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# Employee Benefits Bulletin

A review and analysis of recent developments affecting employee benefits



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# SUPREME COURT RULES THAT BENEFICIARIES MUST BE ALLOWED TO ELECT COBRA EVEN WHEN OTHER HEALTH COVERAGE EXISTS

A recent unanimous Supreme Court decision, *Geissel v. Moore Medical Corp.*, resolved a long-standing split between several circuit courts of appeals. As a result, a bright line has been drawn for employers to use when evaluating whether a qualified beneficiary may be denied COBRA continuation coverage due to coverage under another health plan. Briefly, even if a qualified beneficiary has other coverage at the time a COBRA election is made, the plan may not deny COBRA coverage on the grounds that the beneficiary is covered by another group health plan.

- Having other health coverage at the time of COBRA election does not permit employer to cancel COBRA coverage.
- Similar treatment of Medicare eligible beneficiaries should be anticipated.

In the *Geissel* case, Geissel had health care coverage from his employer, Moore Medical, and also had coverage under his wife's employer's plan. When Geissel's employment was terminated with Moore, he elected COBRA coverage under that plan, while maintaining his coverage under his wife's plan. After approximately six months of COBRA coverage, for which Geissel paid his premiums, the plan administrator informed Geissel that he was never eligible for COBRA coverage due to the coverage he had under his wife's plan, that he would be reimbursed for the premium payments he had made, and that the bills he had submitted for payment would be returned.

The Eighth Circuit Court of Appeals agreed with Moore that COBRA coverage may be terminated when the individual has other coverage on the day of the election, so long as the termination leaves no "significant gap" in coverage. However, the Supreme Court found that the "significant gap" approach was not supported by the statutory language. Furthermore, the Court found that requiring a court to evaluate the significance of a gap between two kinds of coverage is an unsuitable task for a court absent a clear Congressional mandate.

The Supreme Court instead chose to apply the "plain language" reading of the statute: COBRA coverage may

be terminated on "the date on which the qualified beneficiary *first becomes, after the date of the election*… covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary" (emphasis added). The Court interpreted the language "first becomes, after" as requiring the change in coverage status to occur after the date of the election.

This decision has the immediate impact of requiring COBRA notices to all qualified beneficiaries upon the occurrence of a qualifying event, regardless of the existence of other health care coverage. In other words, those employees who have dual coverage prior to the time of the COBRA election must be allowed to elect to continue coverage under their employer's plan, in effect maintaining the *status quo* of dual coverage if they choose.

In addition, prudence dictates that COBRA notices go out to, and elections be accepted from, all employees who are retiring and their covered dependents, even if a retiree is covered by Medicare. The section of the statute interpreted in *Geissel* refers not only to coverage under another group health plan, but also to entitlement to Medicare. Therefore, employers and plan administrators who might not have provided COBRA notices, or may have routinely denied coverage, to beneficiaries over age 65 should consider changing this practice. Reading the statute together with the *Geissel* decision, COBRA coverage may be terminated only when the qualified beneficiary becomes entitled to Medicare coverage *after* electing COBRA coverage.

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## NEW RULES FOR HIPAA CERTIFICATES

On July 1, 1998, the one-year transitional rule for information in certificates of prior creditable coverage expired. The transitional rule provided that certificates issued under the Health Insurance Portability and Accountability Act ("HIPAA") did not need to include the names of all the dependents covered under an employee's

coverage. Instead, during the first year, a certificate was considered adequate if it noted, for example, that the employee carried individual, individual-plus-spouse, or family coverage.

The regulations now require a certificate to list by name the dependents covered under the employee's coverage. If the dependents have the same period of creditable coverage as the employee, a single certificate with all the names listed meets the regulatory requirements. If some members of a family have different coverage information, a single certificate still may be used so long as it breaks out the coverage information by individual and separately states that the information included on the certificate is not identical for each person listed.

For example, when everyone under a given employee's coverage has been covered for at least 18 months, the certificate will only need to list the names of the individuals covered and the fact that they have been covered for at least 18 months. If a dependent was added during the last 18 months, the information provided for that dependent should include the date any waiting period or affiliation period began and the date creditable coverage began and ended.

Plans and insurers that were relying on the transitional rule now need to update the amount of information they are providing on certificates of creditable coverage to comply with HIPAA.

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# IRS APPROVES AUTOMATIC 401 (k) DEFERRALS

Automatic or default 401(k) plan enrollments have received increasing attention as a method of boosting participation, especially by nonhighly compensated employees. Automatic enrollment means a newly eligible employee automatically participates in a 401(k) plan at a preset percentage of compensation, such as three percent, unless the employee elects not to participate or to defer a different percentage. Automatic enrollments often increase

401(k) plan participation and improve nondiscrimination testing results.

Notwithstanding these potential benefits, automatic 401(k) enrollments raise concerns over whether such enrollments constitute "elective contributions" under IRS regulations governing 401(k) plans, and whether their use threatens a plan's tax-qualified status.

**IRS Approves Practice**

In a recent Revenue Ruling (Rev. Rul. 98-30), the IRS directly addressed these concerns, approving a 401(k) plan design providing for three percent of an employee's compensation to be contributed to the plan on a tax-deferred basis unless the employee affirmatively elected otherwise. Under the plan, if a newly hired employee did not promptly return a form stating that he or she did not want to participate, or wanted to participate at a different contribution rate, the employee was automatically enrolled at the three percent pre-tax contribution rate. The IRS found that the automatic enrollment did not cause the contributions made under the default election to fail to be elective 401(k) pre-tax contributions.

The IRS specifically noted three key features which led to the favorable ruling: (1) the employee received written notice explaining the automatic election and the employee's right to elect out or to elect a different level of contributions, including the procedure for exercising that right and the timing for implementing the election; (2) the employee had a reasonable period before compensation was paid in which to return the election form; and (3) the default enrollment was not a one-time irrevocable election. Also, the IRS noted that the default election was part of the terms of the plan, and employees were notified annually of their contribution percentages and reminded of their right to change their percentages at any time.

The IRS ruling is welcome news to 401(k) plan sponsors as it resolves one the principal plan qualification concern raised by automatic enrollments.

**Investment Direction**

One drawback to automatic enrollment is the loss of ERISA Section 404(c) protection for plan fiduciaries. ERISA Section 404(c) provides that if a plan satisfies

certain requirements in permitting participants to exercise control over the investment of the assets in their accounts, and a participant in fact exercises such control, then the plan's fiduciaries will not be liable for any loss that results from the participant's investment choices.

In the 401(k) plan discussed in the Revenue Ruling, contributions made pursuant to a default election went into the plan's balanced fund, which included both diversified equity and fixed income investments. The IRS noted that the Department of Labor's position is that participants who are merely apprised of investments that will be made on their behalf will not be considered to have exercised control over their assets in the absence of instructions to the contrary.

However, in our experience, most plan sponsors which have seriously considered an automatic enrollment feature have not viewed the loss of 404(c) protection for default investments as a sufficient basis for deciding against automatic enrollment.

**State Wage Laws**

Another administrative issue is whether automatic enrollments violate state wage payment statutes. Many states, including Illinois and New York, have statutes requiring employers to obtain an employee's written authorization before making any deductions from the employee's wages other than those required by law.

The Department of Labor has taken the position that these laws are preempted by ERISA to the extent they require written authorization for implementing salary reduction elections. For example, in Opinion No. 94-27A, the Department expressed the opinion that the New York statute requiring an employee's express written authorization before making any wage deduction for pension, health, or other employee benefits was preempted by ERISA to the extent it could be interpreted as prohibiting use of a telephone or voice response system allowing participants to make salary reduction elections. The same analysis appears to apply equally to automatic 401(k) elections.

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# YEAR 2000 REQUIRES ACTION

This is a cybernetic minefield that will take considerable time and effort to clear. No ready technological solution has emerged and experts agree that it is unlikely that one will. Therefore, plan administrators and service providers cannot afford to gamble on a last-minute, technological fix. They must act now.

*Olena Berg, Assistant Secretary,*
*U.S. Department of Labor*

**Nature of the Problem**

The year 2000 problem stems in large part from the early years of the computer industry when storage space (memory) was limited and therefore expensive. To save memory, computer programmers routinely represented the year portion of dates as two digits rather than four. For example, the year 1980 was represented as "80" rather than "1980." Unfortunately, many computer systems currently in use still have hardware or software based upon this outmoded two-digit method.

As a result, the year 2000 will usher in a host of date-related problems. The most obvious date problem, the date inversion or faulty logic problem, affects simple date-related calculations as the future effectively becomes the past. That is, the year "00" will be recognized as 1900, not 2000. For example:

| | |
|---|---|
| Birth date | 01/22/1936 vs. 01/22/36 |
| Four-digit calculation | 1998 - 1936 = 62 |
| Two-digit calculation | 98 - 36 = 62 |
| This calculation presents no problem in 1998, but now consider the year 2000: | |
| Four-digit calculation | 2000 - 1936 = 64 |
| Two-digit calculation | 00 - 36 = -36 |
| Two-digit calculation | 98 - 36 = 62 |

To make matters worse, many systems read numbers as absolute numbers. In other words, -36 becomes 36, making the date inversion error (age 36 instead of 64) significantly more difficult to detect.

In addition to the date inversion problem, others likely to be encountered include sorting, leap year calculations, date ambiguity, and information retrieval. The inadvertent purging of historical data poses another potential problem if automatic record retention programs are used. For example, in the year 2000, data from 1998 may be interpreted by a noncompliant system as being 98 years old and, thus, well beyond the record retention period selected.

These problems are of particular concern to employee benefit plan administrators and service providers because so many benefits are date-dependent in one way or another. Examples include determining eligibility, calculating years of service for vesting and benefit accrual purposes, and determining entitlement to reimbursement for medical expenses incurred. The year 2000 problem involves not only a plan's own recordkeeping system but also employer payroll and other systems which supply data to, or rely upon data from, the plan's own system.

**Need for Action**

Most plan administrators are tackling these problems as part of the employer's comprehensive year 2000 compliance efforts. Steps to be taken may include:

1. Inventory existing employee benefit computer systems to determine which are and which are not year 2000 compliant. Contact the system vendor to determine if a year 2000 compliant version is forthcoming and when. If the vendor will not be remediating the system, the plan administrator will need to consider viable alternatives, such as retaining a competent vendor with year 2000 solution experience and getting it started on upgrading the existing system or replacing it with a new system.

Although software is available to test systems for year 2000 compliance and assist with the

remediation process, there is no "silver bullet" to fix the problem. Personnel and resources are scarce and getting scarcer as the year 2000 approaches.

2. Request year 2000 assessments in writing from service providers and other vendors, including third-party administrators and investment managers.

3. For noncompliant systems, note that existing hardware and software vendor upgrades for year 2000 should be considered, and that the failure to ask the vendor to make the system year 2000 compliant may operate as a waiver. In addition, rights and obligations under software licensing agreements need to be considered. For example, all warranties in a licensing agreement may be voided if the licensee remediates without the licensor's consent. In some cases, even testing may require the licensor's consent and cooperation.

4. Include appropriate year 2000 warranties and other protections in any new agreements.

Allow ample time to test remediated systems for year 2000 problems and nonyear 2000 bugs. Any remediation involving modification of code may introduce new bugs that need to be remedied.

As the Department of Labor has emphasized, plan administrators and service providers that choose to ignore year 2000 problems face potential exposure to breach of fiduciary duty and other legal claims. To reduce the risk of liability, plan fiduciaries need to act now to identify problems and take appropriate actions to correct them.

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# RETIREE HEALTH BENEFITS:

# Supreme Court Declines to Review *Sprague v. General Motors*

Perhaps no other benefits issue has generated as much public debate and controversy as an employer's right to change retiree welfare benefit plans. The most recent development involves the Supreme Court's decision not to review the Court of Appeals ruling in *Sprague v. General Motors*, reported in our March 1998 Labor Law Bulletin. The Supreme Court's action leaves standing the Sixth Circuit's *en banc* decision holding that GM did not violate ERISA when it made changes in the insurance benefits available to its retirees.

The *Sprague* case involved 34,000 "general retirees" who had retired pursuant to GM's normal retirement program and 50,000 early retirees who had retired under various special retirement programs. The retirements at issue spanned a 20-year period during which a wide variety of plan documents, summary plan descriptions, short- and long-form acceptance documents, and other employee communications had been used for GM's regular and other special retirement programs.

Like many employers, GM had not always been careful in explaining to employees and retirees that GM reserved the right to modify the retiree health and life insurance benefits being provided. For example, a 1974 booklet stated, "Your basic coverages will be provided at Corporation expense for your lifetime." However, most of the pamphlets distributed, as well as the summary plan descriptions and the underlying plan documents themselves, clearly stated that GM retained the right to change or terminate retiree welfare benefits at any time.

In late 1987, GM announced a change in its long-standing policy of providing salaried retirees with lifetime comprehensive health benefits free of charge. The changes announced included instituting an annual deductible and 20 percent co-payment provision, and eliminating vision and hearing aid coverages. In response, a class of over 80,000 retirees sued. They argued that the pamphlets and other employee communications GM distributed over the years created a contract under which GM was obligated to pay the full cost of their benefits for their lifetimes.

The trial court held that GM was entitled to change

welfare benefits for the general retirees who had retired under the standard plan documents. However, it also held that GM had made a bilateral contract with each special early retiree to vest health care benefits at retirement. Further, GM was estopped from changing the early retiree health care benefits. A three-judge panel of the Sixth Circuit Court of Appeals affirmed the trial court's rulings in favor of the early retirees. But that decision was vacated when the full Court of Appeals voted to rehear the case.

In its decision, the full Court of Appeals held for GM in connection with the claims of both the general and the special early retirees. In reversing the trial court's rulings on the early retirees, the Court of Appeals held that most of the SPDs had effectively reserved GM's right to amend the benefits so that the promise to provide the benefits was at all times a qualified promise, *i.e.*, limited by GM's right to amend the plan. The fact that some SPDs were silent about GM's right to amend did not negate GM's right which was clearly set forth in the plan itself, the court held.

The theory that GM had established a bilateral contract with the early retirees was also rejected. Anything GM may have said to the early retirees was irrelevant, the full Court of Appeals ruled, because oral modifications to ERISA plans are without effect. Even the written "statements of acceptance" signed by the special early retirees were held to have no effect because they were not modifications to the written plan documents. Finally, the estoppel theory was also rejected. Estoppel could only be applied to an ambiguous plan document. Since the plan document here was unambiguous, estoppel could not be invoked, the Court of Appeals held.

The retirees appealed and, last month, the Supreme Court declined to hear the case, leaving standing the Court of Appeals' *en banc* decision. This is a significant decision in favor of an employer's right to amend welfare benefit plans for retirees. In particular, the facts in this case reflect the less-than-perfect circumstances that often surround plan documents and SPDs issued over an extensive period of time. Ultimately, the fact that the plan documents and most of the SPDs had been clear was the key to a finding that the employer had effectively reserved the right to change these benefits.

The *Sprague* decision, while significant, will not put to

sharing and welfare benefit plans with aggregate assets of several billion dollars. Our employee benefits lawyers also have been involved in major litigation on behalf of benefit plans and their sponsors. Our clients include very large national corporations, smaller professional and business corporations, multi-employer trust funds, investment managers and other plan fiduciaries.

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rest the controversy surrounding the right of employers to modify retiree welfare benefits. A lawsuit involving 100,000 former Sears employees is currently pending and more suits are certain to follow.

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# ELIMINATING AGE 70½ DISTRIBUTIONS FOR ACTIVE EMPLOYEES:

**New Regulations Grant Relief from Anti-Cutback Rules**

After more than a year of consideration, the IRS has cleared up a discrepancy between the Small Business Job Protection Act of 1996 ("SBJPA") and the anti-cutback rules of Internal Revenue Code Section 411. The new regulations make it easier for qualified plan sponsors to eliminate mandatory pre-retirement distributions beginning at age 70½.

**Background**

Internal Revenue Code Section 401(a)(9) requires distributions from qualified retirement plans to commence no later than the "required beginning date." Prior to enactment of the SBJPA, Section 401(a)(9) generally provided that the required beginning date was the April 1 following the calendar year in which a participant attained age 70½. Consequently, plans were required to begin distributions as of this date even if the participant was still working.

The SBJPA amended the definition of "required beginning date." As amended, the required beginning date for a participant who is not a five-percent owner is the April 1 following the calendar year in which the participant (a) attains age 70½, or (b) retires, whichever is later.

Unfortunately, the SBJPA did not specifically provide for any exception to the Code's anti-cutback rules. Code Section 411(d)(6) prohibits plan amendments that decrease the accrued benefit of a participant or eliminate any

"optional form of benefit." The right to begin benefit distributions in any form at a particular time is considered an optional form of benefit. Therefore, prior to the new regulations, if a plan attempted to take advantage of the SBJPA changes by eliminating the right to begin pre-retirement distributions after age 70½, it risked running afoul of the anti-cutback rules.

**Turning Off the Anti-Cutback Rules**

The new regulations are good news for plan sponsors because they allow more flexibility in eliminating mandatory pre-retirement distributions at age 70½. The new regulations effectively "turn off" Section 411(d)(6) as it applies to the definition of "required beginning date" provided certain conditions are met.

**Conditions for Relief from Section 411(D)(6)**

A. ***Protection for Employees Near Age 70½***. Under the regulations, an amendment eliminating a pre-retirement age 70½ distribution option may only apply to benefits for employees who attain age 70½ after December 31, 1998.

B. ***Optional Forms of Benefit***. The regulations also prohibit plans from discriminating against participants over age 70½. Generally, a plan may not preclude an employee who retires after the calendar year in which the employee reaches age 70½ from receiving benefits in any of the same optional forms that would have been available had the employee retired earlier.

C. ***Timing of Amendments***. An amendment to eliminate a pre-retirement distribution must be adopted no later than the last day of the remedial amendment period that applies to the plan for changes under SBJPA. For calendar year plans, this is December 31, 1999. In addition, the regulations provide an extension of this deadline for plans subject to collective bargaining agreements ratified before September 3, 1998.

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# PUBLICATIONS AND PRESENTATIONS

- Charles B. Wolf's article entitled "Preparing for an IRS or DOL Audit" was published in the International Foundation of Employee Benefit Plans' annual book, *Employee Benefit Issues*.

- Thomas P. Desmond presented "Compensation Strategies for Officers and Directors" to the Financial Managers Society's annual national conference.

- Neal I. Korval spoke on "Claims for Benefits Masquerading as Breach of Fiduciary Duty Claims in the Wake of *Variety*" at an American Corporate Counsel Association program.

- Charles B. Wolf spoke on "Developments Involving Multiemployer Plans" at the Mid-Winter Meeting of the Employee Benefits Committee of the Labor Section of the American Bar Association.

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# *NATIONAL LAW JOURNAL* SURVEY RECOGNIZES VEDDER PRICE BENEFITS ATTORNEY

A recent survey by the *National Law Journal* named Charles B. Wolf, a partner at Vedder Price, as one of the country's top employee benefits attorneys. The survey was conducted by asking employee benefits attorneys whom they look to for expert advice in their own field.

Mr. Wolf was winning lead counsel in the Sixth Circuit's landmark case, *Hansen v. White Farm Equipment Co.*, one of the first appellate decisions establishing an employer's right to modify or

terminate retiree welfare benefits in accordance with plan documents. He also is co-author, with Vedder Price's John J. Jacobsen, of a leading treatise, "ERISA Claims and Litigation." Mr. Wolf is co-chair of the Sub-Committee on Multi-Employer Plans of the American Bar Association's Labor Section Employee Benefits Committee, and has written and spoken extensively on employee benefits topics.


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