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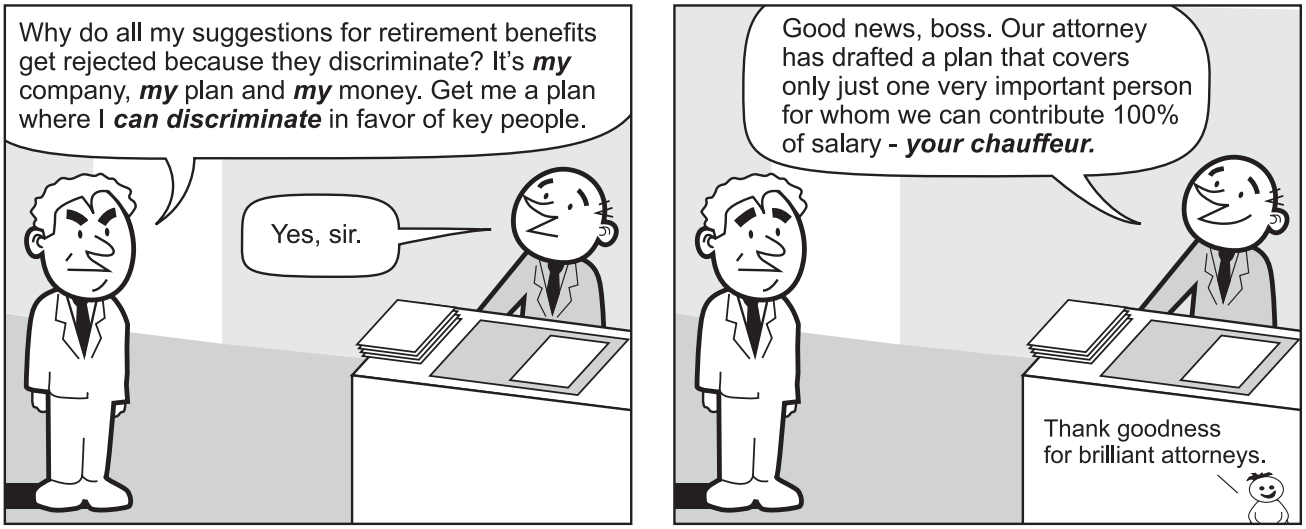

What's Discrimination in the Design of ERISA Plans?

Bethesda Hospital maintained a traditional defined benefit pension plan that normally paid benefits in the form of annuities and only after participants reach retirement age even if they terminate employment before that age. The plan also had the usual cash-out provision providing for an immediate lump sum payment if the present value of the age 65 annuity benefit is $5,000 or less. Along came Brian Rowan, a young African-American, who terminated employment in order to attend medical school and become an orthopedic surgeon. The hospital encouraged this move because it hoped to correct for a lack of African-American orthopedic surgeons on its staff. In order to pay his medical school bills, Rowan persuaded the hospital to amend its pension plan to authorize the immediate payment to him of his vested pension.

The plan amendment was of the rifle shot variety, directing payment of a $6,645 lump sum benefit to him by name notwithstanding the $5,000 cap generally in effect for all other participants. The plan amendment was clearly discriminatory and resulted in demands from other terminated vested employees that they too be allowed to receive immediate lump-sum payments of their benefits. Glenn Coomer, the lead plaintiff in one lawsuit involving sixteen others, had a deferred benefit with a present value of over $100,000 that he wanted to get his hands on. He was also over age 40, the age at which protection begins under the Age Discrimination in Employment Act. His claim was that the Rowan amendment violated both ERISA's and ADEA's anti-discrimination prohibitions. *Coomer v. Bethesda Hospital, Inc.*, 370 F.3d 499 (6th Cir. 2004).

Employee benefit plans are subject to three sets of discrimination rules: (1) the general employment laws, including ADEA, that prohibit an employer from discriminating with respect to any terms and conditions of employment on the basis of race, gender, age, national origin, religion, etc.; (2) the Internal Revenue Code's prohibition of a retirement plan's discriminating in favor of highly-compensated employees; and (3) ERISA's Section 510 prohibition of a benefit plan's discriminating against employees with respect to their benefit plan rights. Since Rowan was not highly compensated, the hospital's amendment did not raise a discrimination issue under the Code and the court speedily dismissed Coomer's age discrimination arguments because there was no evidence that age played a part in Rowan's

good fortune. The hospital was obviously not benefiting younger employees generally at the expense of their elders but merely trying to assist one aspiring African-American to pursue a course of study that would benefit the hospital (makes one wonder why Coomer didn't play the reverse race discrimination card instead of age discrimination).

This leaves ERISA Section 510, a provision with two basic prohibitions. First, it makes it unlawful for an employer to discriminate against or take any other employment action against an employee who exercises his rights under a plan or under the law. For example, an employer would violate this provision if it were to fire an employee who submitted high medical claims. Second, Section 510 prohibits an employer or other persons from interfering with an employee's ability to attain any right to which he might become entitled under a plan; for example, firing an employee to avoid paying high medical expenses after an employee has informed his employer he has contracted a serious illness.

Coomer's problem is that he was not denied any benefit to which he was entitled under the plan nor was he retaliated against. His complaint was that the plan discriminated between himself and Rowan. In other words, Rowan got his benefit but Coomer did not. No question this was discriminatory treatment. It was not, however, prohibited discriminatory treatment. In addition, the plan's administrators did not exercise any discretion in terms of deciding who did or did not receive benefits; they merely followed the express terms of the plan document. The "fault" here lies with the employer because the employer drew a distinction between Rowan and all other plan participants. However, the court observed that the hospital, as employer, was simply exercising its rights as the plan's settlor, which rights include the design, amendment or termination of a plan. It was not required by ERISA to establish any benefit plan in the first place, nor to provide any type of benefit, nor offer any particular level of benefits of the type it does provide, nor to refrain from discriminating among employees in setting eligibility standards for benefits (that is left to other laws). In sum, Coomer got no relief under Section 510.

This case does not mean it is a good idea for plan documents to be quite so blatantly discriminatory as this one. In particular, we have found that any amendment that names a specific individual (i.e., pay Brian Rowan his $6,645 benefit), whether it discriminates in favor of or against him, draws a lot of unwanted attention. After all, we live in a country whose mission statement declares all men to be created equal and anyone perceived to violate this mission is apt to bring out the levelers. Here the levelers were other employees who felt they were just as deserving as Rowan, and the result was a very costly lawsuit (no good deed goes unpunished!). In other circumstances, it could be the IRS or the DOL that suspect that special treatment equals something rotten, and in poking around trying to find it, their agents may uncover some other violation. It is much better if you are so bold as to want to do a favor for one or more persons to muddy up the amendment as Congress does with special interest legislation — disguise the identity of the beneficiary, use innocuous, apparently meaningless language, and make it fit only the narrowly intended circumstances. In other words, the Rowan amendment simply drew too much attention to itself even though it violated nothing.

Elect-It-Yourself Tax Treatment for Disability Benefits

A recent IRS ruling provides a tax planning opportunity for disability benefits. Rev. Rul. 2004-55, 2004 IRB LEXIS 261 (6/28/04). Unfortunately, there is a slight hitch: you must be able to predict the time of your disability. The general rule is that if an individual pays disability premiums pre-tax, then the benefits he receives are taxable. Conversely, if premiums are paid after-tax, the benefits will be tax-free. In other words, you pay tax on either the premiums or the benefits, and can't escape the tax on both. Under the new ruling, an employer's plan ran for many years with the employer paying all the premiums on a pre-tax basis. Then, the employer amended its plan to give the employees the choice of paying the premiums either pre-tax or post-tax. Under the amendment, the employees had to elect the tax treatment of the premiums prior to the beginning of the year. The election had to be irrevocable for that year, but the employees were free, in an annual open enrollment period, to change their elections for the tax treatment of the premiums in the following year. Alternatively, a prior year election could be allowed to continue in effect in all subsequent years until the employee made a change; and the plan even included a negative election that treated the premiums as taxable unless the employee made a positive election to make them non-taxable.

Based on these factors, the IRS held that if an employee becomes disabled during a year, all disability benefits paid to him would be treated as either taxable or tax-free for all years then and thereafter based on the election in effect for that one year. For example, if an employee makes an election in December 2003 to have premiums paid after-tax during 2004 and then becomes disabled in 2004, all benefits paid to him will be tax free even if premiums were paid pre-tax in one or more prior years.

The ruling is important for a couple of reasons. First, it establishes a simple rule — not necessarily the norm for tax rules. Compare it, for example, to the rules for a more typical plan that consists of a combination of employer and employee contributions. In such a contributory plan, each benefit payment will be partially taxable and partially non-taxable according to the proportion of taxable and non-taxable premiums paid over a three-year look-back period. The new ruling is a delight for simple-minded plan

administrators everywhere — everything is either taxable or not; there is no need to tally up taxable and non-taxable premiums to create a fraction that determines the taxable portion of each benefit payment. Second, the elections can be made on a strictly individual basis with older sicker employees perhaps deciding the odds favor paying premiums after-tax in order to have a stream of tax-free benefits while younger healthier employees may make the opposite choice. Moreover, the election is not a lifetime election but can be made annually, allowing one to reassess the risks as one's age and health evolve. Incidentally, the ruling applies to all disability pay — long-term and short-term alike.

Insurance Companies as Plan Fiduciaries

Insurance companies almost invariably take the position they are not fiduciaries of a benefit plan if their sole connection with the plan is to issue the insurance policy and process claims made under it. The contention is that they are just providing a non-discretionary service to the plan administrator who is the real fiduciary. And, they typically insist that all plan documents reflect their non-fiduciary status. Obviously, the insurers' hope is that by denying fiduciary status, they can't be reached by a breach of fiduciary liability lawsuit if they deny someone's benefit claim. Here's a case, however, of an insurer running towards ERISA rather than from it. *Winkler v. Metropolitan Life Insurance Company*, 2004 U.S. Dist. LEXIS 14381, *motion for reconsideration denied*, 2004 U.S. Dist. LEXIS 16866 (S.D.N.Y. 2004).

Winkler was a participant in the long-term disability plan of the Jack Martin Company. The company was designated as the plan administrator and named fiduciary. Metropolitan Life issued the LTD policy and determined eligibility for benefits but was not identified in any plan documents as a fiduciary. As you might guess, Winkler terminated employment from the company claiming he was totally disabled; MetLife denied his claim and this lawsuit ensued. The issue before the court was the legal standard it should use in reviewing MetLife's decision. There were two possibilities: (1) *de novo*, where the court starts fresh, reexamines the entire matter and makes an independent decision on whether a claimant satisfies a plan's requirements or (2) arbitrary and capricious, where deference is given to the claim administrator's decision, a decision that the court will not overturn just because it disagrees with the decision but because the court concludes that it has no reasonable basis, i.e., the fiduciary in charge was arbitrary and capricious. The two standards of review might just as well be labeled "you win" and "you lose" because that almost inevitably defines the outcome of the case from the participant's perspective once the court has determined which review standard it will employ.

These concepts are important because the Supreme Court has held that the *de novo* standard applies in claims cases unless the plan documents expressly give a plan fiduciary the discretion to determine eligibility for benefits. Since the Supreme Court's decision, you better believe that every ERISA lawyer who represents plans has inserted into every plan document the magic discretionary authority language in an attempt to have the "you lose" standard apply to any court review of denied claims. The Jack Martin plan document contained this language, saying that the plan administrator (the employer) and "other fiduciaries" had the authority to exercise discretion in performing their duties. For purposes of this case, MetLife asserted that it was an "other fiduciary" as used in the documents. Winkler, however, pointed out that MetLife was nowhere named as a fiduciary and not where expressly given fiduciary responsibilities. Because MetLife prepared all the plan documents, Winkler argued that if MetLife believed it was a fiduciary, it would have so stated. Here's the interesting part of the case: the court effectively bailed out MetLife by stating that anyone who determines whether a claimant is entitled to receive a benefit necessarily exercises discretion which therefore makes that anyone a fiduciary whether or not he is expressly named as such. So, MetLife won the case. But does it win the war? Anyone who has fought the battle with an insurance company over its refusal to acknowledge in writing that it is acting in a fiduciary capacity when it makes claims decisions is sure to add this case to his arsenal of weapons. Given what insurers actually do — reviewing often ambiguous or conflicting facts, interpreting a plan document and deciding among at least two possible outcomes — a lawyer could be forgiven for concluding that insurers exercise discretion. Nevertheless, the insurers fight it. This case is one suggestion that in the long run they are destined to lose and be held accountable as fiduciaries.

Retiree Health Benefits — Vested or Not?

As we all know, ERISA does not require the vesting of welfare benefits, including retiree health benefits. Such benefits vest only where an employer has made a contractual commitment to vest them. This has led to a deluge of lawsuits by retirees claiming that their benefits cannot be reduced or terminated because a contractual obligation to provide health benefits for the duration exists on account of something the employer said or didn't say or did or didn't do. After reading dozens of these cases, one can pretty much guess when an employer will lose. Take these facts for instance: In 1991 Continental Insurance offered an early retirement incentive to reduce its workforce; part of the incentive included enhanced health benefits; the benefits were described in both written communications and orally as "lifetime" benefits payable over the life of the employee and his spouse; there was no special disclaimer in the incentive plan's communications stating that the company reserved the right to change or eliminate the health benefits in the future; and to top it all off, the lower court concluded

that (1) because there was no suggestion the benefits could be changed, the early retirees fairly assumed that the benefits were vested for life and (2) the assumption the benefits were for life was material to the employees' decision to retire. Notwithstanding the foregoing, a successor employer of Continental decided to eliminate retiree benefits.

Apart from the facts, the assumption of a retiree victory might also have been assumed upon reading the opening paragraph of the court's decision, a two sentence paragraph in which the first sentence observed "widespread efforts of corporations to reduce their liabilities by cutting back on retiree benefits," and the second which observed the law as not providing anything to "cushion the hardship of pensioners faced with a new drain on their limited resources." Typically, when a court sets up a bad guy (corporations seeking to reduce costs) and a good guy (retirees on limited resources), the game is over for the bad guy. Obviously, you know by dint of the excess sarcasm that we have a surprise ending — the bad guy won. *Vallone v. CNA Financial Corporation*, 375 F.3d 623 (7th Cir. 2004).

The court's reasoning is as follows: There is a difference in meaning between the words "vesting," which means forever, and "lifetime," which (believe it or not!) "may be construed as 'good for life unless revoked or modified.'" The conclusion that "lifetime" can be a conditional promise while "vesting" cannot was important to the court's further thinking because it said that communications, both written or oral, for the early retirement incentive cannot be read in a vacuum. Since, it concluded the incentive was only a modification of the company's underlying benefits program, i.e., the promised health benefits were just enhancements to the normal benefit program, it must look at that program to help interpret the word "lifetime." Well, wouldn't you know it, upon examining the SPD for the normal program, the court found the routine statement that welfare benefits can be amended or modified by the employer at any time. Now, the court did not fully endorse the company's decision to yank the benefits, observing that in hindsight the company would have better served its employees if it proactively declared its intent at the time of the early retirement offer that it had the ability to change the retiree health benefit because it has left its long-term former employees feeling betrayed. However, it nevertheless concluded that the company's failures are not "actionable" under ERISA, i.e., the retirees lose this action as well as their lifetime health benefits.

So, what are the lessons from this decision? None — the case should be considered a lucky break for the employer. It is probably best for an employer to treat "lifetime" as a naughty word and strike it from further usage; it is certainly best to qualify *all* communications, including supplemental communications, not just an SPD, with a warning that the benefits discussed therein are subject to modification in the future; and unless an employer is very clearly offering nothing of value, it should consider that any special lifetime health benefits contained in an early retirement incentive will be considered by everyone, including the courts, as vested. The reason is that vesting depends on the existence of a contract — in legal terms, an offer followed by an acceptance and accompanied by consideration. When an employee accepts your offer of health benefits by retiring, he is giving up the valuable right of continued employment and courts generally will not usually be searching high and wide for an SPD, or any other document for that matter, that will let you later renege on your offer once the employee has relinquished his job.

Brief Briefs

Recovery of Benefits Paid in Error. Last issue we reported a case where the court refused to let a plan recover disability benefits it paid in excess of the amount actually owed to a participant. The court reasoned that under ERISA's all-encompassing enforcement scheme, a plan can sue a participant only for equitable relief, and a money judgment would be legal, not equitable, relief. Well, we've uncovered another case that blows right by this ERISA limitation. *North American Coal v. Roth*, 2004 U.S. Dist. LEXIS 3476 (D.N.D. 2004). Roth was a participant in North American Coal's 401(k) plan. Following his divorce, Roth's former spouse obtained a QDRO awarding her 65% of his account balance. However, when Roth terminated employment he asked for and was given, in error, 100% of his account. The plan discovered the error, asked for the excess back, Roth refused, and the plan sued him. This court was not troubled by ERISA because it ignored the statute completely. Instead, it observed that Roth knew he wasn't entitled to his former wife's share of the account, knew that it was paid in error, and should have expected he would have to return it. Moreover, society's interests and the interests of proper plan administration are best served by making Roth cough up the money. Thus, the money was ordered returned (gasp, a legal remedy!) under the theory of unjust enrichment — a nice example of not letting an excess of ERISA erudition stand in the way of common sense.

Creditors Allowed to Reach Participants' Pension Benefits After They Leave a Plan. At the time ERISA was enacted, Congress believed that employers were improperly holding back pension payments owed to retirees, namely, by unfairly subtracting from the payments amounts an employer asserted the employee owed the employer. The belief was that many of these assertions (theft or misuse of employer assets) were trumped up pretexts to cheat pensioners. To prevent such self-help, ERISA contains a blanket prohibition on the assignment or alienation of plan benefits. The prohibition, extending well beyond employer money grabs, soon proved to be too much and has been ameliorated in a variety of circumstances. For example, both the courts and Congress adopted the exception allowing the assignment of benefits in a do-

mestic relations situation (QDROs) and Congress adopted a provision allowing for a reduction in benefits otherwise owed to a participant who is convicted of a crime against the plan (i.e., stealing money from the plan) but nevertheless demands an unreduced benefit even though he has failed to repay the plan. Here's another work-around: *Hoult v. Hoult*, 373 F.3d 47 (1st Cir. 2004). Hoult the plaintiff-daughter obtained a $500,000 judgment against Hoult the defendant-father which he spent years trying to avoid, including hiding his assets. A court eventually issued an order requiring the father to deposit his monthly pension check in a designated bank account and to withdraw no more from that account than a specified amount, with the remainder to be paid over to his daughter. The father claimed the order was unenforceable on account of ERISA's anti-assignment provision.

The circuit courts are split on this issue, but this court sided with the majority which hold that ERISA prohibits only a "plan" from paying benefits to a third party. Once the benefits have left the plan, ERISA is not implicated. Since this order was directed against the participant with respect to assets that have left the plan, it held ERISA does not apply. The lesson here is that anyone can reach pension benefits once they leave the plan. This is true with respect to employers against whom the anti-assignment provision was originally directed. If you wish to reach these benefits before a participant can make them disappear, you should, before paying them, obtain an enforceable agreement or a court order requiring the participant to hand over his benefits once the plan pays them. You ask why a participant might agree to hand his benefit over to his employer? Well, if the employer agreed not to press criminal charges, an employee just might think the assignment of his benefit to be a perfectly reasonable alternative to jail time.

Putting Money Into a Plan to Protect It from Creditors. Dr. Yates was the sole owner of his professional corporation of which he was also an employee and his P.C.'s retirement plan trustee and plan administrator. Like Mr. Hoult in the *Hoult* case, he also had creditors hot on his heels. Shortly before the creditors threw him into involuntary bankruptcy, Dr. Yates had a sudden urge to repay an old $20,000 plan loan on which he had not previously seen fit to pay any installments or interest. So he sold his house and, from the proceeds, paid the plan nearly $60,000 for overdue principal and accrued interest on the loan. He then told the bankruptcy trustee that he was sorry but he could not return the $60,000 as it was protected under ERISA against assignment. The lower courts all upheld the bankruptcy trustee, holding that the good doctor's transfer of assets to the retirement plan one step ahead of bankruptcy was an impermissible "preferential transfer" under the bankruptcy laws. The case got all the way to the Supreme Court, which reversed. *Yates v. Hendon*, 124 S. Ct. 1330 (2004). The precise issue before the Court was whether someone who owns 100% of a business is an "employee" entitled to the protections of ERISA or an owner who is not. The Court's decision was that Dr. Yates could be an "employee" for ERISA purposes even though he might also be an owner. The decision was based on the fact that both ERISA and the Code treat "working owners" like Dr. Yates as employees. There was one qualification to this holding: it works only where the plan also includes other employees besides the owner and his spouse. The case is of particular importance to doctors, lawyers and other professionals whose greatest fear is that their financial fortunes are one malpractice judgment away from going down the drain. At least this case holds out hope that even if all other assets get flushed, their retirement savings will (if they have a plan with other employees) remain intact.

An Heretical Thought. Let's terminate the PBGC. The agency was formed thirty years ago when defined benefit plans ruled the kingdom and benefit security, along with job security and other employment-related securities seemed attainable. This is a different era. 401(k)s were not even invented thirty years ago and now they rule the roost. Anyone covered by a 401(k) (or, for that matter, a 403(b), IRA or any other defined contribution) plan — which includes most of us — has no guarantee. Thus, ERISA has ended up with a guarantee system that works only for the minority of us, and there is no clear policy reason why that minority deserves more security than the majority of us. In fact, if current trends continue and the PBGC can't meet its obligations, the majority will, as taxpayers, be obligated to pony up funds (i.e., taxes) to make good on the guarantee of the minority's benefits while the majority's retirement benefits remain at risk. Is there any policy reason why people with depressed 401(k) accounts should be forking over money to guarantee benefits for the participants in pension plans? Second, the very concept of insuring pensions is flawed. True insurance is the spreading of a risk among a large group that in the aggregate is reasonably predictable (e.g., with life insurance a certain number of persons in a given age group will die each year) but is unpredictable with respect to specific individuals (very few die on their exact life expectancy but rather earlier or later). PBGC insurance, however, is essentially insuring (1) an event (primarily economic and financial market losses) that affects not only a portion of the group but virtually the entire group at the same time and (2) an event (the same economic and financial markets) that is scarcely predictable and is without downside limits. If we consider that five years ago virtually all pension plans were fully funded but today only a fraction are, despite on-going contributions, it appears obvious that the underfunding is more a function of the double whammy of falling interest rates and falling equity markets affecting all plans than it is any company or plan specific event. Sure, there are the cases of the declining industries (steel, airlines, etc.) but does this really make the case for the insurance? It means that

we are prolonging the life of companies or industries that seem bound to fail, and the longer we keep them alive, the higher will be our losses in the end. Of course, there is the argument that the PBGC really exists to give people confidence in the pension plan system. Well, maybe, but the fact is that we haven't created much confidence so far given the fact the defined benefit system has been in decline for thirty years with fewer and fewer plans covering fewer and fewer participants. Most of this decline is due to the changing times. But surely the additional layers of bureaucracy, the cost of PBGC premiums, and the knowledge that notwithstanding the payment of premiums the PBGC can still claim 100% of corporate assets on plan termination, all play a role in discouraging employers from embracing a defined benefit plan. It just might be that the absence of a PBGC would boost the pension system more than its presence.

But wouldn't the demise of the PBGC return us to the bad old days of that "broken promise" of a pension that ERISA was meant to prevent? Maybe, but maybe we should look to other requirements to preserve that promise. One might be to limit contribution holidays that employers customarily take when pension funding begins to look good (as it did in the nineties) by requiring contributions to be made every year unless the funding level is, say, 125% or more of full funding. And maybe we should prohibit employers from making any future promises (i.e., additional accruals) if funding falls below a certain funding level — maybe 80% of full funding. There is something obscene about letting employers and unions decide to continue or to upgrade pensions in an underfunded plan when the ability to fund the promises is doubtful, and they know the PBGC is standing in the wings to make good on their promises. With a phase-in period for new plans, if the plan doesn't have the assets, it should stop further accruals until the assets rise enough to support the promises. If one stops the promise, then there will be no promise to be broken. Is this fair? Well, it probably wouldn't have been fair thirty years ago but in today's era of the mobile workforce and the ascendancy of defined contribution plans, most of us are living with the uncertainties of our retirement assets not keeping up with our needs. In terms of investment risk, those of us with defined contribution plans have effectively seen our benefits frozen for the last five years except for the young among us whose contributions have managed to offset market losses. Moreover, those of us working in financially strapped companies have seen decreases in matching and other contributions pending a turnaround. Is there a reason why some of us must face these uncertainties while others of us are insulated from them by PBGC guarantees?

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