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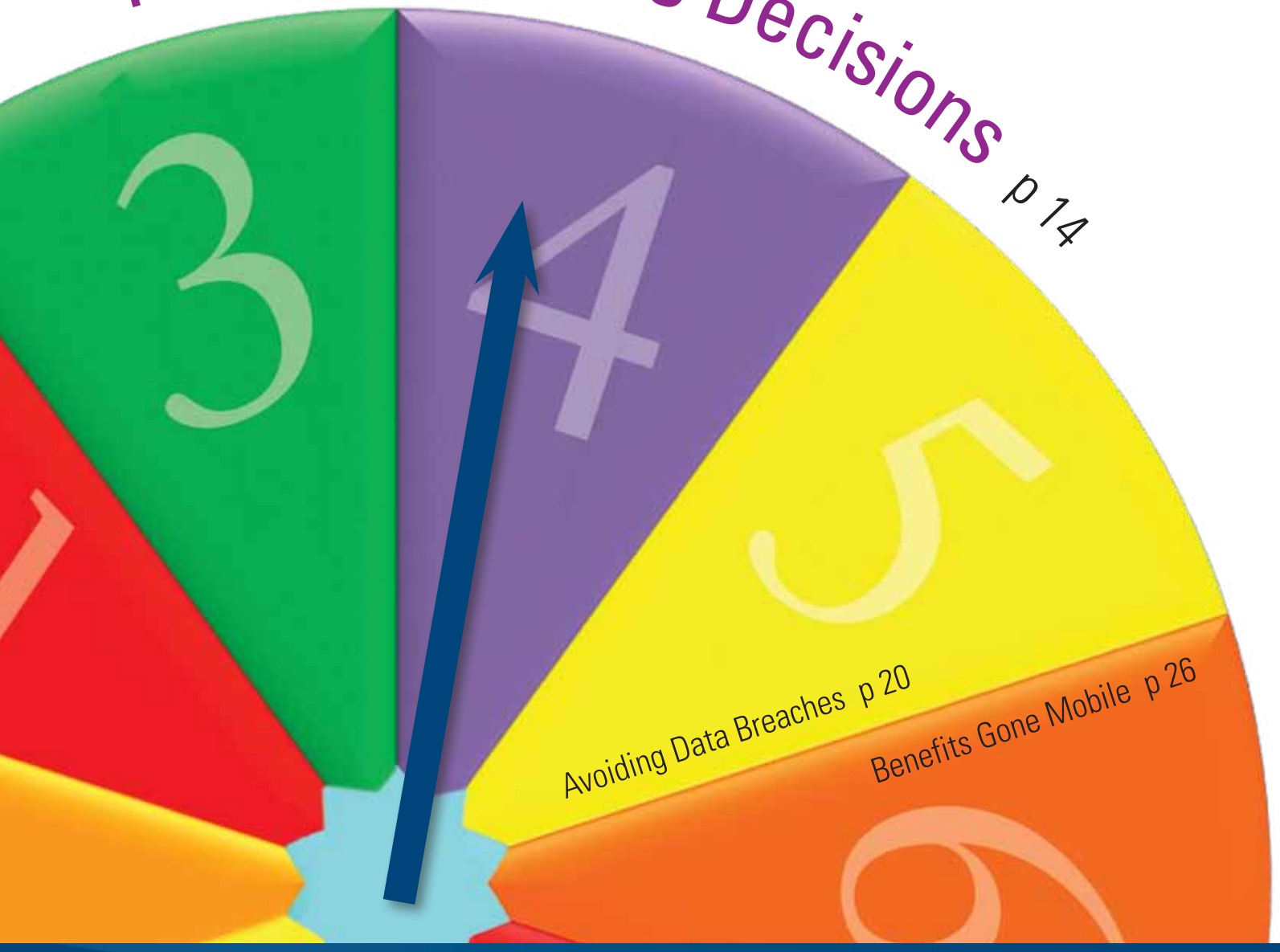

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Obama's "Year of Action" and What It Means for Employers

Stymied by Congress in efforts to pass legislation such as the Fair Minimum Wage and Paycheck Fairness Acts, President Obama has been using his executive powers to impact employment laws. Additional executive action may be on the way.

by | **Brett E. Coburn** and **Kristen W. Fox**

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Using Data to Drive Decision Making

by | **C. Anton Ames**

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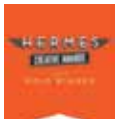

2014 Gold Award Hermes Creative Awards

2013 Platinum Award MarCom Awards

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Although educators and other public employees have several options for investing money in their 403(b) and 457 plans, some carry additional fees that can diminish an employee's account. **Carole Anne Luckenbach, CEBS,** manager of the Risk Management/Business Initiatives and Development Department for California Teachers Association (CTA), writes about the model portfolios CTA has designed as a way to help educators.

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For a group health plan, allowing protected health information to fall into the wrong hands can be a costly violation. **Mary A. Chaput,** CFO and chief compliance officer at Clearwater Compliance, a HIPAA/HITECH advisory firm in Brentwood, Tennessee, writes about how to better manage business associates to make data breaches less likely.

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Plan participants increasingly want to be able to visit their fund office virtually—from a computer, tablet or smartphone. **Jenna Morrell,** an account executive, and **Kathryn Lane,** communication manager at Innovative Software Solutions, Inc. (ISSI) in Maple Shade, New Jersey, write about the accommodations website designers need to make so that participants get the most useful view of the site on their devices.

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When fiduciaries hire administrators and advisors in part to insulate themselves from some fiduciary responsibility, they need to make sure that's what provider contracts actually do. Wilkins Finston Law Group LLP partners **Felicia Finston** and **J. B. Friedman Jr.** explain ERISA fiduciary roles and considerations.

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Rather than relying on a traditional investment model—using an investment consultant, perhaps with several specialty consultants, to lead the overall asset allocation strategy—pension plan sponsors may want to consider a multibalanced manager model. **Brian A. Schroeder,** a founding partner of Investment Change Evaluations, LLC, thinks that approach would lead to better diversification. Schroeder has more than 20 years of institutional investment experience and has spoken at several International Foundation conferences.

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Researchers from A.T. Still University, Arizona School of Health Sciences, wondered what additional pressures the Affordable Care Act is putting on Taft-Hartley health and welfare trust funds and how fund leaders may respond. **Geoffrey W. Hoffa, D.H.Sc., Kathleen Mathieson, Ph.D., and Catherine V. Belden, D.H.Sc.,** along with **Simone L. Rockstroh,** president and treasurer of Carday Associates, Inc., and a past president of the International Foundation, write about the results of their recent survey of International Brotherhood of Teamsters union leaders of health funds.

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Introducing "Word on Benefits"

We frequently talk about the dynamic changes happening in the industry, usually referring to legislative and economic upheaval. Another radical change is causing less heartburn yet is dramatically affecting how we share information: social media.

The Foundation has been active on all of the major social media channels—LinkedIn, Facebook, YouTube and Twitter—for quite some time. If you haven't checked it out, I encourage you to do so. Each channel can be helpful in keeping you plugged in to industry happenings.

I am also very pleased to announce the launch of the Foundation's blog, called *Word on Benefits*. Designed to be a scan-friendly hub of information, the blog will keep you current on the latest happenings in the industry, as well as programs and services that can help you. And since so many different staff members will be contributing to the blog, it will be fun to read!

You can find the blog at www.ifebp.org/blog. You can also follow the Word on Benefits on our other social media channels.

Blogs have become the go-to source for current information across just about every industry, frequently replacing more traditional channels. The Foundation will continue to provide the information you need in your preferred medium, whether it's in print or online—or whatever comes next.

Now, on to find what's coming next . . .

Michael Wilson

Michael Wilson
Chief Executive Officer

benefit trends

finding, motivating and retaining talent a priority globally

What total rewards issues are on the minds of employers from around the world? What will concern them in the years ahead? As the business landscape continues to become more globalized, the need to attract, engage and retain top talent remains at the top of employers' priority lists.

The *2014 Global Top Five Total Rewards Priorities Survey* from Deloitte, the International Society of Certified Employee Benefit Specialists (ISCEBS) and the International Foundation of Employee Benefit Plans is an annual barometer of talent and rewards management challenges. Conducted globally for the second year, the survey asked employers in 22 countries to rank the top five priorities for 2014 and answer a series of questions on their approaches to total rewards.

Across all geographies surveyed, attracting, motivating and keeping talent was both the top priority and the top challenge of the next three years for HR leadership. This concern reflects the talent paradox companies around the world continue to face as they struggle to fill technical and skilled jobs. The pressure mounts as employers compete for a group of skilled workers that is smaller than the market.

The top five priorities for 2014 are:

1. Aligning total rewards with business strategy by attracting, motivating and retaining employees
2. Costs of providing benefits to employees
3. Motivating staff when pay increases are flat or nonexistent
4. Demonstrating appropriate return on investment for reward expenditures
5. Creating a rewards program that reflects the culture and goals of the organization.

The priorities list remained fairly stable from 2013 to 2014. One noteworthy change is that the cost of providing benefits to employees jumped from the fourth place in 2013 to second this year. This also was one of the key differences in priorities among the geographies—The Americas region places a greater emphasis on the cost of providing benefits to employees. Particularly in the United States, there is a great deal of uncertainty around health care benefits and the role they could play in the incentive structure for talent.

A survey finding of particular concern was that only half (50%) of employers agreed with the statement, "My organization has the correct total rewards strategy in place to recruit and retain the talent we need in our workforce." Overall, this suggests organizations continue to struggle with finding the right way to align total rewards with their overall business strategy; however, organizations do not appear idle or content.

The top action taken last year (or expected to be taken next year) regarding total rewards was increasing health and well-being initiatives. The Americas place considerably more emphasis on wellness compared with the rest of the world. There is a growing interest among both employers and employees in the Americas to provide and participate in wellness and disease management programs.

Increasing employee communication and education is the top change employers plan to make. This reflects recognition of the value employees place on career development, as well as the continued need for employers to train and educate their workforce to stay current and competitive and develop the next generation of leaders. Employees often have high expectations of employers to be transparent and openly share information. In addition, the complexity of communication and education efforts continues to escalate as aging workforces worldwide are increasingly concerned with retirement security and health.

"Employers recognize the critical nature of total rewards as a primary way to attract, motivate and retain employees," said Michael Wilson, CEO of the International Foundation and ISCEBS. "Equally important is for employees to understand the **value** of their total rewards. Employer-provided education and communication is imperative for employees to better understand and make use of their rewards. Additionally, employers are educating beyond benefits literacy to

include topics such as personal finance, health and wellness."

Compensation programs continue to garner significant attention as they are generally the most visible and costly component of a rewards strategy. Organizations looking to redesign their compensation programs are most likely to focus on variable pay and performance-based pay. As further evidence of the shift toward pay for performance, among those that are considering compensation plan redesign, seven of the top ten choices selected were directly related to performance-based pay and/or incentive compensation.

While the design of total rewards programs is the most important aspect in driving value, correctly administering and delivering these programs continues to be extremely important from a talent and risk management perspective. More and more, the communication and delivery of the total rewards programs is how success will be perceived and measured. Administration should be aligned with both the capabilities of the organization and the goals of the total rewards strategy. Asked to identify how they restructured administration of some or all reward programs within the past 12 months (or how they'll do so over the next 12 months), respondents indicated the top focus was increasing the use of employee self-service technologies, including decision support tools to help employees make informed rewards program decisions.

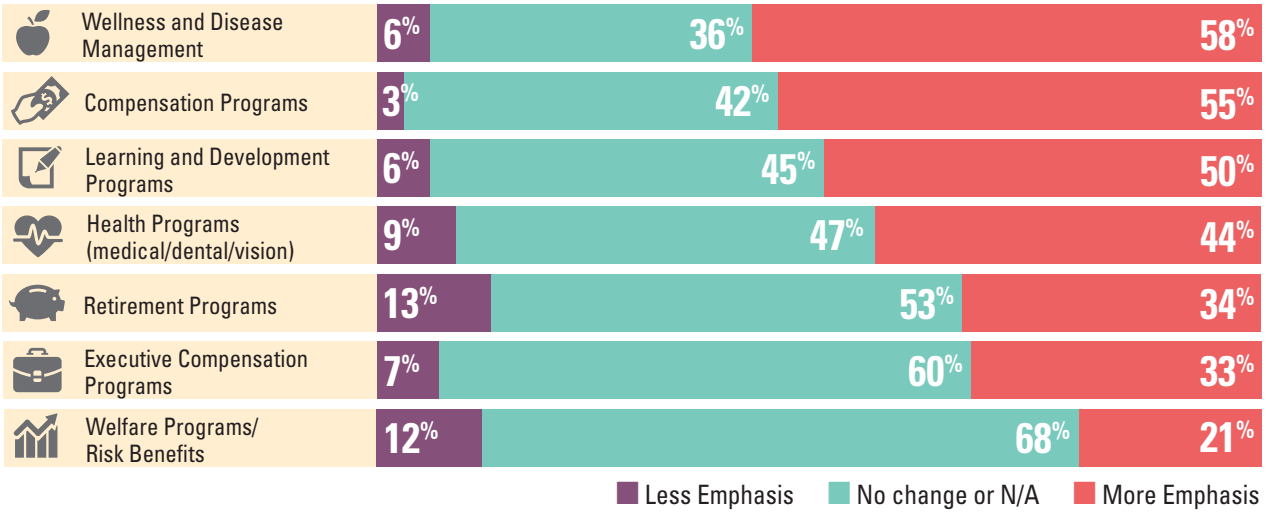
In an ever-changing economic environment, organizations continue to review and evaluate the total rewards programs they have in place to understand the return on investment for this area of significant cost. Going forward, the best companies will continuously evaluate whether specific rewards programs are good fits for their employees, gauging the value the employees place on the benefits.

by | **Neil Mrkvicka, Senior Research Analyst**

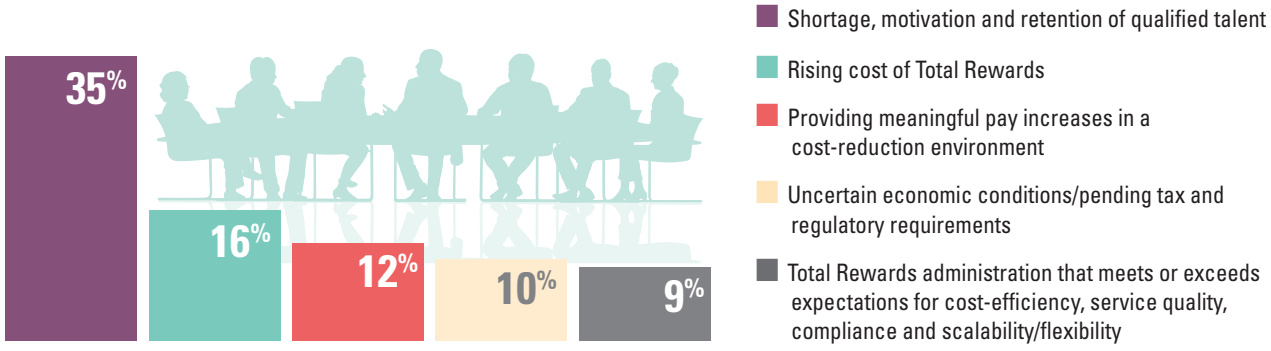
quick look | global top five priorities

What's keeping benefits professionals awake nights? Each year, in collaboration with the International Society of Certified Employee Benefit Specialists (ISCEBS) and the International Foundation, Deloitte surveys employers on their top five Total Rewards priorities. See the previous pages for a fuller report on the 2014 survey, which for the second year was conducted globally. Findings include:

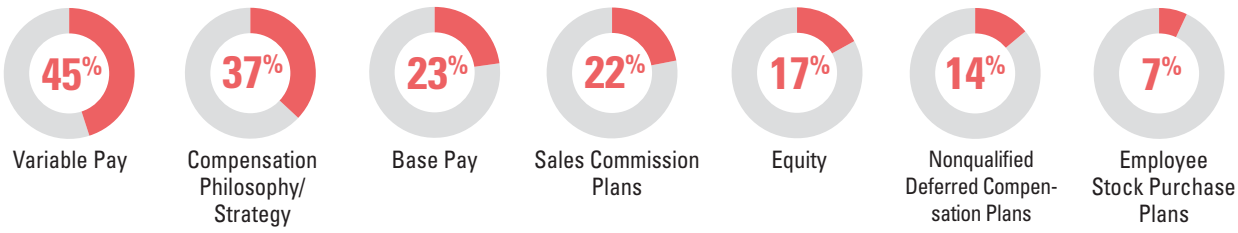
For employers that plan to adjust the Total Rewards Program mix, which programs will receive more or less emphasis?



What is the most significant Total Rewards challenge organizations will face in the next three years?



These areas of compensation and equity plans have been redesigned in the past 12 months (or will be redesigned in the next 12 months):



what's working | must-attend financial education

Ten years ago, many of the tradespeople who worked for M. A. Mortenson Company weren't participating in the general contractor's 401(k) plan. Some said their retirement plans were to work as long as they could and then move in with their children.

"It was driving me crazy when I would talk to them," said Annette Grabow, CEBS, the company's manager of retirement benefits. "Their reason (for not saving) was always, 'I can't afford to.' Along with that, they would justify it: 'I have to be able to pay my rent, and I've got my car loan, and I've got this loan, and I'm overdrawn on my credit cards . . .' I kept thinking, 'If you'd just manage your finances properly, you could afford to do this.'

"So many people don't know how to live off a budget or even make one. Or they think they have one in their head, but they don't know how to track spending. And then you have these new-hire engineers that come in right out of school. All of a sudden they're making a decent wage and they're in debt before you know it. Nobody taught these kids about money."

The company matches contributions to its two 401(k) plans dollar for dollar up to 4% of pay. Salaried workers also have a profit-sharing plan. Since 2008, the company has been automatically enrolling every new employee, and the contribution levels for salaried employees are automatically escalated.

Although Grabow wanted to tell employees they couldn't afford *not* to put money into their 401(k) plan, "You can't say that to someone in debt up to their ears—because they can't hear you. They're stressed out. And that was the other thing: They're spending half the day on the phone because of personal financial problems. And they're sick all the time. There are just so many reasons" to provide financial education to employees.

Grabow began small, finding free resources and tapping the 401(k) plan provider's educational tools, which then focused on retirement rather than economics—although that has been changing.

About half of Mortenson's tradespeople in states such as Colorado, Texas and Arizona are Hispanic, which can complicate education aimed at boosting plan participation. Many originally are from Mexico, and Grabow said they have a deep distrust of banks and government programs.

Through hard work and trial and error, Grabow hit on strategies she has found effective for both hourly tradespeople at jobsites and for a salaried workforce in regional offices throughout the United States and in Canada.

In Mortenson's Denver, Colorado office, tradespeople from local construction jobs—crews that fluctuate between 300 and 900—are required and paid to attend a Fiesta Breakfast from 5:30 to about 10:00 a.m. on a weekday each fall. A big reason for the breakfasts' success has been the financial educator Grabow hires through the 401(k) recordkeeper.

"He's Hispanic and he translates," Grabow said. "He has come a number of years, so they've gotten to know him and they like him. He's very down-to-earth and makes it very understandable for them."

She said that Mortenson has worked hard to be aware of cultural differences between Hispanic workers at jobsites throughout the country. "In the translations we've done, we've made sure they're the correct form. In Florida, it might be one kind of Spanish, but in Colorado it's another and even in Texas it's different." Although the workers understand each other, they may use different words and idioms depending on location. "They perk up and listen when they see that you understand that. They really appreciate it."

Annette Grabow

First, the financial educator talks about basic financial wellness, perhaps focusing on an aspect like the damage taking a hardship loan or withdrawing money from a 401(k) plan can cause. To give people a break and keep them

alert and engaged, the morning is interrupted with a raffle of practical items—nice jackets, fishing gear, good winter work gloves. Grabow makes sure everyone gets prizes like T-shirts, cool hats, multitools and "goofy" things she has found.

The second half of each session is devoted to information about health and welfare benefits and filling out the easy enrollment forms for the retirement plan and the health insurance forms on paper.

"We have what we call advocates—people who we know, who have worked for us a long time and who are Hispanic or can speak Spanish—work the room with us. My educator, my benefits guy and I will be working the room, as well. We'll have these advocates at different tables, and they'll sign up whole tables."

Grabow noted that the Colorado breakfast last fall drew about 350 tradespeople. She has found that with such a large group, trying to use laptop computers for online enrollment doesn't work because lines become too long. She may experiment with bringing iPads to help with enrollment for smaller groups.

"When we're done, almost everybody has enrolled," Grabow said. She looks at participation rates each quarter and finds the companywide average participation is around 76%. The workforce has a lot of turnover that skews the numbers.

She said a past frustration was that although hourly workers would enroll in the plan at a breakfast or lunch session, they would drop out of the plan when their employment ended over the winter. When they were rehired in spring, they tended to wait until the next fall's breakfast to reenroll. So Mortenson began enrolling new employees, including rehired workers, automatically.

A high percentage of employees—60% to 80%—are properly diversified in investments, which Grabow credits to the financial education they receive. Besides 11 individual funds participants can invest in, "we have four premixed risk-based allocation strategies, and those are what we put on the easy enrollment form. We don't tell them how to invest, but we make sure they understand how the strategies work. They tend to go with the conservative or moderate risk strategies, although some of the younger ones are starting to choose more appropriately aggressive ones."

Office-based employees also receive financial education, although their meetings are not mandatory. Workshops for smaller groups are held at 20-30 other regional offices and worksites from September through November each year. That group has become increasingly sophisticated about budgeting, credit, saving and investing. "I'm not getting as many people in the basic classes," Grabow said. "They want intermediate and advanced investing. And I feel that if they're asking for more, they're ready for more."

Grabow said she keeps up the grueling fall educational schedule because "I have a passion for people being ready for retirement and not being dependent on the government. But the bottom line for the company is it's very competitive to find well-trained team members. Other construction companies are all looking for these men and women if they have good skills. You want to have strong plans available to them.

"On the office side, not only do you have fierce competition for these people who are engineers and are very skilled, but you have workplace stress caused by finances, you have absenteeism, you have lack of productivity. It really addresses a lot of these types of issues if you can educate your team members properly about finances in general.

"Leadership wanted us to focus on fees in 2012, so we had a workshop that I did everywhere that was all about fees and making sure people understood them. Last year, it was all about adding a Roth 401(k) to our plan, and I did a workshop on Roth 401(k)s."

Several years ago Grabow conducted a request for proposals for financial educators and hired a firm that it has used for all types of financial workshops for many years. In the past two years, the firm has been used only for new hires. "All new hires have to attend a webinar workshop to get them off on the right foot," she said.

Grabow said she remains concerned that the company's tradespeople too often withdraw money from their 401(k) plans to meet expenses when they aren't working. That's something she's trying to educate people about. But if she asks them what their plans for retirement are and whether they still plan to move in with their children eventually, "they're offended. They say that no, they are saving for retirement and plan to stay independent."

by | **Chris Vogel, CEBS** | chrisv@ifebp.org

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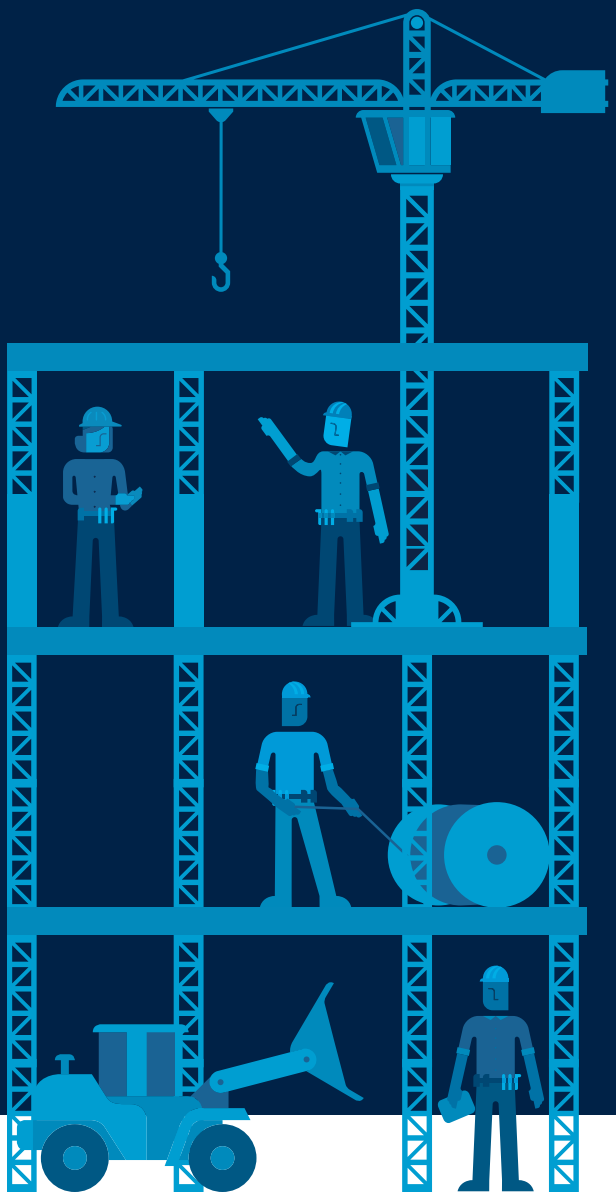

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Model Portfolios:
Helping Educators Make Objective

Public employees often count on a DC plan to close the retirement income gap left by a DB pension. A choice of model portfolios can help them make the most appropriate asset allocation decisions.

by | **Carole Anne Luckenbach, CEBS**

DC Plan Decisions

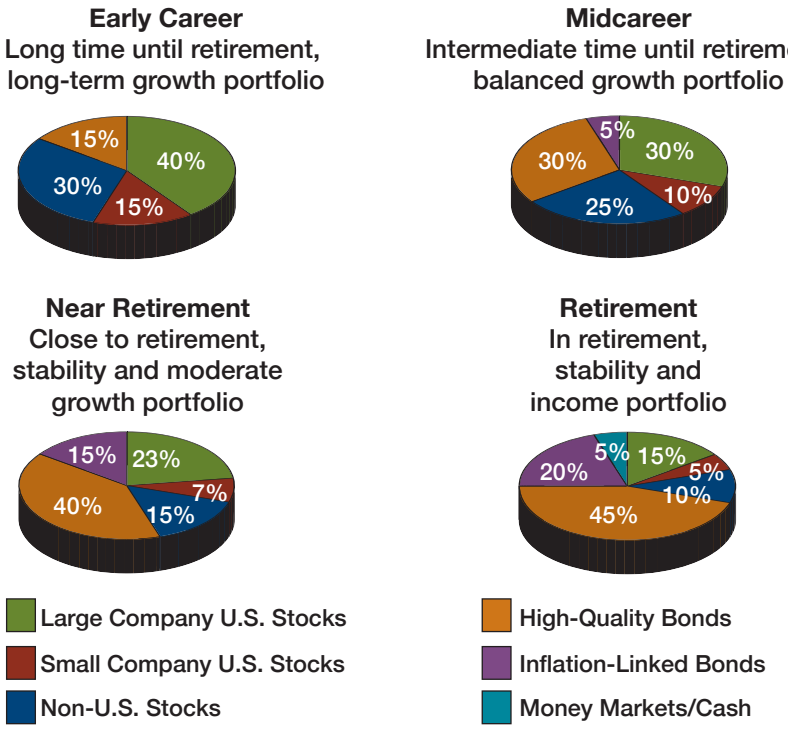
Remember the old three-legged retirement stool? It referred to the most common sources of retirement income—employee pensions, personal savings and Social Security.

In California, certificated educators have a two-legged retirement stool. Their retirement plan consists of the California State Teachers' Retirement System (CalSTRS) and personal savings. CalSTRS provides educators with a defined benefit plan that is based on the retiring member's years of service, age at retirement and final compensation.

California educators do not contribute to Social Security for CalSTRS-covered employment. And if educators are eligible for Social Security while working in a nonteaching job or as a spouse, widow or widower, there are government pension offsets that can reduce or eliminate those benefits. The average salary replacement ratio for CalSTRS is between 45% and 60%, depending on hire date and other factors.[1] This results in a large income gap for an educator who wants to maintain his or her standard of living in retirement.

FIGURE 1

Model Portfolios



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PSCA's 2013 403(b) Plan Survey
PSCA. 2013.
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California educators, along with most public sector employees, may need to supplement their defined benefit pension plan. Fortunately, public sector and other eligible employees can contribute to a tax-deferred retirement plan through a 403(b) and/or 457 plan.

So far, so good. But after deciding whether to contribute to a tax-deferred plan, participants' next step is figuring out where to invest their 403(b) or 457 contributions.

Investment Options in a 403(b) or 457 Plan

Insurance companies and mutual fund companies are the most common 403(b) and 457 vendors. Insurance companies historically have led 403(b) sales through the use of fixed and variable annuities, but annuities can have disadvantages:

- Investing in a tax-deferred annuity inside a tax-deferred retirement account has been compared to "wearing a raincoat indoors." These products offer no additional tax benefit.
- Variable annuities often include surrender fees and high-cost subaccounts and can include annual mortality and expense fees up to 1.25%. The Securities and Exchange Commission has advisories on its website concerning the sale of variable annuities within a retirement plan.[2]
- Fixed annuities also often include surrender fees and tend to credit low interest rates that are typically most similar to returns available from extremely conservative investments. For most long-term investors, fixed annuities are not likely to offer investment returns high enough to help close the retirement income gap. And they often include liquidity restrictions.

Fortunately, public sector participants have better options. A 403(b)(7) custodial account or a 457 plan can provide access to low-fee target-date funds and a diversified lineup of no-

load active and passive funds from many mutual fund companies. Sales of these types of plans are increasing as plan sponsors and participants are demanding more transparency and lower fee alternatives to the traditional 403(b) and 457 plan annuity options. Fees are an important component of investing success. While investors don't have much control over the economy or market returns, they do have a choice in account fees.

Public sector employees with a defined benefit pension plan already have an annuity or payment for life, and contributing to an annuity through a tax-deferred 403(b) or 457 retirement plan can be a disadvantage and a redundancy. A better alternative is for participants to take advantage of 403(b)(7) custodial account plans and invest in target-date funds, core funds or managed accounts. These are similar to investment offerings used in private sector 401(k) plans.

Target-date funds allow participants to make one investment decision with their contributions and select the target-date fund most appropriate for the anticipated year of retirement or the age of 65.

Managed accounts offer participants a hands-off solution that delegates the responsibility of managing contributions to a vendor that uses an independent financial engine or software to determine an asset allocation based on the core menu of investment options offered by the 403(b) vendors. For California educators, this option may not be well-matched. Managed account participants—often older participants with large account balances—pay an asset-based fee for the service in addition to the investment fees.

What about the participant who wants more control over his or her investment strategy and doesn't have extra money to pay managed account fees? Developing an asset allocation that takes advantage of low-cost mutual funds and is appropriately structured for the participant's circumstances may be a good option.

The California Teachers Association (CTA), which represents approximately 325,000 educators in California and is the nation's largest public education organization, has been leading efforts to help educators with their supplemental 403(b) and 457 savings plans. CTA investment education has been provided through an education portal—ctainvest.org—and consumer guides on 403(b) and 457 plans and on working with advisors, as well as trainings and the creation of an open platform 403(b)(7) custodial account plan that offers direct access to a menu of low-fee mutual funds. The plan and investment menu were developed using a rigorous fiduciary process. As part of its investment education initiative, CTA developed a series of model portfolios for its members.

takeaways >>

- Fixed and variable annuities have a number of drawbacks as investment options.
- Low-fee target-date funds and a diversified lineup of no-load active and passive funds are available from many mutual fund companies.
- Managed accounts offer participants a hands-off investment solution but carry an asset-based fee for service, in addition to other fees.
- Model portfolios geared toward different retirement time horizons can help investors create an asset allocation strategy.
- Investing only in low-returning safe investments introduces significant shortfall risk.

The model portfolios were created to help educators take the next step in evaluating their current investment strategy and provide guidance in creating an asset allocation strategy. The portfolios are designed with different "career points" in mind (such as early career, midcareer, near retirement and retirement) to help educators easily identify which allocation mix most appropriately aligns with their current situation.

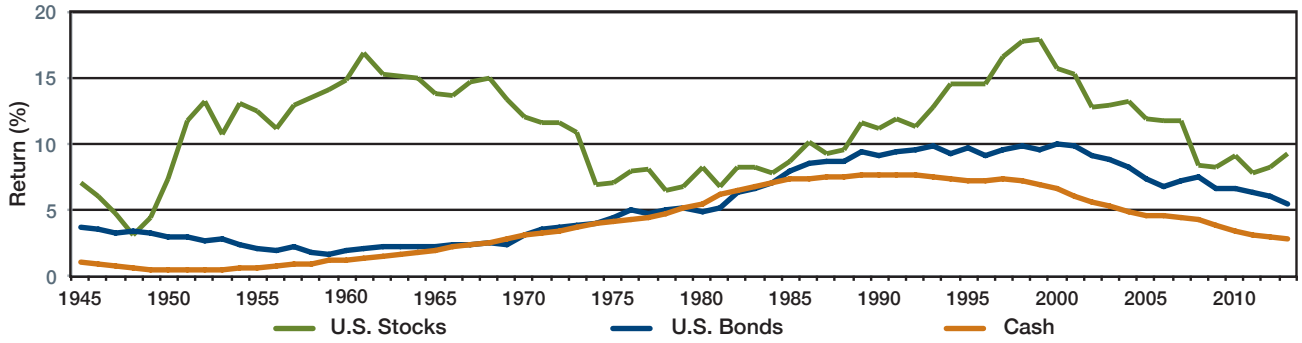
Model Portfolio Asset Allocation Study

CTA engaged RVK, Inc., an independent investment consulting firm that works with institutional investment portfolios and plan sponsors, to develop model portfolios for California educators. A model portfolio asset allocation study incorporated information regarding the unique characteristics of California educators, including salaries and expected pension income, projected long-term asset class characteristics (return, risk and correlation) and simulation modeling of projected investor contribution and withdrawal patterns.[3]

While model portfolios may not meet the needs of each unique circumstance, they have been an extremely helpful guide for educators looking for help in developing an asset allocation approach that is appropriate for the time horizon remaining until retirement. The portfolios are more objective than risk tolerance surveys, which can be overly influenced by emotions and fear.

FIGURE 2

Stocks vs. Bonds—Annualized Rolling Return Through December 31, 2013



A Look at Four Model Portfolios

Early Career—Long-Term Growth Model Portfolio

Objective: Long-term growth

Investor profile: Early career, very long time horizon, relatively small balance relative to contributions.

Midcareer—Balanced Growth Model Portfolio

Objective: Long-term growth, balanced with safety

Investor profile: Midcareer, moderately long time horizon, growing asset balance is now relatively large compared with contributions.

Nearing Retirement—Stability and Moderate Growth Model Portfolio

Objective: Safety balanced with growth and inflation protection

Investor profile: Relatively close to retirement; would have a difficult time with significant volatility, yet still has some need for growth and inflation protection.

In Retirement—Stability and Income Model Portfolio

Objective: Safety, liquidity, income generation, modest growth and inflation protection

Investor profile: In retirement and making annual withdrawals to supplement pension income.

Model portfolios can't guarantee participants won't experience investment losses and are subject to the underlying risks of the mutual funds that construct the asset allocation. Investment in stock mutual funds carries more risk than investments in bonds or cash instruments. However, investing only in low-returning safe investments introduces significant shortfall risk. Showing participants historical returns and reminding them to use their time horizon as a guide to manage the ups and downs of the market are helpful. Figure 2, showing rolling returns of stocks vs. bonds, is used in CTA's investment education seminars to demonstrate clearly to participants that over the long term, stocks generally are more advantageous than conservative bond investments.

Next Steps for 403(b) Participants

Response to the CTA model portfolios has been positive. A frequent question educators ask is, "Which portfolio is right for me?" Figure 3 was created to help participants self-select the model that aligns with their current situation.

The model portfolios are helping CTA's investment education efforts to encourage educators to save early, save as much as they can and take advantage of 403(b)(7) custodial accounts that offer appropriately priced mutual fund options. It is not difficult to create or use the CTA model portfolios as a guide to create an asset allocation as long as there is a 403(b)(7) mutual fund provider available to participants. Often, the 403(b) or 457 recordkeeper can automate rebalancing of the portfolio quarterly or annually.

Participants using the model portfolios may be able to avoid the expense of using investment advisors or managed account options from their vendor to design or customize

a portfolio. These options can add an additional 1-2% in fees annually, in addition to the investment fees, and may not be necessary for some participants. CTA will be providing more education and support to help its members use the model portfolios.

Summary

Public sector employees need to have good options and tools for their supplemental savings plan. Educators' 403(b) or 457 supplemental retirement plan must earn enough over their working career to account for inflation, longevity, health care and other retirement expenses. Once the decision to save has been made, appropriate asset allocation and avoidance of unnecessarily high fees are two critical factors in building a nest egg large enough to help shrink the retirement income gap.

Endnotes

1. "What's Working: Retirement Benefits Counseling," *Benefits Magazine*, January 2014, pp. 10-11.
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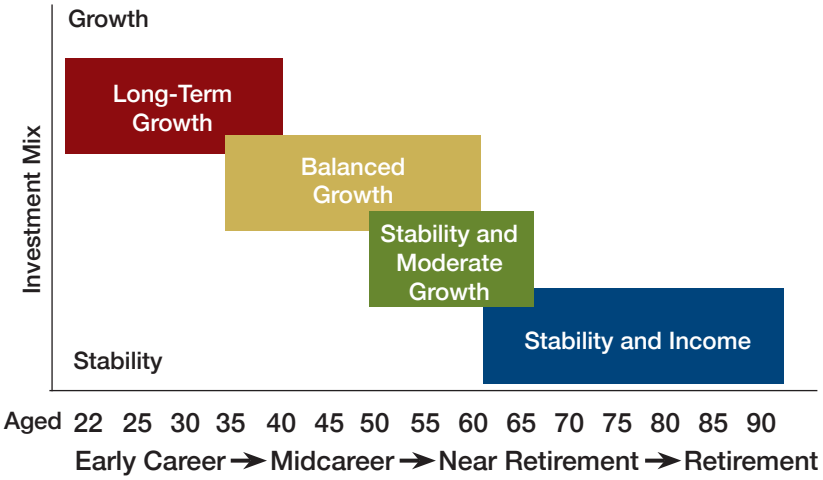
3. CTA, *EBT Model Portfolios Asset Allocation Study,* December 2013.

FIGURE 3

Model Portfolios—How Do I Know Which Is Right for Me?



<< bio

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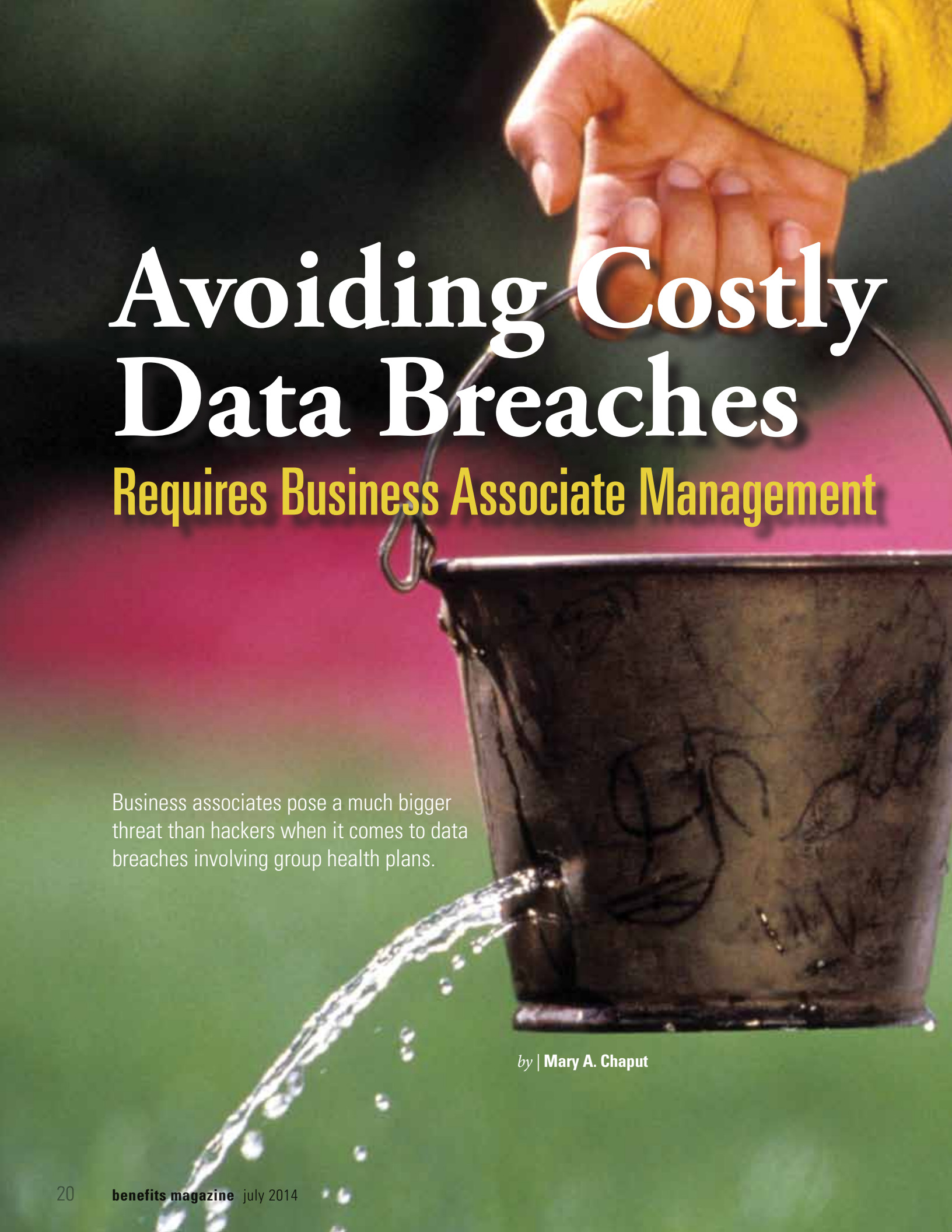

Avoiding Costly Data Breaches

Requires Business Associate Management

Business associates pose a much bigger threat than hackers when it comes to data breaches involving group health plans.

by | **Mary A. Chaput**

A notorious page on the Department of Health and Human Services (HHS) website—www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachtool.html—is often dubbed the "Wall of Shame."

Visitors to this page will find the names of hundreds of well-known health care organizations responsible for about 900 data breaches affecting more than 30 million Americans.

Because of the high-profile security breach at Target stores last year, it would be easy to conclude that these health care breaches are the work of teenage hackers in Eastern Europe. But only about 8% of the breaches listed on the Wall of Shame are due to hacking or security incidents; 92% are caused by employees—those of organizations and their business associates (BAs).

About 25% of the breaches (affecting about 15 million patients) are attributable to health care organizations' own BAs. In recent months, the list has included big names like K-Mart Pharmacy, Healthcare Management Systems and Shred-It International.

Some recent studies reveal that the problem is growing worse. In its fourth annual study on patient privacy,[1] the Ponemon Institute

reported that nine in ten health care organizations had experienced a data breach in the past two years, with 38% experiencing more than five incidents. About 41% of these breaches were attributable to BAs, and 73% of the organizations surveyed had no confidence that their BAs could meet the requirements of their BA agreement to detect, investigate and notify them in the event of a security incident.

This is particularly alarming for group health plans, which use an array of BAs to handle enrollment and claims processing, Consolidated Omnibus Budget Reconciliation Act (COBRA) administration, pharmacy claims, data backup/recovery and much more.

TSYS Employee Health Plan learned this only too well when a temporary employee at Paragon Benefits, Inc., a BA administering health benefits on behalf of TSYS, was charged with felony identity theft of more than 5,000 former TSYS employees and family members,[2] landing TSYS on the HHS Wall of Shame.

Penalties Growing More Severe

An Office for Civil Rights (OCR) investigation resulting from a complaint or data breach that reveals "willful neglect" on the part of the covered entity formerly carried a maximum fine of $25,000. Now it's a whopping $1.5 million per violation[3]—and a single data breach usually involves multiple violations of the Health Insurance Portability and Accountability Act (HIPAA).

According to the Ponemon study, the average economic impact of a data breach over the past two years is almost $2 million.[4] Then there are the harder-to-quantify costs, such as reputational damage, that drive current and prospective customers away when data breaches are reported. Any data breach involving more than 500 patient records must immediately be reported to HHS and, if 500 or more are from the same state or jurisdiction, the incident must also be reported to the media. In a benchmark research study conducted by the Ponemon Institute, the average loss of customers in the health care industry following a data breach is 4.2%.[5]

If the data breach is really serious, patients sometimes band together in class action lawsuits. A Temple University study found that the average settlement award in a data breach class action suit is $2,500 per plaintiff, with attorney fees averaging just over $1 million.[6]

Some health care organizations believe that they can inoculate themselves from the problem by taking out cyber liability insurance. But premiums often are prohibitively expensive. For most health care organizations, cyber liability insurance involves annual premiums in the $200,000 range and deductibles as high as $500,000.

Many cyber liability insurance policies condition coverage upon the insured being in compliance with the HIPAA/HITECH requirements—and many states (and general principles of tort liability) provide that insurance cannot insulate a company from violations of the law. Of note, there was a recent Stanford Hospital and Clinics decision where Hartford Casualty Insurance Company argued that the coverage of a breach was excluded from the policy due to it being a statutory infraction. Stanford argued that Hartford should cover the breach anyway due to underlying common law and constitutional notions of privacy. Stanford prevailed, but insurance companies may begin to draft their exclusions more carefully as they consider the implications of this case.[7] Holders of cyber liability insurance should read their policy very carefully.

New Regulatory Requirements for BA Contracts

Every health care organization's BA contracts already include specific provisions for permitted and required uses and disclosures of protected health information (PHI). (See the sidebar for the complete list of HIPAA regulatory requirements for BA contracts.) The Omnibus Rule has expanded the scope of these agreements to include:

- Ensuring that BA subcontractors that create, receive, maintain or transmit PHI agree to the same restrictions and conditions as the BA
- BA compliance with the expanded Privacy Rule regulations.

There are also regulatory requirements specific to group health plans. A group health plan's plan documents must be amended to include provi-

learn more >>

From the Bookstore

HIPAA Privacy for Health Plans After HITECH, Second Edition

Reinhart Boerner Van Deuren. 2013.

Visit *www.ifepb.org/books.asp?8950* for more details.

HIPAA Regulatory Requirements for BA Agreements[1]

Highlighted sections show new requirements imposed by the Omnibus Rule:

- Establish the permitted and required uses and disclosures of protected health information (PHI).
- Business associate (BA) may not authorize the use or further disclosure of PHI that violates the Privacy Rule.
- Provide that the BA will:
  - —Not use or further disclose the information other than as permitted or required by the contract or as required by law
  - —Use appropriate safeguards **and comply, where applicable, with the Security Rule with respect to electronic PHI** to prevent use or disclosure of the information other than as provided for by its contract
  - —Report to the covered entity (CE) any use or disclosure of the information not provided for by its contract of which it becomes aware, **including breaches of unsecured protected health information.**
- **Ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of the BA agree to these same restrictions and conditions.**
- Make PHI available in accordance with an individual's right of access.
- Make PHI available for amendment and incorporate any amendments.
- Make PHI available as required to provide an accounting of disclosures.
- **To the extent the BA is to carry out a CE's obligation, comply with the Privacy Rule regulations that apply to the CE.**
- Make its applicable internal practices, books and records available to the HHS secretary for purposes of determining the CE's compliance with the Privacy Rule.
- At termination of the contract:
  - —If feasible, return or destroy all PHI received from, or created or received on behalf of, the CE
  - —If such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible or
  - —Authorize termination of the contract by the CE if the CE determines that the BA has violated a material term of the contract unless such authorization is inconsistent with the statutory obligations of the CE or its BA.

BA Contracts With Subcontractors

These requirements apply to the contract or other arrangement between a BA and a BA that is a subcontractor in the same manner as such requirements apply to contracts or other arrangements between a CE and BA.[2]

Specific Requirement for Group Health Plans

The plan documents of the group health plan must be amended to incorporate provisions to ensure that any agents to which it provides PHI agree to the same restrictions and conditions that apply to the plan sponsor, including disclosing employment-related actions and decisions or using the information in connection with any other benefit or employee benefit plan of the plan sponsor.[3]

Endnotes

1. §164.504 Uses and disclosures: Organizational requirements (e)(2).
2. §164.504 Uses and disclosures: Organizational requirements (e)(5).
2. §164.504 Uses and disclosures: Organizational requirements (f).

sions to ensure that any agents to whom it supplies PHI agree to the same restrictions and conditions that apply to the plan sponsor.[8]

Strengthening a BA Management Program

It's clear that data security needs to be a cornerstone of every BA agreement and relationship. Here are some practical pointers on how to tailor a BA management program that can make an organization far less vulnerable to data breaches.

Inventory BAs

An organization should start by taking stock of every BA that has access to the organization's PHI, along with an estimate of the number of records they're entrusted with and what type of health information they have. Although *sensitive information* (for example, concerning conditions such as addiction, HIV, sexually transmitted diseases or mental illness) has yet to be defined by the regulators,[9] we can expect that impermissible access or disclosures of such information[10] can result in

takeaways >>

- Only 8% of data breaches listed on the HHS "Wall of Shame" are due to hacking or security incidents; 92% are caused by employees and 25% by business associates.
- A group health plan is responsible for data breaches caused by BAs that handle enrollment, claims processing, COBRA administration, data backup and much more.
- A data breach resulting from willful neglect now carries a maximum fine of $1.5 million per violation, and a single breach of HIPAA often results in multiple violations.
- Cyber liability insurance has high premiums and deductibles and may condition coverage on compliance with HIPAA HITECH.
- The best way for a plan to understand its risk of a breach is to complete a rigorous security risk analysis, as required by the HIPAA Security Rule.

increased liability for the covered entity.[11] The organization should determine the most recent date of BA audits or attestations and find out how many incidents or breaches have occurred since BA agreements were effective. Then it should assess the risk level to the organization: critical, high, medium or low. The critical and high-risk BAs may need to be managed more closely.

Vet New BAs Before Contracting

An organization can ward off problems preemptively by sending prospective BAs a questionnaire on privacy/security policies and requesting previous reportable breaches and remediation plans. BAs also should provide information on where data will be stored (overseas or in the United States only), subcontractors used, data disposal at contract termination and results of previous HIPAA assessments.

Review All BA Agreements

For starters, an organization should make sure that specific BA contract requirements stemming from the Omnibus Rule have been incorporated into amended or new contracts.

It's important to communicate more frequently with BAs than ever before. Organizations should insist on tight time lines for reporting incidents and breaches (e.g., five days upon discovery) so that they have sufficient time to investigate and prepare for public notification if required. Organizations should ask their BAs to immediately inform them of any major operational or technical changes the BAs make, including any acquisitions or divestitures.

Now is the time for organizations to deepen their relationship with BAs' privacy/security officers. If organizations are not hearing from these officers regularly, they either don't have a good incident-reporting process or they're simply not reporting them at all.

It's also wise to enlist legal assistance to ensure that all BA agreements include appropriate liability and indemnification clauses, along with notification responsibilities, in the event of a data breach.

Don't Overlook NPP Responsibilities

Every individual enrolled in a group health plan has the right to receive a timely notice of privacy practices (NPP). A group health plan must maintain an NPP and provide it upon request if the plan provides health benefits solely through an insurance contract with a health insurance issuer or health maintenance organization and creates or receives more PHI than just summary health information or details on an individual's plan participation or enrollment/disenrollment.[12]

This document must be updated for any material changes to the uses or disclosures of PHI—and BAs need to be informed promptly of those changes that affect the services they provide.

Keep Off the Wall of Shame

There is an unbiased way to determine an organization's financial exposure to a data breach and to use that information for obtaining additional funds to strengthen its security program. The American National Standards Institute (ANSI) offers a free publication entitled *The Financial Impact of Breached Protected Health Information.* It is available at webstore.ansi.org/phi.

The ANSI paper provides an excellent overview of data breach issues and includes tools for calculating the cost of a breach specifically for an organization's group health plan.

One preventive step an organization must take is to complete a rigorous risk analysis as required by the HIPAA Security Rule. It's probably the best way to make sure its name is not added to the Wall of Shame.

Endnotes

1. Ponemon Institute, *Fourth Annual Benchmark Study on Patient Privacy and Data Security,* March 12, 2014; available at www.ponemon.org/blog/fourth-annual-benchmark-study-on-patient-privacy-and-data-security.
2. Ben Wright, "Man charged in TSYS identity theft violated computer policy at Paragon Benefits," Columbus, Georgia *Ledger-Enquirer,* October 15, 2013; available at www.ledger-enquirer.com/2013/10/15/2745341/drew-johnson-hearing-district.html.
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12. §164.520 Notice of privacy practices for protected health information (a)(2)(ii).

bio

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Benefits Gone

As participants increasingly use smartphones and tablets to access the Internet, plan sponsors may need to be sure their benefits website is mobile-friendly.

Many benefit fund administrators have embraced the Internet as an invaluable medium for communicating with their participants, employers, trustees and providers. Most use customized websites as the face of the benefit fund on the Internet. Progressive adopters of this technology offer secure "self-service" portals on their websites, essentially giving site visitors access to a 24/7 virtual employee at the benefit fund office.

These benefit fund websites and self-service portals often range from simple, one-page static home pages that list fund office contact information and provide access to plan summaries to content-rich, professionally designed interactive websites that allow plan participants to view eligibility, claims history, account balances and pension statements.

by | **Jenna Morrell** and **Kathryn Lane**

Mobile

When designing a website to be displayed on different devices—for example, a traditional desktop PC, a tablet and a smartphone—it is most important that a designer embed functionality that automatically identifies the type of device used by the site visitor and correctly displays the appropriate version.

Many of these sites allow members to fill out and electronically submit virtual forms to the fund office. In some cases, participants can even make online premium payments via credit card or automated clearing house (ACH) bank transactions. These robust sites often include a portal for providers to securely access claims and explanation of benefit (EOB) details or the ability to inquire about coverage eligibility for a patient. Furthermore, benefit plans throughout the industry are realizing the tremendous cost efficiencies and improved accuracy associated with online employer reporting. These remittance portals allow employers to file reports and make contributions to the fund office electronically.

As so many groups have begun to embrace online communications, it is extremely important to be prepared for the new ways members, employers and providers are accessing these websites. More web users are going mobile and expect to be able to access their benefit fund website (and all websites, for that matter) from their handheld devices, specifically smartphones and tablets. However, the vast majority of websites in our industry were designed to be accessed using a desktop computer. Most are not mobile-friendly, and even fewer offer any type of mobile support or smartphone "app."

Cisco Systems Inc. recently released its annual *Global Mobile Data Traffic Forecast Update* containing eyeopening statistics on the explosion of mobile web usage.[1]

- Last year, mobile data traffic increased 81% worldwide.
- In 2013, smartphone usage, on average, increased by 50%.
- Last year, the number of tablets connected to wireless networks increased 2.2 times to 92 million.
- By the end of this year, there will be more mobile-connected devices than people in the world.

With more and more participants using mobile devices, information technology directors, benefit communication managers and fund administrators may want to consider the design and adoption of a mobile website communication strategy as soon as possible.

takeaways >>

- Traditional websites typically are viewed on a desktop computer with a large screen, allowing for more content on the site. The amount of content, options, graphics and images need to be reduced as screen size is condensed.
- It's important to leave enough space between menu options on mobile websites for touchscreen navigation.
- Mobile websites should display content such as multimedia, graphics, images and video in a more efficient, streamlined design to accommodate for slower speeds due to lower bandwidth.
- A well-designed site supports multiple versions of Microsoft's Internet Explorer, Mozilla Firefox, Google Chrome and Apple's Safari, as well as the most common mobile operating systems.
- The same security measures used to protect information on websites accessed through traditional desktop PCs can be used for access with handheld devices.

Differences Between PC and Mobile Websites

So what are the major differences between a traditional PC website and a mobile website or app?

First and foremost, traditional websites typically are viewed on a desktop computer with a screen size of 17 inches or larger. This size allows for substantially more content on the site. The larger screen accommodates more complex design elements and more pages and subpages and better supports multimedia elements such as graphics, audio and video. Simply put, ample content can be posted cleanly and efficiently on a traditional desktop PC website. Depending on the relevance and utilization of this content, that may or may not be a good thing.

Navigation presents another point of difference between traditional and mobile websites. Traditional websites are designed for point-and-click navigation with a mouse. Because mobile websites are navigated with the "swipe" and "swoosh" of a finger and a tap on the touchscreen, sites must allow enough space between menu options for touchscreen navigation.

Design Considerations

When implementing a mobile benefit website, designers have several elements to consider. For example, screen size, or lack thereof, on mobile devices presents some challenges. Essentially, there is less space to convey the message. Most organizations solve this issue by shortening messages and posting only the most important pieces of information on the site. The smaller screen size of mobile devices requires space-efficient content; therefore, designers should eliminate unnecessary text and graphics.

When designing a website to be displayed on different devices—for example, a traditional desktop PC, a tablet and a smartphone—it is most important that a designer embed functionality that automatically identifies the type of device used by the site visitor and correctly displays the appropriate version. With the proliferation of mobile web users, this functionality is paramount in the design of any contemporary website.

Bandwidth should also be considered in website design and implementation. Most mobile web users will be visiting the site over a wireless Internet connection with slower bandwidth/connectivity speeds than a traditionally hard-wired or networked desktop PC. Mobile websites should use a more efficient, streamlined design with less bandwidth-intensive content (such as multimedia, graphics, images and video) to accommodate slower speeds. That being said, this concern seems to be waning as network carriers and service providers try to attract new mobile customers by offering wireless networks boasting the fastest speeds with the most bandwidth and coverage areas.

Multibrowser and operating system support creates one of the biggest challenges for website designers. Designers always have had to account for differences in desktop PC web browsers that can affect how (and sometimes whether) a website will display. A well-designed site will support multiple versions of Microsoft's Internet Explorer, Mozilla Firefox, Google Chrome and Apple's Safari. This challenge intensifies when designing websites for mobile devices with a multitude of operating systems. Each of these operating systems and mobile web browsers can dramatically affect how a website performs on a mobile device. Android, BlackBerry, iOS from Apple and Windows Mobile from Microsoft are the most common mobile operating systems. All of these should be accounted for in the design of a mobile benefit fund website.

For example, Adobe Flash can create viewing issues on mobile sites for visitors using iPads or iPhones since Apple and its iOS do NOT support Adobe Flash. Many of us have gone to a website using our Apple devices only to have the site (or some portion of it) appear blank. Often the site was designed using Adobe Flash. That same site would likely display correctly if accessed from a desktop PC or Windows-based tablet. Considering the popularity of Apple devices, benefit administrators should give pause before using Adobe Flash as a design component in their mobile website solution.

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Reinhart Boerner Van Deuren. 2013.

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Security and Legislative Issues

Protecting member data, particularly electronic protected health information (ePHI), remains a constant concern for benefit funds. Some may worry that providing mobile access to sensitive information, such as EOBs or account balances, will increase the fund office's exposure to Health Insurance Portability and Accountability Act (HIPAA) or other security breaches.

In reality, the same security measures used to protect information on websites accessed through traditional desktop PCs can be used for access with handheld devices. All sites should employ Hypertext Transfer Protocol Secure (HTTPS) to provide encrypted access to site visitors.

Additionally, interactive portals on both traditional and mobile sites should require strong passwords and automatically log out users after a period of inactivity.

Admittedly, smartphones and tablets are more likely to be misplaced or stolen than desktop computers. Therefore, benefit funds should encourage mobile users to enable standard security features on handheld devices. Nearly all smartphones and tablets can be password-protected, and many support encryption tools as well.

While the responsibility for securing handheld devices rests with site visitors, benefit funds can encourage secure practices by including safety tips as part of the site disclaimer. This disclaimer, which details the terms of use, should appear whenever visitors sign on to the portion of the site containing personal information.

Anyone with access to more than their own or their dependent's information, such as employers and administrators, should be especially cautioned to secure their handheld devices. Users with access to extensive ePHI, such as providers utilizing a provider portal, should install encryption tools and enact the strictest security settings.

Of the breaches affecting 500 or more individuals reported to HHS, at least 11% involved a nonlaptop, portable electronic device, such as a tablet or smartphone. Nearly all of these breaches resulted from a lost device and, therefore, could have been mitigated by using encryption tools.[2]

Conclusion

With more and more members using mobile devices to access their benefit information, fund offices should consider designing websites compatible with smartphones and tablets. Fewer graphics and larger navigation buttons are a must for smaller touchscreens and slower bandwidths.

While benefit funds can provide the same security features for mobile sites as traditional sites, it is ultimately up to end users to protect their personal information, whether they access their benefits from a desktop or anywhere on the go.

<< bios

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Chris Brogan is CEO and President of Human Business Works, an education publishing and media company dedicated to helping professionals work better, do the work they want and be brave. He is the *New York Times* bestselling co-author of *The Impact Equation* and a sought-after professional keynote speaker. He also plays in the band D3one3 with Jacqueline Carly.

DIANA NYAD
Long-Distance Swimmer Noted for World-Record Endurance Championships

At the age of 64, in her fifth and final attempt, Diana Nyad successfully fulfilled her lifelong dream of completing the 110-mile swim from Cuba to Florida on September 2, 2013. Upon completing her grueling 53-hour journey, a breathless Nyad told the world, "I have three messages. One is we should never, ever give up. Two is you are never too old to chase your dreams. And three is it looks like a solitary sport but it takes a team."

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Are Your Service Providers Fiduciaries of Your 401(k) Plan?

Hiring the right service providers can insulate retirement plan sponsors from some fiduciary liability—But it depends on the service agreement itself and how plan governance is structured.

by | **Felicia A. Finston and J. B. Friedman Jr.**

With the increased scrutiny regarding retirement plan investments and administration under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, many plan sponsors are seeking ways to minimize their fiduciary liability by hiring service providers to serve in a fiduciary capacity.

Specifically, a service provider may serve as an ERISA Section 3(21) fiduciary, an ERISA Section 3(16) administrator or an ERISA Section 3(38) fiduciary. Whether an arrangement is successful in delegating fiduciary liability will depend not only on the statutory capacity of the service provider under the service agreement, but on the terms of the service agreement itself. It is important that plan sponsors understand the various ERISA fiduciary roles so they can properly structure their plan governance.

This article explores these types of arrangements as well as the issues plan sponsors need to review when seeking this type of independent third-party contractual insulation. Absent appropriate contractual provisions, the fiduciary protection could prove more illusory than real. Following are issues to consider when entertaining these types of contractual fiduciary delegation and their statutory underpinnings.

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Fiduciary Standards and Liability Under ERISA

Section 404 of ERISA provides four basic rules under which retirement plan fiduciaries must operate: (1) the exclusive purpose rule, (2) the prudence rule, (3) the diversification rule and (4) the plan document rule.

- The *exclusive purpose rule* requires plan fiduciaries to administer the plan for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying the costs of administering the plan. This rule often places plan sponsor fiduciaries in a conflict-of-interest position, where the interests of plan participants are different from those of the plan sponsor.
- The *prudence rule* requires plan fiduciaries to administer the plan with the care, skill, prudence and diligence that a prudent man would use under similar circumstances. ERISA prudence is largely procedural, meaning did the right questions get asked, was expert assistance sought and was the fiduciary diligent in making inquiries.
- The *diversification rule* requires that a plan fiduciary diversify the plan's assets to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. An important exception to the diversification rule applies to investments in employer stock.
- The *plan document rule* requires a fiduciary to follow the terms of the plan to the extent it is consistent with ERISA.

A plan fiduciary who breaches any of the above duties may be held personally liable for such failure and required to make the plan whole for any losses, surrender any profits received and pay civil penalties. Criminal penalties may be imposed on the plan fiduciary in egregious cases.

ERISA prohibits a plan from containing provisions that might relieve a plan fiduciary from fiduciary responsibility or liability. However, a plan sponsor may purchase fiduciary insurance or provide indemnification for losses or actions not due to the fiduciary's gross negligence or willful misconduct.

Reason to Delegate Fiduciary Responsibility

Increased litigation brought by zealous plaintiffs' lawyers and regulatory developments regarding retirement plan fee disclosures are causing increased scrutiny of the fiduciary role and fueling plan sponsors' desire to insulate themselves from fiduciary liability.

The proliferation of fiduciary litigation commenced with "stock drop" cases typically involving public companies that offered employer stock as an investment option in their 401(k) plans. These cases came to fruition when the value of such stock declined precipitously and 401(k) plan participants experienced large investment losses. As a result of these cases, many plan sponsors divested their plans of employer stock or employed independent fiduciaries to manage the investment of company stock under the 401(k) plan.

Stock drop cases were followed by "excessive fee" cases where plaintiffs have taken aim at fees paid by 401(k) plans and their participants, typically arguing that the revenue-sharing arrangement, share class and/or related plan service fee levels were inappropriate given the size of the trust corpus. Most of the excessive fee cases have resulted in liability to those fiduciaries who failed to analyze or monitor the plan's fee arrangement or follow applicable investment policy documents, rather than a conclusion that the fee levels or revenue-sharing arrangements themselves violated ERISA. However, such cases led in part to the Department of Labor's development of new rules that require service providers to provide detailed fee disclosures to plan sponsors and require plan fiduciaries to pass on these disclosures to plan participants.

The threat of liability caused by these lawsuits and the additional information required to be provided to participants via the fee disclosure rules have caused plan sponsors (and their advisors) to search for ways to minimize or shift fiduciary responsibility and liability to qualified third parties. As a result, the industry has brought to the forefront different types and levels of service with the aim of providing

enhanced insulation for plan sponsor fiduciaries (or at least marketing the services as geared to that end).

Types of ERISA Fiduciaries

ERISA provides three types of retirement plan fiduciaries, each of which occupies a different role and assumes a different level of fiduciary responsibility and liability:

1. *A Section 3(21) fiduciary.* Section 3(21) sets forth the standards by which any individual performing services for a plan might become a fiduciary due to the functions he or she performs (or has the ability to perform). Any individual can be a fiduciary if he or she (1) exercises any authority or control over the management of the plan or the management or disposition of its assets, (2) renders investment advice for a fee (or has any authority or responsibility to do so) or (3) has any discretionary responsibility in plan administration. Section 3(21) will always encompass the plan sponsor, since it is ultimately responsible for the administration and operation of the plan. However, it may or may not extend to plan advisors. For example, an advisor that simply makes recommendations to and for the plan for which it has no discretionary authority or responsibility is not a fiduciary and therefore has no legal liability under ERISA as a fiduciary. When an advisor is not a fiduciary under this definition, the plan sponsor is not relieved of fiduciary risk or liability.
2. *A Section 3(16) administrator* is a person designated as the administrator under the plan's governing documents. Such a person is responsible for the administration of the plan and bears fiduciary responsibility and liability for doing so. A plan sponsor that appoints an advisor to serve as the plan administrator will be relieved of fiduciary responsibility and liability for the acts of the administrator provided that the sponsor prudently selects and continues to monitor the acts of

Checklist of Contract Provisions to Help Determine Fiduciary Capacity

Applicable Provisions	Yes	No	N/A
Description of services to be provided			
Capacity of service provider			
• Agent?			
• Fiduciary?			
• Acknowledgment of fiduciary status?			
Standard of care			
• Industry standard of care?			
• Negligence?			
• Gross negligence?			
Term			
• Fixed term?			
• Evergreen?			
Fees			
• Description of all fees to be paid?			
• Source of payment of fees (e.g., trust or employer)?			
• Billing protocol?			
• Performance guarantees?			
Confidentiality			
• Reciprocal?			
• Exceptions (e.g., audit, governmental investigation, etc.)?			
• Duration?			
Assignment			
• Is contract assignable?			
• Liability when assigned?			
• Reciprocal?			
• Consent required?			
Limits of liability ERISA prohibits exculpatory provisions for fiduciary breaches, fraud or willful misconduct. Consider nature of service, price or current market conditions and likelihood of harm.			
Indemnification			
• Obligation to defend included?			
• Reciprocal?			
Insurance			
• Obligation to maintain specific types and levels of insurance?			
• Reciprocal?			
Choice of law			
Dispute resolution			
• Mediation?			
• Arbitration?			
Force majeure			
Termination			
• Breach?			
• Convenience?			
• Return of records obligation and cost?			
• Fees?			

the advisor to ensure they are compliant with ERISA. To the extent the administrator advisor fails to comply with Section 404 of ERISA, the plan sponsor must take appropriate remedial action.

3. *A Section 3(38) fiduciary* is an investment manager with actual discretion and control over the plan's assets and is, by definition, a fiduciary because of the ability to manage the plan's assets. ERISA provides that a plan sponsor can delegate the significant responsibility (and significant liability) of investment management to a Section 3(38) investment manager/fiduciary. A 3(38) fiduciary can be only a bank, an insurance company or a registered investment advisor subject to the Investment Advisers Act of 1940. Once a 3(38) fiduciary is properly named, the plan sponsor effectively hands over authority to the 3(38) fiduciary to make investment decisions. The 3(38) fiduciary therefore assumes legal responsibility and liability for the investment decisions it makes, which gives a plan sponsor significant protection from fiduciary risk. Notably, however, the plan sponsor cannot completely eliminate its fiduciary liability, as it remains responsible for the prudent selection and monitoring of the Section 3(38) investment manager similar to that required with a Section 3(16) administrator.

A plan sponsor wishing to insulate itself from fiduciary liability will need to determine the extent of protection it seeks by hiring service providers to fulfill the roles above as appropriate for the plan sponsor's plan governance structure. For example, a plan sponsor that already has a functioning 401(k) investment committee may feel comfortable employing a Section 3(21) fiduciary to assist the committee in reviewing and selecting investment options, with the understanding that the committee will make the final fiduciary decision. Conversely, a plan sponsor that does not have such a committee or that desires to relieve its committee from as much fiduciary responsibility and liability as possible may seek to hire both a Section 3(16) administrator to serve as the administrator of the plan and a Section 3(38) fiduciary to assume the investment management.

Clear Documentation—The Devil Is in the Details

Once a plan sponsor has decided on a fiduciary structure, it should be documented through service agreements, and those agreements should be reviewed by legal counsel to ensure that the plan sponsor is actually obtaining the fiduciary protection it seeks. Often there is a discrepancy between what the plan sponsor believes it has "purchased" and what has been "sold." In addition, the service agreement should address other common contractual terms, as outlined later in the article.

A February 28, 2014 decision by the Fifth Circuit Court of Appeals in *Tiblier v. Dlabal* reiterates the importance of having clear documents regarding an advisor's fiduciary status. In *Tiblier*, the Fifth Circuit absolved a retirement plan's financial advisor of all fiduciary responsibility for investment advice he provided on the basis that the advisor was not a fiduciary in connection with the alleged conduct because he was not paid by the plan.

The facts in *Tiblier* are straightforward: A physician cash balance plan hired the defendant (a licensed broker and registered investment advisor representative) of a subsequently defunct registered investment advisor entity. Of key importance ultimately was the engagement agreement. The *entity* was designated as the "Advisor" and the defendant, Dlabal, as the "Registered Representative." Discretionary authority under the engagement agreement was vested in the advisor (the entity) rather than the defendant.

The district court concluded that there was a material fact as to whether the defendant was a fiduciary, but nevertheless the court granted summary judgment in favor of the defendant on the basis that he made adequate disclosure to the plan's fiduciary of the investment itself. The appeal ensued.

takeaways >>

- A plan fiduciary can be personally liable for breaches of fiduciary duty and may face criminal charges for especially serious breaches.
- An ERISA plan can't have provisions that relieve a plan fiduciary of fiduciary responsibility.
- Because of increased litigation—particularly in stock drop and excessive fee cases—and regulatory changes, plan sponsors are seeking to minimize or shift fiduciary responsibility and liability to qualified third parties.
- Each of the three different types of retirement plan fiduciaries has different roles and assumes a different level of fiduciary responsibility and liability.
- A fiduciary structure should be documented through service agreements reviewed by legal counsel to ensure the plan sponsor is obtaining the protection it seeks.

<< bios

Felicia Finston is a partner in the Dallas, Texas office of Wilkins Finston Law Group LLP, a firm practicing exclusively in the area of employee benefits and executive compensation. She has more than 24 years of experience handling benefit and compensation issues for Fortune 500 and other public and private companies and tax-exempt entities. Finston previously worked at Vinson & Elkins, LLP and Baker Bots LLP. Finston earned a B.S. degree in business (human resource management) from Arizona State University, an M.S. degree in human resources management from the University of Utah and a J.D. degree from the University of New Mexico School of Law. Best Lawyers in America selected Finston as the 2014 Dallas Litigation–ERISA Lawyer of the Year.

J. B. Friedman Jr. is a partner in the San Antonio, Texas office of Wilkins Finston Law Group LLP. He has more than 30 years of experience with employee benefit aspects of mergers and acquisitions and in all aspects of qualified retirement plans, with an emphasis on the implementation and operation of employee stock ownership plans. Friedman also has extensive experience in the area of plan mergers and issues concerning collective bargaining agreements and the impact of multiemployer pension plans and the imposition of withdrawal liability. He previously was a partner at Norton Rose Fulbright. Friedman, a certified public accountant, earned a B.B.A. degree in accounting from the University of Texas and a J.D. degree from South Texas College of Law. He was selected by Best Lawyers in America as the San Antonio 2014 Employee Benefits (ERISA) Law Lawyer of the Year.

The Fifth Circuit concluded that Dlabal was not a fiduciary as defined by Section 3(21) of ERISA. In analyzing the basis of fiduciary status, the Fifth Circuit summarily dismissed that status under 3(21)(A)(i) (exercising discretionary authority or control) because the plan's trustees had ultimate decision-making authority on plan investment decisions. Similarly the court found that the defendant did not actually exercise the requisite control.

The significance of the opinion, and what is sure to create the most interest, is the Fifth Circuit's rationale concerning the application of Section 3(21)(A)(ii), which identifies a fiduciary as someone that "render[s] investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan." The Fifth Circuit concluded that the defendant could not be a fiduciary with respect to the plan under Section 3(21)(A)(ii) because he did not receive a fee from the plan in connection with the subject investment. The court made no mention of the "direct or indirect" language of the statute but rather relied on a 1988 Fifth Circuit case for the binding precedent that a brokerage commission is not a fee under Section 3(21)(A)(ii), hence no fee was received "from the plan," and fiduciary status could not be proven under 3(21)(A)(ii).

The *Tiblier* decision is sure to cause interest in the advisor community. Clearly, when plans contract with investment advisors and their firms, considerable attention should be paid to both the capacity of the parties as well as the licensing of those individuals and firms. Given the proliferation of investment professionals and firms entering the marketplace of providing "3(38)" investment advisor roles, "3(21)" investment advisor roles and now full "3(16)" designated plan administrator roles, plan sponsors should carefully review provider agreements to understand fully the role of the advisor and the enforceability of contractual liability provisions should things go awry during the course of the engagement.

Service Provider Contractual Terms

Negotiating fiduciary service agreements that appropriately insulate the plan sponsor from fiduciary liability requires diligence by the plan sponsor and its legal advisors to ensure that the appropriate services will be provided, that the advisor serves the desired fiduciary role and that only reasonable compensation is paid. The checklist accompanying this article may serve as a useful tool to plan sponsors with respect to such agreements.

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Multibalanced Model:

Last year's strong returns and the continuation so far in 2014 may tempt plan sponsors to finally take a breather and relax. But with many plans still underfunded, the entrepreneurial saying, "If you're not improving, you're falling behind," continues to hold true.

As vigilant investors seeking improvement, institutional plan sponsors may alter their asset allocation, change managers or replace their investment consultant. They may even change their overall investment strategy to a passive, liability-driven or risk parity approach.

But how many plan sponsors are considering changing their investment model? This more fundamental question is rarely asked but deserves careful consideration.

by | **Brian A. Schroeder**

The Missing Link in Investment Approaches?

An investment model using balanced managers can result in diversification of thought and execution for a pension fund.

FIGURE 1

Traditional Model

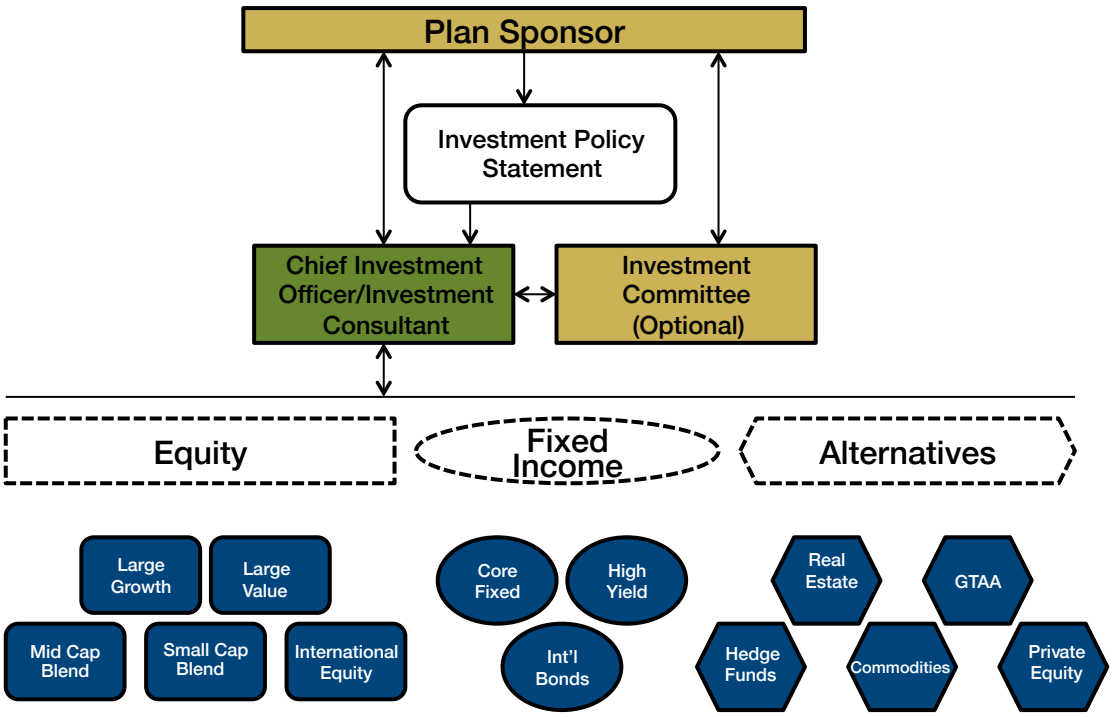
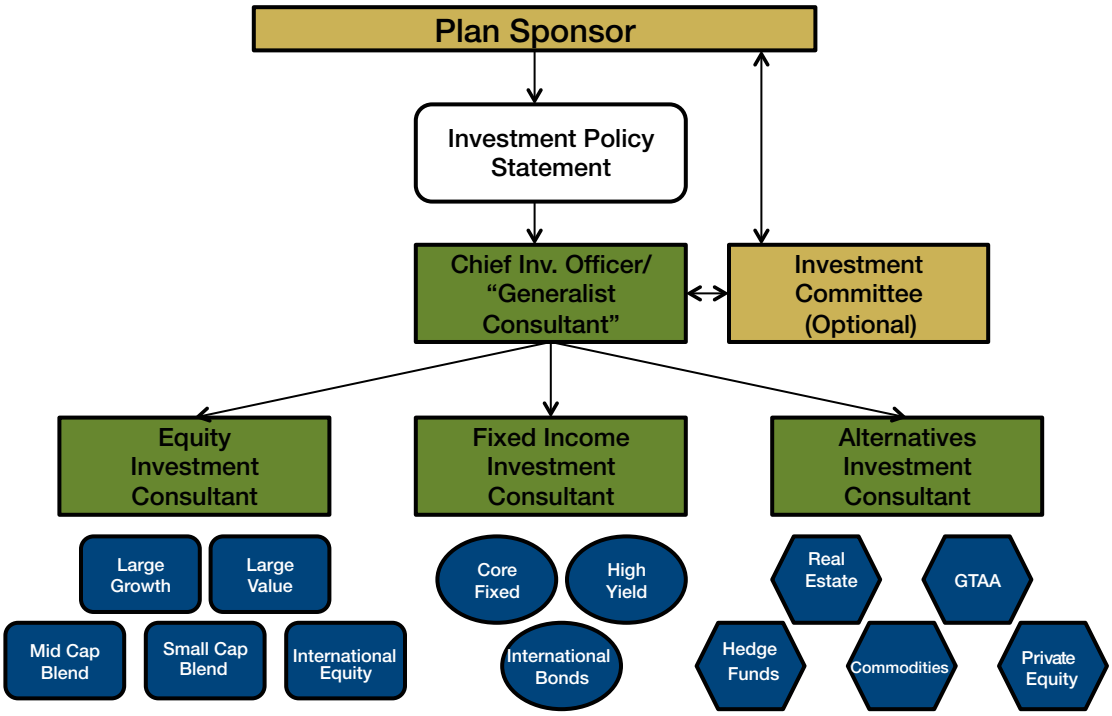


FIGURE 2

Multiple Specialty Consultants Model



Investment Models Keep Evolving

Investment models used by institutional plan sponsors have evolved over time. It used to be that most plans invested 100% in bonds that were managed by a single manager. With the advent of modern portfolio theory, stocks usually were the next asset class added, and the investment model evolved into a single balanced manager.

This evolution continued such that a single balanced manager no longer sufficed. Portfolios were further divided among multiple specialty managers across a myriad of asset classes, with the overall strategy led by an investment consultant. Most plans today have settled on this consultant-centric model (Figure 1). Some plans have taken this model further by using multiple specialty consultants that are coordinated by a generalist consultant (Figure 2).

Within this evolution there is a "missing link"—the multibalanced model (MBM) (Figure 3). It is a powerful and simple investment model that has been passed over in this evolution. However, MBM is starting to gain wider appeal.

The Federal Reserve's Model

A May 13, 2002 editorial in *Pensions & Investments* first brought the MBM to my attention. According to the editorial, "Managers as Asset Allocators," the Federal Reserve's model of using multiple balanced managers has roots going back to 1934. The Fed adopted the model because it did not want to signal the markets if the Fed changed the strategic asset allocation of its defined benefit plan.

In the article, then-Chief Investment Officer Paul C. Lipson was quoted: "We select (balanced) managers who use different asset allocation methodologies. That gives us a kind of diversity no other pension plan has—an asset allocation diversity." That quote is the key to understanding the power of this investment model. The Federal Reserve's model not only brings asset allocation diversity, but has a host of other potential benefits.

Diversification of Thought and Execution

The old saying "simplicity is elegance" has never been more true than when describing the MBM. Its simplicity masks benefits that today's plan sponsors may find appealing. The biggest of these benefits is a more fundamental kind of diversification—diversification of thought and execution.

A comparison of the investment models in Figures 1 and 2 with the MBM shows that each is diversified among various asset classes and managers. *But the decisions of which asset classes to own and in what proportions and which managers to hire are concentrated.* In other words, there is no diversification of thought or execution for the most critical investment decisions of asset allocation, manager selection and rebalancing.

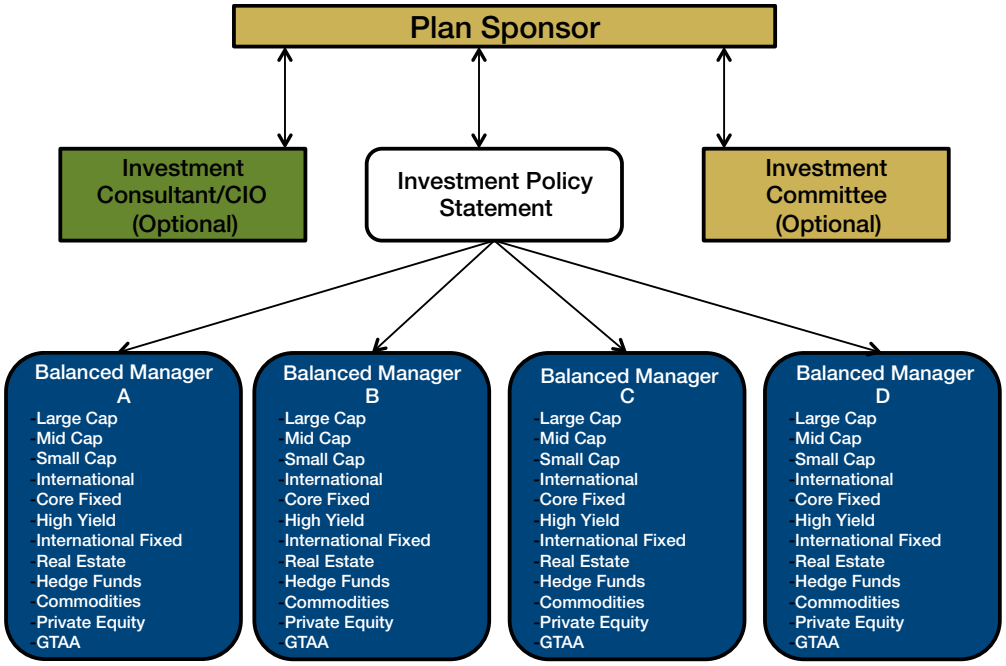
The MBM adds diversification of thought and execution into the investment process. Following broad guidelines, each balanced manager in the MBM can adopt asset allocations depending on its differing outlooks and methodologies. The MBM diversifies asset allocation risk as opposed to following the advice of a single investment consultant. All of the eggs are not in one basket.

The MBM also brings diversification of thought and execution to manager selection. Studies suggest that manager selection by institutional investors does not add value.[1,2] Each balanced manager selecting submanagers diversifies the risk of poor manager selection. This diversification is prudent in light of these studies. Of course, the decision of which balanced managers to hire remains.

The last decisions that are diversified by the MBM concern tactical asset allocation and rebalancing. Timely tactical asset allocation and rebalancing can yield incremental returns and better manage risk. Again, the consultant-centric models rely on the expertise of a single investment consultant, whereas the MBM diversifies these duties among multiple balanced managers empowered to react independently to changing markets.

FIGURE 3

Multibalanced Model



This last point deserves some emphasis. The MBM is more nimble in making adjustments within dynamic financial markets. The consultant-centric models, even when discretionary authority is granted, are still more cumbersome when it comes to timely execution as assets must be moved between managers and, thus, opportunities may be lost. Movement of assets within balanced managers can be better coordinated and executed, thus better capturing incremental gains or managing risk.

It should be noted that if a plan follows a *risk parity strategy* (a strategy that seeks to equalize the risk from each asset class in the portfolio) or *passive approach* (a strategy that uses only index funds), the MBM can still be employed to advantage. Instead of having one centrally directed risk parity portfolio, there can be several, as risk parity managers are all different. Similarly, the MBM using only index managers would add diversification of thought and execution to asset allocation and rebalancing.

Secondary Benefits of the MBM

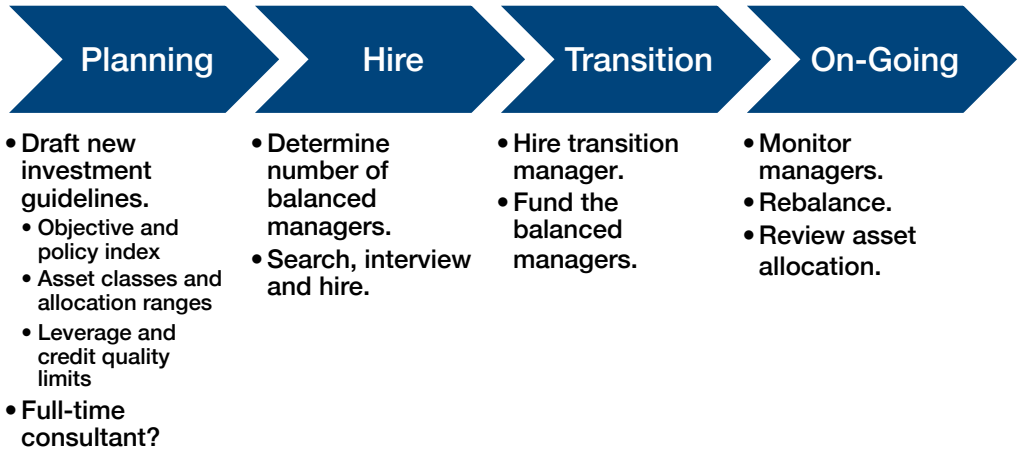
Diversification of thought and execution for asset allocation, manager selection, tactical asset allocation and rebalancing are the primary advantages of the MBM. However, there are several secondary advantages plan sponsors might also appreciate.

Monitoring the investment process is a key fiduciary duty of plan sponsors. This duty cannot be delegated away as the buck ultimately stops with the plan sponsor. Many large plan sponsors today have dozens of managers, and monitoring them can be overwhelming. With the MBM, there are fewer managers and all of them manage against the same benchmark, making comparison easy. In a sense, the plan creates its own manager universe. Of course, rankings among a wider plan universe would still be used.

Monitoring the investment process is not limited to just the managers. Plan sponsors must also monitor their investment consultant's asset allocation ability, effectiveness of manager selection and rebalancing prowess. But relying on investment consultant reports to monitor the investment consultant is a near impossibility due to *benchmark linking* (changing a plan's policy index to mirror changes in strategic asset allocation) and not

FIGURE 4

Steps to Implement Multibalanced Model



tracking fired managers. The MBM eliminates this near impossibility and thus may lower a plan sponsor's potential liability.

Costs may be lower with the MBM. Manager fees typically are on a sliding scale. By widely spreading assets across an array of specialty managers, management fees may be higher than the MBM strategy that has fewer managers with larger mandates. Further, the cost of a full-time investment consultant may be reduced if not eliminated. Of course, the need for occasional investment consultant services such as performance monitoring or asset allocation advice may remain.

Lower fiduciary liability may be another advantage of the MBM beyond the monitoring advantage cited above. Plan sponsors would now be delegating to multiple fiduciaries—instead of to a single consultant—the duties of asset allocation, manager selection and rebalancing. An argument can be made that this diversified delegation is more prudent as it diversifies the risk of poor investment advice.

A final advantage is fewer conflicts of interest. Although plan sponsors and their investment professionals normally are fiduciaries, conflicts of interest remain. For example, in the manager hiring and firing process there are incentives to make defensive decisions that can lead to "buying high and selling low." Investment consultants have a direct conflict if they are not only making recommendations and decisions but also evaluating their own performance and providing reports. The MBM eliminates many of these conflicts and brings greater transparency to the investment process and reporting function.

Are There Potential Problems With the MBM?

Few strategies are without drawbacks, and the MBM is no exception. There are three that should be noted. The first is there could be "group think" among the balanced managers. For example, following the same broad investment guidelines, all the balanced managers may go heavy into an asset class at the wrong time. Of course, poor asset allocation is a possibility in the consultant-centric models.

The second is that balanced managers, if allowed by the investment guidelines, may have a conflict in funding illiquid strategies that are not redeemable for long periods. By separating illiquid investments from the balanced managers, or having such investments separately approved, this conflict can be eliminated.

The third is transparency of fees and trading costs. Depending on how the balanced managers choose to invest plan assets, there may be multiple levels of fees. When monitoring managers, the plan sponsor should pay special attention to management fees and trading costs to ensure full disclosure and transparency.

How Can the MBM Be Implemented?

Implementing the MBM can be accomplished in three

steps. Most likely a plan sponsor would hire an investment consultant to lead the transition.

The first step is to craft investment guidelines with broad asset allocation discretion. These guidelines would not only provide wide ranges for permissible asset classes, but would also address issues such as credit quality, securities lending and leverage. At this time, the policy index and return objective would be identified.

The next step would be to decide on the number of managers and perform a search. In Figure 3, four managers are shown because one balanced manager would report at each quarterly meeting. Of course, there is no "objectively correct" number of balanced managers to employ; the number would be a function of the assets under management.

The final step is to fund the balanced managers. Working with the existing managers and the incoming balanced managers, a transition manager would coordinate the asset transfer to ensure full investment during the transition and to minimize costs.

Going forward, the plan sponsor would only have to monitor performance of the balanced managers and rebalance among them. This should be a much less time-consuming proposition than either of the consultant-centric models with manager interviews, long consultant reports, having managers "on watch," manager searches, asset allocation studies, investment committee meetings, etc. Saving valuable meeting time is another advantage of the MBM.

What Does the MBM Mean to the Consultant Industry?

Plan sponsors have two options on how to use investment consultants following the MBM. Although the MBM diversifies the critical duties performed by investment consultants, there are still many services plans will need. Depending on how plan sponsors implement the MBM, the role of investment consultants could contract to project work or, more likely, greatly expand their scope of service.

The first decision is whether to hire a full-time investment consultant to oversee the MBM by providing reports, asset allocation advice, manager monitoring, manager searches and rebalancing. If a full-time consultant is not used, plans would likely hire on a project basis. Performance reports and manager evaluation could be an annual service. Asset allocation studies could be performed every few years. The rebalancing duty could be set on "autopilot" with triggers based on percent of assets.

The next decision is what kind of balanced managers to hire. Investment consultants have practically morphed into investment managers running balanced portfolios as a "manager of managers." So plan sponsors could hire multiple investment consultants with total discretionary authority to be the balanced managers. Or plan sponsors could hire investment managers to be the balanced managers or a combination of the two.

Is the MBM a Better Mousetrap?

If you accept that the traditional consultant-centric model (Figure 1) works, so must the MBM as it simply recreates traditional investment portfolios multiple times. By doing so, there is now valuable diversification of the key investment decisions. The MBM also delivers a more nimble process to execute tactical asset allocation and rebalancing. It logically follows that improvements in process should lead to an improvement in results.

Although there isn't enough empirical data to quantitatively and definitively say whether returns will be better, research has begun. And as more plans adopt the MBM, a database or

takeaways >>

- MBM diversifies timely tactical asset allocation and among multiple managers with the power to react independently to changing markets.
- Movement of assets within balanced managers can be better coordinated and executed, better capturing incremental gains or managing risk.
- Comparing investment manager performance may be easier with an MBM, as there are fewer managers and all are managing against the same benchmark.
- Lower costs, lower fiduciary liability and fewer conflicts of interest may be among the other advantages of the MBM.
- Drawbacks of the MBM are the possibility all the balanced managers will invest heavily in the wrong asset class at the same time, potential liquidity problems and transparency of fees and trading costs.
- To implement an MBM, a plan sponsor needs to establish investment guidelines with broad asset allocation discretion and perform a search for the number of balanced managers it has decided it needs.

universe will be formed and available for study and comparison.

What's Next for Plan Sponsors?

Today many plan sponsors are experimenting with the MBM without realizing it. For example, some have split off chunks of their consultant-centric plans and given it to another consultant, manager or broker. The idea is to create a competitive environment in hopes of inspiring their investment professionals to achieve better returns. They are just sticking their toe in the MBM pool and may not know what they could achieve by taking the simple and intuitive idea just a bit further.

Is the MBM the missing link of institutional investment models that was lost in evolution? Or is it the next step in the evolution of investment models? Survival of the fittest is not limited to the animal kingdom, and time will tell us the answer to these questions.

Plan sponsors have wide discretion to manage their investment portfolios. The next time plan sponsors question changing their asset allocation, a manager or investment consultant, they should also question their investment model. The MBM is an alternative that may deserve a second look for the first time.

<< bio

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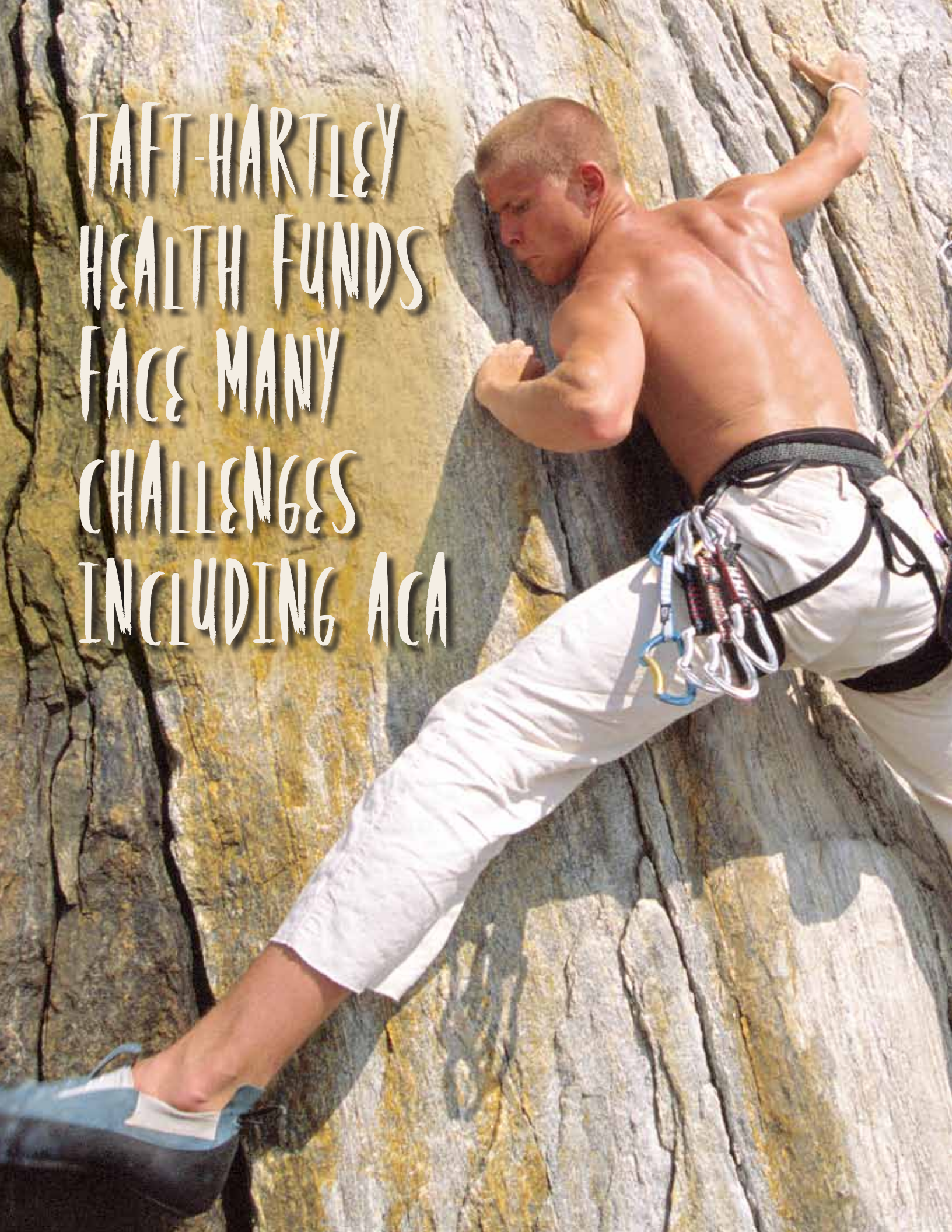
Endnotes

1. Amit Goyal and Sunil Wahal, "The Selection and Termination of Investment Management Firms by Plan Sponsors," *The Journal of Finance,* August 2008. Available at www.hec.unil.ch/agoyal/docs/hirefire_jof.pdf.
2. Howard Jones, Tim Jenkinson and Jose Vicente Martinez, *Picking winners? Investment consultants' recommendations of fund managers,* Private Equity Institute of the Said Business School, University of Oxford. 2013.

Taft-Hartley Health Funds Face Many Challenges Including ACA



A survey of Teamsters union leaders of health and welfare trust funds resulted in seven recommendations regarding organizing, administrative and legislative efforts. The survey probed the leaders' concerns about fund survival in the face of the Affordable Care Act.

by | **Geoffrey W. Hoffa, D.H.Sc., Kathleen Mathieson, Ph.D., Catherine V. Belden, D.H.Sc.,** and **Simone L. Rockstroh**

Despite a waning labor movement, spiraling health care expenditures and increasing pressure to shift costs directly to employees, Taft-Hartley health and welfare plans successfully provide the highest level of benefits for employees across the spectrum of available health care plans. Today, it is still common to find plan participants enjoying benefits without a copayment in monthly premiums.

However, the Affordable Care Act (ACA)—the greatest change in health care legislation since the Social Security amendments of 1965 introduced Medicare and Medicaid—has created problems for Taft-Hartley health and welfare funds. Indeed, ACA threatens the upheaval of employment-sponsored health insurance.[1]

The authors, three of whom are researchers at the Arizona School of Health Sciences at A.T. Still University, surveyed leaders of Teamsters union health and welfare trust funds to gain a better understanding of their perceptions of pressures on Taft-Hartley funds before and after passage of ACA.

To continue operating, Taft-Hartley plans must overcome challenges including:

- Unlimited lifetime coverages
- Unfunded mandates
- The threat of employer flight from the responsibility of providing health benefits by sending employees to tax-subsidized health care exchanges
- Abbreviated waiting periods for initial eligibility
- The pending excise tax on high-cost health insurance plans (the "Cadillac tax").

Because of a lack of guidance and regulations from the executive branch, organized labor has had difficulty adapting to ACA. Labor's options have been limited in discussions with the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury and the Office of Personnel Management (OPM).

A longer, more detailed article on the survey of Teamsters union health and welfare fund leaders, including references, tables and the survey instrument the researchers used, is available at www.ifebp.org/2013teamsterssurvey.pdf.

The challenges of ACA at times eclipse the problems that have existed for Taft-Hartley health and welfare funds long before health care reform. Health trusts struggle to continue providing benefits in the face of decreasing union density, increasing median age of participants, cost shifting, spread pricing and undisclosed drug manufacturer rebates, coupled with the effects of chronic disease, rising prices and greater use of health services.

To meet these challenges, leaders of Taft-Hartley trusts have used strategies such as health care quality improvement, behavioral modification (wellness plans) and, to a limited extent, mergers between trusts to increase the size and market power of health care funds to combat rising costs.

Mergers of funds affiliated with the International Brotherhood of Teamsters (IBT) union have been limited. That may be the product of opposing forces: the pressure to maintain health benefits at current levels by consolidating resources versus the incentive to maintain individual control over trusts funded through trustees' efforts in their parallel occupations as union leaders. Because few IBT initiatives aimed at a coordinated approach to improve market prowess have been successful, it may be surmised that these forces are formidable. Trustees may have resisted pressures to consolidate funds, perhaps to maintain the power to select vendors for sizable contracts with the fund and in defense of their affiliated union's interests locally. The health and welfare trusts would not exist if not for the trustees' affiliated local or regional leadership efforts that establish the collective bargaining agreements (CBAs) contributing money to the funds.

Most Teamsters health and welfare funds were created at the local or regional level. When individuals at international headquarters have proposed a coordinated approach, they often have been met with suspicion that they are trying to usurp local power. This may be changing as pressures mount and trustees of Taft-Hartley health and welfare funds may no longer be confident their funds can survive over the long term without help.

The purpose of this cross-sectional study was to gain greater understanding of the perceptions and concerns of the union co-chairs of all Teamster-affiliated Taft-Hartley health and welfare trusts. Because union co-chairs typically are principal officers of the union locally or regionally, they frequently are responsible for the union's negotiations with contributing employers.

This study provides insight for U.S. health policy and gives the Teamsters (and perhaps organized labor) information needed to craft a strategy to maintain health benefits that began with organized labor. It also suggests the most plausible strategies.

Survey Instrument

Members of the IBT general executive board (GEB), with expertise as health and welfare fund trustees, provided preliminary input on research focus and survey construction. GEB members reported that the rising cost of provider organizations was troubling. They also cited decreasing membership in the funds as a challenge.

All recognized that ACA likely would result in employers ending contributions to funds in future CBAs and that mandated unlimited lifetime benefits threatened the funds financially. Several GEB members related anecdotes about mergers with other Teamsters health funds; others related the troublesome politics or fund liabilities preventing such mergers.

The International Foundation of Employee Benefit Plans provided additional expertise during development of the survey instrument.

The survey focused on (1) the greatest challenges of health funds prior to ACA, (2) the greatest challenges facing health funds as a result of ACA and (3) strategies or plans to ensure continuation of health benefits through Taft-Hartley funds.

The survey consisted of 23 statements (not including demographic questions) submitted to the union co-chairs of Teamsters Taft-Hartley health and welfare funds.[2] Each statement was followed up with a statement of agreement or disagreement scored on a Likert scale of 1 to 5, with 5 indicating *completely agree* with a statement and 1 indicating *completely disagree* with a statement. For items that did not have an applicable answer, a response of *not applicable* was included.

Although the survey was e-mailed to 175 union co-chairs, 42 people responded and four of those were excluded for answering fewer than half of the survey questions. The final sample size was 38, a response rate of 22.9%.

Survey Results and Highlights

Responses to the 23 statements were rank-ordered by the percentage of valid respondents indicating *agree* combined with *completely agree*. The top six statements indicate greater than 70% agree/completely agree. Four of those top six were related to concerns regarding perceived pressures as a re-

sult of ACA, while only one of the top six statements reflected a concern existing prior to the ACA. The rank-ordered results were:

1. The loss of the ability to negotiate with employers for health benefits significantly decreases the ability to organize workers into the Teamsters union, 80.6%.
2. Greater understanding of claims paid will ensure the viability of the fund, 78.4%.
3. The excise tax will negatively affect the level of benefits offered to fund participants, 77.8%.
4. The pharmacy benefits management companies (PBM) exacerbate costs due to undisclosed business relationships with pharmacy retailers and drug manufacturers, 76.3%.
5. The loss of the ability to negotiate with employers for health benefits will affect the level of health benefits for Teamster workers, 75.0%.
6. The ACA will require greater expenditure toward administrative cost for mandated paperwork, 73.0%.
7. I am concerned about the average age of fund participants affecting the funds' viability, 68.4%.
8. The fund is experiencing increased costs associated with growing member claims related to chronic diseases, such as (but not limited to) diabetes mellitus, high blood pressure, heart and vascular disease, 68.4%.
9. "Grandfather" status of the fund under the ACA will be important to the ability of the fund to continue offering health benefits at their current level, 64.9%.
10. Health care quality improvement programs through the fund will ensure the viability of the fund, 64.9%.
11. Pharmacy cost increases will lead to fewer overall benefits from the fund, 63.2%.
12. Greater market power of larger funds as a product of mergers between funds will improve the long-term viability of current plan benefits for participants, 59.5%.
13. Unlimited lifetime maximums for participant benefits threaten the continuation of the current level of benefits offered by the fund, 59.5%.
14. Employers contributing to the health fund through collective bargaining agreements will try to stop contributions as a result of changes from the ACA, 54.1%.
15. My fund will be affected by the excise tax ("Cadillac tax") in 2018, 52.8%.
16. The fund pays more for health care charges through contracts with provider organizations because other payers (Medicare or Medicaid, for example) pay too little (cost shifting), 52.6%.
17. Contracted health services (professional and facilities) fees are increasing to a level where the health plan will have to decrease benefits, 47.4%.
18. The ACA provision affecting health funds by mandating coverage of participants' children until age 26 is a significant financial burden to the fund where plan benefits may need to be decreased, 44.4%.
19. The increasing number of prescriptions written for participants threatens to move the health plan to offer fewer benefits for participants, 40.5%.
20. Without greater market power to lower per member/per month costs of health benefits, my members may lose their health benefits, 37.8%.
21. The member utilization of health services is increasing to a level where the health plan will have to decrease the level of benefits, 36.8%.
22. Behavioral modification programs (wellness programs) have been ineffective in improving the long-term viability of the fund, 35.1%.
23. A new plan offered through the International Brotherhood of Teamsters will ensure the viability of benefits for participants, 29.7%.

That the statement "Greater understanding of claims paid will ensure the viability of the fund" ranked second alludes to the probability that most fund leaders, and probably all trustees, may believe they do not know enough about the important and complex discipline of claims processing, adjudication and payment. Additionally, no procedure has been accepted as the standard regarding claims processing, and there has not been standardization of tools, such as software,

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From the Bookstore

Trustee Handbook: A Guide to Labor-Management Employee Benefit Plans
Seventh Edition
Claude L. Kordus, editor. International Foundation. 2012.
Visit *www.ifebp.org/books.asp?7068* for more details.

takeaways >>

- Among added challenges of ACA are unlimited lifetime coverages, unfunded mandates, employer flight from providing health benefits, shorter waiting periods and the pending Cadillac tax.
- Although few Teamsters health funds have merged, pressures to consolidate funds may be increasing.
- If unions lose the ability to negotiate with employers for health benefits, they face decreased ability to organize workers.
- Fund leaders believe they need a greater understanding of claims paid and need to analyze how to achieve better value in PBM strategies.
- More political effort may be warranted before 2018 to defeat the Cadillac tax.

used to process claims. Note that claims and the relationships with provider organizations likely vary by region and may depend on local business relationships and experience rather than a one-size-fits-all standard applied across the United States. Communicating with public systems (such as the Centers for Medicare and Medicaid Services, for example) could also be fruitful as they could impart their collective experience about large-scale payment systems as well as understanding the effects of large public health systems on private contract, private pay trusts such as Taft-Hartley plans.

The single least agreed-upon statement was that a new plan offered through the IBT would ensure the viability of benefits for participants in funds. Another low-ranking statement was the last one in the survey: "Without greater market power to lower per member/per month costs of health benefits, my members may lose their health benefits," which ranked fourth from last. However, a similar statement administered immediately before that statement fared better: "Greater market power of larger funds as a product of mergers between funds will improve the long-term viability of current plan benefits for participants" ranked number 12. One conclusion is that there may be greater acceptance of market power principles by respondents; but more likely, bias against the last item may have been experienced after the least popular item was answered.

Discussion and Recommendations

The most notable and agreed-upon items in the survey may signal a direction for fund leaders, union leaders and health policy stakeholders to consider when choosing a strategy to preserve the substantial benefits Taft-Hartley health and welfare funds historically have delivered.

Note that although the authors have identified and discussed the top six statements agreed upon by the respondents, a look at the bottom four ranked items reveals that they are the only statements that fell below 40% combined *agree*/*completely agree*, with 16 of the 23 total items (69% of all non-demographic survey items) garnering more than half of the participants who responded in agreement. Most of these topics appear to be important enough to union co-chairs to warrant further discussion and study.

Seven recommendations result from this study:

1. It is important to maintain control over the ability to provide health care through the CBAs for the sake of organizing and preserving the high standard of health benefits enjoyed by Teamster-affiliated health trusts.
2. Greater consideration and political effort should be given to defeating ACA's Cadillac tax that is slated to take effect in 2018.
3. An effort could be made to gather a task force to work through agencies charged with overseeing Taft-Hartley health and welfare fund compliance with ACA. Legislative efforts may be warranted to reduce the cost of paperwork and eliminate burdensome filings wherever possible.
4. Based on concerns about spending on pharmacy goods and services, further analysis may be warranted of the market power of multiple funds in their interactions with PBMs. An analysis of which funds achieve the greatest value in their PBM strategy and relations—perhaps using costs of most frequently prescribed medications and the costliest medications—might be the most practical. Useful purchasing coalitions may arise from collaboration in this effort.
5. Communication between fund administrators may be the key to understanding claims processing. Professional organizations such as the International Foundation could conduct seminars devoted to achieving a standard

in claims adjudication and processing, as well as improving the understanding of complex payment systems. A commission of interested administrators and trustees from multiple Teamster-affiliated health trusts could be formed to advance knowledge and coordinate programs that could benefit the funds through lower costs.

6. At this time, mergers between existing funds may be a more acceptable solution than the idea of a new plan offered through the IBT. However, for almost a third of the represented leaders, an IBT plan may be an alternative trust for those struggling to continue benefits at their current levels.
7. Further analysis of survey results may be helpful. The variables of this study could be recoded to compare fund size with selected strategy items found in the survey responses. This would allow greater delineation of the perceptions of union co-chairs leading trusts of varying size and may yield greater insight as to where a broader coordinated strategy such as mergers would be most helpful.

With approaching health care law issues and long-standing pressures affecting Teamsters Taft-Hartley health and welfare funds, the concerns of the union co-chairs offer a unique perspective from leadership. It is also an opportunity to form a strategy with greater overall support throughout the Teamsters, and possibly the larger labor movement, as organized labor struggles to maintain high standards of health care for its members.

Continued research and analysis, along with measures of successful strategies yielded from studies such as this, ultimately will judge these efforts to sustain or improve the condition of the Teamsters union and the quality of health care benefits enjoyed by its members.

Endnotes

1. S. Singhal, J. Stueland and D. Ungerman. "Healthcare payor and provider practice: How US health care reform will affect employee benefits." *McKinsey Quarterly,* June 2011. Available at http://testagr.georgia.gov/sites/healthcarereform.georgia.gov/vgn/images/portal/cit_1210/37/6/172957333McKinsey%20Survey.pdf.
2. Participants were recruited from the Teamsters Benefits Database of Multi-Employer Health and Welfare Funds, and authorization was obtained through the Office of the General Secretary-Treasurer of the IBT for use of the Teamsters Benefits Database in this study. Union co-chairs/fund leaders (some funds do not identify a "co-chair," but a leader is still distinguishable) were identified and the best available e-mail addresses used for contact. The goal was to survey all Teamster Taft-Hartley health and welfare fund co-chairs serving in that capacity as of 2013.

<< bios

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Five Features of Value-Based Insurance Design Plans Were Associated With Higher Rates of Medication Adherence

Value-based insurance design (VBID) pays more for treatments proven to be clinically effective, often minimizing cost sharing on essential medications for chronic disease. Plan design details vary. Researchers evaluated medication adherence in terms of plan characteristics for 76 plans. They found the plans achieving the best adherence were more generous, targeted higher risk patients, incorporated wellness programs and required mail-order drug delivery but did not offer disease management programs. Several explanations are possible for the negative correlation between the availability of wellness programs and the cost-saving effect of the VBID. Patient targeting, mail order and wellness programs are relatively low-cost and easy to implement to improve pharmaceutical adherence. Overall, the factors studied resulted in a 3% to 5% average improvement in adherence.

Niteesh K. Choudhry, Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdish, Olga S. Matlin, Troyen A. Brennan, Jerry Avorn and William H. Shrank | *Health Affairs* | March 2014 | pp. 493-501 | 0165143

IRS Issues Key Qualified Plan Regulatory Guidance

To provide further guidance on in-plan Roth rollovers, the Internal Revenue Service (IRS) in late 2013 issued Notice 2013-74 explaining numerous points on conversions. Points of clarification include that only fully vested amounts can be converted, that a 402(f) notice is not required, that only certain types of accounts are eligible for in-plan Roth conversions and that converted amounts are still subject to earlier distribution restrictions. The guidance is expected to prompt an increase in adoption of Roth conversion features. IRS also issued Notice 2014-5 to provide temporary relief for nondiscrimination issues that often rise with a soft freeze on a defined benefit pension plan. If such plans are tested in combination with a defined contribution plan, they can base testing on equivalent benefits for plan years starting before January 1, 2016, as long as other conditions are met.

Mark S. Weisberg | *Employee Benefit Plan Review* March 2014 | pp. 26-28 | 0165220

Recent Changes in the Gains From Delaying Social Security

Two changes in access to Social Security benefits implemented in the 1990s and early 2000s increased the advantages of delaying benefits. The delayed retirement credit was made more generous, and married individuals can claim spousal benefits when the spouse either claims benefits or reaches full retirement age. The changes effectively increased the gain from delaying receipt of benefits by 5% to 6% for dual-earning couples, 2% to 4% for single-earner couples and 1% to 2% for singles. Simulations on hypothetical couples illustrate how the factors affect gains from delaying benefits. The greatest effect comes from the delayed retirement credit, though longevity increases and reduced interest rates also contribute. The result is greatest for those who turned the age of 62 in 2000 or later because of the effect of interest rates.

John B. Shoven and Sita Nataraj Slavov | *Journal of Financial Planning* March 2014 | pp. 32-41 | 0165175

Loans, Loans, Everywhere! Addressing the Plan Loan Utilization Issue

Loans from 401(k) plans are on the rise, undermining retirement savings and complicating recordkeeping. The Internal Revenue Service even permits plans with contracts in effect before 2004 to allow participants who default on a loan to borrow again. Plan sponsors have a variety of strategies available to address excessive loans, apart from eliminating the popular option. They should start by improving participant communications on the loan provision, pointing out pros and cons, to balance vendor marketing. The tax consequences and effect on retirement saving should be highlighted. Sponsors can promote repayments by allowing payroll or automatic checking account deductions. They can limit the number of outstanding loans, limit the number of loans in a given time period or change the fee structure. Sponsors can also allow borrowing only from elective deferrals, block further loans after a default or limit participant access to loans through just one vendor or a specified few vendors.

Michael Webb | *The 401(k) Handbook*
March 2014 | pp. 7, 10 | 0165110

Managing Loan and Assignment Issues When Merging 401(k) Plans

When 401(k) plans are merged, careful attention must be paid to coordinating provisions for plan loans. Eliminating loans entirely when they have been available would require immediate repayment, a hardship for affected participants. The Internal Revenue Service (IRS) sets rules for certain loan features, but plans may tighten those rules and establish rules for the number of simultaneous loans, loan frequency and other matters. Amendments may be needed to grandfather existing loans into a surviving plan, possibly through reamortization, and differences in loan periods must be harmonized. The interest rate must be commercially reasonable. IRS prohibits participants seeking hardship withdrawals from employee or employer deferrals for at least six months. Surviving plans must ensure they have necessary data for qualified domestic relations orders for seamless administration.

Todd B. Castleton | *Guide to Assigning & Loaning Benefit Plan Money*
March 2014 | pp. 2-3 | 0165108

Plotting the Mission

Improving a retirement plan starts with identifying what is needed. Over half of plan sponsors at a 2013 national conference had no goal for their plan, and 82% had no definition for its success. Just as a plan participant should know his or her retirement goal and how to work toward it, a sponsor should have a plan mission statement that clarifies what the sponsor wants to achieve and provides the basis for near-term goals. Achievable objectives for 2014 might start with following a fiduciary calendar and organizing key documents. Other short-term goals may include benchmarking the plan design, evaluating recordkeeper services and doing a request for proposals on competitors' fees and services, doing a plan-level gap analysis to assess participants' progress toward retirement readiness goals and developing an education and communications strategy to boost employee salary deferrals.

Judy Ward | PLANSPONSOR
February 2014 | pp. 22-27 | 0165113

Sea Change for ERISA Litigation

The future of Employee Retirement Income Security Act (ERISA) class action suits is in doubt in the wake of six U.S. Supreme Court decisions between 2009 and 2013. Contrary to theory, class actions are inefficient, offer adverse economic incentives for plaintiffs' lawyers and often yield little benefit for the plaintiffs. The Court approved an express waiver of class action claims in a written arbitration agreement in *American Express Co. v. Italian Colors Restaurant,* left it to an arbitrator to decide if the arbitration agreement is unconscionable in *Rent-A-Car Center, West, Inc. v. Jackson* and vacated an arbitrator's decision in the absence of an agreement on class arbitration in *Stott-Nielsen S.A. v. Animal Feeds International.* Neither ERISA nor the Fair Labor Standards Act prohibits arbitration. This makes it advisable for ERISA plans to adopt mandatory arbitration clauses that meet certain conditions. To counteract finality in arbitration, the American Arbitration Association is trying to introduce appellate review of arbitrators' decisions.

James P. Baker | *Employee Benefit Plan Review*
March 2014 | pp. 6-8 | 0165217

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Considering Roth Accounts as Part of a Retirement Plan Savings Strategy

Independent Roth IRAs and designated Roth accounts within 403(b) and 457(b) plans are among the many options employees have to accumulate retirement savings. A 2010 provision permits participants to transfer pretax plan assets as in-plan Roth rollovers, allowing interest to grow tax-free and avoiding early withdrawal penalties as long as funds remain for a minimum of five years. The choice between pretax contributions or Roth contributions using after-tax dollars is personal and depends on circumstances such as the years until retirement and the current and near-future tax bracket. The writer encourages those considering Roth contributions to start making designated Roth contributions within their retirement plan if allowed, while simultaneously making small contributions to an outside Roth IRA. With the five-year qualification period started in the outside Roth IRA, additional funds can be transferred to that account at any time.

Conni Toth | *403(b)/457 Plan Requirements Handbook* | March 2014 | pp. 4-6 | 0165211

Deciphering How 457(f) Plans Differ From 457(b) Plans

Despite sharing digits, 457(f) plans differ significantly from 457(b) plans. The key difference is that the 457(f) version must involve a substantial risk of forfeiture, prompted by some trigger or an event not accomplished, such as involuntary termination without cause, change in control, plan termination, death or disability. Compensation funds in a 457(f) plan must be subject to the plan sponsor's general creditors. Any earnings on compensation in a 457(f) fund generated before a significant risk of forfeiture is over are taxable from the date when the risk ends, with taxes becoming due when the funds are paid or are made available.

403(b)/457 Plan Requirements Handbook
March 2014 | pp. 12-13 | 0165212

Ineligible Plans Under Section 457(f)

Deferred compensation plans that provide executive benefits beyond the limits set out in Internal Revenue Code Section 457(b) are ineligible plans, and their tax treatment is described in Section 457(f). Ineligible plans generally are subject to Section 409A requirements. The Internal Revenue Service has ruled that a plan maintained by a governmental employer is not an eligible plan unless all assets and rights purchased with the deferred compensation and all assets granted by the deferred compensation are held in trust for the exclusive benefit of the participants and their beneficiaries. Ineligible plans have a number of restrictions and requirements imposed on them by the Code and by the Employee Retirement Income Security Act.

Bruce J. McNeil | *Journal of Deferred Compensation*
Spring 2014 | pp. 1-40 | 0165125

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Supreme Court Holds SUB Payments Subject to FICA Taxes

SEVERANCE

The U.S. Supreme Court unanimously held that certain severance payments or supplemental unemployment benefits (SUB) not tied to the receipt of state unemployment insurance and made to involuntarily terminated employees are subject to tax under the Federal Insurance Contributions Act (FICA).

In this case, the defendant taxpayers, a retailer and its affiliates, sought a refund of FICA taxes from the federal government, the Internal Revenue Service (the plaintiff). The defendants had paid and withheld FICA taxes from severance payments to employees who lost their jobs as part of a Chapter 11 bankruptcy. The payments were not connected to any state unemployment compensation and were not attributable to any specific service performed by the employees. The plaintiff did not allow or deny a refund to the defendants, but the bankruptcy court ruled in favor of the defendants.

The district court and the Sixth Circuit both affirmed the bankruptcy court's decision in favor of the defendants, holding that SUB payments are not wages for FICA purposes. The Sixth Circuit held that the Internal Revenue Code provides that SUB payments are nonwage payments treated "as if" they are wage payments only for the purposes of federal income tax withholding. Thereafter, the plaintiff sought review by the Supreme Court.

After granting certiorari to resolve a dispute between the circuit courts over the treatment of SUB payments and FICA taxes, the Court concludes that the SUB payments at issue fall within Section 3121 of the Code's broad definition of "wages" for FICA tax withholding purposes and rejects the defendant's argument that the payments' tax treatment was altered by a special withholding provision in Section 3402 of the Code.

Under the Code, a SUB payment is any payment that is: (1) paid to an employee, (2) paid pursuant to an employer plan, (3) paid as the result of an employee's involuntary separation from employment, (4) paid as a result of a reduction in force, discontinuance of a plant or operation, or other similar conditions, (5) includable in the employee's gross income. FICA taxes must be withheld from wages paid to employees for services performed, while federal income tax must be withheld from wages and certain other payments to employees. The FICA tax law defines *wages* as "all remuneration for employment" for both income tax withholding and FICA tax withholding. The Code further provides that, for federal income tax withholding purposes, SUB payments are treated "as if" they are wages.

The Court sets forth the first issue as whether FICA's definition of wages encompasses severance payments. The Court reasons that under the FICA definition, wages must include payments for "not only work actually done but the entire employer-employee relationship for which compensation is paid." Therefore, the Court holds that severance payments are payments of wages for FICA tax purposes.

The Court next addresses whether Section 3402 of the Code relating to income-tax withholding is a limitation on the meaning of "wages" for FICA purposes. The court holds that although the Code treats SUB payments "as if" they are wages for federal income tax purposes, the "as if" lan-

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Court Holds No Violation of Anticutback Provisions and Claims Are Collaterally Estopped

BENEFIT LITIGATION

The U.S. Court of Appeals for the Seventh Circuit affirmed that a group of employees' claims that a change in their defined benefit (DB) pension plan violated the Employee Retirement Income Security Act (ERISA), Internal Revenue Code or contractual anticutback provisions of the underlying plan were collaterally estopped by a previous 2011 decision of the court.

In December 2008, the plaintiff employees of an industrial steel product manufacturer filed a complaint against their employer's DB plan, its fiduciaries and the employer under Section 502 of ERISA alleging they were entitled to an immediate distribution of pension benefits while they were still working for their employer. The employees also claimed that the employer's adoption of a plan amendment repealing an earlier plan termination amendment (which called for distributions to plan participants) violated the plan's anticutback terms and Sections 411(d)(6) and 204 of ERISA.

In June 2008, the employer notified the defendant, the commissioner of Internal Revenue, that it was no longer planning to terminate. The employer requested a favorable determination letter from the defendant that the plan continued to qualify for favorable tax treatment under the Code and apprised the defendant of the pending litigation. The employer stated its position that its plan amendment was not a prohibited cutback because it deleted a provision that was superfluous since the plan did not terminate. In November 2009, the defendant sent a favorable determination letter that the plan had retained its tax-qualified status.

In February 2010, the plaintiffs filed a petition for declaratory judgment against the defendant under Section 7476 of the Code in the U.S. Tax Court. The employer asserted in its answer that the district court had granted summary judgment in the underlying litigation between the plaintiffs and the employer and in doing so rejected the arguments the appellants had presented in their Tax Court petition. In August 2011, the Seventh Circuit affirmed the district court's judgment in favor of the employer and holding that the preretirement distribution of pension benefits under the plan was not an accrued ERISA benefit because the plan had not terminated. Therefore, the plan's anticutback clause did not apply.

In May 2013, the Tax Court ruled that the plaintiffs were collaterally estopped by the Seventh Circuit's decision from challenging the defendant's November 2009 determination letter. The plaintiffs appealed the Tax Court's May 2013 ruling to this court.

The defendant and the employer contend that the case is barred by collateral estoppel. The court notes that the plaintiffs previously had exercised their full and fair opportunity to litigate the present issue of the plan's termination. Final judgment was entered in that litigation, and the plaintiffs had an opportunity to appeal, which they exercised by appealing to the court and by filing a petition for hearing en banc (which the court denied). The plaintiffs declined to exercise their right to file a petition for a writ of certiorari in the U.S. Supreme Court. Thus, the court states that the only dispute left to decide is whether the issue the plaintiffs seek resolution of in the Tax Court was the one conclusively decided in the plaintiffs' litigation against their employer. The court holds that the "scenario is textbook collateral estoppel." The court already held that the plan did not terminate. The plaintiffs had a full and fair opportunity to litigate the issue they seek to have adjudicated in the Tax Court, specifically whether the plan terminated. However, the plaintiffs' unsuccessful earlier litigation and the court's previous holding collaterally estops the Tax Court from making another determination whether the plan terminated. Thus, the court affirms the Tax Court's decision in favor of the defendant.

Carter v. Commissioner of Internal Revenue, No. 13-2822 (7th Cir. Mar. 25, 2014).

Court Affirms VEBA's Denial of Disability Benefits

DISABILITY BENEFITS

The U.S. Court of Appeals for the Second Circuit upholds the district court's decision and rules that the defendant did not abuse its discretion in denying disability benefits to the plaintiff.

The district court granted summary judgment in favor of the defendant plan administrator of a voluntary employee benefits plan (VEBA), upholding the defendant's decision to deny disability benefits to the plaintiff.

On appeal, the plaintiff challenges the district court's award of summary judgment in favor of the defendant. The plaintiff asserts that the defendant's decision finding the plaintiff not disabled was arbitrary and capricious because the defendant: (1) abused its discretion by selectively reviewing the administrative record, (2) committed legal error by applying the lifting standards of a sedentary-level position and (3) was affected by a conflict of interest.

The court states that it may upset the defendant's determination that the plaintiff was not disabled only if the decision was arbitrary and capricious or was without reason and unsupported by substantial evidence or erroneous as a matter of law. The court disagrees with the plaintiff that the defendant abused its discretion in determining that the plaintiff was not disabled by ignoring evidence favorable to her claim and misconstruing the record. The court finds that the administrator properly consulted independent physicians, conducted a functional capacity examination of the participant and considered the medical opinion of the participant's treating physician in determining that she was not disabled within the definition of the plan. The court is not persuaded by the plaintiff's argument that the defendant committed legal error by improperly applying the criteria of a claims examiner—a sedentary position that requires a worker occasionally lift ten pounds—when her actual job duties corresponded to that of a claims adjuster, which was a light-level work occupation that required the ability to lift 20 pounds. Lastly, the court rejects the plaintiff's claim that the defendant's status as the entity that both determines eligibility and pays disability claims was a conflict of interest that affected the disability determination against her. Thus, after rejecting the plaintiff's three allegations, the court affirms the district court's award of summary judgment in favor of the defendant.

St. Onge v. Unum Life Insurance Company of America, No. 13-cv-1926 (2d Cir. Mar. 13, 2014).

SUB Payments Subject to FICA Taxes

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guage does not mean that severance payments are not wages for other purposes. When this language was added to the Code, many states provided unemployment benefits to terminated employees only if the terminated employees were not earning wages at the time. Since these payments are subject to federal income tax, if the unemployment benefits were not subject to withholding at the time of payment, the terminated employees could have faced large tax bills at the end of the year. Congress sought to mitigate that risk by treating SUB payments "as if" such payments were wages, thereby requiring federal income tax withholding. The Court determines that the "as if" language solves the income tax withholding problem but does not address whether SUB payments are wages for FICA tax purposes. Since the Court determines that all severance pay is remuneration for employment, it holds that SUB payments are wage payments for FICA tax purposes and rules in favor of the plaintiff.

United States v. Quality Stores, Inc., No. 12-cv-1408 (Mar. 25, 2014).

Court Dismisses Benefit Claims Under the ERISA Antiretaliation Statute

RETALIATION

The U.S. Court of Appeals for the Fifth Circuit affirms the district court's order granting the defendant's motion for summary judgment and holding that the plaintiff failed to establish that the defendant terminated him with a specific intent to interfere with his ability to obtain Employee Retirement Income Security Act (ERISA) benefits for which he would have later become eligible.

The plaintiff was terminated from his employment with the defendant employer after working at the company for approximately ten years. The plaintiff missed several days of work in November and December of 2007. He claims he notified the defendant, to the extent he was able, on days he could not work because of his disability. The defendant claims that the plaintiff failed to report his absences on various occasions in accordance with its notification policy.

The plaintiff sued the defendant in Mississippi state court, claiming he was wrongfully terminated in violation of state and federal law. According to the plaintiff, the defendant fired him to avoid paying costs associated with his medical treatment—among other things, a liver transplant—in violation of his rights under the Family and Medical Leave Act (FMLA) and the Americans with Disabilities Act. The defendant removed the action to federal court, and the plaintiff eventually conceded that all of his claims under FMLA should be dismissed. The plaintiff filed an amended complaint alleging that the defendant terminated his employment in order to prevent him from collecting disability and medical benefits in violation of the antiretaliation statute in Section 510 of ERISA. The district court found that the plaintiff failed to establish a case that the defendant terminated him with a specific intent to interfere with his ability to obtain ERISA benefits he would become entitled to. The court found that the plaintiff never applied for long-term benefits; therefore, he could not show he was entitled to receive or would have been entitled to receive benefits under the long-term disability (LTD) plan. The court also found that the short-term disability (STD) plan was not an ERISA plan because it was excluded from ERISA coverage by the Department of Labor's payroll practice safe-harbor provision. The district court granted the defendant's motion for summary judgment dismissing the plaintiff's ERISA claim, and the plaintiff appeals.

The court addresses the plaintiff's claims for benefits under the defendant's LTD plan, STD plan and medical benefit plan. First, the court finds that the record establishes that the plaintiff never applied for long-term benefits; therefore, the defendant could not have terminated him with the specific intent to retaliate against him for exercising his right under the long-term plan. Second, the court agrees with the district court that the STD plan cannot be the basis of an ERISA retaliation claim by operation of the payroll practices safe-harbor provision. Lastly, in response to the plaintiff's claim that the defendant fired him in order to avoid paying his medical benefits, the court agrees with the defendant that the plaintiff is unable to state a prima facie case that his termination deprived him of medical benefits in violation of Section 510 of ERISA because he was physically unqualified to hold his position with the defendant. Because the qualification requirement is part of an employee's prima facie claim, case law dictates that a disabled employee unable to perform his job will not establish a prima facie claim of ERISA retaliation, even if it is otherwise undisputed that the employer terminated him solely to avoid paying ERISA benefits. As a result, the court affirms the district court's grant of summary judgment in favor of the defendant.

Parker v. Cooper Tire and Rubber Company, No. 12-cv-60503 (5th Cir. Mar. 21, 2014).

Court Awards Attorney Fees to Successful Plaintiff in Claim for Disability Benefits

DISABILITY BENEFITS

The U.S. Court of Appeals for the Second Circuit holds that the district court properly entered summary judgment for the plaintiff on his Employee Retirement Income Security Act (ERISA) claim for disability benefits from the defendant but erred in denying his request for attorney fees since it failed to identify a particular justification for not awarding such fees.

The plaintiff, an employee and plan participant, filed a suit against the defendant administrator of his employer's long-term disability (LTD) plan, after being denied LTD benefits. In December 2001, while still employed, the plaintiff had surgery to replace his aortic valve. An unanticipated side effect of the surgery was that he could feel and hear his prosthetic valve. The plaintiff saw a psychiatrist because of the side effects, and the psychiatrist stated that the audible noises of the plaintiff's valve replacement added significantly to the anxiety he already experienced in his employment. The psychiatrist subsequently diagnosed the plaintiff with "major depression." In June 2003, after attempting to return to his regular work schedule, the plaintiff submitted a claim for LTD benefits. On December 22, 2003, the defendant denied the claim on the basis of its own consulting psychiatrist's recommendation after reviewing the plaintiff's medical file. The plaintiff exhausted the internal appeals process and appealed the denial in district court. The defendant moved for summary judgment. On June 27, 2012, the district court adopted the magistrate judge's report and recommendation and entered summary judgment for the plaintiff but denied his request for attorney fees.

On appeal, the court concluded that the defendant's denial of LTD benefits was arbitrary and capricious mainly because the defendant ignored substantial evidence from the plaintiff's treating physicians that he was incapable of performing his current occupation and failed to offer any reliable evidence to the contrary. Accordingly, the court affirms the district court's summary judgment for the plaintiff on his ERISA claim for LTD benefits.

The court then addresses the district court's denial of the plaintiff's request for attorney fees on the basis that he failed to show any bad faith by the defendant in making its benefit determination. The court reviews the district court's denial for "abuse of discretion." The court states that ERISA's fee-shifting statute provides that "the court in its discretion may allow a reasonable attorney's fee and costs . . . to either party." Here, the court finds that there is no question that the plaintiff is eligible for an award of attorney fees as the prevailing party. The court finds that the district court erred in solely addressing whether the defendant acted in bad faith and failing to address the "relative merits" of the case. Granting a prevailing plaintiff's request for fees is appropriate absent "some particular justification for not doing so." Based upon the court's review of the record, it holds that there is no particular justification for denying the plaintiff's request for attorney fees and awarding them in this case furthers the policy interest in vindicating the rights secured by ERISA. Thus, the court vacates the district court's denial of the plaintiff's request for attorney fees and remands the case back down to the district court to calculate a reasonable amount to award the plaintiff.

Donachie v. Liberty Life Assurance Company of Boston, No. 12-cv-2996 (2d Cir. Mar. 11, 2014).

Court Upholds District Court's Calculation of Attorney Fees

The U.S. Court of Appeals for the First Circuit denies both the plaintiffs' and defendants' appeals and affirms the district court's calculation and award of attorney fees and expenses to the plaintiffs.

After a bench trial before the district court, the plaintiff multiemployer pension fund and various affiliates obtained a money judgment against the defendant contributing employer. The judgment included unpaid employee benefit fund contributions and attorney fees and costs due under the collective bargaining agreement (CBA) and the Employee Retirement Income Security Act (ERISA). The district court awarded the plaintiffs $18,000 in attorney fees and expenses of $16,688.15, a steep reduction from the sum they sought. The plaintiffs appealed both the merits underlying the ruling and the alleged inadequate fee award, while the defendants cross-appealed, asserting that the fee award was overly generous.

On appeal, the court reviews the amount of the attorney fees award for an abuse of discretion. The court states that the standard is highly deferential, and it "will set aside a fee award only if it clearly appears that the trial court ignored a factor deserving significant weight, relied upon an improper factor, or evaluated all the proper factors, but made a serious mistake in weighing them." The plaintiffs' entitlement to attorney fees rests on two independent grounds, the CBA's language and ERISA's fee-shifting provision, but the court sees no reason to distinguish between the two sources of rights and analyzes the parties' appeals in terms of ERISA.

The court applies the *lodestar approach* to calculate the shifted attorney fees, which involves calculating the number of hours reasonably expended by the attorneys for the prevailing party and then multiplying that amount by the determined reasonable hourly billing rate(s). The lodestar may be further adjusted based on other court considerations, such as the degree of a prevailing party's success.

In response to the plaintiffs' challenge, the court concludes that the district court did not abuse its discretion in concluding that the proportionality of fees to damages was a relevant factor in setting the amount of the fee or in formulating the modest lodestar value. In response to the defendants' cross-appeal, whereby the defendants seek a reduction in fees as well as a disallowance of travel-related expenses, the court finds that the district court properly made an across-the-board one-third reduction to billed hours to account for a multitude of factors, including various "excessive or unnecessary charges." After implementing this cut, the district court settled upon the lodestar approach plus a reduction of 75%. Although it chose "to paint with broad strokes," the court concludes that the district court did not abuse its wide discretion with respect to the treatment of travel time and expenses. Therefore, the court leaves the parties as it found them and affirms the district court's order awarding attorney fees and expenses to the plaintiffs.

Central Pension Fund of the International Union of Operating Engineers v. Ray Haluch Gravel Co., No. 11-cv-194411 (1st Cir. Mar. 11, 2014).

ATTORNEY FEES

ERISA Claims Accrue With First Clear Underpayment

STATUTE OF LIMITATIONS

The U.S. Court of Appeals for the First Circuit rejects the plaintiff's argument that payments made under an Employee Retirement Income Security Act (ERISA) long-term disability (LTD) plan are analogous to an installment payment plan for the purposes of calculating the applicable statute of limitations. The court also holds that an ERISA cause of action accrues when the plan's repudiation of a claim is first made known to the beneficiary.

The plaintiff worked as an associate general manager for the defendant employer. After experiencing chronic pain and depression, the plaintiff left his role and received short-term disability (STD) benefits. He later returned to work but in a lower paying, nonmanagerial position. When his pain returned the following year, he once again left work and received STD benefits and later was approved for LTD benefits. The defendant calculated the plaintiff's LTD benefits using his lower, nonmanagerial salary, resulting in a smaller monthly benefit (factoring a Social Security offset) than if his managerial salary had been used. When the plaintiff received the first payment on April 15, 2005, he disputed the calculation and refused to cash the check. The defendant continued to send payments until December 2005, when the plaintiff requested the payments stop.

The plaintiff brought a state court suit in 2007 that was later dismissed. He then sued in district court under ERISA on March 22, 2012. The defendant moved for summary judgment, arguing that the suit was time-barred. The district court granted the motion, and the plaintiff appealed.

On appeal, the court affirms dismissal of the action. The court notes that because ERISA does not provide a statute of limitations in this action to recover unpaid benefits from a nonfiduciary, it applies the most analogous statute of limitations, a six-year period for breach of contract from the forum state of Massachusetts. In applying federal common law to determine when the claim accrued, the court rejects the plaintiff's claim that the ERISA plan must be treated as a continuing violation or as an installment contract with a new limitation period for each payment. Under this argument, the plaintiff's ERISA benefits claim would still be timely as to the monthly payments made within six years of when the claim was filed. However, the court joins three other circuit courts (Second, Third and Ninth) in holding that the claim accrues on the date the plaintiff received and noted the first underpaid amount. Therefore, even if ERISA payments are made periodically over the course of time, the statute of limitations begins to run on the date the plaintiff received that first insufficient payment. As a result, the plaintiff's claim is time-barred. The court reasons that its approach is consistent with the purpose of statutes of limitations, which is to ensure the timely litigation of disputes before the evidence becomes stale. It is also consistent with the policies underlying ERISA to promote predictability of a plan sponsor's benefits liabilities and to enable ERISA plans to rely on their initial calculations. Therefore, the court affirms the district court's grant of the defendant's motion for summary judgment.

Riley v. Metropolitan Life Insurance Company, No. 13-cv-2166 (1st Cir. Mar. 4, 2014).

Court Finds Lack of Standing in Challenge to ACA Implementation

HEALTH CARE REFORM

The U.S. District Court for the Eastern District of Wisconsin dismisses the plaintiff's separation-of-powers challenge to the defendant's decision to delay implementation of the Affordable Care Act's (ACA) employer mandate while allowing the ACA's individual mandate to take effect as planned.

ACA imposes two mandates: the individual mandate that requires individuals to buy health insurance or pay a fine and the employer mandate that requires large employers to provide health insurance for their employees. Both mandates originally were scheduled to go into effect in January 2014, but the defendant, the Internal Revenue Service commissioner, delayed implementation of the employer mandate. Employers with 100 or more employees must comply with the law by 2015, and employers with 50-99 employees have until 2016 to comply. The mandates are enforceable through penalties imposed by the defendant.

The plaintiffs, an association of physicians and one of its members, argue that the ACA mandates are an *inextricable pair,* meaning one mandate may not be implemented without the other. By delaying implementation of the employer mandate, the plaintiffs argue that the defendant changed legislation passed by Congress and violated the separation-of-powers doctrine and the Tenth Amendment. The plaintiffs allege that association members will lose patients and revenue as a result of the delay. Association members have practices that rely on direct payments from patients rather than insurance payments. The plaintiffs contend that implementing the individual mandate without the employer mandate means that employers will not offer ACA-compliant health insurance plans in 2014 and will shift the burden of paying health insurance premiums to individuals. That shift will force patients to use their discretionary health care dollars on insurance premiums instead of direct payments to physicians.

The defendant moved to dismiss the complaint, arguing that the plaintiffs lack standing to pursue their claims.

The court agrees with the defendant and holds that the plaintiffs lack standing because the injuries they claim from the delay are entirely speculative. The court sets forth the issue as whether the defendant's action delaying implementation of the employer mandate directly affects and injures the plaintiffs. The court states that in order for a plaintiff to have standing, an individual must demonstrate three elements:

(1) An "injury in fact," which is an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical;

(2) A causal relationship between the injury and the challenged conduct, such that the injury can be fairly traced to the challenged action of the defendant and not from the independent action of some third party before the court; and

(3) A likelihood that the injury would be redressed by a favorable decision.

Standing is more difficult to establish when the plaintiffs are not the object of the defendant's action being challenged, the court said. A plaintiff's burden is heightened further when it challenges the defendant's decision to tax, or not to tax, a third party, the court said. "Parties typically lack standing to litigate the tax obligations of others because such suits are generalized grievances that operate to disturb the whole revenue system of the government."

The court states that "each link of Plaintiffs' causal chain is tenuous, and in combination, the allegations fail to establish any injury that is 'imminent' or 'certainly impending.'" The court reasons that the plaintiffs lack standing because their claim relied on a series of discretionary acts

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Washington Update

Treasury and IRS Release Final Regulations Governing Employer Reporting Under ACA

On March 5, 2014, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) issued a pair of final regulations governing employer reporting requirements under the Patient Protection and Affordable Care Act (ACA) under Sections 6055 and 6056 of the Internal Revenue Code of 1986, as amended.

Employers that are required to report under both Sections 6055 and 6056 may do so on one streamlined form, drafts of which are expected to be released soon.

Section 6055 Requirements

Any entity, including health insurance issuers and sponsors of self-insured health plans, that provides minimum essential coverage to an individual will be required to file an annual information return and transmittal with the IRS. The employer will be required to provide the IRS with the following information by February 28, 2016 (March 31, 2016 if applying electronically):

- Name, address and employer identification number (EIN) of the reporting entity required to file the return
- Name, address and taxpayer identification number (TIN), or date of birth if a TIN is not available, of the responsible individual. Reporting entities may, but are not required to, report the TIN of a responsible individual not enrolled in the coverage.
- Name and TIN, or date of birth if a TIN is not available, of each individual covered under the policy or program
- For each covered individual, the months in which the individual was enrolled in coverage and entitled to receive benefits for at least one day
- Any other information specified in forms, instructions or other published guidance.

The reporting entity must furnish a statement to each employee containing the policy number and the name, address and a contact number for the

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Court Finds Lack of Standing in Challenge
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by third parties. It is entirely speculative for the plaintiffs to argue that employers would provide ACA-compliant health plans in 2014 if not for the delay. Regardless of when the employer mandate takes effect, an employer may opt to pay a penalty rather than provide the insurance. The court notes that individuals have the option under the ACA individual mandate to pay a fine rather than buy a health plan. The court states that it is also speculative to argue that employee health plans will not cover the services plaintiffs' members provide to patients, or to argue that even if the services are not covered, individuals will not choose to pay for them out-of-pocket.

Further, the court concludes that the plaintiffs fail to establish that their injury would be fairly traceable to the defendant. Ultimately, the court concludes that the plaintiffs cannot plead a claim that satisfies standing requirements and grants the defendant's motion to dismiss.

Association of American Physicians & Surgeons, Inc. v. Koskinen, Commissioner of the Internal Revenue Service, No. 13-cv-1214 (E.D.Wis. Mar. 18, 2014).

Other Recent Decisions

RETIREE HEALTH BENEFITS

International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Kelsey-Hayes Company

The defendant employer entered into a collective bargaining agreement (CBA) with a union that represented the employees in its Detroit manufacturing plant, including the plaintiff retirees. The 1998 CBA provided comprehensive health care coverage to retirees and their surviving spouses. It also specified that any health care-related disputes would be exempt from otherwise applicable provisions requiring disputes to be resolved through arbitration. In 2001, the defendant closed its Detroit manufacturing plant and negotiated a general release and termination agreement (plant-closing agreement) with the union. This agreement released the defendant from most of its obligations under earlier CBAs, but the health care benefits negotiated under the 1998 CBA remained intact and were incorporated by reference into the 2001 plant-closing agreement. The 2001 plant-closing agreement also included a general arbitration provision providing that any disputes with the union would be resolved through arbitration. Following execution of the plant-closing agreement, the defendant provided health care benefits for ten years. However, in September 2011, retirees received letters informing them that the defendant planned to terminate their participation in its retiree health care plan and require them to purchase individual plans. In October 2011, the plaintiffs filed suit against the defendant under Section 301 of the Labor-Management Relations Act alleging violations of Section 502 of the Employee Retirement Income Security Act (ERISA) and claiming that the defendant breached the plant-closing agreement and 1998 CBA. The defendant moved to compel arbitration. The district court concluded that a subset of the plaintiffs, those who had retired prior to the plant closing in 2001, could not be bound by the terms of the plant-closing agreement because those retirees' rights had already vested prior to that agreement's execution under the 1998 CBA. The defendants filed a notice of appeal challenging the district court's order partially denying its motion to compel arbitration. The issue before the court is whether the employees who retired prior to the plant closing in 2001 and before the execution of the plant-closing agreement incurred any obligation to arbitrate their dispute concerning their health care benefits. The court affirms the district court's decision partially denying the defendants' motion to arbitrate, finding that the plaintiffs retired prior to the 2001 plant-closing agreement and were not union members at the time of the plant closing. Therefore, the plaintiffs did not consent to the terms of the plant-closing agreement and cannot be compelled to arbitrate under provisions in that agreement. No. 12-cv-1824 (6th Cir. Mar. 3, 2014).

SUBROGATION

Central States, Southeast and Southwest Areas Health and Welfare Fund v. Beverly Lewis & David T. Lashgari

In July 2011, the principal plaintiff, a multiemployer health plan, along with its board of trustees, moved the district court for an entry of a preliminary injunction against the defendants, an injured plan participant and her lawyer, disposing of settlement proceeds until the plaintiff received its $180,000 share pursuant to a subrogation lien. The defendants obtained a $500,000 settlement after bringing a tort suit in Georgia state court against a driver of a car in the accident that injured the defendant. The plaintiffs had a subrogation lien against any money the defendant participant obtained in a suit arising out of the accident to offset the cost they incurred

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Final Regulations on Employer Reporting
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reporting entity in addition to the information that must be reported to the IRS. This statement must be provided on or before January 31 of the year following the calendar year to which the return relates.

Section 6056 Requirements

The final regulations require applicable large employers to furnish the IRS with information to determine whether the employer owes a shared responsibility penalty. The employer also must provide employees with a report to allow them to determine whether they are eligible for a subsidy to purchase coverage through the exchange. Applicable large employers that employ between 50 and 100 full-time employees are still required to report for 2015, even though such employers may be subject to transition relief from liability under Section 4980H. Applicable employers will be required to provide IRS with the following information by February 28, 2016 (March 31, 2016 if applying electronically):

- Name, address and EIN of the applicable large employer member
- Name and telephone number of the applicable large employer member's contact person
- The calendar year for which the information is reported
- Certification of whether the applicable large employer member offered to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, by calendar month
- The months during the calendar year for which minimum essential coverage under the plan was available
- Each full-time employee's share of the lowest cost monthly premium (self only) for coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month
- Number of full-time employees for each month during the calendar year
- Name, address and TIN of each full-time employee during the calendar year and the months, if any, during which the employee was covered under the plan
- Any other information specified in forms, instructions or published guidance.

Additionally, the regulations require that employers provide a statement to each full-time employee that includes the applicable large employer member's name, address and EIN, as well as the information required to be shown in the Section 6056 return. This statement must be provided on or before January 31 of the year following the calendar year to which the return relates.

The final regulations issued under Sections 6055 and 6056 of the Code can be found at www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf and www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf, respectively.

Other Recent Decisions
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as a result of the accident. Upon receiving the settlement proceeds in June 2011, the defendant lawyer claimed that the plan was not owed its $180,000 share of the $500,000 settlement, because the settlement was solely intended to compensate the participant for the driver's "post-accident tortuous conduct" against her. The district court granted the plaintiffs' motion for a preliminary injunction and ordered the defendants to place at least $180,000 in a client trust fund account pending final judgment in the case. The defendants did not comply with the order. One year later, the district court held them in civil contempt and ordered them to produce records that would establish their financial situations. The court also ordered the lawyer to submit documentation to the general counsel of Georgia for possible disciplinary proceedings. The defendants appealed the district court's order holding them in contempt. First, the court rules that it has the proper jurisdiction to consider an appeal of an order of contempt. Second, turning to the merits, the court states that the defendants' appeal is frivolous and "pathetic," their conduct has been willful and outrageous and they submitted "absurdly inadequate" financial records. Therefore, the court orders the defendants to show cause why they should not be sanctioned for filing a frivolous appeal and directs the district court to determine whether the defendants should be jailed until they comply with the order to deposit the settlement proceeds in a trust account. No. 13-cv-2214 (7th Cir. Mar. 12, 2014).

WITHDRAWAL LIABILITY

Knall Beverage, Inc. v. Teamsters Local Union No. 293 Pension Plan

The plaintiffs, three employers that were formerly contributing members of a multiemployer pension plan, brought suit against the defendant pension plan and approximately nine other defendants claiming that they engaged in a scheme that caused the plaintiffs to owe approximately $12 million in withdrawal liability following the plan's termination. The plaintiffs withdrew from the plan in 2007 and 2008. The plan later was terminated by a mass withdrawal of all remaining contributing employers. Because of this termination, the plan's board of trustees assessed an additional $12 million in reallocated withdrawal liability to the plaintiffs. After initiating, but not completing, the statutorily mandated arbitration process under the Employee Retirement Income Security Act (ERISA), the plaintiffs filed suit claiming that the mass withdrawal was null and void as a legally prohibited scheme to evade or avoid ERISA liability. The plaintiffs also purported to bring breach-of-fiduciary-duty and prohibited transaction claims under ERISA. The defendants moved to dismiss on the grounds that the plaintiffs' complaint failed to state actionable claims. In the alternative, the defendants moved to stay the matter pending completion of arbitration. The district court dismissed the action without prejudice and held that the plaintiffs must arbitrate their claims. Without reaching the merits, the court affirms the dismissal on the same basis as the district court, concluding that the plaintiffs' central claim was to recoup the reallocated withdrawal liability and that such claims must be arbitrated under ERISA. No. 13-cv-3698 (6th Cir. Mar. 4, 2014).

CONTRIBUTIONS

Trustees of the Construction Industry & Laborers Health & Welfare Trust v. Archie

The plaintiff trustees of multiemployer benefit funds commenced an action against the defendants, officers, directors and/or owners of a corporation claiming that they are liable as Employee Retirement Income Security Act (ERISA) fiduciaries for the corporation's judgment by virtue of their ownership and control of the corporation. In a prior lawsuit, the plaintiffs obtained a judgment against the corporation based on its failure to make required contributions to employee benefit funds. Both parties filed cross motions seeking summary judgment. The court begins by noting that the defendants are proceeding in the matter pro se; therefore, their documents are held to less stringent standards under applicable law. The court then states that the defendants argue but fail to provide any evidence to support their accusations that the plaintiffs' judgment obtained against the corporation was somehow fraudulent and is invalid. The court notes that the primary inquiry is limited to whether the defendants can be held liable to the plaintiffs for the unpaid contributions. Under the applicable law, the defendants are liable as fiduciaries if the unpaid contributions are trust

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fund assets and the defendants exercised authority or control over those assets. First, the court finds that the language contained in the applicable agreements and policies make sufficiently clear that due but unpaid contributions qualify as trust fund assets. Second, the court finds that the defendants exercised discretion and/or authority over the contributions the corporation was required to make to the benefit funds in question. Defendants do not proffer any evidence or argue that they did not exercise discretion or control over the disbursement of contributions. Therefore, the court holds that the defendants are fiduciaries under ERISA and by their failure to make the required contributions as required by the applicable collective bargaining agreement, the defendants are both individually and personally liable for the plaintiffs' judgment against the corporation. Accordingly, the court grants the plaintiffs' motion for summary judgment. No. 12-cv-00225-JCM-VCF (D.Nev. Mar. 3, 2014).

ADMINISTRATIVE REMEDIES

Bryant v. Community Bankshares, Inc.

The plaintiff employees of a bank commenced an action in district court against the bank's holding company, plan administrator and several other individual employees pursuant to the Employee Retirement Income Security Act (ERISA) for the defendants' failure to correctly process the plaintiffs' requests to diversify their assets invested in the employee stock option plan. The plaintiffs claim the defendants' actions resulted in a loss of hundreds of thousands of dollars they invested in the plan. The defendants seek dismissal of the complaint because the plaintiffs failed to exhaust their administrative remedies under the plan before they filed the instant suit. The defendants claim the plaintiffs also failed to allege a sufficient excuse for failing to exhaust their administrative remedies. The court states that in order to overcome the defendants' motion to dismiss, the plaintiffs must "make a clear and positive showing of futility." The court states that the plaintiffs fail to sufficiently allege a futility exception to the exhaustion of administrative remedies requirement. The plaintiffs were not denied "meaningful access" to the administrative review process and did not allege that the plan's language caused them to reasonably believe that they did not have to comply with the exhaustion requirement. Nor did the plaintiffs allege that they attempted to file an appeal or grievance of some sort, only to be denied or otherwise affirmatively blocked from pursuing their administrative remedies. Lastly, the plaintiffs could not demonstrate futility by alleging that the plan lacked assets and, therefore, an adequate remedy could not be afforded if they pursued their administrative remedies. In sum, the court holds that the plaintiffs failed to sufficiently allege a lack of "meaningful access" to the plan's administrative review procedures such that their failure to exhaust should be excused. The plaintiffs could have pursued their administrative remedies after they learned their diversification requests had not been completed as desired. Accordingly, the court does not excuse the plaintiffs from the law's strict exhaustion prerequisite to filing under ERISA and grants the defendants' motion to dismiss. No. 12-cv-00562-MEF-CSC (M.D.Ala. Mar. 3, 2014).

Washington Legislative Update

Congressman Roe Receives 2014 Public Service Award

Because of his strong support for pension reform and retirement security, the International Foundation presented Congressman Phil Roe (R-Tennessee) with the 2014 Public Service Award at the Washington Legislative Update on May 5.

"I am honored to receive this award and remain committed to finishing the work we have started on pension reform," Roe said. "PBGC's multiemployer program is facing insolvency—threatening the benefits of many retirees. I look forward to strengthening and preserving the pensions upon which working Americans and retirees depend."

As chair of the Subcommittee on Health, Employment, Labor and Pensions, Roe has demonstrated a deep understanding of the employee benefits industry and a genuine concern for the retirement security of working Americans.

In presenting the award, Kenneth R. Boyd, President and Chair of the International Foundation, said the Foundation appreciates what Roe has done to underscore the importance of the multiemployer pension system.

"Last October, a key hearing drilled into the heart of the issues, and it was a culmination of nearly two years of work," Boyd said. "On that day, Congressman Roe spoke about the plight of our plans. . . . His remarks clearly demonstrated an understanding of the intricacies of how the plans work and their broader impact. He was right when he said that improving the multiemployer pension system goes beyond retirement security. It's about saving jobs and protecting the competitiveness of America's workplaces."

Congressman Phil Roe, R-Tennessee, (right) receives the Public Service Award from International Foundation President and Chair Kenneth R. Boyd.

From left, Lawrence R. Beebe, CPA, a partner at Bond Beebe, Accountants and Advisors; Richard J. Sawhill, executive vice president of the Airconditioning, Refrigeration and Mechanical Contractors Association of Southern California; and Stanley I. Goldfarb, actuary and managing consultant at Horizon Actuarial Services, LLC, are among panelists discussing pension reform and retirement security.

Assistant Secretary of Labor Phyllis Borzi gives an overview of the Department of Labor's regulatory agenda, enforcement activities and recent and proposed guidance.

Attendees hear about the latest legislative and regulatory actions.

plan | ahead

Benefit Communication and Technology Institute

Anyone who develops communications for plan participants—administrative and human resources staff, trustees and communications consultants—knows technology and social media rapidly are changing what's possible. And new benefits legislation and regulations are changing what's needed. This institute gives attendees tools to stay ahead of the changes, including help with strategic planning and writing skills. They'll leave with practical ideas to ensure plans meet their objectives and effectively engage participants.

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www.**ifebp.org**/benefitcommmunication

Certificate Series

By taking the two-day courses Retirement Plan Basics and Investment Basics, plus either Public Sector 401, 403, 457 Plans or 401(k) Plans, an attendee can earn a Certificate in Retirement Plans. Any two of those courses (except 401(k) Plans) plus Introduction to Public Sector Benefits Administration lead to a Certificate in Public Sector Benefits Administration. These courses provide a quick but solid understanding of the history, trends, legal environment and operational aspects of managing and supporting benefit plans.

July 21-31, 2014
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/certificateseries

International Investing and Emerging Markets

Individuals who already have a solid knowledge of investment management principles will learn about the opportunities and risks of investing internationally and in several emerging countries. Topics also include the mechanics of international diversification, global bonds and exchange rates, foreign investment vehicles and developed market equities.

July 28-30, 2014
San Francisco, California
www.**ifebp.org**/wharton

33rd Annual ISCEBS Employee Benefits Symposium

The Symposium attracts hundreds of credentialed benefits professionals representing corporations, consulting firms, health care organizations, hospitals, banks, insurance companies, investment and administration firms, jointly trusteed and public employee benefit plans, law firms and other organizations. They come for networking and for solution-oriented workshops, discussions, case studies and strategic sessions. Registration is open to those who have earned a CEBS, CMS, GBA or RPA designation, corporate members of the International Foundation and students who have completed at least one CEBS exam.

September 7-10, 2014
Phoenix, Arizona
www.**ifebp.org**/symposium

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July 2014

14-15 Benefit Communication and Technology Institute
San Jose, California
www.**ifebp.org**/benefitcommunication

21-31 Certificate Series
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/certificateseries

28-30 International Investing and Emerging Markets
San Francisco, California
www.**ifebp.org**/wharton

September 2014

7-10 33rd Annual ISCEBS Employee Benefits Symposium
Phoenix, Arizona
www.**ifebp.org**/symposium

15-16 Public Employee Policy Forum
Washington, D.C.
www.**ifebp.org**/publicemployee

15-19 Certificate in Global Benefits Management
Boston, Massachusetts
www.**ifebp.org**/global

15-25 Employer Benefits Producer Training Program
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/producertraining

October 2014

11-12 Administrators Masters Program (AMP®)
Boston, Massachusetts
www.**ifebp.org**/amp

11-12 Trustees Masters Program (TMP)
Boston, Massachusetts
www.**ifebp.org**/tmp

11-12 Certificate of Achievement in Public Plan Policy (CAPPP®) Pensions and Health Part II
Boston, Massachusetts
www.**ifebp.org**/CAPPP

12 TMP Advanced Leadership Summit
Boston, Massachusetts
www. **ifebp.org**/tmp

12-15 60th Annual Employee Benefits Conference
Boston, Massachusetts
www.**ifebp.org**/usannual

27-29 Certificate in Canadian Benefit Plans
Vancouver, British Columbia
www.**ifebp.org**/canadacert

27-Nov. 1 Certificate Series
Providence, Rhode Island
www.**ifebp.org**/certificateseries

November 2014

17-18 Collection Procedures Institute
Santa Monica, California
www.**ifebp.org**/collections

February 2015

8 Trustees and Administrators Institutes—Preconference
Lake Buena Vista (Orlando), Florida

9-11 Trustees and Administrators Institutes
Lake Buena Vista (Orlando), Florida

23-28 Certificate Series
Lake Buena Vista (Orlando), Florida

March 2015

9-11 Investments Institute
Rancho Mirage, California

April 2015

13-15 Health Care Management Conference
Santa Monica, California

20-30 Employee Benefits Producer Training Program
Brookfield (Milwaukee), Wisconsin

May 2015

4-5 Washington Legislative Update
Washington, D.C.

June 2015

1-4 Essentials of Mulitemployer Trust Fund Administration
Brookfield (Milwaukee), Wisconsin

8-12 Certificate in Global Benefits Management
Chicago, Illinois

9-12 Certificate of Achievement in Public Plan Policy (CAPPP®)—Pension and Health, Parts I and II
Chicago, Illinois

[schedule subject to change]

benefit fringe | perks of going green

Almost everyone knows about the energy-efficiency benefits of green buildings, but can going green make employees happier and more productive?

Officials at Johnson Controls say yes.

"Most people associate green buildings with energy efficiency, but green buildings are a holistic approach to making buildings that are more comfortable, more productive and more healthy as well as more energy- and resource-efficient," said Clay Nesler, Johnson Controls vice president for global energy and sustainability. Heating, ventilating and air conditioning equipment and building management systems used in green buildings are among the products Johnson Controls manufactures and markets.

Four buildings at the company's Milwaukee, Wisconsin-area corporate headquarters campus have achieved platinum certification, the highest level, in the Leadership in Energy and Environmental Design (LEED) green building rating system.

A number of the company's buildings have "personal environmental modules" that provide individualized comfort conditions in workstations, Nesler said. He compared them to individualized comfort control features in a luxury car. Johnson Controls makes the product.

Employees who have the devices can control air temperature and flow, and some workstations also have radiant floor panels to provide extra heat when needed. Workstations have light and sound controls, allowing employees to personalize lighting and introduce white noise. To increase efficiency, an occupancy sensor turns off the units when employees leave their workstations.

Employees appreciate other features in the company's green buildings—day lighting, fresh air ventilation and outdoor features like water reservoirs and native plantings, Nesler said.

"An anecdote in the industry is once you've worked in a green building, you never want to work in a nongreen building," Nesler said. "We've certainly found that with our employees. They're very reluctant to want to move to another area which may not have these green amenities."

Some research attributes productivity gains to green buildings, and the facilities can serve as a recruiting and retention tool, Nesler noted, "particularly for the next generation of employees who are very sensitive to the environment and social responsibility."

by | **Kathy Bergstrom** | kathyb@ifebp.org

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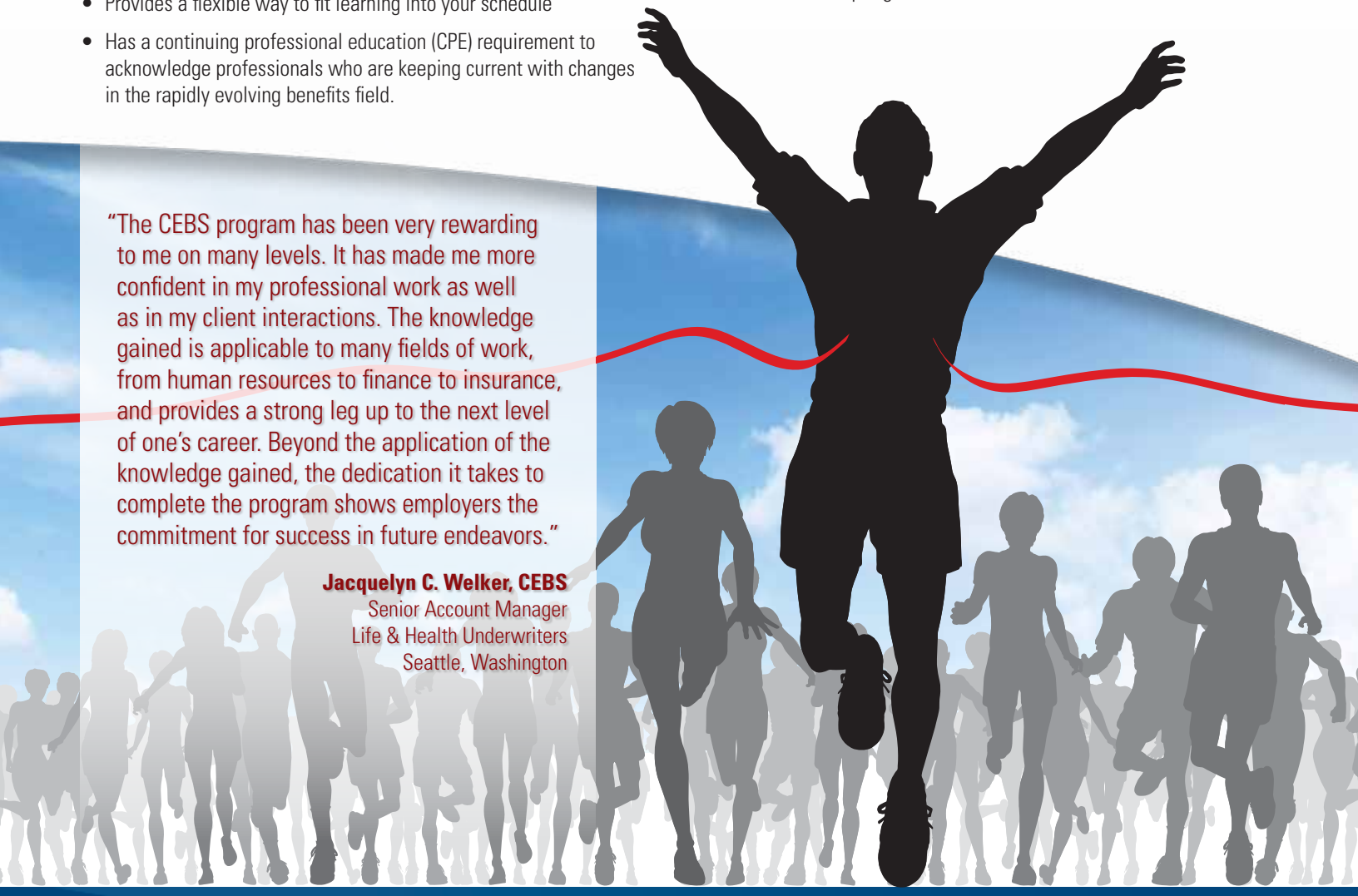

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Jacquelyn C. Welker, CEBS
Senior Account Manager
Life & Health Underwriters
Seattle, Washington

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