ROBINSON & COLE LLP
Employee Benefits & Compensation

DOL Provides Guidance on Allocation of Expenses in a Defined Contribution Plan

Many plan sponsors charge some plan administration expenses to plan assets. Since an inappropriate charge could violate a plan sponsor's fiduciary duties under ERISA, the method used to allocate expenses must be appropriate. The DOL has issued Field Assistance Bulletin 2003-3 to provide guidance on the proper allocation of reasonable plan administration expenses that may be paid out of a defined contribution plan's assets. According to the DOL, a pro rata method of allocation based on each account's assets will generally be the most appropriate method, particularly where fees, such as investment management fees, are based on account balances. A per capita method of allocating expenses equally to each account can be a reasonable method of allocating certain fixed administrative expenses, such as recordkeeping expenses. Plan fiduciaries should act prudently and have a rational basis for selecting an appropriate allocation method for a particular expense.

The Bulletin also provides guidance as to when plan expenses can be charged to a particular participant's account, rather than to plan assets as a whole. Examples of plan expenses that can be charged to a participant's account are:

· Expenses incurred in determining whether a participant is eligible for a hardship withdrawal.

· Expenses associated with the calculation of benefits under different distribution options and expenses incurred in the distribution of benefits.

· Expenses relating to investment advice services if the service is utilized by the participant.

· Expenses incurred for QDRO determinations (reversing a prior position taken by the DOL).

Significantly, the Bulletin also states that expenses may be charged to the accounts of separated vested participants even if expenses are not allocated to active participants' accounts.

This guidance is welcome and provides a flexible approach for plan sponsors to use when allocating plan expenses. Plan documents will need to be amended to properly reflect the

methodology used to allocate plan expenses, especially those charged directly to participants' accounts. If a plan's allocation method is changed as a result of this guidance, the summary plan description should also be updated to identify those cases where expenses will be charged against participants' accounts.

Although this Bulletin dealt with defined contribution plans, it is the understanding of many practitioners that these guidelines, to the extent applicable, could also be applied to defined benefit plans.

Flurry of COBRA Activity

The DOL has issued proposed regulations clarifying the COBRA notice provisions. In addition, on June 3, 2003, Connecticut's Governor Rowland signed into law legislation beefing up Connecticut's state continuation of health coverage requirements. Both of these laws generally require group health plans to permit employees and their covered dependents (qualified beneficiaries) to continue their coverage under the group health plan for a certain period of time after the employee or dependent would otherwise lose coverage due to a qualifying event, such as a termination of employment, divorce, or loss of dependent status.

The proposed regulations issued by the DOL provide guidance on how plan administrators can comply with COBRA's notice requirements. The proposed regulations require plan administrators who receive a notice of a qualifying event from an otherwise ineligible participant to notify the participant as to why he or she is not eligible for COBRA; require plan administrators to provide an initial COBRA notice to employees and dependents within 90 days of the time coverage under the group health plan begins; and require plan administrators to notify qualified beneficiaries if COBRA coverage is terminated early. In addition, the proposed regulations provide information on the Trade Act of 2002, which establishes additional notice requirements for certain qualified beneficiaries and clarify that plans must contain reasonable procedures for qualified beneficiaries to notify the administrator of qualifying events.

In addition to federal law, insured plans that are regulated by Connecticut's state insurance laws will have to comply with Connecticut's new coverage continuation law, as well. Connecticut will require group health insurance plans to give employees and dependents who would otherwise lose coverage due to a termination of employment, leave of absence, or reduction in hours because of eligibility to receive Social Security retirement benefits, the ability to continue coverage under the group plan until such employee is covered by Medicare. The effect of this provision is to potentially increase the amount of time a qualified beneficiary may obtain continuation coverage beyond the general period of 18 or 36 months. The effective date of Connecticut's new law is October 1, 2003.

IRS Updates Correction Program

The IRS has released an updated version of its correction program, the Employee Plans Compliance Resolution System (EPCRS). EPCRS permits plan sponsors to correct errors in plan documents or that occur in connection with the operation of the plan. The program provides for three levels of correction: a self-correction option that does not require a

submission to the IRS; a voluntary correction option for more serious errors that requires submission to the IRS and IRS approval of the correction; and an audit correction option for errors discovered on IRS audit. The prior version of EPCRS offered a number of voluntary correction options, each of which involved different fees and procedures. The revised EPCRS streamlines the voluntary correction program by adopting a single correction option with a fixed fee schedule. It also offers a new correction under the voluntary correction program for plans that failed to adopt EGTRRA amendments by the EGTRRA good faith amendment deadline. Although the revisions do not take effect until October 1, 2003, plan sponsors may make corrections under the revised version of the program now.

High Deductible Health Plans are now Permitted in Connecticut

Archer Medical Savings Accounts (Archer MSAs) allow self-employed persons and employees of small employers to save money to pay for future medical expenses. Archer MSAs must be used in conjunction with high deductible health plans. Such accounts previously have not been available in Connecticut since state law does not permit high deductible health plans. However, effective July 1, 2003, Connecticut law has been revised to allow high deductible health plans to be used to establish Archer MSAs.

Supreme Court Rejects "Treating Physician Rule" for ERISA Plans

The United States Supreme Court has held that plan administrators are not required to give special consideration to the opinion of a participant's treating physician and do not have a burden of explanation when there is reliable evidence that conflicts with the treating physician's evaluation. In Black and Decker Disability Plan v. Nord, a participant filed a claim for benefits with his group disability plan. The participant's treating physician had determined that he was unable to work as a result of degenerative disk disease and chronic pain. The physician retained by the plan found that the participant could perform some sedentary work if he took pain medication. Based on this information, the plan administrator denied the claim for disability benefits.

The Ninth Circuit Court of Appeals found that the plan administrator had not provided adequate justification for the denial of benefits and found in favor of the participant, relying upon the "treating physician rule." Under that rule, if a plan administrator rejects a treating physician's opinion, it must have a specific reason for that rejection based on substantial evidence in the record.

The United States Supreme Court reversed the Ninth Circuit and held that although plan administrators can't act arbitrarily and refuse to consider reliable evidence, including the treating physician's opinion, the treating physician's opinion does not need to be given special consideration. This case is good news for plan sponsors who rely upon the judgment of independent physicians in making disability determinations. It also highlights the importance of maintaining adequate records documenting claims decisions.

State Law Negligence Claims against Actuary not Preempted by ERISA

The Second Circuit Court of Appeals ruled in Gerosa v Savasta, that a run-of-the-mill state law professional negligence claim could be brought against a non-fiduciary in state court. In this case, a pension fund sought reimbursement by the fund's actuaries for the shortfall that the pension fund would experience as a result of the actuaries' negligent services. The Court found that the claim for restitution was not available under ERISA, which only authorizes equitable relief. However, the Court found that the pension fund would have a state law negligence claim against the actuary, a non-fiduciary plan advisor.

IRS Rules on Contributions of Vacation and Sick Leave to Governmental Plans

The IRS has ruled that a participant in a governmental qualified profit sharing plan could elect to have the employer contribute to his or her plan account an amount equal to the value of the participant's unused vacation time, which could not be carried over to the next year. Since the participant could not elect to receive such amounts in cash, the IRS found that this arrangement did not constitute a cash or deferred arrangement - significant since such plans can't be offered by governmental entities. The IRS also ruled that if unused sick leave accumulated from year to year, upon retirement, the value of the unused sick leave could be contributed to a governmental qualified retirement plan, or if elected by the employer, to a retiree medical plan. The rulings provide governmental employers with planning opportunities for accumulated leave and such employers should consider whether such programs could be incorporated into existing benefit programs.

IRS Issues Guidance on Medical Expenses that can be Reimbursed under an FSA

In a series of rulings, the IRS has clarified the deductibility of certain medical expenses. It is important for sponsors of medical expense reimbursement plans to keep informed of developments in the deductibility of medical expenses, since only deductible unreimbursed medical expenses can be reimbursed through flexible spending accounts.

· Egg donor expenses, including agency fees and legal fees involved in preparing a contract between the participant and the egg donor, are deductible because the fees are preparatory to the performance of a medical procedure.

· Breast reconstruction surgery expenses following a mastectomy for cancer are deductible. Although the cost of cosmetic surgery is not deductible, if the surgery is designed to ameliorate a deformity related to congenital abnormality, a personal injury, or a disfiguring disease, it is deductible. Because breast reconstruction surgery resulting from the loss of a breast to cancer emulates a deformity directly related to a disease, these expenses are deductible. Although group health plans are required to cover breast reconstruction surgery following a mastectomy, the coverage may be subject to an annual deductible. A participant can take advantage of a medical expense reimbursement account to pay any out-of-pocket expenses.

· Eye surgery, including LASIK and radial keratotomy, to correct defective vision is a procedure promoting the proper function of the body and thus the cost of the surgery is deductible.

· Teeth whitening procedure is a type of nondeductible cosmetic surgery. The discoloration of teeth is not a deformity and is not caused by a disfiguring disease and thus the cost of teeth whitening is not deductible.

· Non-prescription drug costs are not deductible even if the drug is recommended by a physician. However, amounts paid for non-prescription equipment, such as crutches, and diagnostic devices, such as blood sugar tests, are deductible if they involve the diagnosis, cure, mitigation, treatment, or prevention of disease or are paid for the purpose of affecting any structure or function of the body.