ROBINSON & COLE LLP
Employee Benefits & Compensation

DOL Says Plans Permitted to Prohibit Loans to Executive Officers and Directors

A plan sponsored by a publicly traded company may prohibit loans to executive officers and directors of the sponsoring employer. On April 15, 2003, the DOL issued a Field Assistance Bulletin, which concludes that given the uncertainty surrounding the permissibility of loans to executives and officers of publicly held companies under the Sarbanes Oxley Act, plans may be amended to prohibit plan loans to officers and directors without violating ERISA's nondiscrimination requirements.

The Sarbanes Oxley Act generally prohibits publicly traded companies from making loans to officers and directors. However, it is unclear whether this prohibition applies to plan loans, as such loans are loans of the amounts in a participant's plan account, not the assets of the company. The SEC has not yet taken a position on whether plan loans constitute prohibited loans under Sarbanes. However, some plan administrators have opted to prohibit such loans until the SEC issues further guidance. The DOL's opinion is a response to those plan administrators who did not wish to run afoul of Sarbanes but who also were concerned about violating ERISA.

IRS Provides Guidance on the use of Debit/Credit Cards under Flexible Spending Accounts and Health Reimbursement Arrangements

The IRS has provided guidance to employers regarding the use of debit or stored-value credit cards to obtain reimbursement of medical expenses under Flexible Spending Accounts and Health Reimbursement Arrangements. If a plan substantiates expense reimbursement by such cards within the IRS guidelines, amounts received by employees under the plan will not be includible in the employees' income.

The IRS approved a plan with specific attributes:

• Electronic reimbursement up to the maximum dollar amount of coverage can be made with the card while the employee is a plan member.

• Upon enrollment, the employee certifies that the card will only be used for eligible medical expenses of the employee, his or her spouse and dependents. The employee also certifies that he or she will not seek reimbursement under any other health plan for any expense paid with the card.

• A certification statement is included on the back of the card and the employee reaffirms the certification each time the card is used.

• Employees are required to retain sufficient documentation to substantiate the nature of the reimbursed expense, such as invoices and receipts.

• The card can only be used with certain providers.

Eligible medical expenses must be substantiated in order to be eligible for tax-favored treatment. If a provider supplies substantiation at the time the card is used, or if the dollar amount of the transaction equals the co-payment for that service under the plan, or if the expense is a recurring expense that matches a previously approved expense, the employer does not need to obtain additional substantiation. Otherwise, the employer must obtain corroborating evidence that the charge was for a medical expense in order to substantiate the charge. The use of a sampling technique to substantiate reimbursements is insufficient.

If an employer cannot substantiate an expense or determines that an expense that was reimbursed was not a qualified medical expense, the employer should request the employee to return the ineligible amount to the plan. If the employee does not repay the plan, the IRS indicated that the amount could be withheld from the employee's wages if permissible by applicable law. This option will not be utilized in most cases since most states do not permit employers to withhold unauthorized amounts from employees' wages. The IRS stated that the employer could offset the ineligible amount against subsequent claims until the improperly paid amount was repaid or could deny further access to the card until the plan had been repaid. As a last resort, the employer can treat the amount as a business indebtedness.

The guidance also contains a controversial requirement that debit and credit card plan payments are reportable on Form 1099-MISC.

This guidance will be helpful to plan sponsors who would like to allow employees to use debit or credit cards in conjunction with their Flexible Spending Account or Health Reimbursement Arrangement. Allowing a debit or credit card to be used can increase participation in Flexible Spending Accounts, since employees do not have the burden of submitting paper documentation of the expense before receiving reimbursement. However, in order for the use of debit or credit cards to be successful, a plan administrator must first have in place the necessary systems to support the use of cards.

The Ruling is effective for plan years commencing in 2004.

Post-Death QDRO Approved by Court

In Patton v. Denver Post Corporation, the Court allowed a Qualified Domestic Relations Order (QDRO) to be entered after a participant had died. The participant and spouse were divorced in 1988. At that time they were informed by the plan sponsor, the Denver Post, that the husband was eligible for benefits from one pension plan when in fact he was eligible for benefits from two pension plans. The spouse was awarded one-half of the interest in the plan that was disclosed. After the participant's death, the spouse became aware of the second pension plan. The Court allowed a post-death QDRO for the plan that had not been disclosed at the time of the divorce. The Court rejected the plan sponsor's contention that the Order was not qualified because it increased the plan's liability and because it was not in

existence at the date of the participant's death. The Court allowed the QDRO retroactive to the date of divorce, finding it significant that the plan administrator was in part responsible for the failure to identify the plan to the parties at the time of their 1988 inquiry.

Some courts have held that a participant's interest in a defined benefit plan ceases at death and cannot be resurrected by a post-death QDRO. This Court found that ERISA does not require notice of a QDRO prior to a participant's death. Additionally, the Court found that a QDRO that is entered into retroactively to the date of original divorce was not an impermissible increase in benefits. This case highlights the importance of monitoring QDROs and fully communicating with the parties with respect to all benefits at the time a QDRO is being prepared.

ERISA Preemption did not Bar a Mixed Coverage/Medical Treatment Malpractice Claim

ERISA will no longer provide an automatic bar to state medical malpractice claims against HMOs in the Second Circuit. In Cicio v John Does, the Second Circuit Court of Appeals found that ERISA was not intended to preclude state medical malpractice claims independent of an ERISA plan. The Court recognized that doctors no longer monopolize appropriate health care outcomes. A state law malpractice claim where the coverage decision cannot be untangled from a physician's decision regarding treatment will not be preempted by ERISA if the claim challenges a questionable medical judgment regarding the patient's medical symptoms. The Court only held that ERISA does not preempt state malpractice claims in this context. It did not rule on the underlying claim.

This decision has the potential to significantly impact group health plans and could result in increased litigation against HMOs.

Current Tax Bill Could Impact Non-Qualified Deferred Compensation Plans

The tax bill currently before the Senate contains proposals that could have significant consequences to sponsors of non-qualified deferred compensation plans. At this point in time it is unclear whether all of the proposed changes will be included in the final bill, but it appears that the tax bill will contain some changes to the deferred compensation rules, effective in 2004.

House Passes Pension Reform

For the second year in a row, the House has passed a bill which would allow participants to purge their company stock funds in their 401(k) plan, provide participants more information concerning the plan and allow more flexibility in providing investment advice. It is unclear how the Senate will act on the bill, but the bill is supported by the Administration.

Plan Sponsors Should Monitor Timely Deposit of Participant Contributions

Under its Employee Contributions Project, the DOL Office of Enforcement has been actively auditing 401(k) plans and cafeteria plans for compliance with its regulations requiring participant contributions to timely be treated as plan assets. Since a

delay in segregating participant contributions and depositing contributions into trust can be considered to be a breach of fiduciary duty and a prohibited transaction, it is important for plan sponsors to monitor payroll practices to confirm compliance with the rules.

The maximum time period for an employer to transmit participant contributions to a 401(k) plan trust is the earliest date on which such contributions can reasonably be segregated from the employer's general assets, but no later than the 15th business day of the month following the month in which the contributions are received by the employer, or the 15th business day of the month following the month in which the contributions would otherwise have been paid to the participant in cash, where the amounts are withheld from wages. For participant contributions to a welfare plan, such as a cafeteria plan, contributions become plan assets at the earliest date on which such contributions can reasonably be segregated from the employer's general assets, but no later than 90 days from the date such contributions are received by the employer, or 90 days from the date such contributions would otherwise have been paid to the participant in cash, where the amounts are withheld from wages. Although cafeteria plan assets do not need to be held in trust, these amounts are still plan assets that must be used to pay benefits and offset reasonable administrative expenses.

If participant contributions can be segregated earlier than the latest permissible date (15 or 90 days), then they must be segregated at the earlier date. On audit, the DOL will look at the relevant facts (such as the size of the employer, number of payrolls and number of locations) to determine when participant contributions became plan assets.

In the case of a multiemployer defined contribution plan, the DOL has taken the position that any time frames set forth in a collective bargaining agreement or employer participation agreement must be taken into consideration in determining when participant contributions can reasonably be segregated from an employer's general assets; however, in no event can this period exceed the maximum time frames established under DOL regulations.

HIPAA and Flexible Spending Accounts

The April 14th deadline for compliance with HIPAA's Privacy Rule may have come and gone, but the U.S. Department of Health and Human Services (DHHS) continues to finalize its interpretation of the Privacy Rule. For example, DHHS recently confirmed that flexible spending accounts, to the extent they are plans providing health benefits to employees, are covered entities that must comply with the Privacy Rule and the other regulations established under HIPAA's Administrative Simplification provisions, such as the Security Standards. Such plans will be required to comply with HIPAA, unless they have fewer than 50 participants and are self-administered.

Employers that sponsor a health FSA should examine the structure of the FSA to determine whether it must comply with the Privacy Rule, and if so, whether the compliance date for small plans applies. To make this determination, employers that sponsor a health FSA should ascertain whether or not it is part of a larger wrap-around health plan. If the health FSA is not part of a wrap-around plan, then the employer/plan sponsor should determine whether the FSA has 50 or more participants. If the FSA has fewer than 50 participants, then the employer/plan sponsor should look at whether the FSA is administered by the employer/plan sponsor or administered by an outside service provider. If the

FSA has fewer than 50 participants and is self-administered, then it will be exempt from the Privacy Rule. A different analysis may apply if the FSA is part of a wrap-around plan. If the FSA has 50 or more participants or is administered outside the organization by a third party administrator, then the FSA must comply with the Privacy Rule. However, the April 14, 2004 compliance deadline for small plans may apply. If an FSA that is not part of a larger wrap-around health plan pays out less than $5 million in claims, then the compliance date for the FSA is April 14, 2004.