Health Savings Accounts - A Different Option for Employers

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Health savings accounts have received a lot of media attention, but, so far, employers have been slow to embrace this new approach for providing health care coverage for employees. The basic concept involves a high-deductible health plan (HDHP), coupled with a tax-favored, portable individual health savings account (HSA) that allows individuals to save for future health care expenses. The HSA may be funded by the individual, the employer or both. Withdrawals from the HSA for "qualified medical expenses" are tax-free. Contributions to and earnings on the account that are not needed for qualified medical expenses can accumulate tax-free and be carried over from year to year. Ideally, this tax-free growth opportunity will be an incentive to individual account owners to become more savvy and discerning health care consumers, thereby saving themselves money and reducing utilization and overall health care costs.

An HDHP coupled with HSAs could lead to radical changes in the way employees perceive and use their health care benefits. But this approach may also require significant changes to the way employers conceptualize and manage their health care benefits. Some of the things employers should keep in mind when considering this approach are outlined below.

Eligibility

An HSA may be established and contributed to only by or for an individual who:

- is covered by an "eligible high deductible health plan," and
- with certain limited exceptions, has no other health care coverage.

An "eligible" HDHP is a plan having an annual deductible of $1,000 for employee-only coverage and $2,000 for family coverage (although plans can have lower (or no) deductibles for preventative care). Although the deductible amounts are indexed, the IRS recently announced that these deductible limits would not change for 2005. Eligible HDHPs also must have maximum out-of-pocket limits for 2005 of $5,100 and $10,000 for employee-only and family coverage, respectively. Prescription drug programs or other health insurance plans that include lower deductibles for certain benefits (including state-mandated benefits) will not qualify as eligible HDHPs.

The requirement that an eligible HDHP be the employee's only health care coverage may be the single largest impediment to widespread HSA adoption. There are exceptions for dental, vision and long-term care coverage, accident and disability insurance, and insurance covering a specific disease or condition. Recent guidance from the Treasury Department explains that certain employee assistance, disease management and wellness programs also will be excluded in determining whether individuals are eligible to establish **HSAs**. Individuals enrolled in Medicare may not establish or contribute to HSAs, thereby limiting their utility as a means of controlling retiree medical expenses in the short term.

The IRS has recognized that the insurance marketplace needs more time to develop eligible HDHPs, and so has provided some transitional relief. Until January 1, 2006, separate prescription drug coverage will not disqualify an individual with an HDHP from establishing or contributing to an HSA, as long as the other HDHP requirements are met. In addition, high-deductible health plans might not be available in some states because state insurance laws require that health care policies provide certain benefits without regard to deductibles or below the HDHP/HSA minimum annual deductible.

> *Notably, Connecticut was such a state, as state law limited the deductible on home health care to $50. See Conn. Gen. Stat. §38a-493. The legislature amended this statute in the last session to include an exception for high-deductible health plans used to establish HSAs. P.A. 04-174.*

The IRS transitional relief includes an exception for health plans which otherwise would qualify as eligible HDHPs except for the fact that they comply with state law requirements regarding deductibles for certain benefits. Such plans will be treated as eligible HDHPs until January 1, 2006.

Establishing an HSA

HSAs may be set up by an individual or an employer, but they can only be established through a qualified HSA trustee or custodian. The IRS has clarified that in addition to banks and insurance companies, any other person or institution already approved by the IRS to be a trustee or custodian of Individual Retirement Accounts (IRAs) or Archer Medical Savings Accounts (MSAs) may be an HSA trustee or custodian. Because these products may not immediately be available locally, the IRS has created a special rule allowing short-term relief. An individual who is participating in an eligible HDHP and wishes to participate in an HSA in 2004 has until April 15, 2005 to establish and contribute to an HSA. Once the HSA is established and funded, that individual may take tax-free distributions for all qualified medical expenses incurred after the later of January 1, 2004, or the date the individual became covered under an eligible HDHP.

Contributions to an HSA

The maximum annual contribution that may be made to an HSA for 2005 (whether by an employer, employee or both) is the lesser of the HDHP deductible or $2,650 ($5,250 for family coverage). These maximums are indexed. Individuals between the ages of 55 and 64 may make additional "catch up" contributions in the amount of $600 per year for 2005, phasing up to $1,000 in 2009. Contributions may not be made on behalf of individuals who no longer qualify as "eligible individuals" (for instance, because they are entitled to Medicare or are no longer covered by an HDHP). Contributions made on an after-tax basis by an individual are tax deductible, even if the individual does not itemize deductions. Contributions by an employer are not included in the employee's income for purposes of federal income taxation, FUTA or FICA. Employers may also permit employees to make pre-tax contributions to an HSA through a cafeteria plan.

If an employer contributes to an employee's HSA, the new law requires that the employer make comparable contributions on behalf of all "comparable participating employees" during the same time period, or be subject to an excise tax. Contributions will be considered "comparable" if they are the same amount or the same percentage of the HDHP deductible. The IRS has clarified that "comparable participating employees" means those employees who are participating in the same HDHP during the same time period, and that the comparability rule is applied separately with respect to part-time employees. The comparability requirement does not apply to contributions through a cafeteria plan or to amounts rolled over from an Archer MSA or another HSA.

Distributions from an HSA

An individual may receive distributions from an HSA at any time. Distributions used to pay "qualified medical expenses" of the individual, spouse or dependents are excludible from gross income; with limited exceptions, distributions for any other purpose are includible in income and subject to an additional 10% tax. "Qualified medical expenses" generally include all expenses that are reimbursable through a flexible spending account (including over-the-counter medications). In general, HSA distributions may not be used to pay health insurance premiums, but there are exceptions. HSA distributions can be used for COBRA premiums, long-term care insurance premiums and health insurance premiums while the individual is receiving unemployment benefits. In addition, although individuals who are enrolled in Medicare can not make contributions to an HSA, they may use accumulated HSA funds to pay Medicare premiums or to pay their share of employer-sponsored health coverage, including retiree coverage.

ERISA Coverage

A HDHP offered by a non-governmental employer will be an ERISA welfare benefit plan subject to all of ERISA's requirements (5500 filing, providing an SPD, etc.). The Department of Labor clarified, however, that an HSA that is offered in conjunction with an HDHP will not be considered an ERISA plan, provided the employer does not:

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Recent Supreme Court Rulings Affecting Employer-Sponsored Health Plans

Tort Claims Against HMOs Preempted By ERISA

On June 21, 2004, in *Aetna v. Davila*, the U.S. Supreme Court unanimously held that ERISA completely preempts state law tort claims against HMOs for injuries allegedly suffered as the result of the HMO's failure to authorize physician-recommended care. The decision struck down a Texas law, the Texas Health Care Liability Act, which made insurers and managed care companies liable for damages caused by their failure to exercise ordinary care in making treatment decisions, and limited the application of the Court's decision in *Pegram v. Herdrich*, 430 U.S. 211 (2000), in which the Supreme Court had found that ERISA did not preempt claims against HMOs making "mixed" treatment and eligibility decisions. In the new case, the court clarified that the "*Pegram* exception" to ERISA preemption only applies where the underlying harm is caused by a treating physician exercising medical judgment. In the *Pegram* case the HMO doctor had determined both the course of treatment and whether the treatment would be covered by the HMO, whereas in the Davila case the HMO had only decided whether a certain treatment would be covered under the terms of the plan.

Davila means that individuals enrolled in ERISA plans will only be able to sue HMOs to recover the cost of the benefits that were not provided or to enforce their rights under the terms of the plan; they will not be able to recover punitive damages or damages for pain and suffering.

In Connecticut, the Davila decision will have little short-term impact: Connecticut does not have any laws relating to a patient's right to sue a managed care company, and previous Supreme Court opinions make clear that statutes such as Connecticut's external review law (providing for an appeal to the Insurance Commissioner from decisions of insured plans) are not preempted by ERISA.

Although the Supreme Court decision was unanimous and solidly grounded in the statutory language of ERISA, Supreme Court Justice Ginsberg, in her concurring opinion, called on Congress to "revisit what is an unjust and increasingly tangled ERISA regime." Congress responded swiftly by proposing the Patients' Bill of Rights Act of 2004 (Proposed H.R. 4628) that would require, among other things, the right to hold an HMO liable if an HMO's negligent medical decision results in injury or harm. Whether such legislation will be enacted, however, remains to be seen.

Subrogation decisions

Health plan subrogation rights, i.e., rights to recover money for benefits paid on behalf of a participant who later receives a third-party personal injury settlement, have been uncertain since the Supreme Court's 2002 decision, *Great-West Life & Annuity Insurance v. Knudson*. Recently, however, the Supreme Court let stand two lower court decisions, both of which allowed plan sponsors to sue under ERISA to recover these costs.

The *Great-West* case held that an ERISA plan could not seek reimbursement from a beneficiary after the settlement or award from a lawsuit against a third-party had been disbursed. Employers are limited to seeking *equitable* relief (such as an injunction) against *identifiable* funds (such as funds kept in an attorney's trust account).

In both of the newer decisions, the lower court had found that the plan's actions were permitted under ERISA. In *Varco v. Administrative Committee of Wal-Mart Stores, Inc. Associates' Health and Welfare Plan*, the plan paid medical expenses on behalf of Varco, who had been injured in an automobile accident, and asked that a "constructive trust" be imposed on any funds received in settlement of the claims arising from the accident, so as to protect the plan's subrogation rights. When Varco reached a settlement, the plan obtained a preliminary injunction prohibiting the disbursement of the settlement funds until the plan had been repaid. The Seventh Circuit concluded that *Varco* was distinguishable from *Great-West*, because the funds had not been disbursed and were not in the beneficiary's possession, and so the plan's claim for restitution was an equitable claim permitted by ERISA. Similarly, in *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer*, the Fifth Circuit concluded that a plan's lawsuit seeking to impose a "constructive trust" on settlement funds that were held in an attorney's trust fund was equitable in nature. In both cases, by letting the lower court decisions stand, the Supreme Court has signaled that it agrees that health plan subrogation rights still can be enforced in certain circumstances.

The facts in *Varco* and in *Bombardier* highlight the importance of taking appropriate steps to protect your plan. In both decisions, the plan documents specifically said that the plan participant was required to reimburse the plan for benefits paid if the participant also received compensation from a third party for the same claim, and, further, that the participant was responsible for all attorney's fees (thus preempting the "common fund doctrine" which otherwise would have required the plan to share proportionately in the costs of the attorney's fees incurred by the participant to settle the claim).

Employers should review their plans and summary plan descriptions to make sure that the subrogation/reimbursement section has been updated to reflect current law. Plans may also provide that partici-

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- require employees to establish an HSA;
- limit the ability of participants to roll over funds to another HSA;
- impose conditions on the use of HSA funds;
- make or influence investment decisions with respect to HSA funds;
- represent that HSAs are an employee welfare benefit plan established and maintained by the employer; or
- receive any payment or compensation in connection with the HSA.

HSAs are part of a growing movement toward "consumer directed health care," which places more of the risk and reward of health care utilization on employees in an effort to encourage prudent buying behavior. Smaller employers or companies that have not been able to afford health benefits for their employees may find them an attractive option, as may larger employers who are willing to limit their health benefit coverage to high-deductible health plans. HSAs are controversial - opponents argue that they will attract only the healthiest and wealthiest employees, creating adverse selection problems for more traditional health plans and ultimately making the cost of health insurance more expensive for all. It is too soon to tell whether HSAs will actually reduce health care costs over the long term, but interested employers should watch the market develop and determine whether the option is right for their business.

COBRA Reminder

The Department of Labor issued final COBRA regulations concerning the notice obligations of plan sponsors earlier this year. The regulations apply to plan years beginning on or after November 26, 2004. This means that calendar-year plans must be in compliance starting January 1, 2005. The final regulations are, for the most part, identical to the proposed rules issued in 2003. If you have not already done so, employers should amend their plans and summary plan descriptions (SPDs) to include a description of the new notice procedures, and revise their COBRA notices to incorporate the new requirements.

For additional information, see Wiggin and Dana's client advisory on the topic (Summer 2003), which is available on our website, www.wiggin.com (go to Publications, Advisories). Copies of DOL's model COBRA notices are also available on our website (go to Publications, Client Alerts, Employee Benefits).

Recent Supreme Court Rulings

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pants are responsible for all attorney's fees and court costs in any third-party litigation. Plan Administrators should monitor any personal injury or other claims of participants receiving benefits under their plan, and be prepared to take quick action if a settlement or other award is made.

If you have question about any of the recent developments described in this Advisory concerning health care benefits or would like to discuss how these developments may affect your plans, please contact Jennifer Willcox, Karen Clute or Sherry Dominick, all of whom are in our New Haven office (203) 498-4400.

For further information on federal and state age discrimination laws as they pertain to downsizing programs, or any other employment-related issue, please feel free to call John Zandy, Peter Lefeber or Steve Harris in New Haven (203) 498-4400, Marcia Keegan in Hartford (860) 297-3700, or Larry Peikes in Stamford (203) 363-7600.

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Important New Second Circuit ADEA Decision: *Meacham v. Knolls Atomic Power Laboratory*

The United States Court of Appeals for the Second Circuit recently issued a significant decision in *Meacham v. Knolls Atomic Power Laboratory* interpreting the application of the federal Age Discrimination in Employment Act ("ADEA") to employers' downsizing programs. The decision underscores the necessity that employers carefully plan for and implement reduction-in-force programs in order to ensure that they do not have a disparate impact upon older workers.

Background

Knolls Atomic Power Laboratory ("KAPL") is a government-owned research and development facility under contract with the Department of Energy. In 1996, KAPL was required to eliminate 143 of its approximately 2,063 exempt employees for budgetary reasons. In order to achieve the desired staffing level, KAPL instituted a voluntary separation plan, which included severance packages to select employees, job transfers and retraining. In addition, KAPL implemented an involuntary reduction-in-force ("IRIF") program to further reduce its workforce.

In accordance with the IRIF plan, managers were instructed to select employees for participation in the IRIF by ranking them based upon job performance, flexibility, criticality of their skills, and length of service. The lowest ranked employees were identified as candidates for termination under the IRIF. After managers identified employees for layoff, a KAPL human resources representative performed a disparate impact analysis by comparing the average age of the workforce before and after the IRIF, which did not yield a significant difference. KAPL's legal counsel then reviewed the IRIF process by verifying the managers' rankings for mathematical accuracy and speaking with some, but not all, of the managers about the employees whom they had ranked the lowest. Ultimately, thirty-one employees were terminated under the IRIF, thirty of whom were over forty years of age.

Most of the KAPL employees terminated under the IRIF joined in filing an age discrimination lawsuit in the United States District Court for the Northern District of New York. The employees alleged that KAPL had discriminated against them based on age because the IRIF had a disparate impact on older workers. The jury returned a verdict in favor of the employees and awarded them $4.2 million in damages. In addition, the trial judge awarded the employees nearly $1 million in attorney fees and costs. KAPL appealed.

The Court's Decision

The Second Circuit Court of Appeals upheld the jury's verdict and acknowledged that previous Second Circuit decisions had held that employer's may be liable for policies which have a disparate impact on older workers even though the employer did not intend to discriminate. The Court recognized that its position is at odds with the majority of federal appellate courts, which have held that the disparate impact theory of liability is not available in age discrimination cases. The Court further recognized that the United States Supreme Court is likely to resolve this issue during its next term.

The Court first set forth the elements of a claim of disparate impact age discrimination. According to the Court, an employee must initially identify a specific policy responsible for the so-called disparate impact such as the selection criteria utilized in an IRIF plan. Next, the employee must present statistical evidence demonstrating that the challenged policy resulted in a substantial disparity in the selection rates of younger and older employees. The employer must then explain the business necessity for the challenged policy. The employee will prevail if he or she can prove that the employer's explanation is a pretext for discrimination, for example, by showing that equally effective alternatives to the challenged policy were available to accomplish the employer's objectives without causing a disparate impact upon older workers.

The Court then went on to address the inadequacies of KAPL's IRIF plan which had resulted in the disparate impact upon older workers. The Court found that of the four criteria utilized by KAPL to identify employees for layoff, flexibility and criticality had the greatest influence on the selection decisions, and that the factors relied upon by managers to rate employees on these criteria were imprecise at best. As a result, the individual managers had a great degree of latitude to make subjective assessments of employees' flexibility and criticality. This problem was compounded by the lack of adequate safeguards to audit the subjectivity and ensure that it did not result in a disparate impact on older workers. According to the Court, if an employer uses subjective criteria as part of its IRIF, the criteria disproportionately impacts older employees, and the employer does nothing to audit or validate the results, it may be liable for age discrimination if equally effective alternatives to the challenged features of the IRIF are available. The Court concluded that one alternative available to KAPL was to make simple adjustments to the criticality

and flexibility criteria so as to make them less vulnerable to managerial bias.

The Court upheld the jury's verdict which found that KAPL willfully violated the ADEA and awarded the employees liquidated damages because the company failed to properly test for age discrimination in the IRIF. That is, KAPL compared the average age of its 2000 plus exempt employees before and after the IRIF (a methodology proven by plaintiffs' expert to be grossly inadequate in identifying statistically significant disparities in the ages of employees selected for the IRIF). Instead, the Court found that KAPL should have compared the age composition of the pool from which the laid off employees were selected with the age composition of the group ultimately selected for layoff.

The analysis, the Court noted, could utilize either of the methods the Second Circuit has approved for identifying adverse impact. These are *the four-fifths rule* which has been approved by the United States Equal Employment Opportunity Commission or *a standard deviation analysis*. Under the four-fifths rule, an adverse impact is presumed to exist where the retention rate of older workers under an IRIF is less then four-fifths, or 80 percent, of the retention rate of younger workers. Similarly, a standard deviation analysis considers the degree to which an obtained result varies from an expected result. An employer that reduces its workforce in a manner that is less than statistically perfect may nevertheless be able to avoid an inference of discrimination based solely on the fact that the number of people chosen for layoff who are 40 or older is not in perfect statistical parity with the number of people under 40 by utilizing one of these two methods of analysis.

The Court also held that KAPL willfully violated the ADEA because it knew that its IRIF had affected a disproportionate number of older employees but implemented the IRIF nonetheless. Furthermore, the managers who selected employees for termination under the IRIF did not receive any training on avoiding age discrimination in the IRIF and KAPL's legal counsel performed only a cursory review of the results of the IRIF.

Implications for Employers

The implications of the decision are significant for employers contemplating an involuntary reduction of its workforce. Until the United States Supreme Court finds otherwise, an employer's IRIF program that has a disparate impact upon older workers potentially violates federal anti-discrimination law. Likewise, Connecticut employers may face liability under the State's Fair Employment Practices Act, which has been interpreted by at least one lower federal court as encompassing claims of age discrimination based upon the disparate impact on older workers of an employer's neutral employment practices and policies. See *Rogers v. First Union National Bank*, 259 F.Supp.2d 200 (D. Conn. 2003). In light of the Second Circuit decision, it is essential that employers carefully plan for and monitor IRIF plans. Fortunately, the *Meacham* decision provides a roadmap that may help employers avoid the problems that led to the result in that case. For example:

- Initially, employers should develop job-related, objective criteria for evaluating employees. To the extent subjective criteria are used to evaluate employees, those criteria should be carefully defined and tailored to limit the degree to which individual managers' subjective assessments influence the selection process. As the *Meacham* decision makes clear, if an employer bases its selection decisions primarily upon subjective criteria which are vulnerable to managerial bias, and that subjectivity results in a disproportionate number of older workers selected for layoff, the employer must be prepared to show that there were no other alternatives to the challenged features of its IRIF plan or face the possibility of being found liable for age discrimination.
- Once employees are identified for termination under the IRIF, a disparate impact analysis should be performed to identify statistically significant differences in the selection rates of older workers or any other protected class of individuals. In conducting this analysis, the employer must be certain it has chosen the right groups to compare (e.g., those broadly considered for layoff versus those actually laid off, rather than including in the analysis employees who were never considered for layoff). This analysis may include use of either the four-fifths rule or a standard deviation analysis.
- Where a disparate impact exists, employers should perform a systematic review of the IRIF process, including (i) an examination of the selection criteria, to ensure that they did not result in the discriminatory distribution of layoffs, and (ii) discussions with all of the managers who made the selection decisions, to ensure that the decisions were based upon legitimate, non-discriminatory factors. Where a particular selection criterion is found to have caused the lopsided result, especially if subjective in nature, employers should attempt to identify other criteria that would accomplish their objectives without causing a disparate impact upon older workers or other protected groups.
- It is essential that all managers involved in the IRIF receive training on avoiding discrimination in the selection of employees for termination and that human resources personnel and legal counsel provide oversight throughout the process.