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This newsletter briefly discusses several recent developments in employee benefits and executive compensation that may be of interest. 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

Government Defines "Grandfathered Health Plan Coverage" Under Health Care Reform

Treasury, DOL and HHS, the three agencies responsible for administering the recent Health Care Reform legislation, have combined to issue regulations that define what plans are "grandfathered" under Health Care Reform.

Health Care Reform mandates that employer-based health plans meet certain requirements. Many of these requirements are not applicable to plans that provide "grandfathered health plan coverage," which generally means any plan *coverage* in which any individual was enrolled on March 23, 2010, the date of enactment of Health Care Reform. The mandates of Health Care Reform, summarized on the attached chart, are likely to increase the costs of employer-provided health benefits. Since plans that provide "grandfathered" coverage are not subject to all of the mandates, maintaining grandfather status could result in significant cost savings for employers.

Since the enactment of Health Care Reform we have been concerned that any change to an employer-based health plan, particularly changes to the detriment of the participants, could result in a loss of grandfather status. The regulations confirm this result, generally taking the position that changes in the plan's cost structure to the detriment of the employees and changes of benefits to the detriment of the employees will forever result in the loss of grandfather status for those benefit packages that are affected. Further, the regulations will result in some plan enhancements not being afforded grandfather status. The regulations take a particularly hard line on insured plans and we believe will result in employers' being less able to use the leverage of shopping for another insurer in order to gain an advantage with the existing carrier.

Specifically, the regulations provide that the following actions would implicate a plan's grandfather status:

- A new policy, certificate or contract of insurance is not grandfathered. The new policy must meet the requirements of Health Care Reform in full. Therefore, a change in carriers will result in an insured plan's losing grandfather status, even though the new contract may include substantially the same coverages and cost structure (or a less expensive cost structure) than the old contract.
- The elimination of all or substantially all benefits to diagnose or treat a particular condition results in the loss of grandfathered status.
- Any increase in a participant's percentage cost sharing requirement results in the loss of grandfather status.
- Increases in a fixed-amount cost sharing requirement (other than a co-payment) that, since March 23, 2010, in the aggregate exceed "medical inflation" plus 15 percentage points, result in the loss of grandfather status. Medical inflation is the increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) as determined by the DOL.
- Increases in a fixed amount co-payment that, since March 23, 2010, in the aggregate exceed the greater of medical inflation plus $5.00 or medical inflation plus 15 percentage points, result in the loss of grandfathered status.

- Decreases in the employer's contribution rate, whether expressed as a percentage or formula, towards the cost of any tier of coverage for any class of similarly situated individuals that, since March 23, 2010, in the aggregate exceed five percentage points, result in the loss of grandfathered status. The employer's contribution rate is based on the amount of employer contributions compared to the total cost of coverage.
- Decreasing or adding an annual limit.

Generally, the status of coverage as grandfathered applies to participants who were enrolled in such coverage as of March 23, 2010, and their family members who enroll thereafter. Grandfather status will also apply to new employees and their family members. However, grandfather status with respect to a new enrollee is lost if:

- Employees are transferred into new coverage from coverage in which the employees were covered on March 23, 2010;
- Treating the change in terms from the old coverage to the new coverage as an amendment to the old coverage, such change in terms would result in the loss of grandfather status as described above; *and*
- There is no "bona fide employment-based reason" for the transfer.

Plans must disclose to participants that the plan believes it is a grandfathered plan. Model language is included in the regulations. Such disclosures must be in place prior to the beginning of the first plan year that begins after September 23, 2010. The statement must appear "in *any* plan materials provided to a participant or beneficiary describing the benefits provided." Plans must also maintain records documenting their terms as of March 23, 2010, and other documents necessary to verify grandfather status.

These rules are applied separately to each "benefit package." Thus, if a plan offers a PPO and an HMO and the cost structure for the PPO changes, such change would result in the loss of grandfather status only for the PPO.

The Government's announcement of the regulations claims that it "makes good on President Obama's promise that Americans who like their health plan can keep it" and further notes:

> "The rule we are announcing today will allow employers to make routine and modest adjustments to co-payments, deductibles and employer contributions to their employees' premiums without forfeiting grandfather status. This flexibility will encourage employers to continue offering health coverage to their employees and help to ensure coverage for all Americans."

We are skeptical that grandfather status gives employers the flexibility they need, and we believe that grandfather status will not be easily maintained. Indeed we believe that grandfather status will eventually and inevitably be lost for virtually every plan. Further, we believe that grandfather status may be lost in part for plan enhancements that unambiguously favor employees. Consider the following:

- A new "benefit package" that is added after March 23, 2010, is not grandfathered and is therefore subject to the mandates for non-grandfathered plans. Accordingly, if an employer adds a new benefit package, a portion of the plan will be subject to all of the mandates and a portion will not.
- The term "benefit package" is not defined. Although we believe it likely refers to broad coverage options within a plan, it could refer to each detail of coverage. If the latter view is correct, then, for example, the addition to a formulary of a previously uncovered drug would be a new benefit package in which a participant was not enrolled on March 23, 2010, and would therefore be subject to all of the Health Care Reform mandates.
- Employers have for a generation been gradually shifting costs for health care coverage to employees and there is no reason to believe that trend will stop. For those plans for which that trend will continue, loss of grandfather status is inevitable.
- The loss of grandfather status is permanent. There is no way to regain it once it is lost. Decisions regarding cost sharing and benefit design are made yearly or prior to the beginning of a new contract term and may be changed as experience dictates. Thus, the analysis of whether grandfather status is worth maintaining is a comparison of the long-term effects of the loss of such status to the short term effects of changes in cost sharing and plan design.

PHS Act Section	Provision	Statutory Effective Date (PY Beginning on or After)	Application to Grandfathered Health Plans
§2701	Fair health insurance premiums	January 1, 2014	Not applicable
§2702	Guaranteed availability of coverage	January 1, 2014	Not applicable
§2703	Guaranteed renewability of coverage	January 1, 2014	Not applicable
§2704	Prohibition of preexisting condition exclusion or other discrimination based on health status	January 1, 2014 For individuals under age 19, September 23, 2010	Applicable to grandfathered group health plans and group health insurance coverage.
§2705	Prohibiting discrimination against individual participants and beneficiaries based on health status	January 1, 2014	Not applicable
§2706	Nondiscrimination in health care	January 1, 2014	Not applicable
§2707	Comprehensive health insurance coverage (applicable to issuers in the individual and small group markets)	January 1, 2014	Not applicable
§2708	Prohibition on excessive waiting periods	January 1, 2014	Applicable
§2709	Coverage for individuals participating in approved clinical trials	January 1, 2014	Not applicable
§2711	No lifetime or annual limits	September 23, 2010	Applicable
§2712	Prohibition on rescissions	September 23, 2010	Applicable
§2713	Coverage of preventive health	September 23, 2010	Not applicable
§2714	Extension of dependent coverage until age 26	September 23, 2010	Applicable
§2715	Development and utilization of uniform explanation of coverage documents and standardized definitions	September 23, 2010 **Statutory delayed applicability date: the first disclosure is not required before March 23, 2012.	Applicable
§2716	Prohibition on discrimination in favor of highly-compensated individuals (not applicable to self-insured plans)	September 23, 2010	Not applicable
§2717	Ensuring quality of care	September 23, 2010 **Statutory delayed applicability date: the Departments must develop reporting requirements implementing §2717 by March 23, 2012.	Not applicable
§2718	Bringing down cost of health care coverage (for insured coverage)	September 23, 2010	Applicable to insured grandfathered plans
§2719	Appeals process	September 23, 2010	Not applicable
§2719A	Patient protections	September 23, 2010	Not applicable

Government Begins Instituting Health Care Reform Early Retiree Reinsurance Program

The Health Care Reform legislation provides government subsidies for employers and employer-based health plans that provide health benefits for early retirees and their spouses. The Department of Health and Human Services issued regulations in May that set forth the requirements for the program. In general, those requirements are:

- The employer must submit an application to participate in the program.
- The health plan must include programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with chronic and high-cost conditions.
- The plan must be certified by HHS.
- There must be an agreement between the employer and the insurer/plan that permits the disclosure to HHS of information necessary for compliance with the program.
- The government subsidy must be used to reduce the employer's premiums or costs or to reduce the participants' premiums, co-pays, deductibles, co-insurance or other out-of-pocket costs.

HHS has developed an application, which may be accessed at www.hhs.gov/ociio/Documents/application.pdf and answers to frequently asked questions may be accessed at www.hhs.gov/ociio/Documents/application_faq.pdf. Applications will not be accepted until the end of June, but funding for the program is limited to $5 billion and applications will be processed in the order they are received. Therefore, plan sponsors that are contemplating applying to the program should begin to work through the application as soon as possible so that application may be made when the program opens.

Supreme Court Holds That An Award Of Attorneys Fees May Be Made To A Non-Prevailing Party Under Erisa

Section 502(g)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA") permits a court to order a party in a lawsuit under ERISA to pay "reasonable attorney's fees and costs" to the other party. The Fourth Circuit Court of Appeals interpreted Section 502(g)(1) to permit attorneys' fees and costs to be awarded only to a "prevailing party." In *Hardt v. Reliance Standard Life Insurance Company,* the Supreme Court held that an award of attorneys' fees may be made to either party as long as it has achieved some degree of success on the merits, even though it may not have fully prevailed.

BACKGROUND

Hardt v. Reliance resulted from Bridget Hardt's claim for disability benefits under an insured long term disability plan sponsored by her employer. The insurer, The Reliance Standard Life Insurance Company, decided whether a claimant qualified for benefits and paid any benefits awarded under the plan. Hardt made her initial claim during August 2003. The insurer denied her claim. Hardt filed an administrative appeal and the insurer reversed in part, finding that Hardt was totally disabled only from her *regular* occupation and was therefore entitled to temporary disability benefits for 24 months. In February 2005, the Social Security Administration granted Hardt's application for disability benefits.

About two months later, Reliance told Hardt that her temporary disability benefits would expire at the end of the 24 month period and explained that only individuals who are "totally disabled from all occupations" were eligible for additional benefits. Reliance also demanded a refund of some of the temporary disability benefits because of Hardt's receipt of Social Security disability benefits. Hardt paid the refund to Reliance. Hardt filed another administrative appeal with Reliance contesting the expiration of benefits. During March 2006, Reliance affirmed its decision to terminate her benefits.

Hardt sued Reliance in Federal district court. Hardt and Reliance filed cross-motions for summary judgment which the court denied. In rejecting Reliance's motion, the court found that Reliance's decision to deny benefits was not based on substantial evidence.

In rejecting Hardt's motion, the court found "compelling evidence" in the record that Hardt was totally disabled. Although inclined to rule in Hardt's favor, the court gave Reliance another opportunity to reconsider the claim. The court instructed Reliance to act on Hardt's application by adequately considering all the evidence and warned that a judgment would otherwise be issued in favor of Hardt. After conducting the review, Reliance reversed and awarded Hardt full disability benefits.

Hardt requested attorney's fees and costs under Section 502(g)(1). The court assessed her request under the Fourth Circuit's three-step framework. Step one asks whether the fee claimant is a "prevailing party." Step two determines whether an award of attorneys' fees is appropriate by examining five factors. If appropriate, the attorneys' request is reviewed and limited to a reasonable amount.

The court concluded that she was a "prevailing party" and after applying the other steps, the court awarded attorneys' fees to Hardt. The Fourth Circuit reversed on the basis that

Hardt was not a "prevailing party," which, under Fourth Circuit precedent, required that she obtain an enforceable judgment on the merits or a court ordered consent decree. It found that the district court's order that Reliance reconsider the claim did not actually require Reliance to award benefits to Hardt so that it was not an enforceable judgment.

SUPREME COURT HOLDING

The Supreme Court reviewed two questions. First, did the Fourth Circuit correctly conclude that Section 502(g)(1) permits a court to award attorneys' fees only to a "prevailing party?" Second, did the Fourth Circuit correctly identity the circumstances under which a fee claimant is entitled to attorney's fees under Section 502(g)(1)? The Supreme Court reversed the Fourth Circuit and held that Section 502(g)(1) does not impose the condition that the fee claimant be a "prevailing party." Justice Thomas observed that the words "prevailing party" do not appear in Section 502(g)(1) and nothing else in Section 502(g)(1) purports to limit an award of attorneys' fees to a "prevailing party."

Addressing the second question, the Court reasoned that a fee claimant must show some degree of success on the merits, other than a trivial or procedural success, before a court may award attorney's fees under Section 502(g). The Supreme Court found that the standard for a fee award was met because Hardt persuaded the district court that she did not receive the type of review that ERISA required, the district court found compelling evidence of total disability, the district court was inclined to rule in her favor and, absent an adequate review, judgment would be entered in Hardt's favor.

The Internal Revenue Service Begins 401(k) Compliance Questionnaire Program

In its Retirement News for Employers, Volume 7, Spring 2010 (available at www.irs.gov), the Internal Revenue Service reports that the IRS Employee Plans Compliance Unit (EPCU) has sent letters to 1,200 employers sponsoring 401(k) plans asking them to complete a 401(k) Compliance Check Questionnaire. According to the IRS, the Questionnaire was developed because 401(k) plans have assumed a critical role in the private pension system in the United States amounting to nearly half a million 401(k) plans covering 50 million participants.

The IRS website states that the letter is a "compliance check" and does not constitute an audit or investigation. However, the IRS states that a failure to respond or to provide complete information will result in further action or examination.

The EPCU will use a secure website to collect responses. Information is sought on the following topics: demographics; plan participation; employer and employee contributions; top-heavy and nondiscrimination testing; distributions and plan loans; other plan operations; automatic contribution arrangements; Roth features; and plan administration. Specific information is also requested on the following matters: the number of other qualified and nonqualified retirement plans sponsored by the employer sponsor; whether a determination letter was requested for the plan; an explanation of those employees who are excluded from the plan; matching contributions; top-heavy status; information on ADP/ACP testing and the correction of failed tests; plan loan usage and procedures; hardship distributions; 415 violations; losses due to fraud or theft; investment in employer stock; usage of the Employee Plans Compliance Resolution System, including comments to improve that system; whether the IRS Fix-It Guide has been used; and what difficulties the plan faces when complying with the requirements of the Internal Revenue Code.

Many of the questions require that the plan sponsor's representative who completes the Questionnaire have appropriate expertise, including an in-depth understanding of the terms of the plan and its operation. He or she may need to consult with other parties who provide services in connection with the plan (for example, third party record-keepers and legal counsel).

Comment: To the extent that any issue relating to the plan or errors in plan administration are uncovered during the completion of the Questionnaire, prompt and appropriate correction should be considered to maintain the "qualified" status of the plan.

Final Regulations Under Code Section 401(a)(35) Diversification Requirement For Certain Defined Contribution Plans

The Pension Protection Act of 2006 added Section 401(a)(35) to the Internal Revenue Code, which establishes an additional qualification requirement for defined contribution plans, (other than certain ESOPs and single participant plans) that hold "publicly traded employer securities."

Code Section 401(a)(35) became effective for plan years beginning after December 31, 2006, except to the extent that a delayed effective date applied. In Notice 2006-107, the Internal Revenue Service ("IRS") issued interim Code Section 401(a)(35) guidance, which was followed by proposed regulations. On May 19, 2010, the IRS issued final regulations

under Code Section 401(a)(35). The final regulations are effective and applicable for plan years beginning on or after January 1, 2011. Prior to the regulatory effective date, a plan is permitted to rely on Notice 2006-107, the proposed regulations or the final regulations.

Generally, compliance with Code Section 401(a)(35) requires that a covered plan must provide that a participant who has completed at least three years of service, an alternate payee with respect to such a participant or a beneficiary of a deceased participant must be allowed to diversify his or her account attributable to employer contributions out of employer stock, and a participant, an alternative payee or a beneficiary must be able to diversify his or her account attributable to employee contributions (including rollovers and elective deferrals) out of employer stock, regardless of the participant's length of service.

There must be at least three other investment options, each of which is diversified and has materially different risk and return characteristics. An investment option that satisfies the broad range of investment alternatives under the DOL Section 404(c) regulations is treated as diversified and having materially different risk and return characteristics. A plan may limit the time for divestment and reinvestment of the proceeds to periodic, reasonable opportunities which occur no less frequently than quarterly.

Generally, no restrictions or conditions may be imposed directly or indirectly with respect to the investment of employer securities that are not imposed on the investment of other assets of the plan.

The primary difference between the proposed regulations and the final regulations relates to the holding of employer stock in commingled investment funds, such as mutual funds, common, collective or pooled investment funds and certain insurance company pooled investment funds. Although these funds may continue to hold some stock of the plan sponsor, they are treated as not holding employer stock (and, therefore, the diversification rule does not apply) if (1) the investment in employer stock is held in a fund under which there are stated investment objectives and the investment is independent of the employer and any affiliate and (2) the aggregate value of the employer stock held in the fund does not exceed 10 percent of the total value of all of the fund's investments. ■

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