Employee Benefits Law

Internal Revenue Service Issues Ruling on Debit Card Use for FSAs and HRAs

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On May 6, 2003, the Internal Revenue Service issued long-awaited guidance, approving the reimbursement of qualified medical expenses from a health flexible spending account (FSA) or health reimbursement arrangement (HRA) through the use of a "debit" card. Revenue Ruling 2003-43 permits employees to pay for eligible health care expenses with a card that looks and acts like a debit card, rather than through making claims and being reimbursed by their employer or third party administrator (TPA). These cards, which are already offered by a handful of vendors, are designed to reduce the administrative costs of FSAs and HRAs by eliminating the need to file paper claims for employee reimbursements and expenses not covered by health care plans.

Under Revenue Ruling 2003-43, the employer and TPA can select or customize how they substantiate FSA and HRA claims based on their health care plan. Reimbursements are excludable from employees' gross income under Code Section 105, provided procedures substantiate that withdrawals are only for medical expenses. The employer must also adopt meaningful correction procedures for claims that are subsequently discovered as impermissible. Such correction procedures include: (1) requiring the cardholder to reimburse the plan the amount of the improper payment; (2) withholding the amount of the improper payment from the employee's compensation; or (3) utilizing a claims substitution or offset approach if the improper payment still remains outstanding.

The Internal Revenue Service held that the cards are an appropriate expense reimbursement vehicle, if, among other things, the employee certifies each year that the card will be used only for eligible medical expenses and that the cardholder's use of the card is limited to the maximum dollar amount of coverage available in the FSA or HRA. Participants may use the debit card for eligible health care such as medical deductibles, co-payments not covered by a health plan, prescriptions, dental or vision related expenses, etc. All charges to the card—except for co-payments, recurring expenses and expenses that can be substantiated at the point of sale—are treated as conditional pending confirmation of the expense. When the card is used, the merchant or service provider is paid the full amount of the charge and the cardholder's maximum coverage remaining is reduced by that amount, assuming sufficient coverage is available.

FSAs also have been in the news for other reasons: On May 15, the IRS issued two revenue rulings clarifying whether certain medical expenses are deductible under Code Section 213, and thus potentially reimbursable under an FSA. The rulings cover breast reconstruction and vision correction surgery, teeth whitening procedures and nonprescription drugs, equipment, supplies or diagnostic devices. The basic distinction is between amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, which generally are deductible, versus cosmetic surgery or other similar procedures, which generally are not deductible. The bottom line: LASIK is reimbursable, but teeth whitening is not. (Revenue Rulings 2003-57 and 2003-58). On May 14, Rep. Johnson (R-Conn.) introduced the Long Term Care and Retirement Security Act of 2003 (H.R. 2096), a bill that would allow long term care (LTC) insurance to be offered under an FSA.

"Any Willing Provider" Statute Not Preempted by ERISA

Last month, the Supreme Court revised the test for determining whether a state insurance statute or regulation regulating HMOs is preempted by the Employee Retirement Income Security Act of 1974 (ERISA). In *Kentucky Association of Health Plans, Inc. v. Miller* (123 S. Ct. 1471, 4/2/03), the Court found that a Kentucky insurance statute that prohibited health insurers from excluding from their health plan networks any providers in their geographic coverage areas willing to meet participation standards was saved from ERISA preemption.

Previously, in determining whether ERISA preempted state insurance laws, courts focused on whether the state law or regulation applied to the business of insurance, as defined by the McCarran-Ferguson Act. In making this determination, courts considered whether the state law (1) had the effect of spreading the policyholder's risk, (2) was an integral part of the policy relationship between the insurer and the insured, and (3) was limited to entities within the insurance industry.

In *Miller,* the Supreme Court throws out this 15-year-old test and articulates a new test: (1) is the state law specifically directed toward entities engaged in insurance, and (2) does the state law substantially affect the risk pooling arrangement between the insurer and the insured? The new standard does not radically differ from the previous test. Rather, the primary intention of the Court in articulating the revised test seems to be to focus the inquiry of whether a state law regulates insurance and eliminate the potential for distracting inquiries into the conduct regulated by the law or whether the law was limited to the insurance industry or had the effect of transferring or spreading risk.

This decision, following other recent ERISA preemption cases before the Supreme Court, seems to mark a trend permitting greater state regulation of HMOs. Last year, in *Rush Prudential HMO, Inc. v. Moran (*536 U.S. 355, 2002), the Court found that an Illinois law that required HMOs to provide for an external, independent medical review of denied claims was not preempted by ERISA. Although the claim was sufficiently related to an employee benefit plan to place it in a federal court, it was saved from preemption because the state law on which it was based regulated insurance.

In deciding whether a law regulates insurance, the Supreme Court started with a common sense view of the matter, requiring a law to "be specifically directed toward" the insurance industry. The Court then tested the results of the common sense inquiry by employing the three factors (articulated above) used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act.

The *Miller* decision contains an odd footnote that may significantly affect the administration of self-insured benefit plans. ERISA provides that a self-insured plan cannot be "deemed" to be an insurer for purposes of state law. However, Justice Scalia, in addressing the insurance industry s argument that the Kentucky "any willing provider" statute was aimed more broadly than just insurance, suggested that administrators of self-insured plans act "like" insurers and might be held to state insurance rules. This language, if given effect, could have an ominous result on the design and administration of self-insured plans.

"Deemed Denials" Spell Trouble

In a case of first impression, the United States Court of Appeals for the 10th Circuit determined that if a plan administrator does not complete a claims inquiry, and the claim is thus "deemed denied," then the court will use the *de novo* standard of review in hearing the case. In *Gilbertson v. Allied Signal Inc.* (10th Cir., No. 01-2324, 5/6/03), the court determined that where a claim for long term disability benefits was denied as a result of the insurer failing to finally notify the claimant of the denial, the plan administrator was not entitled to the deferential standard of an "arbitrary and capricious" review. If the administrator had substantially complied with the procedural requirement, the deferential standard of review might have applied, the court said. However, an administrator can be in substantial compliance with ERISA's procedural requirements only if there is a process in which the plan participant is kept informed as to what is required on his or her part, according to the court. "In the context of an ongoing, good faith exchange of information between the administrator and the claimant, inconsequential violations of the deadlines or other procedural irregularities would not entitle the claimant to *de novo* review," the court said. However, in this case, there was no such "meaningful dialogue." The lesson here: "Deemed denials" can get a plan administrator in trouble. Generate and retain a thorough file on any claims review, as it may make a significant difference in subsequent litigation.

Case Law News

Disability Plans vs. Treating Physicians

In a recent decision of the United States Court of Appeals for the 7th Circuit, *Hawkins v. First Union Corp. Long-Term Disability Plan,* the court ruled that a plan administrator acted arbitrarily and capriciously when it denied benefits to a plan participant whose treating physician had stated in a written report that the participant was disabled. Stay tuned for the final determination on whether or not this action is arbitrary and capricious. The U.S. Supreme Court has agreed to determine whether a disability plan must give deference to the treating physician's determination of disability, and a ruling is expected this year.

Breaking News

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Deferred Compensation Escapes Unscathed: The Jobs and Growth Tax Relief Reconciliation Act of 2003 signed by President Bush on May 28th, 2003 was stripped of its deferred compensation provisions before passage. Prior to conference, the bill had a very aggressive set of provisions that essentially would have eviscerated a company's ability to utilize nonqualified deferred compensation. While employers can breathe easier about their executive compensation programs for the moment, it appears likely that these provisions will be reintroduced in another bill.

EPCRS Program Streamlined: In Revenue Ruling 2003-44, issued on June 5, 2003, the Internal Revenue Service reorganized the Employee Plans Compliance Resolution System (EPCRS) under which a plan sponsor may seek the IRS's blessing of voluntary corrections to certain defects in the sponsor's qualified plans. The ruling combines the programs for various types of plans into one voluntary correction program and changes the compliance fee to a fixed fee schedule based on the number of participants in the affected plan. The ruling also offers "sample" formats for submissions under the program. Finally, the new program permits plan sponsors to use the program to correct errors based on failure to timely adopt EGTRRA amendments.

EBSA Issues COBRA Guidance: On May 27, 2003, the Employee Benefits Security Administration (f/k/a the PWBA) issued proposed regulations regarding a plan sponsor's ability to provide certain required notices under COBRA. Included in this guidance is a relaxed notice provision permitting plan sponsors to communicate an initial COBRA notice as part of the plan's summary plan description (SPD) rather than requiring a stand-alone mailed notice. The guidance also offers a model election notice that may be used by plan sponsors in fulfilling their COBRA notice obligations.

Deemed IRAs Get the Green Light: The Internal Revenue Service issued proposed regulations on May 20, 2003 regarding the implementation of deemed IRAs within a qualified plan as permitted by EGTRRA. A plan sponsor has until December 31, 2003 to implement the structure for the 2003 plan year. The IRS also issued a sample format for the necessary plan amendment in Revenue Procedure 2003-13.

The Department of Labor wants YOU…

…to get your health plan in compliance. The DOL recently unveiled a new compliance assistance program to help employer and health plans fulfill their obligations under health laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act.

The compliance assistance program includes publications for employers describing various obligations of plans, and sample forms to help with compliance with some of the many notice requirements imposed on health plans

One particularly helpful publication is a checklist of legal requirements with examples of common plan provisions that are illegal. A good way to check your plan's compliance would be to complete this checklist. Call your benefits attorney if you need help in completing it, or if you discover any errors in your plan.

Information about the DOL's compliance program, including a printer-friendly version of the compliance checklist, is available on the DOL's website, **www.dol.gov/ebsa** under "Compliance Assistance."

Save the Date

Major Benefits Seminar Comes to Denver - September 11-12, 2003

Co-sponsored by the Western Pension & Benefits Conference, American Society of Pension Actuaries, the IRS, and the Employee Benefits Security Administration of the Department of Labor, the seminar will be held at the Hyatt Regency Hotel. Sheldon Smith, Holland & Hart employee benefits attorney, has been selected as co-chair of the Conference along with Denver pension consultant Sal Tripodi. Irene Gallagher, Holland & Hart employee benefits attorney, will speak on voluntary correction programs.

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The Employee Benefits Law Newsletter

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Jane Francis	*303-295-8599*	*jfrancis@hollandhart.com*
Sheldon Smith	*303-295-8540*	*ssmith@hollandhart.com*
Mike Beaver	*303-290-1631*	*mbeaver@hollandhart.com*
Elizabeth Nedrow	*406-252-2166*	*enedrow@hollandhart.com*
Irene Gallagher	*303-295-8270*	*igallagher@hollandhart.com*
Rebecca Hudson	*303-295-8005*	*rhudson@hollandhart.com*
Leslie Thomson	*406-252-2166*	*lthomson@hollandhart.com*
Kristen Berg	*303-295-8258*	*kberg@hollandhart.com*

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- The Pension and Welfare Benefits Association (PWBA) has been renamed the Employee Benefits Security Administration (EBSA). Their website is now found at **http://www.dol.gov/ebsa.**
- The IRS site for the second white paper on determination letter applications: **http://www.irs.gov/pub/irs-tege/white_paper2.pdf** Note that the second white paper summarizes the first.
- The Department of Labor: **http://www.dol.gov**
- The Pension & Welfare Benefits Administration (PWBA): **http://www.dol.gov/dol/pwba**
- Current Issue of IRS Employee Plan News: **http://www.irs.gov/pub/irs-tege/spr03.pdf**

Employee Benefits Group

HOLLAND & HART LLP

www.hollandhart.com/employeebenefits/

Attorneys at Law
Employee Benefits Group
Suite 3200
555 Seventeenth Street
Denver, Colorado 80202-3921

LAWYER ADVERTISEMENT

Jane Francis
303-295-8599
PRACTICE GROUP MANAGER
Denver
jfrancis@hollandhart.com

Sheldon Smith
303-295-8540
Denver
ssmith@hollandhart.com

Mike Beaver
303-290-1631
Denver Tech Center
mbeaver@hollandhart.com

Elizabeth Nedrow
406-252-2166
Billings
enedrow@hollandhart.com

Irene Gallagher
303-295-8270
Denver
igallagher@hollandhart.com

Rebecca Hudson
303-295-8005
Denver
rhudson@hollandhart.com

Leslie Thomson
406-252-2166
Billings
lthomson@hollandhart.com

Kristen Berg
Legal Specialist
303-295-8258
Denver
kberg@hollandhart.com

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