ROBINSON & COLE LLP

Employee Benefits & Compensation

Pension Funding Equity Act Provides Funding Relief for Plan Sponsors

On April 10, President Bush signed the Pension Funding Equity Act of 2004, providing welcome relief to defined benefit plan sponsors in funding plans during this period of unusually low interest rates. The Act replaces the 30-year Treasury bond interest rate with an interim composite rate based on conservatively invested long-term corporate bonds for plan years beginning in 2004 and 2005. The new rate should reduce minimum funding obligations and required quarterly contributions, as well as PBGC premiums.

IRS Proposes New Anti-Cutback Regulations

Qualified plans must comply with ERISA's anti-cutback rule which prohibits plan sponsors from amending a plan if the amendment would reduce a participant's accrued benefit. Optional forms of benefit, early retirement benefit and retirement type subsidies provided under a plan are considered to be part of a participant's accrued benefit under the anti-cutback rule. The IRS has proposed regulations designed to provide specific guidance on the circumstances under which a plan may reduce a participant's accrued benefit.

If the optional forms of benefit provided by a plan have become burdensome or complex for a plan sponsor and participants, some of the forms of benefit can be eliminated using one of two methods provided under the proposed regulations, provided that the rights of participants are not adversely affected in more than a de minimis manner.

First, a form of benefit can be eliminated if it is redundant with respect to a different optional form of benefit that remains available to participants under the plan. A form of benefit is redundant with respect to another form of benefit if the forms of benefit are in the same family of optional forms. For example, all forms of benefit that provide greater than ten years of level installment payments are in the same family of benefits. However, a participant's right to receive a lump sum distribution may never be eliminated pursuant to this redundancy rule. If a redundant form of benefit is removed, the plan amendment will not apply to a participant with an annuity starting date less than 90 days after the date the amendment is adopted.

Under the second method, a plan can be amended to eliminate optional forms of benefit provided that certain core options remain available. The core options that must continue to be provided after the amendment are a straight life annuity, a 75% joint and contingent annuity, a ten year certain and life annuity, and the most valuable option for a participant with a short life expectancy. A plan amendment that eliminates a noncore form of benefit will not apply to participants with annuity starting dates less than four years after the amendment is adopted.

Amendments that reduce early retirement benefits or retirement subsidies are only permitted if those benefits or subsidies have created significant burdens and complexities for the plan sponsor and participants and the amendment does not adversely affect the rights of any participant in more than a de minimis manner. Whether or not early retirement options have become complex and burdensome is based on facts and circumstances, including whether

the terms and conditions of each category of early retirement benefit are difficult to summarize in a manner that is easily understood by participants. The regulations also clarify that retirement-type subsidies that are contingent upon the occurrence of an unpredictable event, such as a plant shutdown, cannot be reduced with respect to service before the amendment. This is the case even if the contingency has not yet occurred.

Plan sponsors cannot rely upon the regulations until they are finalized. Once finalized, these regulations will provide plan sponsors with an opportunity to simplify plan administration provided that the options that are important to participants are retained. This should be valuable to sponsors of plans that have accumulated numerous optional forms of benefit or that offer other benefits that have increased the cost of plan administration.

IRS and DOL Guidance on Health Savings Accounts

The IRS recently released much anticipated guidance regarding Health Savings Accounts ("HSAs"). HSAs are tax-favored accounts used to pay for health expenses and were established under last year's Medicare prescription drug legislation. Generally, an individual who participates in a high-deductible health plan ("HDHP") can contribute funds tax-free to an HSA, from which the individual may be reimbursed for qualified medical expenses. Only individuals covered under a HDHP are eligible to make contributions to an HSA.

First, in Revenue Ruling 2004-38, the IRS clarified that an individual may not contribute to a HSA if he or she receives prescription drug benefits through a separate plan that is not a HDHP or if he or she receives prescription drug benefits that are not subject to the deductible in what would otherwise qualify as a HDHP. Recognizing that many plans have been providing prescription drug benefits in a way that would preclude eligibility for HSAs under this guidance, the IRS also provided some transition relief for participants who receive prescription drug benefits in such a fashion. In Revenue Procedure 2004-22, the IRS explained that individuals who participate in a HDHP and who also receive prescription drug coverage either through a separate drug plan or through a rider to the HDHP, even if that coverage is not subject to a deductible, may contribute to HSAs in 2004 and 2005. After 2005, however, such individuals will not be eligible to continue HSA contributions unless the prescription drug coverage is subject to the high deductible requirements.

The IRS also provided guidance with respect to preventative care benefits and HDHPs. Preventative care benefits are excluded from the deductible requirements in HDHPs for HSAs participation, but there have been questions about what exactly is included in the definition of "preventative care" benefits. In Notice 2004-23, the IRS set out a preventative care safe harbor that includes periodic health evaluations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and screening services, among other services. A full list of preventative care screening services is set forth in Notice 2004-23. Other types of services may qualify as preventative care, as long as the service is not used to treat an existing illness. Further guidance is expected with respect to whether certain drug treatments and mental health and wellness programs will qualify as preventative care.

The third component of the HSA guidance package released by the IRS included Notice

2004-25. This Notice provides transition relief with respect to certain reimbursements from an HSA. Generally, expenses may be reimbursed from an HSA only if the medical expenses are incurred after the HSA has been established. However, many individuals with HDHPs are having difficulty finding trustees to establish and maintain the HSA and are incurring medical expenses that will not be eligible for reimbursement because no HSA has been established. In Notice 2004-25, the IRS addressed this issue by providing transition relief from this reimbursement requirement as long as the HSA is established by April 15, 2005. This means that if an individual sets up an HSA by April 15, 2005, he or she may receive reimbursement for medical expenses incurred before the date the HSA was established. After that date, only expenses incurred after the date the HSA was established may be reimbursed.

In addition to the IRS, the DOL also released guidance on HSAs. In Field Assistance Bulletin (FAB) 2004-1, the DOL clarified that HSAs generally are not employee welfare benefit plans under ERISA, as long as the employer involvement in establishing the HSA is minimal. For instance, employer contributions to an HSA will not subject the HSA to ERISA, as long as participation in the HSA is voluntary. However if an employer is more than minimally involved in establishing the HSA, for example if the employer places greater restrictions than the IRS on the participant's ability to transfer funds to another HSA, then the HSA may be subject to ERISA. Regardless of whether ERISA applies to the HSA, the accompanying HDHP will be subject to ERISA as long as it otherwise qualifies as an employee welfare benefit plan under ERISA.

ERISA Does Not Apply to Individual Health Insurance Policies That Have Been Converted from an ERISA Plan

A Federal Court in Connecticut has held that if an individual exhausts COBRA coverage and converts the group policy to an individual health insurance policy, the individual policy will not be subject to ERISA. After the conversion, the policy establishes a completely independent relationship between the individual and the insurer. In the case, the insurer, Oxford Health Plans, argued that the individual's claim that Oxford had violated state law when it terminated his coverage could only be brought in federal court since the policy was governed by ERISA as individual insurance policies that are converted from ERISA plans remain subject to ERISA. Since the court refused to dismiss the case, the employee was able to continue his state court action against Oxford in Connecticut state court seeking reinstatement of his coverage.

Failure to Disclose is Breach of Fiduciary Duty

A District Court in Connecticut has found that Northeast Utilities breached its fiduciary duties when it failed to disclose information to participants about an early retirement program it was considering. The court found that Northeast Utilities had commissioned studies for determining the feasibility of different methods for reducing its workforce and had not communicated this fact or other information regarding the contemplated early retirement program to the human resources department which was responsible for responding to participant inquiries. Consequently, when questioned by participants, human resources personnel informed participants that an early retirement program would not be

offered. The court found that the withheld information was material and refused to accept Northeast Utilities' argument that there had been no misrepresentation since the human resources personnel made statements consistent with their belief that there was no planned early retirement program.

Northeast Utilities was ordered to offer the early retirement benefit to 15 participants who retired prior to the formal announcement of the early retirement program.

Since Northeast Utilities was found to have breached its fiduciary duties by its failure to provide relevant information, this case highlights the importance of accurate and complete communication between participants and those employees from whom they obtain benefits information.

EGTRRA Remedial Amendment Period Extended

The IRS has extended the period of time during which plan sponsors must amend plans to remove disqualifying provisions. The extension applies to amendments adopted after 2001 that contain disqualifying provisions, as well as to new plans that initially became effective after 2001. Thus, a sponsor of a new plan need not immediately file for a determination letter and can delay the initial submission until the IRS begins to accept applications for favorable determination under EGTRRA. If such an amendment or a new plan contains a disqualifying provision, a plan sponsor has until the end of the 2005 plan year to correct such disqualifying provisions.

HIPAA Deadline Looms

Today, April 14, 2004, all health plans subject to the privacy regulations (“Privacy Rule”) under HIPAA must be in compliance with the regulations. Penalties for noncompliance include both monetary fines and in certain cases, criminal penalties, including incarceration.

Health plans, including health flexible spending accounts (“FSAs”) are required to comply with the Privacy Rule unless the plan has less than 50 participants and is self-administered. All other health plans must be in compliance with the regulations. Employer plans that offer health benefits through an insurance carrier may be eligible for exclusions from many of the requirements under the Privacy Rule. If you have questions about how the Privacy Rule impacts your health plan, or if you have not yet started your compliance process, please contact us.

Are you compliant?
Compliance Watch

Plan Fiduciaries Must Be Bonded

ERISA requires bonding for every fiduciary and every person who handles plan assets. Certain fiduciaries, such as corporate fiduciaries and insurance companies, need not be bonded. The bond must be in an amount no less than 10% of the value of the plan assets, with a minimum bond amount of $1,000 and a maximum of $500,000.

This is an archive of past issues. As a result, it may contain information that is not current.

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