria plan requirement goes live. It will be interesting to see how all of this develops and I am sure we will all gain new insights from the responses the Ohio superintendent of insurance receives from the federal government to its inquiries under this new law.