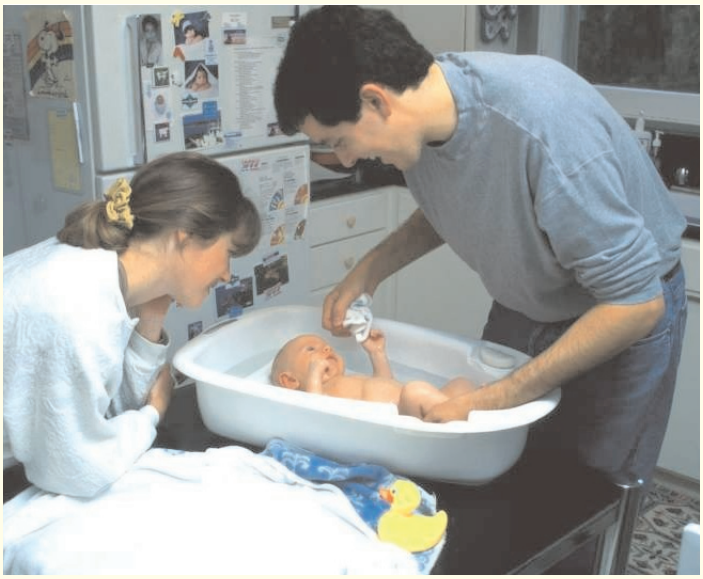
COMPENSATION AND BENEFITS
UPDATE

LEONARD STREET AND DEINARD
Uncommon Wisdom Common Sense®

July 2003



Department of Labor (DOL) Proposes New COBRA Regulations

By Angela M. Bohmann

The Department of Labor has proposed regulations addressing notice issues under COBRA. These regulations are proposed to be effective for plan years beginning on or after January 1, 2004. The proposal would require the following:

General Notices

A general notice of COBRA rights must be given to employees and spouses (if the spouse is covered under the plan). The regulations will make it clear that this general notice should be given within 90 days of an individual's becoming covered under the plan. The notice can be given in a separate document or can be part of the Summary Plan Description if the Summary Plan Description is sent addressed to the employee and spouse. The DOL proposed a model form of notice that can be tailored to specific plans.

Under the proposed regulations, the general notice must contain more information than many COBRA notices typically include, such as the name and address of the person responsible for COBRA administration and the impact of failing to elect COBRA. The model notice meets those new requirements. In addition, the SPD must have more information about COBRA, including information about the new tax credit and special COBRA election available to employees who become eligible for federal trade adjustment assistance that was added in the Trade Act of 2002.

The Department of Labor made it clear that the COBRA notice it promulgated in 1986 can no longer be used because it is so out-of-date. In our experience, while employers may have used that form as the basis of the COBRA notice they now use, employers have modified it to reflect changes in COBRA that have been made since 1986. Employers using an updated form can continue to do so until the regulations are finalized.

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Notice of Qualifying Event

Employers must give notice of certain COBRA qualifying events to the plan administrator so that the administrator can send out COBRA election forms. The proposed regulations clarify that an employer, which also serves as the plan administrator, will have 44 days in which to give COBRA notices with respect to qualifying events of which it must give the notice (death, Medicare entitlement, termination of employment). The proposed regulations also make clear that participants and spouses are required to give notice of events (divorce or dependents reaching limiting age) only if they have received notice that they are required to do so. The model form of general notice discussed above meets this requirement.

The regulations also provide that an employer can require that notice of a qualifying event be directed to a specific person or office to be effective so long as the initial COBRA notice gives the participant the information about how to report a qualifying event.

Election Forms

The DOL has also promulgated a model election form that a plan can use. A single election form is permitted for all qualified beneficiaries. The model form can be tailored for a specific plan. The form must contain specific information about premiums, options, grace periods, etc., for COBRA coverage and the effect of a failure to elect COBRA.

Notice of Denial of COBRA

The proposed regulations would require an employer who receives information about a qualifying event from an employee or family member to give a notice to the individual about why the individual is not entitled to COBRA if the employer concludes that COBRA does not have to be offered. This notice requirement will be new.

Notice of Early Termination of COBRA

In another new requirement, the proposed regulations will require plan administrators to give notice to COBRA continuees as soon as practicable after their COBRA coverage ends, if it ends before the maximum period expires. The notice must explain why and when coverage terminated. The notice can be included with the certificate of creditable coverage that must also be sent when COBRA coverage terminates.

While the model notices and regulations are helpful, there are a couple of areas not well addressed in the regulations. The regulations appear to have been written with major medical plans in mind. There is no discussion of the special COBRA rules that apply for medical expense reimbursement accounts in cafeteria plans (e.g., COBRA coverage generally required only through the end of the plan year). The forms also do not address the fact that employees may have additional rights under state law. For example, Minnesota continuation law, applicable to fully insured plans, gives additional continuation rights on divorce or disability.

The Department of Labor made it clear that the COBRA notice it promulgated in 1986 can no longer be used because it is so out-of-date. In our experience, while employers may have used that form as the basis of the COBRA notice they now use, employers have modified it to reflect changes in COBRA that have been made since 1986. Employers using an updated form can continue to do so until the regulations are finalized.

Employers could begin using the model notices at the present time. However, they would need to make certain that they update the forms if changes are made in the final regulations. Employers who have been using the 1986 model COBRA notice without change should cease using that form immediately.

Employers with questions about COBRA should contact their COBRA administrator or benefits counsel.

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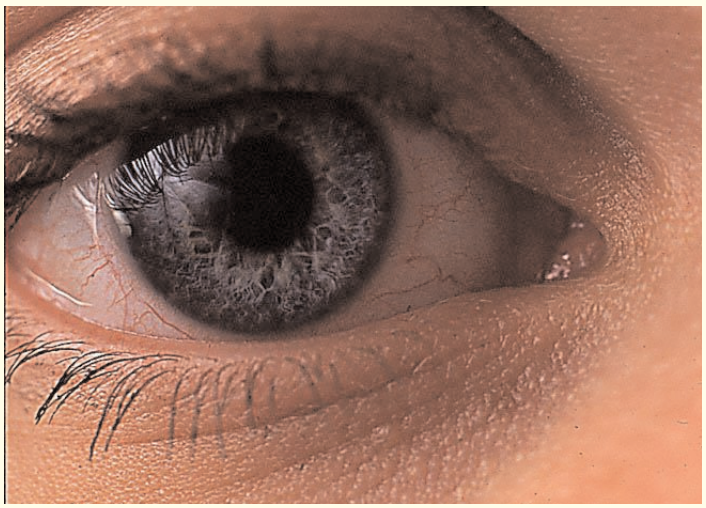


IRS Releases Series Of Rulings On Qualified Medical Expenditures

By Jeff Cairns

In recent months, the Internal Revenue Service (IRS) has issued a number of revenue rulings on the deductibility of certain increasingly common medical expenditures. Amounts treated as tax-deductible medical expenses under Code Section 213 will also generally qualify for tax-free reimbursement under employee pre-tax medical spending accounts offered in connection with cafeteria plans, as well as health care reimbursement accounts funded out of the employer's general assets.

Revenue Ruling 2003-57

In this ruling, the IRS clarified its position regarding breast reconstruction surgery, vision correction surgery and teeth whitening. The primary obstacle to these items being deductible is Code Section 213(d)(9)(a) which prohibits any deduction for amounts expended for cosmetic surgery or other similar procedures unless they are directly related to a congenital abnormality or personal injury resulting from an accident or trauma or disfiguring disease. In its ruling, the IRS found:

- costs of the exam for breast reconstruction surgery after mastectomy is tax deductible because cancer is a disfiguring disease and the reconstruction surgery "ameliorates a deformity";
- laser eye surgery is deductible because the procedure "promotes the proper function of the body"; it corrects defective vision and therefore is deductible in the same way that eyeglasses or contact lenses qualify as medical care; and
- bonding or teeth whitening procedures is non-deductible/non-reimbursable as these amounts are cosmetic and for purposes of improving physical appearance only. The IRS stated that discoloration of the teeth is not a deformity.

Revenue Ruling 2003-58

At the same time as the ruling above, the IRS released Revenue Ruling 2003-58. As several of the popular prescription medicines, such as Claritin®, are becoming available as over-the-counter medicines available without a prescription, the IRS decided to issue guidance on the tax treatment of this and similar medicines and medical equipment available without a prescription. The IRS ruled that:

- aspirin and similar drugs that are available without a prescription, even if recommended by a physician, are not deductible under Code Section 213.
- crutches, supplies, blood sugar test kits and insulin are deductible as they are either (a) not medicines subject to Section 213 or (b) in the case of insulin, specifically deductible by the statute.

As these items still constitute "medical care," they may be reimbursable from employer provided plans even though not deductible. However, many cafeteria plan documents have adopted a Code Section 213 deductible requirement for reimbursement and would require amendment before reimbursements could be made for non-prescription drugs.

Private Letter Ruling 200318017

While the above rulings were issued to the general public and have broad application, earlier this year the IRS issued a Private Letter Ruling to a specific taxpayer regarding deductibility of costs incurred in locating an egg donor. In the case presented, a woman's health plan agreed to cover the expenses of fertilizing and transferring donated eggs but would not cover the out-of-pocket expenses related to locating an egg donor, the donor's fee for time and expenses, the donor location agency's fee, expenses for medical and psychological testing of the donor and legal fees for preparation of the donor contract. In the ruling, the IRS found that the above expenditures were "directly related" to the procedure that qualified as a medical care, so could also constitute medical care for purposes of Section 213. The woman was allowed to deduct these amounts on her individual tax return (subject to the 7-1/2% of adjusted gross income limitation).

Co-Pay on My Prescription? – "Charge it"

In May, the IRS also released Revenue Ruling 2003-43, which examined a number of situations under which employer-provided medical expense reimbursements being made through debit or credit cards and/or other electronic media satisfies the tax requirements for excludable medical reimbursement expenses:

Situation 1

In this situation, each employee is issued a card and signs a certification at the time of enrollment in a flexible spending account (FSA) or health care reimbursement account (HRA) that the card will only be used for eligible medical care expenses. The employee also agrees to retain sufficient documentation for any expense paid with the card including receipts and invoices. The card is cancelled upon termination of employment. The card limits its use to the maximum dollar amount of coverage available under the FSA or HRA. Only certain merchants and service providers will accept the card. Its use is limited to physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers. Under the plan's procedures, all expenses other than co-payments and recurring monthly expenses (i.e., orthodontist), are conditional and subject to the employee submitting additional documentation for review and substantiation. Any amounts improperly charged to the card are subject to reimbursement by the employee. The IRS found that the reimbursement payments through use of the debit or credit cards in the situation are excludable from income by the employee by Code Section 105(b).

Situation 2

The IRS described a similar debit card program but instead of requiring substantiation on all expenditures other than co-pays and repetitive charges (like in Situation 1), the employer utilizes sampling techniques for determining compliance with the proper use. Under this case, the IRS found that reimbursements would be includable in gross income of the employees as the plan does not satisfy the IRS rules for accountability and proper documentation of all medical expenditures.

Situation 3

Under this program, the employer arranges issuance of a credit card to all participating employees under an agreement with a sponsoring bank. Individual limits under the credit card correspond with the health FSA or HRA sponsored by the employer. Each employee signs a certification similar to Situation 1 and the card may only be used with certain specific service providers that agree to use a specified code relating to health care qualifying expenses. The employer pays off all credit card charges with use of its line of credit. All charges are conditional, pending the employee's submission of follow-up documentation for all charges other than co-payments and recurring expenses. Under this program, the IRS ruled that the proper substantiation requirements were satisfied and that amounts would be excludable from the employee's gross income.

Employers considering adopting debit card programs should be aware of another conclusion the IRS reached in this ruling: that the employer must issue a 1099 to any medical service provider receiving payment of $600 or more through a debit card in a plan year. This requirement may make it more difficult and expensive to administer one of these programs.

A Revenue Ruling is an interpretation by the IRS of existing law and regulation. It may be relied upon by a taxpayer under audit by the Internal Revenue Service and in complying with the tax rules. However, the government's interpretation may be overruled by a court upon challenge by a taxpayer. A Private Letter Ruling is issued to a specific taxpayer presenting a specific set of facts. It may not be relied on by another taxpayer. However, it does provide a sense of the government's likely position if faced with a similar fact situation.

DOL Allows Allocation of Expenses to Individual Plan Accounts

By Angela M. Bohmann

In a recent Field Assistance Bulletin, the Department of Labor (DOL) changed its position on the manner in which certain plan expenses can be allocated. In earlier guidance, the Department had determined that plan expenses relating to rights that ERISA requires participants to have could be charged against the plan as a whole, but could not be charged against the specific participant exercising the right. The Department took this position with respect to expenses relating to the determination of Qualified Domestic Relations Orders (QDROs) in Advisory Opinion 94-32A. The Department's reasoning would also preclude an employer from charging against a plan participant fees that a trustee or recordkeeper may impose on required plan distributions.

Field Assistance Bulletin 2003-2 reverses the Department's position. According to the Department, plan administrators may rationally allocate many expenses among all plan participants either on a pro-rata or per capita basis. In most instances, plan expenses allocated to all participants could be allocated prorata based on the participants' relative account balances. However, some fixed administrative expenses, such as recordkeeping charges, could reasonably be allocated on a per capita basis. The Department noted that it would not be reasonable to allocate investment management fees on a per capita basis. The plan fiduciary must follow the provisions of the plan document if the plan document is clear on the matter. If the plan document is silent or ambiguous, the plan fiduciary must consider the decision solely in the interests of participants and must make a prudent and rational decision regarding the selected method.

The Department noted that it may also be appropriate to allocate some expenses directly against the accounts of specific participants, rather than against the plan as a whole. The following expenses are examples of those that the Department of Labor stated could be charged against the account of the affected individual:

- hardship withdrawals
- calculation of benefits payable under different plan distribution options
- benefit distribution (check charges)
- determination of the status of Qualified Domestic Relations Orders and Qualified Medical Child Support Orders

The Department concluded that an employer could choose to subsidize plan expenses for active employees without also having to subsidize those expenses for participants with vested account balances who are no longer employed. Employers should be aware, however, that the IRS has expressed concern about expense allocations that penalize participants who exercise their right under the tax code to defer receipt of their plan benefit. Regardless of the position of the DOL, an employer may not impose a "significant deterrent" on a participant's right to defer receipt of plan benefits.

The Department emphasized that the method of allocation must be consistent with the plan documents. In addition, participants must be given written or electronic notice about the expenses that will be charged to them. Employers may wish to review their plan documents and revise plan communications to reflect different allocations of expenses. In addition, employers wishing to allocate additional expenses to terminated employees who chose not to receive a plan distribution should check with benefits counsel before implementing such a program.

IRS Issues Guidance on Valuing Split-Dollar Life Insurance Benefits

By Jeff Cairns

In a follow-up to the 2002 proposed regulations on the taxation of split-dollar life insurance contracts, the IRS has proposed regulations outlining the rules for valuing economic benefits provided to a non-owner under an equity split dollar life insurance arrangement. In an equity split-dollar life insurance arrangement, one party receives an interest in the policy cash value which is disproportionate to that party's share of policy premiums and typically receives current life insurance protection. Under the July 9, 2002 proposed regulations, described in the October, 2002 edition of Compensation And Benefits UPDATE, equity split-dollar arrangements entered into after the regulations are final are to be taxed under the "economic benefit" regime. The 2003 proposed regulations describe how the economic benefit regime is to be applied.

Taxation of Cash Value Buildup

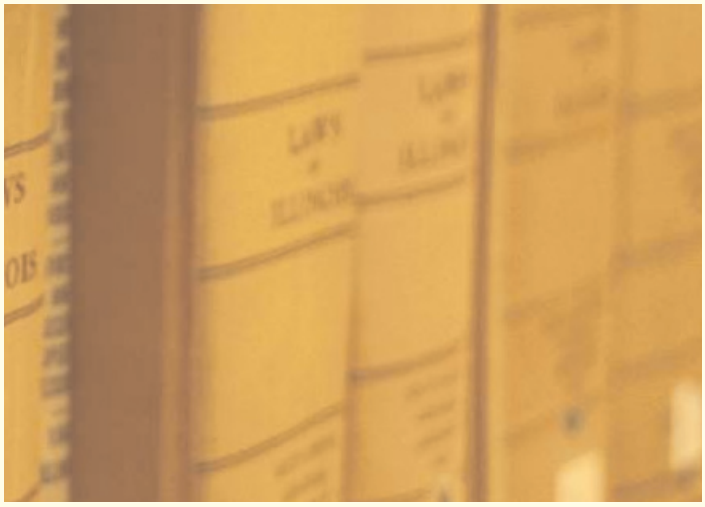
Under the proposed rules, the cash surrender value and the value of the current life insurance coverage is to be determined by the owner of the life insurance policy at the end of each tax year. To the extent that any non-owner (typically an executive employee) has any "current access" to any portion of the cash value, the non-owner is to be taxed on any amount not previously included in income. "Current access" is defined in the proposed regulation as any direct or indirect right of the non-owner of the policy to use, obtain, realize the value from the cash surrender value, including the right to make a withdrawal, to borrow from the policy or to effect a total or partial surrender of the policy, or to anticipate, assign, pledge or encumber the policy, or the ability of a non-owner to prevent the owner from exercising its rights under the policy, or the inaccessibility of the value of the policy to the owner's general creditors. The IRS states in the regulation that in the typical equity split-dollar arrangement, the employee has current access to all portions of the cash value in excess of the amount payable to the employer. Under prior IRS rulings, any increase in cash surrender value has not been taxed until or unless withdrawn by the employee. Under the proposed regulations, the policy's cash surrender value is determined without regard to any surrender charges, back-end loads or other reductions.

Current Term Life Insurance

The proposed regulations also describe a methodology for determining the value of the current life insurance protection to the non-owner. The IRS still provides a factor table to be applied per $1,000 of death benefit coverage. However, the amount of coverage provided is described to be equal to "the excess of the average death benefit of the contract over the sum of the total amount payable to the owner (including any outstanding policy loans that offset amounts otherwise payable to the owner) and the portion of the cash value actually taken into account for the current taxable year or for any prior taxable year." This prevents amounts previously taxed from being taken into account as part of the current death benefit protection.

These rules undoubtedly will generate significant comments from the life insurance industry and major employer groups. The proposed effective date is the date the final regulations are published in the Federal Register and will also apply to arrangements entered into on or before that date that are materially modified after that date.

It is unlikely that these arrangements will be used as a compensation tool if these rules are adopted since the tax shelter feature will no longer exist. Collateral assignment (split-dollar) arrangements still offer some tax leverage under the employer loan treatment in the 2002 proposed regulations, although employers and employees will have to consider carefully the tax costs in determining whether the program has economic benefits.



Cafeteria Plans are Subject to HIPAA

By Angela M. Bohmann

In May the Department of Health and Human Services formally announced that medical reimbursement accounts in cafeteria plans are subject to the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA). This means that employers who sponsor medical flexible spending accounts will have to comply with all requirements of HIPAA for self-funded plans unless there are fewer than 50 participants in the plan and the employer administers the plan itself.

The Compensation and Benefits "UPDATES" of November, 2001, and July, 2002, discuss HIPAA privacy requirements. For medical flexible spending accounts with less than $5,000,000 in claims (most employers we represent), the compliance date is **April 14, 2004**.

Employers with questions about HIPAA compliance should discuss the issue with their cafeteria plan administrator or benefits counsel.

Theresa Corona Joins Compensation and Benefits Group

We are pleased to announce that, effective August 4, Theresa E. Corona will be joining the firm as an associate in the Compensation and Benefits Group. Theresa, a 1999 University of Iowa Law School graduate, has two years of employee benefits law experience with the Altheimer & Gray firm in Chicago, and has for the past two years worked as a tax compliance officer for the University of Indiana. As part of the group, Theresa will be handling pension, health and welfare and executive compensation matters.

COMPENSATION AND BENEFITS PRACTICE GROUP

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