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One of the ways the 2010 Affordable Care Act (ACA) was designed to slow the growth of health care costs is through an emphasis on *quality* of care. For instance, the ACA created a "Patient-Centered Outcomes Research Institute," which is charged with advancing research into comparative clinical effectiveness. To fund this Institute, the ACA imposes a fee on both insured and self-funded health plans for the seven-year period from 2012 through 2019.

The fees payable by health *insurers* are described in a new Section 4375 of the Tax Code, while a new Section 4376 describes the fees imposed on *sponsors* of self-funded health plans. Regulations recently proposed by the IRS would apply substantially similar rules under both of these provisions. This article will therefore focus on the fees payable by self-funded plans.

Plans Subject to This Fee

Virtually all employer-sponsored, self-funded health plans will be subject to this new fee. These include plans sponsored by most governmental employers. Retiree-only plans, although generally exempt from the other ACA mandates, are subject to this new fee.

Among the few *exceptions* to this fee are "excepted benefits," health savings accounts, and employee assistance or wellness programs that do not provide "significant" medical benefits. "Excepted benefits" include stand-alone dental or vision plans, as well as any health flexible spending account (FSA) maintained by an employer that also sponsors a major medical plan and that contributes no more than $500 to an employee's FSA.

Calculating the Fee

For the first year to which this new fee applies (the first plan year ending on or after October 1, 2012), the fee is $1.00 per covered life. The fee is $2.00 per covered life during the second plan year, and will then be adjusted for inflation during the following five years.

Although this fee is generally calculated separately for each plan, this rule is significantly eased by a provision in the regulations allowing an employer to aggregate all self-funded plans having the same plan year. For instance, if an employer sponsors both a self-funded medical plan and a self-funded prescription drug plan, both of which operate on the same plan year, only a single fee must be paid for any individual who is covered under both plans.

Liability for the Fee

In the case of a self-funded plan, the party responsible for paying the fee is the plan's "sponsor." Typically, this is the employer whose employees participate in the plan. The proposed regulations do address other situations, however. For instance, the sponsor of a multiemployer (Taft-Hartley) plan is the plan's joint board of trustees, and the sponsor of a free-standing voluntary employees' beneficiary association (a VEBA) is the trustee of that VEBA. (If a VEBA is simply a funding vehicle for an employer's plan, the *employer* will be the plan's sponsor for this purpose.)

The preamble to these proposed regulations notes that commenters had asked for assurance that, in the case of

either a multiemployer plan or a plan maintained by a free-standing VEBA, the fee could be paid out of plan assets, rather than by the members of the board of trustees or the VEBA's trustee. The IRS noted that this question is beyond its jurisdiction, but that the Department of Labor intends to issue guidance on this point. Because this fee is in the nature of a *tax*, rather than a *penalty*, it seems likely that the DOL will eventually conclude that it may be paid out of plan assets. Nonetheless, this is an issue that will merit monitoring in the months to come.

The proposed regulations also note that, contrary to the typical employee benefit provision, Section 4376 does *not* incorporate the Tax Code's "controlled group" rules. Accordingly, if employees of related employers participate in the same plan, each employer may be viewed as the "sponsor" of the plan with respect to its own employees. Each such employer would then be required to report and pay its proportionate share of the fee. Fortunately, this result may be avoided simply by designating a "sponsor" in the plan document. If this is done – even if only for purposes of this fee – the designated sponsor may report and pay the fee on behalf of all participating employers.

Counting the Number of Covered Lives

As noted above, this fee is to be calculated on the basis of "covered lives." This would include not only the employees or retirees who are covered as *participants*, but also their *dependents*. The proposed regulations describe the following three methods by which a self-funded plan may determine its number of covered lives:

- Actual Count Method – the actual number of lives covered under the plan for *each day* of the plan year, divided by the number of days in that plan year.
- Snapshot Method – the average number of lives covered under the plan, determined on a *quarterly* (or more frequent) basis.
- Form 5500 Method – for plans that file a Form 5500, the average of (i) the number of participants reported for the *first* day of the plan year, and (ii) the number of participants reported for the *last* day of the plan year (subject to the adjustment described below, if the plan offers dependent coverage).

Under the Snapshot Method, the sponsor may use either an *actual count* on each quarterly (or more frequent) date or a *mathematical conversion* specified in the regulations. Under this latter option, the number of covered lives on any snapshot date would be equal to the number of participants with single-only coverage *plus* 2.35 times the number of participants with any other level of coverage (such as employee-plus-spouse or family). In essence, any participant with other than single-only coverage is deemed to have 1.35 dependents.

A different adjustment would be required for any plan using the Form 5500 Method. Because the participant counts shown on a Form 5500 do not differentiate between single-only and other coverage levels, the regulations call for multiplying the average number of participants by 2.0. (This is lower than 2.35 because *some* of these participants will have single-only coverage.) As a result, any plan using the Form 5500 Method (and offering *any*

dependent coverage) may simply multiply the annual dollar amount (e.g., $1.00) by the *sum* of the participants reported for the first day of the plan year and the number reported for the last day.

A sponsor must use the same method of calculating covered lives for all plans to be reported for the same year. However, the sponsor may change between calculation methods from year to year. The proposed regulations also note that, because the first reporting year is already under way, sponsors may use "any reasonable method" to calculate covered lives during this first year.

Special Rules for HRAs (and Certain FSAs)

Health reimbursement arrangements (along with health FSAs that are *not* "excepted benefits") are subject to this new fee. However, the proposed regulations provide certain special rules for these individual account plans.

For instance, as with any self-funded plan, an HRA or FSA that operates on the same plan year as the employer's self-funded major medical plan may be aggregated with that major medical plan when calculating the number of covered lives. Thus, if the plans cover the same group of participants, there would be no additional fee attributable to the HRA or FSA.

A *different* rule applies, however, to an HRA or FSA maintained by an employer that sponsors an *insured* major medical plan. In that case, no aggregation would be allowed. Instead, the *insurer* would pay the fee for the covered lives attributable to the major medical plan, while the *employer* would pay the fee for all participants in the HRA or FSA. The only relief in this case is that the employer may pay the fee for only the actual number of *participants* in the HRA or FSA – disregarding any *dependents* whose expenses might be reimbursable from the account.

Reporting and Paying the Fee

This new fee is to be reported and paid using IRS Form 720. Although this form is captioned "Quarterly Federal Excise Tax Return," the Form would be filed only *annually* in connection with this new fee. It would be due by July 31 of the calendar year beginning after the last day of the plan year to which it relates. Thus, the first filing will be due on July 31, 2013.

A plan sponsor will be *allowed* to file this Form 720 electronically, but it will not be *required* to do so. The sponsor of a self-funded plan will *not* be able to delegate to any other entity – such as a third-party administrator – the obligation either to file the Form 720 or to pay the associated fee. Nonetheless, most third-party administrators will probably assist sponsors in calculating and reporting this fee.

Employer Action Steps

At this point, sponsors of self-funded health plans should proceed as follows:

- Identify all health plans that are subject to this new fee.
- Select a method for calculating each plan's number of covered lives (using the same method for all plans during the same plan year).

- Coordinate the necessary exchange of data with each plan's third-party administrator or other record keeper.
- Budget the amount of money needed to pay this new fee and to make the necessary calculations.

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AS FEE DISCLOSURE DEADLINES APPROACH, DOL ISSUES ADDITIONAL GUIDANCE

After over four years of regulatory starts and stops, plus the threat of a legislative solution, two separate sets of fee disclosure regulations issued by the Department of Labor (DOL) will finally become effective this summer. As we noted in our May 2011 article, these regulations will add significant new responsibilities for fiduciaries of ERISA-covered retirement plans, as well as those who provide services to such plans.

Although the purpose of the regulations is to ensure that plan fiduciaries (and plan participants who direct the investment of their individual accounts) have the information they need to make informed investment decisions, many participants are likely to suffer information overload. Moreover, even if much of the disclosure required by the new regulations is provided by mutual fund companies or other service providers, plan fiduciaries will still need to educate plan participants about the fee disclosure that is soon to come, and then be prepared for questions from participants who will now see – perhaps for the first time – how much they are actually paying for certain services.

Service-Provider Disclosures Under ERISA Section 408(b)(2)

The first set of regulations, issued under Section 408(b)(2) of ERISA, applies to contracts between service providers and fiduciaries of ERISA-covered retirement plans (both defined contribution and defined benefit). These regulations, which are often referred to as the "service provider" or "408(b)(2)" fee-disclosure regulations, require covered service providers to disclose (in writing) to the responsible plan fiduciary both (i) the services that will be provided to the plan and/or plan participants under the contract, and (ii) any and all direct or indirect compensation that the service provider reasonably expects to receive in exchange for providing those services.

Under the final 408(b)(2) regulations that were published in February of this year, the required written disclosure must be provided – with respect to both new and existing services agreements – on or before July 1, 2012. Failure to comply with these 408(b)(2) disclosure regulations constitutes a prohibited transaction (i.e., an "unreasonable" contract or arrangement between the plan and the service provider) – subjecting the service provider to a 15% excise tax and exposing the plan fiduciary to personal liability for breach of fiduciary duty.

Fiduciary Disclosures Under ERISA Section 404(a)

The second set of regulations, issued under Section 404(a) of ERISA, applies only to individual account plans (such as 401(k) plans) that provide for participant direction of investment. Under these

rules, often referred to as the "participant fee disclosure" regulations, a plan fiduciary must, as part of its general fiduciary duties under Section 404 of ERISA, provide each plan participant (on or before the date they are first allowed to direct the investment of their account and at least annually thereafter) with information regarding (i) fees and expenses for general plan administrative services (**"**plan-level" expenses), (ii) fees and expenses for individual participant transactions, such as loans or distributions ("participant-level" expenses), and (iii) fees and expenses associated with the plan's designated investment options. In addition, at least quarterly, the plan fiduciary must disclose the actual dollar amount of plan-level or participant-level fees and expenses that have been charged to each individual participant's account during the previous quarter.

The deadline for providing the initial disclosure of the fees that *may* be charged against a participant's account is August 30 (60 days after the effective date of the service-provider fee disclosure regulations, above). The deadline for providing the first quarterly disclosure of *actual* expenses incurred (for expenses incurred during the third quarter of calendar-year plans) is November 14, 2012.

Final Service-Provider Fee Disclosure Regulations

As noted in our August 2010 article, the DOL issued "interim final" regulations under Section 408(b)(2) on July 15, 2010. In response to comments from the service-provider industry, the DOL issued "final" regulations on February 3, 2012.

The final service-provider fee disclosure rules clarify that:

- Certain 403(b) contracts or custodial accounts (generally, those exempt from ERISA's plan audit requirement) are exempt from the 408(b)(2) fee disclosure rules;
- Disclosures regarding "indirect" compensation must include a description of the arrangement between the payer of that compensation and the service provider;
- Disclosures regarding the expenses of each designated investment alternative must be made in the same manner that the plan fiduciary is required to disclose those expenses to plan participants under the participant fee disclosure regulations;
- The service provider must provide the information the plan fiduciary needs for its reporting and disclosure obligations "reasonably in advance of" the date by which the responsible plan fiduciary indicates it needs the information;
- Changes in investment-related fee information need only be provided annually, whereas changes in other fee information must be provided within 60 days; and
- In order to avoid a prohibited transaction (and a fiduciary breach) where a service provider fails to disclose the required information to an innocent fiduciary, the fiduciary must promptly request the information, and if the information is not disclosed by the service provider within 90 days, the plan fiduciary must determine whether to terminate or continue the contract.

Final Participant Fee Disclosure Regulations

The final participant fee disclosure regulations were published on October 14, 2010, and were to be effective for plan years beginning on or after November 1, 2011 (January 1, 2012 for calendar-year plans). However, under a transitional rule, the initial disclosure (regarding the fees that may be charged against a participant's account) is not required to be made until 60 days after the effective date of the service-provider fee disclosure regulations (or if later, 60 days after the first day of the first plan year that begins on or after November 1, 2011). In addition, the first quarterly disclosure of fees actually charged to each participant's account is not required until 45 days after the end of the first quarter that begins after the effective date of the service-provider fee disclosure regulations.

Because the service-provider fee disclosure regulations will now be effective as of July 1, 2012, the initial disclosures under the participant fee disclosure regulations must be made by August 30, and the first quarterly disclosure of actual fees charged will be due (with respect to the third quarter of the 2012 calendar year) on November 14, 2012. By those dates, plan fiduciaries must be prepared not only to provide the required fee disclosures, but also to respond to participant questions and/or complaints regarding the fees that may be (or have been) charged against their accounts.

The Most Recent Guidance

On May 7, 2012, the DOL issued Field Assistance Bulletin 2012-02, which includes 38 questions and answers concerning the Section 404(a) participant fee disclosure regulations. Among many items, the Field Assistance Bulletin clarifies that:

- Section 403(b) annuity contracts or accounts that are exempt from the 408(b)(2) regulations are also exempt from the 404(a) participant fee disclosure regulations;
- Fees that are paid solely from forfeitures (or, if the forfeitures are insufficient, solely by the plan sponsor) need not be disclosed;
- Fees associated with a brokerage window or self-directed brokerage account must be disclosed to all participants, even if only a small percentage actually use that feature;
- Investment-related fee information must be provided for investment options that are closed to new money, but still available for existing funds;
- The plan may provide more than one comparative chart regarding investment-related fee information, but the charts must be provided at the same time and in the same mailing; and
- A model portfolio comprised solely of investment options offered under the plan is generally not a separate "designated investment alternative" requiring separate fee disclosure.

The questions and answers in FAB 2012-02 provide useful answers to many of the most common questions regarding the participant fee disclosure rules. Consequently, it is a "must read" for any plan fiduciary that is preparing for the August 30 compliance date. The DOL also intends to issue a second set of frequently asked questions regarding the 408(b)(2) service-provider fee disclosure regulations.

Preparing for Fee Disclosure

So what should plan sponsors and fiduciaries be doing now? If you have not already done so, you should contact each "covered service provider," meaning any service provider that expects to receive $1,000 or more for providing any of the following types of services to your plan:

- Services as a fiduciary or a registered investment advisor;
- Third-party administrative services or brokerage services in connection with providing a "platform" of investment alternatives; or
- Services for which the service provider receives "indirect" compensation (compensation from a party other than the plan or the plan sponsor).

As the "responsible plan fiduciary," you should obtain assurances that (i) the service provider will give you the information required under the 408(b)(2) regulations by July 1, 2012, and (ii) if the service provider is also providing a platform of investment alternatives, the service provider will give you the information that you are in turn required to disclose to plan participants (under the 404(a) fee disclosure regulations) by the August 30 deadline, and will be able to include fee information (regarding actual expenses charged to each participant account) on its quarterly statements by no later than November 14.

You may also wish to schedule one or more employee meetings to educate plan participants about the additional fee information that they will be receiving in the coming months.

For answers to questions about your fiduciary responsibilities under either the 408(b)(2) service-provider fee disclosure regulations or the 404(a) participant fee disclosure regulations, please contact any member of Spencer Fane's Employee Benefits Practice Group.

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A COMMON PLAN MISTAKE: MISCALCULATING MATCHING CONTRIBUTIONS

Sponsors of 401(k) plans often fail to make the proper employer matching contribution called for under the terms of the plan document. Although there are any number of causes for this failure, a common one involves the *timing* of matching contributions.

A plan's terms generally state that employer matching contributions will be a percentage of each participant's deferrals, up to a specified level. Plans may describe these matching contributions in terms of either an *annual* amount or *pay-period* amounts. If an employer calculates its matching contribution on a pay-period basis, when the plan calls for an annual calculation, the sum of these pay-period amounts may not comply with the terms of the plan.

For example, assume Employer ABC sponsors a calendar-year 401(k) plan. The plan provides that ABC will make a matching contribution equal to 100% of the annual amount deferred by each

participant, up to 6% of compensation. Therefore, any participant deferring at least 6% of pay should receive a matching contribution equal to 6% of pay. Participants are paid semi-monthly and the plan allows participants to change their deferral levels on the first day of each month.

During the 2011 plan year, ABC erroneously computed its matching contribution on a pay-period basis, rather than an annual basis. Michelle, a plan participant, received annual compensation of $50,000. She elected a 9% rate of deferral for the first half of the year ($25,000 x 9% = $2,250 in elective deferrals), but she reduced her deferral rate to 3% for the second half of the year ($25,000 x 3% = $750). Over the course of the year, ABC made matching contributions on Michelle's behalf totaling $2,250 ($25,000 x 6% = $1,500 *plus* $25,000 x 3% = $750).

Under the plan's terms, however, Michelle was entitled to a $3,000 match. This is because she deferred a total of $3,000 for the plan year ($2,250 plus $750). As a result, ABC needs to make an additional ("true-up") matching contribution of $750 to Michelle's account. This true-up contribution may be made as late as the deadline (including extensions) for filing ABC's federal tax return. As a calendar-year employer, this deadline would be September 15, 2012.

If the required true-up contribution is *not* made by that date, the plan would have an operational failure. By calculating the matching contribution on a pay-period basis, rather than an annual basis, ABC would not be following the plan's terms.

Accordingly, assuming the other eligibility requirements are satisfied, ABC could use the IRS's Self-Correction Program (SCP) to correct the mistake. (See our March 2012 article for a discussion of the various correction methods available to plan sponsors under the Employee Plans Compliance Resolution System.) Note that, under SCP, any true-up contribution would have to be increased to reflect lost earnings.

If your 401(k) plan document calls for an *annual* matching contribution, you should consider one of the following options:

- Waiting until year-end to make the matching contribution.
- Contributing each pay period, but then making a true-up contribution at year-end (if necessary).
- Amending the plan to provide for the calculation of matching contributions on a pay-period basis.

Finally, here are some suggestions for *all* 401(k) plan sponsors on how to avoid this common plan mistake:

- Review your plan document to determine the proper timing of matching contributions.
- Review the timing of the matching contributions that you are actually making.
- If your plan document calls for a match to be calculated on an annual basis, but you actually match on a pay-period basis, make a timely true-up contribution.
- Stay informed of any changes to your plan's matching contribution formula.

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FEDERAL APPEALS COURT REJECTS EQUITABLE REMEDIES WHEN SPD PROMISES MORE GENEROUS BENEFITS THAN PENSION PLAN DOCUMENT

In some ways, the Ninth Circuit's recent decision in *Skinner v. Northrop Grumman Retirement Plan B* is a garden-variety example of a classic fact pattern: the terms of a summary plan description (SPD) promise better benefits than the plan document it summarizes, and participants sue for the difference. *Skinner* demands our attention, however, because it is the first decision by a federal court of appeals to interpret the Supreme Court's most recent high-profile decision on ERISA remedies: *CIGNA Corp. v. Amara*.

The Ninth Circuit held that the terms of the more generous SPD were *not* enforceable under any of the theories advanced by the plaintiffs. But to understand *Skinner's* significance, we must view it in context of the Supreme Court's prior decisions. That means it's time for a little ERISA 101.

Plaintiffs' Theories Proposed in *CIGNA Corp. v. Amara*

ERISA imposes myriad obligations on plan sponsors and fiduciaries, but it rarely specifies a *remedy* for violations of those obligations. When no remedy is specified, participants may (and always do) seek the "other equitable relief" authorized under Section 502(a)(3). In broad terms, "equitable" relief is any form of relief *other* than damages under a contract. In the ERISA context, it means any relief other than payment of a benefit under the terms of the plan. Because of the catch-all nature of this provision, the federal courts have long wrestled with the question of precisely what "other equitable relief" means.

The Supreme Court has generated an impressive line of bewildering cases on the subject. As human-resources and benefits professionals know, these cases have sought answers to cutting-edge questions about benefit plans in hair-splitting contests about the equitable remedies that were available before the federal courts of law and equity were merged in 1938 (or, as Justice Scalia likes to say, "in the days of the divided bench"). These were—literally—cases about bags of gold and oxen. To call these decisions "abstruse," "convoluted," "opaque," and "infuriating" would be both accurate and enjoyable, so let's do so.

As we reported in our August 2011 article, the Supreme Court's *Amara* decision foreclosed a favorite plaintiff's tactic when it held that the terms of a plan's SPD are not a part of the plan, and therefore cannot be enforced as if they were. This holding appeared to put to rest, once and for all, the long-standing debate among the federal courts as to whether the *plan* or the *SPD* should govern when the two documents differ and the terms of the SPD would provide a larger benefit.

Realizing at the last moment that they had almost blundered and created a bright-line rule, the Court hastened to speculate that other equitable remedies that it had previously suggested were *not* available might, in fact, *be* available after all. Hitting its stride, the Court went on to muse about whether plaintiffs in such hypothetical cases would have to prove causation, harm, and damages.

Specifically, the Court suggested that the following remedies might be available to participants under ERISA Section 502(a)(3) when the terms of an SPD describe more generous benefits than the terms of the plan:

- ***Estoppel*** (denying a plan sponsor the right to rely on the plan's terms when it has made contrary representations to participants about their benefits);
- ***Reformation*** (revising the plan's terms to conform to the terms of the defective SPD); and
- ***Surcharge*** (a form of monetary revenge against a trustee or other fiduciary for breaching its duty to the participant).

These are the three theories the Ninth Circuit considered—and rejected—in *Skinner*.

The *Skinner* Decision

The facts of the *Skinner* case can be summarized very simply: When the plaintiffs retired, the terms of their SPDs said they would receive larger benefits than the terms of the plan. After the plaintiffs received only the smaller benefits, they sued both the plan sponsor and the administrative committee (the Committee) that had prepared the SPD.

The plaintiffs argued that the court should enforce the terms of the SPD. In doing so, they initially relied on previous Ninth Circuit decisions holding that the SPD is a part of the plan and that it controls when the underlying plan document is less generous. *Amara* foreclosed this argument by expressly holding that the SPD is *not* a part of the plan and is therefore unenforceable.

The *Skinner* plaintiffs then did what plaintiffs all over the country will do: they recast their arguments to align with the new theories articulated in *Amara*. Because ERISA plans are similar to both trusts and contracts, the court's analysis of these arguments was complicated by the need to review each theory under the principles of both areas of law.

1. Estoppel

The plaintiffs in *Skinner* did not pursue the estoppel theory. To recover on the basis of estoppel, a plaintiff must demonstrate not only that the sponsor made conflicting representations about benefits, but also that he or she *relied* on the more favorable representations. The *Skinner* plaintiffs conceded that they had presented no evidence at trial that they had relied on the inaccurate SPDs.

2. Reformation

The court first noted that the remedy of reformation is available only in cases of "mistake" and fraud. If a plan is viewed from the perspective of trust law, the "mistake" is a deviation from the plan sponsor's intent. Under contract law, "mistake" refers to a deviation from the mutual intent of both parties to a contract. The court rejected both theories because the plaintiffs provided no evidence that the plan failed to reflect the drafter's (or anyone else's) intent.

The court rejected the trust version of the fraud theory because the plaintiffs provided no evidence of fraud, duress, or undue influence in the preparation of the plan document. It rejected the contract version of this theory because there was no evidence that the Committee intended to deceive anyone. (In doing so, the court drew a sharp contrast to the facts in *Amara*, where the plan sponsor had intentionally misled its employees.)

3. Surcharge and the Critical Question of "Harm"

The most interesting part of the court's analysis—particularly for plan sponsors—came in response to the participants' assertion that the Committee had breached its fiduciary duty to the participants. Under this theory, a fiduciary is financially liable for breaching its duty to a participant only if the fiduciary is *unjustly enriched*, or the participant is *harmed*, by the breach.

The plaintiffs argued that there were actually two such breaches. The first was a breach of the Committee's supposed duty to enforce the more favorable terms of the SPD instead of the terms of the plan. The court rejected this argument out of hand. Citing the central holding of *Amara*, it held that the terms of the SPD itself were not enforceable under ERISA, and that in this context the Committee's fiduciary duty was, in fact, to enforce the terms of the *plan*.

The court gave more credence to the plaintiff's argument that the Committee had a statutory obligation to prepare an accurate SPD. Although the plaintiffs had presented no evidence at trial that the Committee was unjustly enriched, there was a serious question as to whether participants had been harmed by the Committee's failure to clearly explain the terms of the plan.

This question was important because the majority opinion in *Amara* had expressly suggested that the deprivation of a right guaranteed by ERISA could constitute "harm" for this purpose. The *Amara* dissent, on the other hand, had argued that such harm required either actual reliance on the defective SPD or the lost opportunity to object to a change in the benefit formula.

If the Ninth Circuit had adopted the *Amara* majority's suggestion that depriving participants of their statutory right to an accurate SPD satisfied the "harm" requirement, the path would have been clear to a damages award against the Committee. The court nipped this interpretation in the bud, however, by flatly stating that the plaintiffs had failed to demonstrate that their position would be any different had they received accurate SPDs.

What Does This Mean for Plan Sponsors?

At first glance, *Skinner* looks like good news for plan sponsors and fiduciaries. After all, the first federal court of appeals to apply *Amara* has flatly rejected the most expansive interpretation of the majority opinion—i.e., that the terms of an inaccurate SPD might be enforceable because the inaccuracy itself "harms" the participant. And that *is* good news for sponsors and fiduciaries.

But this is only one way to look at the case. Viewed from another perspective, *Skinner* was a disaster for the plan sponsor. It may have won the case, but it spent five years in *entirely preventable* litigation with its own retirees because it had distributed an inaccurate SPD. The only safe approach to ERISA's disclosure requirements is to provide *timely* and *accurate* participant communications. Doing anything less than that is simply asking for trouble.

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COSTLY FIDUCIARY BREACHES IN 401(K) FEE CASE PROVIDE MANY LESSONS

A recent decision handed down by a Missouri federal trial court has been the focus of the 401(k) world – and a costly reminder of the importance of strictly adhering to the many duties ERISA imposes on plan fiduciaries. *Tussey v. ABB, Inc.* was the first case to go to trial out of a series of lawsuits filed over the past few years challenging 401(k) plan fee practices. (Click here for more information about those lawsuits.) Following a month-long trial in 2009, and then three years of deliberation and post-trial wrangling, the court concluded that the plan's sponsor, fiduciaries, and service provider (Fidelity) had breached numerous fiduciary duties. The result was a damages award of nearly $37 million.

Although the court's decision in this case has already been appealed, and may well be reversed, it provides a number of "teachable moments" for ERISA fiduciaries. For instance, the ABB plan's fiduciaries contributed greatly to their own liability by adopting an unusually rigid investment policy statement (IPS). Among other things, the IPS provided that "at all times . . . [revenue sharing] rebates will be used to offset or reduce the cost of providing administrative services to plan participants." Unfortunately for the ABB fiduciaries, however, they did *not* use revenue sharing to offset the cost of administration. Indeed, they could not have done so, because they failed even to calculate the dollar amount of the recordkeeping fees that Fidelity charged, and thus could not know whether the money Fidelity received from investment funds as revenue sharing exceeded those fees. The court concluded that by failing to follow the terms of their own IPS, the ABB plan's fiduciaries breached their duty to administer the plan according to its terms.

In addition, the IPS outlined a strict protocol that the plan's investment committee was to follow when deciding whether to replace an investment fund. This process required the fiduciaries to examine the fund's performance over a three- to five-year period, place any underperforming fund on a watch list, and remove the fund after six months if its performance did not improve. The court found that the ABB plan's fiduciaries did not follow these protocols when they replaced the Vanguard Wellington Fund with the Fidelity Freedom Funds. Instead, the fiduciaries relied solely on the recommendation of one member of the investment committee, who had failed to present any evidence to support his recommendation. As it happened, the

Wellington Fund did exceptionally well after it was replaced, while the Freedom Funds underperformed. Because the fiduciaries did not follow the protocol set forth in the IPS for a fund's replacement, the court found them personally liable for the lost earnings opportunity.

A clear lesson here is that a plan's investment policy statement should be drafted carefully, so that it can be used as a defensive device to help fiduciaries *avoid* liability, rather than as an offensive weapon that *creates* liability. Had the IPS in the *Tussey* case not been so rigid, the court might still have ruled against the fiduciaries. But by ignoring their own policies and procedures, the ABB plan's fiduciaries made it easy for the court to find fault.

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