ROBINSON & COLE LLP
Employee Benefits & Compensation

IRS Considers New Determination Letter Program

The IRS has been actively exploring alternative procedures for issuing determination letters to qualified retirement plans. The IRS has issued a draft Revenue Procedure which proposes that qualified plans will apply for determination letters on a regular basis using a staggered five year cycle. Under this new system, plan sponsors that wish to obtain favorable determination letters from the IRS with respect to the qualified status of a plan will need to adopt amendments as required by changes in the law and will need to apply for a new determination letter every five years. Under this system, different plans would have different five year cycles, which would be assigned based on the plan sponsor's taxpayer identification number. Special rules will apply in the case of plans that are maintained by more than one employer and in the case of plan mergers and spinoffs.

The draft Revenue Procedure also proposes that the IRS will begin to accept some applications for EGTRRA determination letters on February 1, 2006. The Revenue Procedure was released in draft form and the IRS is seeking public input prior to finalization of these procedures.

Debate Continues Over the Impact of Consumer-Driven Health Care

As discussion about consumer-driven health plans, such as Health Savings Accounts ("HSAs") and Health Reimbursement Arrangements ("HRAs"), becomes more widespread, different groups are coming to different conclusions about the impact these types of arrangements will have on health care spending. While both of these types of arrangements allow funds to be rolled over from year to year, HSAs are accounts set up by individuals in connection with high deductible health plans and are owned by the individual. They are made up of contributions from individuals, employers, or both, and are portable from job-to-job. HRAs are employer-funded accounts, often offered in connection with high deductible health plans, and generally are not portable from job-to-job. The perceived effectiveness of these arrangements in decreasing health care spending depends upon who you ask.

On September 1, the Employee Benefit Research Institute ("EBRI") released a report questioning whether HSAs will have the desired impact of reducing health care spending. The report concluded that even though purchasers of health care services may consider more carefully how they use services, this may only delay the time at which someone reaches the annual deductible and not impact an individual's overall annual spending for health care services, particularly for high-end users of health care services. With respect to HRAs, the EBRI reports that such arrangements may actually increase spending for health care services. This is because HRAs are funded with employer contributions, not employee contributions and employees may not view the money in their HRAs as their own money.

Therefore, employees may be less discriminating when using their HRAs, and may even obtain unnecessary health services to use up money in the account before leaving a job, since the accounts generally are not portable from job to job. This result is less likely to occur with HSAs since the funds in the account are owned by the individual, not the employer, and can be maintained from job to job.

On the other hand, one consultant released information on September 7 stating that certain companies who have adopted consumer-driven health plans, such as HRAs and HSAs, have seen an average drop in health care costs of seven to ten percent. While the savings varies based upon a company's specific characteristics, 67% of the companies in the survey expected to achieve at least some cost savings by implementing consumer-driven health plans while 33% of the companies surveyed expected such plans to be cost neutral or more expensive. Additionally, the survey showed that 33% of the companies participating had implemented or were planning to implement a consumer-driven health plan by 2006.

Adopting a consumer-driven health care option into your benefit plan may be a way to address continuing rising health care costs, and many companies are offering such an option with the expectation that such costs will decrease. More information about the impact of these options on health care costs will become available in the future as more of the companies offering these options gather sufficient information to analyze these options.

ERISA Preemption Holds Firm in Recent Cases

The concept of ERISA preemption means that any claim relating to an employer's ERISA plan can only be brought as an ERISA claim, usually in federal court. Other types of claims, such as negligence and bad faith claims, which could potentially result in an award of punitive damages, cannot be brought against ERISA plans. Such common law and state law claims are preempted by the federal law. Remedies are limited to those provided under ERISA, which do not include punitive and other extra-contractual damages.

Earlier this year, in the case of Aetna Health, Inc. v. Davila, the United States Supreme Court advanced the concept of ERISA preemption when it held that HMO participants could not sue an HMO for malpractice when the HMO, which was providing benefits under an employer's group health plan, denied coverage for a medical procedure. The Court found that the malpractice claim was preempted by ERISA since the denial of benefits on which the claim was based came under an ERISA plan. Thus, participants could not bring suit in state court alleging negligence.

Recently, in Land v. CIGNA Health Care, the Eleventh Circuit Court of Appeals held that a participant who was covered by an HMO through his employer's group health plan could not bring a malpractice claim against CIGNA, the HMO. Consistent with Aetna v. Davila, the court found that the claim related to the denial of benefits under an ERISA plan. Since CIGNA's decision related to coverage of medical treatment provided under an ERISA plan, it was the type of administrative decision that is preempted by ERISA.

A Federal District Court in Massachusetts has ruled that an employee could only seek disability benefits as an ERISA claim. In the case of Tobin v. Liberty Mutual Insurance, an

employee was terminated from his employment with Liberty Mutual Insurance Company in 2001 after he failed to meet his sales quotas. He brought a lawsuit against Liberty Mutual, claiming that his supervisors knew that he intended to apply for disability benefits if he was unable to satisfy his sales quota and that his supervisors wanted to prevent him from filing a disability claim because it would prevent Liberty Mutual from terminating his employment. The court found that this claim was an allegation of interference with ERISA rights and could only be brought as an ERISA claim. As a result, the employee could not pursue other claims alleging retaliation and infliction of emotional distress, as these claims would be preempted by ERISA.

In a third recent case, Barber v. UNUM Life Insurance Company, the Third Circuit Court of Appeals found that ERISA preempts a Pennsylvania statute relating to bad faith insurance claims. In Barber, an employee became disabled and applied for disability benefits under his employer's group insurance plan. Although he initially qualified for benefits, UNUM later determined that the employee was no longer disabled and terminated his benefits. The employee sued UNUM for breach of contract and also brought a claim under Pennsylvania's bad faith statute, which provided for punitive damages. The court found that the employee's only recourse would be an ERISA claim as the contract and bad faith claims were preempted by ERISA. Because ERISA limits the amount that an individual can receive to the amount of the denied benefit, the punitive damages available under the Pennsylvania law were unavailable to the employee. This court cited Aetna Health, Inc. v. Davila as support for its determination.

These three cases show that ERISA preemption is alive and well and continues to provide plan sponsors with protection from state and common law claims and from punitive damages claims.

Qualified Retirement Plans Must Maintain QDRO Procedures

In the event that a participant in a retirement plan is legally separated or divorced, the participant's spouse can obtain a court order, called a Qualified Domestic Relations Order (QDRO), awarding the spouse a portion of the participant's benefit. If the court order satisfies certain requirements, a plan sponsor must honor the order and pay out benefits to the spouse as directed under the order, provided the order is not contrary to the plan's distribution rules. Plan administrators must maintain written QDRO procedures that must be followed in determining whether or not a court order meets the QDRO requirements. Upon receiving a court order, a plan administrator must notify the participant and the spouse that it has received a court order and must provide them with a copy of the court order. After a plan administrator timely determines whether or not the court order satisfies the QDRO requirements, another notice should be provided to the participant and the spouse informing them of the determination. Plan administrators should have QDRO procedures in place and

should be familiar with those procedures so that court orders can be promptly and consistently processed.