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ADAMS AND REESE / LANGE SIMPSON LLP
2100 Third Avenue North
Suite 1100
Birmingham, AL 35203
Tel: 205-250-5000
Fax: 205-250-5034

ERISA AND EMPLOYEE BENEFITS PRACTICE TEAM

Deborah B. Hembree, Attorney
(251) 433-3234
deborah.hembree@arlaw.com

Frances King Quick, Attorney
(205) 250-5081
frances.quick@arlaw.com

JoAnne Ray, Attorney
(713) 308-0149
joanne.ray@arlaw.com

Robert C. Schmidt, Attorney
(225) 336-5200
robert.schmidt@arlaw.com

John Martin Sheffield, Attorney
(205) 250-5052
martin.sheffield@arlaw.com

Diane Averitt, Legal Assistant
(205) 250-5076
diane.averitt@arlaw.com

Laurie Anders, Secretary
(225) 336-5200
laurie.anders@arlaw.com

Lee Ann Glover, Legal Secretary
(205) 250-5931
leeann.glover@arlaw.com

Norman Stein, Contributing Editor

www.adamsandreese.com

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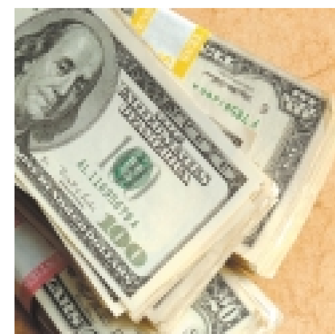
When Doing Nothing is the Right Thing: Automatic-Enrollment 401(k) Plans

401(k) plans offer a great savings platform for employees. They are tax-advantaged. They provide employees with economies of scale and pre-screened and diversified investment opportunities. And they make savings easy and systematic through regular payroll deduction.

The only problem with 401(k) plans is that they are voluntary and not all employees elect to participate.



In a series of rulings dating from 1998, the IRS indicated that automatic enrollment plans were permissible under the Internal Revenue Code.

An employee's failure to participate has two possible consequences: first, the employee is probably not adequately saving for retirement; and second, the level of 401(k) participation among non-highly compensated employees limits the amount that higher paid employees can contribute in basic 401(k) plans. For these reasons, some employers (those concerned with the welfare of their employees and/or maximizing contribution levels for highly-paid employees) try to increase their employees' 401(k) participation and contribution rates.

In the past, employers who wanted to increase enrollment could try one of two approaches: offering employees larger matching contributions or providing education on the value of saving for retirement. The former approach, however, is expensive and the latter approach is not always effective.

In the last several years, some employers have tried something new to increase enrollment: automatically enrolling employees in 401(k) plans unless they affirmatively opt out. Such plans generally have significantly higher levels of employee participation and should be considered by any employer that wants to increase employee 401(k) participation.

Initially there was some uncertainty about whether the IRS would consider such plans lawful. But in a series of rulings dating from 1998, the IRS indicated that automatic enrollment plans (also called opt-out plans, negative enrollment plans, default plans, and auto-pilot plans) were permissible under the Internal Revenue Code. An example in the guidance up to this year considered an automatic enrollment plan in which the default deferral percentage was 3% of compensation. (Earlier guidance also considered a section 403(b) plan with a 4% default option.)

Some cautious advisers believed that the 3 and 4% deferral percentages were intended as a safe harbor and believed that an employer who adopted an automatic enrollment plan with a higher percentage ran at least some risk of IRS disap-

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proval. Thus, many of the early automatic enrollment plans provided a default deferral rate of only 3 or 4 percent.

Studies of these early plans showed that they generally had a positive effect on enrollment, since few employees opted out. But a problem did emerge, since many employees ended up with the 3% or 4% default deferral percentage which many plan designers believed was lower than what an employee would have chosen in a regular 401(k) plan. Thus, compared to regular 401(k) plans, the early automatic enrollment plans seemed to increase the number of employees who chose to participate, but at the cost of a lower average savings rate.

The IRS, in a general information letter issued earlier this year, clarified that a plan could adopt any otherwise permissible deferral rate as its default option. The general information letter also approved a variation on the automatic enrollment plan, originally designed by two economic professors, Shlomo Benartzi and Richard Thaler. Under their variation on automatic enrollment plans, the initial default percentage is set reasonably low to encourage participation, but unless an employee affirmatively elects otherwise, the deferral percentage automatically increases each time an employee gets a raise. Benartzi and Thaler believe that this approach provides a fairly painless and effective way for employees to increase their savings rate over time.

There are a number of design issues for employers interested in the concept of automatic enrollment, including the designation of a default investment option. But the key fact about automatic enrollment plans is that they seem to work; they make doing nothing a sure path to retirement savings.

In the new revenue ruling, the IRS explains the circumstances under which an employer can offer its employees a Health Reimbursement Account or the opportunity to utilize a health Flexible Spending Account without jeopardizing the employee's ability to contribute to an HSA.

IRS Releases Further Guidance on Health Savings Accounts

The April Newsletter included an article on Health Savings Accounts, which were authorized by the 2003 Medicare bill. Since that article, the IRS has issued further guidance on HSAs; the new guidance, Rev. Rul. 2004-45, considers the interaction of HSAs with flexible spending accounts and Health Reimbursement Accounts.

Background

An HSA is essentially a tax-deferred savings account, similar to an IRA, except that most medical expenses paid from the account are permanently excluded from income. A person (or his employer) is eligible to contribute to an HSA in any month in which he is covered by a "high-deductible health plan" (HDHP) and is not covered by any health plan that is not a HDHP. The HDHP cannot pay for medical expenses until the employee meets the high deductible (which must be at least $1,000 for individual coverage and $2,000 for family coverage).

There are exceptions to these rules, however: a person is still eligible to contribute to an HSA even though he is covered by "permitted insurance" or has "permitted coverage" that is not subject to the statutory high deductible.

Permitted insurance includes insurance for a specific disease (such as cancer insurance) and insurance that pays a fixed amount per day for hospitalization. Permitted coverage is coverage for dental care, vision care, long-term care, accidents, and disability. An HDHP can also provide preventive care before the plan's statutory deductible is reached.

In the new revenue ruling, the IRS explains the circumstances under which an employer can offer its employees a Health Reimbursement Account or the opportunity to utilize a health Flexible Spending Account without jeopardizing the employee's ability to contribute to an HSA.

Health Reimbursement Accounts and Health Flexible Spending Accounts

A health reimbursement account is an account, generally unfunded, which an employer creates for an employee. The account pays or reimburses the employee for medical expenses. The employer may design the account to allow the employee to carry over unused amounts from year to year and even into retirement.

To set up a medical spending account, an employee elects to forgo cash salary, which is credited to the account. The account pays or reimburses the employee for out-of-pocket medical expenses. Under the rules applicable to FSAs, the employee forfeits any amounts left in the account after payment for all eligible medical expenses for the year.

The employer may design either an HRA or FSA so that it will pay for only certain types of medical expenses.

The Interaction of the HSA with HRAs and FSAs

In Rev. Rul. 2004-45, the IRS notes that HRAs and FSAs are themselves health plans. As a result, the ruling goes on to say, individuals generally cannot contribute to an HSA if they are covered by either an HRA or FSA that reimburses medical expenses before the HDHP deductible limit is satisfied.

But there are situations where an HRA or FSA will not disqualify an individual for HSA contributions. Generally speaking, these are situations where the HRA or FSA provides only permitted insurance or coverage, or where it does not reimburse medical expenses that are subject to the plan's statutory deductible limits. In essence, the HRA or FSA can pay expenses that the HDHP could itself provide.

In particular, the revenue ruling recognizes five types of HRAs and FSAs that will not disqualify an otherwise eligible individual for HSA contributions. These are

1. *Limited Purpose FSA.* A limited purpose FSA may pay or reimburse benefits for permitted coverage (but not for long-term care services) and for preventive health care.

2. *Limited Purpose HRA.* A limited purpose HRA can pay or reimburse benefits for permitted insurance, permitted coverage other than long-term care, and preventive care.

3. *Post-deductible HRA or FSA.* A post-deductible HRA or FSA can pay or reimburse medical expenses only after the statutory annual deductible is met. For example, assume that the HDHP has a $1,000 deductible and then pays 80% of covered medical expenses. A post-deductible HRA or FSA could pay the 20% co-pay on medical expenses once the $1,000 deductible is met. Or assume that an HDHP does not pay for certain types of care. A post-deductible HRA or FSA could pay for that care once the $1,000 deductible is satisfied.

In the revenue ruling, the IRS indicated that a post-deductible HRA or FSA can begin paying or reimbursing expenses once the statutory deductible is met, even if the HDHP's own deductible exceeds the statutory deductible. Thus, consider an HDHP that has an individual deductible amount of $2,500. An employee with single coverage could begin using a post-deductible HRA or FSA once the employee has incurred $1,000 in qualifying medical expenses. (In such a case, however, the maximum HSA contributions by or on behalf of the employee will be capped at $1,000.)

4. *Suspended HRA.* A suspended HRA is an HRA that will not pay any medical expenses (other than preventive care, permitted coverage and/or permitted insurance) during a period of time. The individual will be eligible for HSA contributions during the suspension period. For an HRA to qualify as a suspended HRA, it must be designed to allow the individual to elect a suspension period and the individual must make an affirmative election to suspend otherwise prohibited medical expenditures during the suspension period. Note that a suspended FSA does not appear to be possible because unused amounts in an FSA must be forfeited.

5. *Retirement HRA.* A retirement HRA is an HRA that can pay or reimburse medical expenses only after retirement. The individual will lose eligibility to contribute to an HSA once the retirement HRA is able to pay or reimburse medical expenses. Note that the HSA rules themselves bar HSA contributions once a person is eligible for Medicare.

The IRS also indicates that a combination of the arrangements described above is permissible. Thus, for example, the revenue ruling indicates that an employer could offer a combined post-deductible and limited purpose FSA without jeopardizing an employee's ability to make HSA contributions. Presumably, a suspended HRA could under this principle provide that a suspension period ends once the individual accumulates out-of-pocket expenses that satisfy the year's statutory deductible amount.

HMOs Get Supreme Protection

The Supreme Court had no trouble in deciding a widely watched case raising the question of whether a participant in an HMO employer-sponsored plan could sue the HMO under state law for wrongfully denying treatment. In a 9-0 decision, the Supreme Court ruled that federal law preempts lawsuits brought under state law. Thus, a participant can sue only in federal court and only under federal law, which generally is less favorable to the participant than state law.

The Court's decision actually decided two consolidated cases. In one of the cases, *Aetna Health Inc. v. Davila*, an HMO required an arthritic participant to try an inexpensive drug that had a greater risk of side effects than a more expensive drug. The cheap drug resulted in the participant being rushed to a hospital with bleeding ulcers. In the other case, *Cigna Healthcare of Texas, Inc. v. Calad,* an HMO decided that a woman needed to spend only one day in a hospital after undergoing a hysterectomy, overruling the patient's doctor recommendation for a longer stay. The patient experienced complications from the surgery and almost died.

In both cases, the patients brought a civil suit in state court, where large damages—including damages for pain and suffering and punitive damages—were available. The HMOs, however, argued that the cases belonged in federal court and that the only available remedy was an order requiring the HMO to pay for the wrongfully denied treatment.

The trial courts agreed with the HMO and "removed" the case to federal court. The patients appealed and the appellate court reversed, finding that federal law did not preempt state law civil actions for "mixed" eligibility/treatment decisions and restoring the state court actions.

The Supreme Court, however, disagreed with the appellate decisions. In its opinion, the Supreme Court indicated that the real wrong that the patients alleged was simply a denial of benefits under the terms of an employer-sponsored plan. Congress, when it enacted ERISA, determined that civil actions for benefit denials were to be governed exclusively by federal law and federal remedies.

Davila and Calad made three principal arguments, which the Supreme Court rejected.

Congress, when it enacted ERISA, determined that civil actions for benefit denials were to be governed exclusively by federal law and federal remedies.

1. Davila and Calad first argued that federal law preempted state contract law but not state tort law and that their state civil actions sought to remedy tortuous rather than contractual wrongs. The Supreme Court rejected this argument as one that put form over substance. According to the Court, the substance of the complaints against the HMOs was that they wrongfully denied benefits under an ERISA-regulated plan; this duty arose under ERISA and could be remedied only through the remedial scheme created by ERISA.

2. Davila and Calad also argued that the Supreme Court in an earlier case—*Pegram v. Herdich*—had ruled that a treating doctor did not act as an ERISA fiduciary when she made a mixed eligibility/treatment decision that resulted in a delay in treatment. Most commentators understood this decision to imply that an aggrieved patient could bring a state-law malpractice action against the treating doctor. In the *Davila* case, however, the court drew a distinction between a treating physician making a mixed eligibility/treatment decision and an HMO making a benefit eligibility decision. An HMO's decision on eligibility for a benefit arises under ERISA and a person challenging such a decision must contest it in federal court under federal law.

3. Davila and Calad finally argued that the state laws under which they sued the HMOs were laws regulating insurance, which ERISA does not preempt. The Court rejected this argument because "under ordinary principles of conflict pre-emption… even a state law that can arguably be characterized as regulating insurance will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."

What are the consequences of the Supreme Court's decision in *Davila*? We believe the following:

1. HMOs that currently involve treating physicians in benefit eligibility determinations will consider transferring that function to individuals other than treating physicians, since the treating physician can be sued in state court but the HMO cannot.

2. The decision may in the short run help control employer health-care costs to the extent that the health care market results in HMOs sharing the financial benefits from the Supreme Court's decision with employers who contract with them.

3. There will be renewed pressure on Congress to enact some sort of patients' bill of rights, which will either expand federal remedies for cases involving wrongful denial of health care or will limit the reach of ERISA preemption against state law cases against HMOs for wrongful benefit denials.

4. States may consider enacting laws similar to those approved by the Supreme Court in *Rush Prudential HMO v. Moran*, which provide health plan participants with certain procedural protections (such as peer review panels of benefit denials) but not with alternative judicial remedies.

5. The courts will increasingly be asked to consider whether ERISA authorizes make-whole remedies against fiduciaries for certain violations of fiduciary behavior. In a concurring opinion in *Davila*, Justices Ruth Ginsburg and and Stephen Breyer suggest that "fresh consideration of the availability of consequential damages" against fiduciaries in ERISA actions "is plainly in order."

TIPS AND TIDBITS

Hi. We're from the IRS and We're Here to Help You.

The IRS has begun publication of a retirement plan newsletter for employers. The newsletters and information about subscribing to this free publication is available at www.irs.gov/ep.

IRS OKs Notice by Powerpoint

ERISA requires retirement plans to give participants notice of amendments that reduce future benefit accruals. The IRS, in a private letter ruling, agreed with a plan sponsor that such notice could be provided through a Powerpoint presentation at a meeting for employees, so long as paper copies of the presentation were available.

Hi. We're from the PBGC and We're Here to Help You

Under Title IV of ERISA, certain underfunded defined benefit plans have to provide notice to their participants; plans that fail to provide the notice are subject to steep financial penalties. The PBGC recently announced an amnesty program for plan administrators that failed to comply with the notice requirements for the 2002 and 2003 plan years. Under the program, the PBGC will waive penalties if notice is provided as part of the 2004 Notice (if a 2004 Notice is required) or by the time the 2004 notice would have been due (if a 2004 Notice is not required).

Some Good Judicial News for Cash Balance Plans

Late last year, cash balance plans took a double-judicial whammy in the Seventh Circuit. In one case—Berger v. Xerox-- the Seventh Circuit Court of Appeals ruled that federal law requires some cash balance plans to pay a terminating employee more than the employee's cash balance account. In the other and more dramatic case—Cooper v. IBM— a district court ruled, in effect, that the cash balance form itself is illegal.

But in early June a district court in Maryland disagreed with the Cooper v. IBM decision, holding that cash balance plans are not per se illegal. In the case, Tootle v. ARINC, the judge ruled that for age discrimination purposes, accruals in cash balance plans should be defined as the annual growth in the employee's account balance.

Other recent cash balance news: the Department of Treasury, under pressure from all quarters, withdrew its proposed regulations on cash balance plans. Also afoot is legislative consideration of cash balance plans.

It may be another year or so, however, before the basic question of the legality of cash balance plans finishes playing out in the courts, in Congress, and in the agencies.

NEW GUIDANCE

EEOC Finalizes Rule Permitting Health Care Plans to Drop Coverage for Medicare-Eligible Retirees

The EEOC, reversing its prior position, has ruled that a health care plan can drop retirees from coverage when they become eligible for Medicare (or similar state-sponsored health care plan) without violating the Age Discrimination in Employment Act. The rule resolved a tension between two different policy perspectives: critics of the rule argued that this was simply discrimination in the provision of health benefits because of age; supporters of the rule countered that this rule will help retirees, since employers will be more likely to adopt retiree health plans for those under 65 if they can reduce or drop coverage for people once they become eligible for Medicare. The EEOC based its decision on its ability to carve out reasonable exemptions to the ADEA due to the public interest.

IRS Finalizes Regulations on Required Minimum Distributions from Retirement Plans

The IRS released the final version of the regulations on required minimum distributions on June 15. The final regulations made only modest changes from the proposed regulations. A future edition of the Newsletter will explore the new rules, which generally provide greater flexibility and longer payout periods than the former rules.

IRS Rules that Medicare Entitlement is Not a COBRA Second Qualifying Event (unless the plan so provides)

COBRA requires most group health plans to permit qualified employees and beneficiaries to purchase continued coverage under the plan when they lose coverage because of a qualifying event. The period of continuation is generally 18 months if the qualifying event is loss of employment or reduction in hours (this can be extended to 29 months for disability) and 36 months for other qualifying events (such as divorce or entitlement for Medicare).

A special rule applies to spouses and dependent children of a covered employee whose initial continuation period is 18 months (or 29 months): if a second qualifying event—such as divorce—occurs during the initial continuation period, the beneficiary can extend his or her coverage period to 36 months.

The IRS recently considered an unresolved question: can Medicare eligibility of the employee be a second qualifying event, permitting the employee's spouse or dependent children to extend their coverage period to 36 months. In Rev. Rul. 2004-22, the IRS answered this question in the negative.

Thus, COBRA does not require Medicare eligibility of a covered employee to be a second qualifying event. But a plan can provide continuation rights that exceed those provided by COBRA. It is thus important for group health care plans to review their plan, their summary plan description, their COBRA continuation notices, and other documents and procedures to ensure that they do not treat Medicare eligibility as a second qualifying event.

Adams and Reese/Lange Simpson LLP
2100 3rd Ave. North, Suite 1100
Birmingham, AL 35203

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Adams and Reese/Lange Simpson LLP
Attn. Lee Ann Glover
2100 3rd Ave. North, Suite 1100
Birmingham, AL 35203

We will try to address your question or topic in a future newsletter.

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