

Executive Compensation, Benefits and Employment Law Focus

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Seventh Circuit Decision in *Hecker v. Deere & Co.* Sets Guiding Precedent For Pending “Excessive Fee” and “Revenue Sharing” Cases

Introduction

On February 12, 2009, the Seventh Circuit affirmed the US District Court for the Western District of Wisconsin’s dismissal of the plaintiff’s complaints in *Hecker v. Deere & Co.* The plaintiffs had alleged that the plan sponsor of two 401(k) plans, the plans’ trustee and the plans’ vendor breached their fiduciary duties under the Employee Retirement Income Security Act of 1974 (“ERISA”) to the plans’ participants by charging “excessive fees” and failing adequately to disclose certain so-called “revenue sharing” arrangements. The *Deere* decision comes as the first Seventh Circuit precedent on the issues of “excessive fees” and nondisclosure of “revenue sharing” agreements, and may be relevant to the numerous other pending cases making similar allegations against ERISA fiduciaries.

Background

Deere & Company relied on Fidelity Management Trust (“Fidelity Trust”) to act as the directed trustee and recordkeeper for two of its 401(k) plans. The investment

options available at the elections of participants under each 401(k) plan included 23 different Fidelity mutual funds, two investment funds managed by Fidelity Trust, a fund for investment in Deere company stock, and a Fidelity-operated BrokerageLink facility which gave participants the option to invest in 2,500 additional funds managed by other companies. Fidelity Management & Research Company (“Fidelity Research”) acted as the investment advisor to the Fidelity mutual funds offered by the plans.

The plaintiffs, participants in the 401(k) plan, alleged that Fidelity Research engaged in fee-sharing with Fidelity Trust on the fees it earned from managing the mutual funds. Fidelity Trust treated these amounts as compensation for its services as the plans’ trustee, instead of charging Deere a fee directly for its services. The plaintiffs argued that Deere, Fidelity Research and Fidelity Trust, as ERISA fiduciaries, had violated their fiduciary duties under ERISA by offering investment options which charged fees and costs that were (i) excessive and unreasonable, (ii) not incurred solely for the benefit of the plans and the plans’ participants and (iii) undisclosed to participants.



The White & Case EXECUTIVE COMPENSATION, BENEFITS AND EMPLOYMENT LAW FOCUS is prepared for the general information of our clients and other interested persons. This memorandum is not, and does not attempt to be, comprehensive in nature.

The contents of this employment update should not be construed or relied upon as legal advice or a legal opinion.

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Analysis of the Seventh Circuit Decision

Fidelity Research and Fidelity Trust were not ERISA Fiduciaries

The Seventh Circuit first addressed the issue of whether Fidelity Trust and Fidelity Research were ERISA fiduciaries to the Deere 401(k) plans and, hence, proper defendants. The plaintiffs had argued that Fidelity Trust was a “functional” or “de facto” fiduciary under ERISA to the plans because it had played a role in the selection of investment options to be offered by the 401(k) plans, and that Fidelity Research was also an ERISA fiduciary because it had determined how much revenue to share with Fidelity Trust, therefore exercising discretion over the disposition of the plans’ assets.

The Seventh Circuit affirmed the district court’s decision and held that neither Fidelity Research nor Fidelity Trust were ERISA fiduciaries. The court noted that although Fidelity Trust had “played a role” in the selection of investment options, Deere had retained “final authority” over such decisions. The court stated that “there is an important difference between an assertion that a firm exercised ‘final authority’ over the choice of funds, on the one hand, and an assertion that a firm simply ‘played a role’ in the process,” and held that the latter activity was not enough to make Fidelity Trust an ERISA fiduciary. The court similarly found that Fidelity Research’s activities did not establish it as an ERISA fiduciary, as the fees in question had become Fidelity Research’s assets upon their transfer from the mutual fund’s assets to Fidelity, and thus were not “plan assets.” This analysis is arguably consistent with the overall statutory

scheme; indeed, a contrary holding may well have discouraged potential providers from continuing to provide needed services.

Deere Had No Duty to Disclose Revenue-Sharing Agreements

The Seventh Circuit then addressed the question of whether Deere had breached its fiduciary duty by not informing the plan participants that Fidelity Trust had entered into a revenue-sharing agreement with Fidelity Research. The plaintiffs had argued that nondisclosure of the revenue-sharing agreement breached Deere’s general fiduciary duty under ERISA, contending that such an arrangement was “wrong” for ERISA purposes. In agreeing with the district court, the court held that, before such a violation can be found, there must either be an intentionally misleading statement or a material omission. Noting that the plaintiffs had not alleged that Deere had made any intentionally misleading statements, the court focused on whether Deere’s omission of information on the revenue-sharing arrangement was material. The court noted that, at the time of the underlying facts giving rise to the complaint, nothing in ERISA or the Department of Labor regulations thereunder required Deere to disclose the revenue-sharing arrangement.¹ The court explained that Deere had provided plan participants with information about the total fees for the funds and had directed the participants to information on expenses at the individual fund-level.

The court stated that “the total fee, not the internal, post-collection of the fee, is the critical figure for someone interested in the cost of including a certain investment in her portfolio and the net value of that

¹ On November 16, 2007, the Department of Labor issued final form revisions and a final regulation, generally effective for plan years beginning on or after January 1, 2009, providing new requirements for reporting service provider fees and other compensation on the Schedule C of the 2009 Form 5500, which require detailed disclosure of revenue-sharing arrangements and other fee information. On December 13, 2007, the DOL promulgated a proposed regulation to Section 408(b)(2) which would require service providers to disclose certain direct and indirect compensation, as well as potential conflicts of interests. See generally American Bar Association—Section on Taxation, “Comments on the Proposed ‘Service Provider’ Regulations Under Section 408(b)(2) of ERISA,” (Nov. 19, 2008). On July 14, 2008, the DOL published a series of “FAQs” on the fee reporting rules under Schedule C of the 2009 Form 5500. See White & Case’s Client Alert on the FAQs; see also Oringer, “Now the DOL is FAQuing It—Having Fun with ‘Funds’ on the Form 5500,” BNA Pension & Benefits Blog, (Jul. 15, 2008). In addition, on July 22, 2008, the DOL proposed regulations under Section 404(a) and amended regulations under Section 404(c), which would require plans to disclose additional fee and expense information, relating to plan administration and investments, to plan participants. See also Oringer, “Another Piece of the Extended Puzzle—Proposed DOL Regulations Reach to General Prudence Rules,” BNA Pension & Benefits Blog, (Jul. 24, 2008).

investment,” and pointed out that participants had the choice to direct their investments to funds based on the fees charged, if they chose to do so. Further, the court noted that the plan participants had no interest in how the fees charged by each mutual fund were allocated by Fidelity. As such, the court held that Deere had not omitted material information and had no duty to disclose the revenue-sharing arrangement, and thus had not breached its fiduciary duty under ERISA. The court’s holding raises an interesting distinction between what information may be helpful to plan fiduciaries choosing investments who may have the ability to negotiate investment terms, on the one hand, and what information may be appropriate for plan participants, on the other.²

Deere Offered a Sufficient Mix of Investments

The plaintiffs argued that Deere had violated its fiduciary duties under ERISA by selecting investment options with excessive fees and by limiting investment options under the plans to Fidelity mutual funds. The Seventh Circuit disagreed, noting that expense ratios under the Fidelity mutual funds and the Brokerage Link funds ranged from .07 percent to just over one percent, which reflected market competition, as the funds were also offered to investors in the general public, and further observed that “nothing in ERISA requires every fiduciary to scour the market to find and offer the cheapest possible fund (which might, of course, be plagued by other problems).” The court also affirmed the district court’s holding that Deere had not violated its fiduciary duties by limiting investment options, finding that there was no ERISA statute or regulation which prohibited a fiduciary from selecting funds from only one management company.³

404(c) Acts as a Cushion for Deere’s Selection of Investment Options

The Seventh Circuit also discussed the applicability of ERISA Section 404(c)’s “safe harbor” as an alternate defense, which had been the district court’s primary ground for dismissal of the plaintiff’s claims. Generally, where a plan fiduciary meets Section 404(c)’s “safe harbor” requirements, that fiduciary will not be held liable for any loss of breach that results from the participant’s exercise of investment control. Citing their earlier allegations of “excessive fees” and nondisclosure of the revenue-sharing arrangement, the plaintiffs had argued that Deere was not eligible for “safe harbor” protection. The Seventh Circuit held that Deere’s actions fell within the scope of the 404(c) “safe harbor,” pointing back to its earlier findings that the revenue-sharing arrangement was not a material omission and that the plans had offered a sufficient mix of options with varying fees and expenses. Section 404(c)’s “safe harbor” protection thus provided an alternate ground for the court’s dismissal.

Practice Pointer

- White & Case personnel have been quoted as explaining a concern that the Seventh Circuit’s decision could encourage sponsors to include a greater number of investment choices than they might otherwise be inclined to offer.⁴
- Over time, some have questioned whether there is value in satisfying the Section 404(c) requirements. While the Seventh Circuit did not go as far as the district court in expanding the scope for Section 404(c)’s safe harbor, its decision makes it harder to argue that the Section 404(c) rules are without value.

² Recent legislation, e.g., The Fair Disclosure for Retirement Security Act, H.R. 3185, 110th Cong. (2007), The Defined Contribution Plan Fee Transparency Act, H.R. 3765, 110th Cong. (2007), and The Defined Contribution Fee Disclosure Act, S. 2473, 110th Cong. (2007), arguably fails fully to recognize this distinction.

³ In its opinion, the court even questioned whether Deere’s decision to restrict the plans’ investment options to a single vendor would even be considered a fiduciary function, or might be more properly classified as a settlor function, which might serve as an additional defense against allegations of fiduciary duty violations.

⁴ “ERISA Plan Fees Cases Face Uphill Battle After Seventh Circuit Ruling,” Pension & Benefits Daily (BNA), D-8 (Mar. 6, 2009).

Conclusion

Currently, there are many cases across the US in which plaintiffs are alleging that plan fiduciaries and vendors violated their ERISA fiduciary duties by charging “excessive fees” or failing to disclose revenue-sharing agreements. The court in *Deere* flatly rejects common arguments that revenue-

sharing arrangements should have been disclosed. Additionally, the court’s reasoning may help defendants where plan fiduciaries are able to show that the plan offers a sufficient mix of investment options. White & Case would be happy to consider *Deere*’s implications with plan sponsors and providers.

New Law Significantly Modifies HIPAA Privacy and Security Rules

Background

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposed privacy and security standards upon all “covered entities,” which include group health plans and health care providers. The American Recovery and Reinvestment Act of 2009 (the “ARRA”) provides a number of rules designed to strengthen and extend HIPAA’s privacy and security protections. Specifically, ARRA (a) provides that “business associates” are independently subject to HIPAA, (b) adds requirements for notifying the Department of Health and Human Services (“HHS”) and/or individuals of security breaches, (c) expands individuals’ privacy rights and (d) enhances HIPAA’s enforcement provision.

ARRA’s New HIPAA Requirements

Business Associates Subject to HIPAA

Prior to the ARRA, only covered entities were subject to the requirements of the HIPAA privacy and security rules. Because the administration of group health plans is burdensome and complex, especially for companies not engaged in the business of providing health care, covered entities typically engage third party service providers to administer their group health plans. In this regard, the HIPAA privacy and security rules require covered entities to enter into contracts with their “business associates,” which contracts obligate business associates to safeguard “protected health information” (“PHI”)

that they receive from, or create on behalf of, a group health plan. Prior to the ARRA, however, business associates were not specifically subject to such requirements, except to the extent that they undertook to comply with such requirements on behalf of the covered entity under the business associate agreement.

Under the ARRA, business associates are now separately subject to the substantive provisions of the HIPAA privacy and security rules, along with the civil and criminal penalties for violating those standards, generally in the same manner and to the same extent as covered entities.

As a result of these new requirements, business associates will now need to increase their compliance efforts in connection with both privacy and security. With respect to the privacy rule, business associates will be required to develop written policies and procedures, workforce training and discipline and periodic compliance reviews. With respect to the security rule, business associates will be required to adopt physical, administrative and technical safeguards, and to adopt security policies and procedures. In addition, ARRA expressly instructs covered entities and business associates to modify their business associate agreements to incorporate the applicable new requirements of ARRA.

Notifications of Privacy or Security Breaches

Prior to ARRA, there was no requirement to notify HHS or individuals of a privacy or security related PHI breach. Under ARRA, the covered entity must

notify individuals of any security “breach” and keep a log of such breaches, which must be submitted annually to HHS. For these purposes, a “breach” means the unauthorized acquisition, access, use or disclosure of PHI that compromises the security, privacy or integrity of PHI.

If there is a breach of “unsecured PHI” (i.e., PHI that is not secured through the use of a technology that makes the PHI unusable, unreadable or indecipherable to unauthorized individuals, or other methodology approved by HHS), the covered entity is required to notify each individual whose PHI has been breached without unreasonable delay, but in no event later than 60 days after the breach has been discovered. The notification must be in writing by first class mail, or, in some cases, by e-mail. If a possibility of imminent misuse of the PHI exists, notification must be by telephone or other appropriate means. If the breach involves more than 500 individuals, the covered entity must notify HHS at the time of the discovery and must notify “prominent media outlets” in the area. Such breaches will be posted on the HHS website for public viewing.

Expansion of Individuals’ Rights

Prior to ARRA, individuals had a right to receive an accounting of disclosures of their PHI made by the covered entity over the prior six years, except for disclosures made to carry out treatment, payment or health care operations of the covered entity. However, under ARRA, with respect to covered entities or business associates that use an “electronic health record,” such exception from the accounting of disclosures is eliminated and they will need to retain this information for a period of three years.

Under HIPAA, the use or disclosure of PHI is, in most, but not all cases (i.e., disclosures to or requests by a health care provider, uses or disclosures to be made to the individual as permitted or required by HIPAA, uses or disclosures made pursuant to an authorization and certain disclosures made to HHS or as required by HIPAA or other law), limited to that which is “minimally necessary” to accomplish the intended purpose of such use or disclosure. ARRA provides that the covered entity must now

limit all of its uses, disclosures or requests for PHI to that which is minimally necessary to accomplish the intended purpose of such use, disclosure or request.

Under HIPAA, an individual may request access to his or her PHI. ARRA expands this right to allow an individual to request PHI in an electronic format and to direct it to be sent to another designated person or entity.

ARRA also adds a new prohibition on any covered entity or business associate selling any individual’s PHI, without the specific authorization of the individual.

ARRA requires health care providers to comply with an individual’s request not to share his or her PHI with his or her group health plan if the provider has been paid out of pocket in full for its services.

Enhanced Enforcement Provisions

The maximum civil monetary penalty for violations of identical HIPAA provisions within one year has been increased from US\$25,000 to US\$1.5 million.

In addition, the Secretary of HHS is now required to conduct periodic compliance audits of business associates and covered entities. ARRA also requires a formal investigation of complaints, plus imposition of monetary penalties for violations due to willful neglect.

State Attorney Generals are now authorized to bring civil actions against individuals who violate HIPAA’s privacy and security standards in order to enjoin any further violation and to seek monetary damages for such violations.

ARRA’s Effective Date

ARRA’s HIPAA provisions are generally effective February 17, 2010, but some provisions are specifically made effective at earlier times (e.g., the section of ARRA dealing with notification of security breaches indicates that such section applies to breaches that are discovered on or after the date that is 30 days after the publication of final regulations,

and such section goes on to mandate the Secretary of HHS to promulgate such final regulations no later than 180 days after enactment of HHS).

Conclusion

Group health plans and business associates that are subject to HIPAA must now revisit their HIPAA

privacy and security efforts to comply with the new rules. In particular, they must (a) review and revise their HIPAA privacy and security notices, policies, administrative materials and training manuals; (b) review, negotiate and revise their business associate agreements and (c) train any employees who have access to PHI with respect to the changes to HIPAA's rules as a result of ARRA. White & Case would be pleased to assist you in this regard.

Children's Health Insurance Program Reauthorization Act of 2009 Imposes New Requirements on Group Health Plans

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (the "Act"). The Act extends and expands the State Children's Health Insurance Program ("SCHIP") to allow states to subsidize premiums for employer-provided group health coverage for eligible children and their families. The Act applies to both fully insured and self-insured plans, and imposes new notice and disclosure obligations on employers that maintain group health plans. Additionally, the Act provides for new special enrollment rights. Employers are not required to comply with the Act's notice and disclosure requirements until the first plan year after model notices and disclosure forms have been issued. However, the effective date of the Act's premium subsidy and special enrollment provisions is April 1, 2009, and thus requires immediate employer action.

Background

SCHIP was enacted by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act to provide health insurance to uninsured children in families with low incomes that are too high to qualify for Medicaid. SCHIP is jointly financed by the federal and state governments, and administered by the states. States may design their SCHIP eligibility requirements, payment levels for

coverage, benefit packages and policies within broad federal guidelines. Some states have been authorized to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

As SCHIP was set to expire in 2007, a temporary reauthorization of SCHIP was passed in December 2007 to extend the program through April 2009. The Act reauthorizes and extends SCHIP through 2013, and changes the formal name of the "State Children's Health Insurance Program" to the "Children's Health Insurance Program" ("CHIP").

Premium Assistance Subsidy

The Act allows states to offer a premium assistance subsidy, instead of providing health insurance directly, to eligible low-income children and their families for qualified employer-sponsored coverage. The Act defines "qualified employer-sponsored coverage" as a group health plan or health insurance coverage offered through an employer (i) that qualifies as "creditable coverage" as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), (ii) for which the employer contributes at least 40 percent of any premium for such coverage and (iii) that is offered to all individuals in a nondiscriminatory manner. This definition excludes

health flexible spending accounts or high deductible health plans.

The premium assistance subsidy may be provided as a reimbursement to the employee or as a direct payment to the employer, with an opt-out option for employers. Thus, employers will need to decide whether or not to opt out, taking into consideration that the amount of subsidy and the mechanics of how it can be received by the employer will vary by state. If an employer chooses to opt out, the premium assistance subsidy will be paid directly to the employee, but the employer must still permit the eligible individuals to enroll in the plan and to pay for coverage through salary reductions. If the premium assistance subsidy is provided and an eligible individual is enrolled in an employer group health plan, the state may also need to furnish supplemental coverage on a secondary basis to ensure that a minimum level of coverage is provided. Employers may need to update their plan documents to reflect this coordination of benefits rule. The effective date of the premium assistance subsidy is April 1, 2009.

The Act also directs states to create a process that will allow the parent of a child receiving a premium assistance subsidy to disenroll the child from the employer's group health plan during any month and enroll the child in the state's CHIP plan. Employers may need to amend their plan documents to reflect this new election right as well.

New Notice Requirement

The Act requires employers with group health plans in states that provide the premium assistance subsidy to provide written notice to their employees informing them of such subsidies. Employers may provide these notices along with other plan documents notifying employees of health plan eligibility, with open enrollment materials, or when furnishing a summary plan description. The Act directs the US Department of Health and Human Services ("HHS") to develop national and state-specific model notices by February 4, 2010. This new notice requirement is effective for plan years beginning after the date on which the model

notices are first issued. Failure to comply with this notice requirement may result in penalties of up to US\$100 per day, per violation, with respect to any employee.

New Disclosure Requirement

Under the Act, the administrator of a group health plan that covers a Medicaid or CHIP participant must disclose information about the benefits available under the plan to the relevant state upon request. This information will help states to determine the cost-effectiveness of providing the premium assistance subsidy and whether it is necessary for the state to provide supplemental benefits. HHS and the Department of Labor are required to develop a model disclosure form by August 4, 2010, for plan administrators to complete. States may not request the disclosure form until the first plan year that begins after the date on which the model disclosure form is first issued. Failure to comply with this disclosure requirement may result in penalties of up to US\$100 per day, per violation, with respect to any employee or beneficiary.

New Special Enrollment Rights

Under existing HIPAA rules, group health plans must allow special enrollment for eligible individuals to enroll in the plan without having to wait until the plan's next open enrollment period under two circumstances: (1) an eligible individual who previously declined coverage because of other health coverage loses eligibility for the other coverage, or (2) an eligible employee acquires a new spouse or dependent by marriage, birth, adoption, or placement for adoption. The special enrollment period under HIPAA is 30 days; that is, to special enroll, an employee or dependent must request special enrollment within 30 days of the loss of coverage, or within 30 days after the marriage, birth, adoption, or placement for adoption, as applicable. HIPAA requires employers to provide a notice of special enrollment rights to all employees, not just those who decline coverage,

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at or before the time an individual is initially offered the opportunity to enroll in a group health plan.

The Act supplements HIPAA's special enrollment rules by requiring group health plans to permit eligible employees and dependents who are not enrolled for coverage to enroll under two new circumstances: (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or (2) the employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. Whereas HIPAA's special enrollment period is 30 days, the special enrollment period under the Act is 60 days; that is, to special enroll under one of the two new circumstances, an employee or dependent must request special enrollment within 60 days after the loss of Medicaid or CHIP coverage, or within 60 days after the employee or dependent is determined to be eligible for a Medicaid or CHIP subsidy, as applicable.

The effective date of the Act's special enrollment provisions is April 1, 2009. In addition to administering these new rules, employers will need to add information regarding the new special enrollment rights to the HIPAA special enrollment notice, and also to amend any plan documents that describe special enrollment rights.

Conclusion

Although employers will not need to meet the notice and disclosure obligations under the Act until the first plan year beginning after the date on which the model notices and disclosure forms are issued, employers do need to take certain immediate action to comply with the Act's premium assistance subsidy and special enrollment provisions, which are effective April 1, 2009. As always, White & Case would be happy to answer any questions you may have, as well as to assist you with implementing any changes required by the Act.

Final Rules for Group Health Plans Under the Newborns' and Mothers' Health Protection Act

On October 20, 2008, final regulations were issued under the Newborns' and Mothers' Health Protection Act of 1996 (the "Newborns' Act"). The Newborns' Act was enacted to provide protections for mothers and their newborn children with regard to hospital lengths of stay following childbirth. Interim rules implementing the Newborns' Act were published on October 27, 1998, and they have now been replaced by the final regulations. The final regulations were effective on December 19, 2008, and apply to group health plans for plan years beginning on or after January 1, 2009.

Generally, the final regulations do not change the 1998 interim rules. Below is a summary of the final regulations:

- **Hospital Length of Stay.** The general rule under the Newborns' Act is that group health plans may

not restrict mothers' and newborns' benefits for a hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The exception is that a mother or newborn child may be discharged earlier than the 48-hour or 96-hour stay, as applicable, if the decision to do so is made by an attending provider in consultation with the mother. The final regulations retain the interim rule that if delivery occurs in a hospital, the hospital stay is considered to begin at the time of delivery (or, in the case of multiple births, at the time of the last delivery) instead of at the time of admission or onset of labor. If delivery occurs outside a hospital, the stay begins at the time the mother or newborn child is admitted to the hospital as an inpatient in connection with childbirth. In this case, the attending provider makes the medical

determination of whether a hospital admission is in connection with childbirth. The final regulations do not distinguish between a delivery planned for outside a hospital and other deliveries occurring outside a hospital.

- **Definition of Attending Provider.** The final regulations, like the interim rules, define the attending provider as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. Whereas the preamble to the interim rules noted that this definition could include a nurse midwife or physician assistant, the final regulations do not provide a list of titles or positions that qualify as attending providers. However, the final regulations do specify that a plan, hospital, managed care organization, or other health insurance issuer is not an attending provider.
- **Compensation of Attending Providers.** The final regulations retained the interim rule prohibiting plans from directly or indirectly penalizing, or otherwise reducing or limiting the compensation of, an attending provider who provides care in accordance with the regulations. Under both the interim rules and the final regulations, plans are also prohibited from directly or indirectly providing monetary or other incentives to an attending provider to induce the provider to provide care in a manner that is inconsistent with the regulations. However, both the interim rules and the final regulations allow plans to negotiate with attending providers the level and type of compensation for care furnished in accordance with the regulations.
- **Denial of Coverage and Payments to Mothers.** The final regulations, like the interim rules, prohibit group health plans from denying a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the regulations. The interim rules and the final regulations also prohibit a plan from providing payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under the regulations.

- **Authorization and Precertification.** Under both the interim rules and the final regulations, a group health plan may not require a physician or other health care provider to obtain authorization from the plan for prescribing the 48-hour or 96-hour stay, as applicable. Also, a plan may not restrict the benefits for any portion of the 48-hour or 96-hour stay to be less favorable than benefits provided for a prior portion of the stay. Note that this rule does not prevent a plan from requiring precertification for any portion of a stay after the first 48 hours or 96 hours, as applicable, or from requiring precertification for an entire stay. Also, a plan may not increase an individual's coinsurance or cost-sharing for any later portion of a 48-hour or 96-hour stay. Note that a plan may require a participant to notify the plan of a pregnancy before hospital admission in order for an individual to obtain more favorable coverage or coinsurance under the plan, as long as any cost-sharing provisions or level of benefits are consistent throughout the required 48-hour or 96-hour stay.
- **Notice Requirements for ERISA Group Health Plans.** Both the interim rules and the final regulations require group health plans that are subject to ERISA to comply with the summary plan description (SPD) disclosure requirements at 29 C.F.R. 2520.102-3(u). Under those requirements, the SPD of an ERISA group health plan that provides post-childbirth hospitalization benefits must describe any federal or state law requirements applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital lengths of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the different areas and the federal or state law requirements applicable in each. The SPD disclosure requirements provide model language for plans subject to the federal Newborns' Act requirements. According to the preamble to the final regulations, the notice requirements may be met electronically if ERISA's requirements for disclosure through electronic media are met.

Applicability in States. The Newborns' Act applies to both self-insured and fully-insured plans. However, with respect to fully-insured plans, the provisions of the Newborns' Act will not apply if there is a state law regulating health insurance coverage that meets any of the following requirements:

- The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section;
- The state law requires the coverage to provide for maternity and pediatric care in accordance with the guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

The final regulations clarify that the only guidelines that need to be considered for this criterion are those that deal with care following childbirth; or

- The state law requires that decisions regarding the appropriate length of hospital stay be left to the attending provider in consultation with the mother. The final regulations, like the interim rules, explain that state laws that require the decision to be made by the attending provider with the consent of the mother satisfy this criterion.

Although the final regulations do not vary significantly from the interim rules, they do make some clarifications. As always, White & Case would be pleased to discuss any questions or concerns you may have regarding the final regulations under the Newborns' Act.

Kennedy v. DuPont Administrative Committee: Ask Not What your QDRO Can Do For You

Introduction

On January 26, 2009, the United States Supreme Court unanimously held in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan, et al.*¹ that a plan administrator correctly paid retirement benefits to an ex-spouse who was named as beneficiary under the plan, notwithstanding a divorce decree in which such ex-spouse had waived her right to such benefits. The Court held that plan benefits must be paid in accordance with the plan terms, which provided for payment to the named beneficiary.

Background

In 1974, William Kennedy, a participant in his employer's defined contribution plan, designated his wife at that time, Liv Kennedy, as his sole beneficiary. William and Liv were divorced in 1994; however, William never executed a new beneficiary form designating another individual as his beneficiary under the plan. William died in 2001,

his estate asked for a distribution, and the plan administrator refused, citing the beneficiary designation on file.

The estate sued, arguing that Liv had effectively waived her rights to any benefit under SIP under the divorce decree. The decree stated that Liv was "...divested of all right, title, interest and claim in and to...[a]ny and all sums...the proceeds [from], and any other rights related to any...retirement plan pension plan, or like benefit program existing by reason of [William's] past or present or future employment."

The US District Court entered summary judgment for the estate, concluding that a beneficiary can waive his or her rights to the proceeds of an ERISA plan, provided that the waiver is explicit, voluntary, and made in good faith. The Fifth Circuit reversed, citing ERISA's "anti-alienation" provision, and holding that Liv's waiver constituted an unlawful assignment or alienation of her interest in the SIP benefits to the estate. Because the Kennedy divorce decree did not meet the strict requirements

for a qualified domestic relations order (a “QDRO”), the Fifth Circuit held that ERISA prohibited the plan administrator from paying out benefits to anyone other than the designated beneficiary on file.

Analysis and US Supreme Court Decision

The Supreme Court noted the then-existing split in the lower courts over (i) whether a divorced spouse could waive pension benefits via a divorce decree and (ii) whether a beneficiary’s federal common law waiver of plan benefits is effective if such waiver is in contravention of plan documents. The Court viewed the QDRO analysis as wholly inapposite, as the waiver (in *Kennedy*) did not purport to assign benefits to an alternate payee. Thus, the anti-alienation rules were insufficient to cause the plan to be required to make the distribution to Liv. However, while the estate won that battle, the Court then looked to the requirement in ERISA that a plan generally be administered in accordance with its terms, and held that the purported waiver in the divorce decree was ineffective to require the plan administrator to fail to follow the beneficiary designation (of Liv) on file. Thus, the payment to Liv as the named beneficiary was proper. The Court noted that to hold otherwise would create uncertainty and confusion for plan administrators, whose plan documents serve the purpose of establishing uniform procedures to guide the processing of claims and the disbursement of benefits.

Practice Pointer

- In a recent PLI audioconference on the *Kennedy* case, commenters suggested that a plan sponsor could proactively avoid a situation similar to that in *Kennedy* by developing plan language specifying waiver-related rules; at least one sponsor appears to have a provision under which a participant’s spousal beneficiary designation is automatically revoked upon divorce.²

The Court, in a footnote, left open the possibility that the Estate may have been able to pursue a claim against Liv, following her receipt of benefits from the SIP.³ White & Case personnel have been cited as having identified this aspect of the case as being extremely significant for a practitioner.⁴

Other Recent Cases

There are two other recent benefits-related domestic relations cases in the lower courts that may be of some interest. In *Owens v. Automotive Machinists Pension Trust*,⁵ the Ninth Circuit held that Norma Owens, who had been in a quasi-marital relationship with Phillip Owens for over thirty years, was entitled to half of Mr. Owens’ monthly pension benefit pursuant to a valid QDRO. In part, the Court applied Washington state domestic relations law to determine that Ms. Owens was entitled to “marital property rights” and that the order was therefore a valid QDRO. In *Lewis v. New York State Dep’t. of Civil Service*,⁶ the New York Supreme Court, Appellate Division, held that New York’s “marriage recognition rule” allowed the state to recognize out-of-state same-sex marriages, and that parties to marriages recognized under the rule were entitled to benefits provided to spouses of state employees.

Conclusion

Developments in the domestic relations area continue to have an impact on benefit plans, and their sponsors and administrators. As always, White & Case would be happy to assist you in a review of your plan documents and procedures to determine how these developments may affect your plan.

1 129 S. Ct. 865 (2009).

2 “Beneficiary Designations: Attorneys in *Kennedy* Case Offer Insight Into Court’s Adoption of Plan Documents Rule,” 36 Pens. & Benefits Rep. (BNA) 497 (Mar. 3, 2009).

3 *Kennedy*, 129 S. Ct. at 875, n.10.

4 36 Pens. & Benefits Rep. (BNA), supra, at 497 (Mar. 3, 2009).

5 551 F.3d 1138 (9th Cir. 2009).

6 872 N.Y.S.2d 578 (N.Y. App. Div. 2009).

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