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February 2014 Employee Benefits Update

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IRS PROVIDES GUIDANCE ON IN-PLAN ROTH CONVERSIONS TO DESIGNATED ROTH ACCOUNTS

The Internal Revenue Service (IRS) recently issued Notice 2013-74 (Notice) providing guidance on the expansion of eligibility for rollovers within 401(k), 403(b) or governmental 457(b) retirement plans to designated Roth accounts in the same plan (known as in-plan Roth conversions or in-plan Roth rollovers). The Notice clarifies certain provisions of the 2012 American Taxpayer Relief Act (ATRA), which went into effect January 1, 2013. ATRA extended the existing in-plan Roth conversion rules to include amounts not otherwise distributable under the terms of the plan. Before 2013, plans could allow only in-plan Roth conversions of amounts that participants had a right to take out of the plan.

Importantly, the Notice gives plan sponsors until the end of 2014 to amend their plans to provide for ATRA's expanded in-plan Roth conversion option.

Rules Applicable to In-Plan Roth Conversions. The Notice provides that a plan may permit an in-plan Roth conversion of any vested amount (other than an amount held in a designated Roth account) to a designated Roth account in the same plan. Thus, amounts eligible for in-plan Roth conversions include amounts that are not otherwise distributable under the terms of the plan, such as elective deferrals, matching contributions, nonelective contributions and annual deferrals made to governmental 457(b) plans. The Notice clarifies, however, that any otherwise non-distributable amounts and applicable earnings remain subject to the same distribution restrictions that were in effect before the in-plan Roth conversion.

Taxability. In-plan Roth conversions are taxable events (though subsequent earnings are not). The Notice clarifies that, because an in-plan Roth conversion of an otherwise non-distributable amount must be made by a direct rollover, no withholding applies. Also, because this amount is not distributable, no part of the rollover may be withheld for voluntarily withholding. Thus, the IRS warns, an employee making an in-plan Roth conversion may need to increase his or her withholding or make estimated tax payments to avoid an underpayment penalty.

Plan Amendments Permitting In-Plan Roth Conversions of Otherwise Non-distributable Amounts. The Notice provides that, in general, a plan amendment that permits in-plan Roth conversions of otherwise non-distributable amounts may not be

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adopted later than the last day of the plan year in which the amendment is effective. However, the Notice provides for a one-time extension to the general rule: Plan sponsors of 401(k) and governmental 457(b) plans that offered in-plan Roth conversions of otherwise non-distributable amounts in 2013 will have until December 31, 2014, to adopt the appropriate plan amendment.

Further, plan sponsors of safe harbor 401(k) plans may adopt this feature during 2014 if the plan is amended by December 31, 2014. Normally, safe harbor 401(k) plans are prohibited from making certain mid-year changes to plan provisions; the Notice provides temporary relief from that prohibition. The extension also applies to the following related amendments: (1) amendments that permit elective deferrals under the plan to be designated Roth contributions; (2) amendments that provide for the acceptance of rollover contributions by designated Roth accounts; and (3) amendments that permit in-plan Roth conversions of some or all otherwise distributable amounts.

Additional Guidance. The Notice also permits additional options regarding in-plan Roth conversions, including allowing a plan to limit the kinds of contributions eligible for an in-plan Roth conversion, limit the frequency of in-Plan Roth conversion, and discontinue in-plan Roth conversions in an ongoing Roth qualified contribution program (subject to the nondiscrimination requirements under Treasury Regulation section 1.401(a)(4)-5).

SELECT COMPLIANCE DEADLINES AND REMINDERS

Deadline Extended for Pre-Approved Defined Benefit Plans

In its Announcement 2014-04, the IRS extended the deadline to submit on-cycle opinion and advisory letter applications for pre-approved defined benefit plans for the second six-year remedial amendment cycle until February 2, 2015. Without this extension, the applications for these plans would have been due by January 31, 2014.

Rationale for Deadline Extension. The extended deadline gives the IRS time to expand the defined benefit pre-approved plan program to include pre-approved plans with certain cash balance features. Previously, plan sponsors of cash balance plans could not use a preapproved plan document.

The extended deadline applies to all on-cycle pre-approved defined benefit plans, regardless of whether they will be modified to include cash balance features. The IRS will issue guidance in the future announcing which cash balance features will

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be permitted under the pre-approved program and when applications for opinion and advisory letters may be submitted. Until then, plans with cash balance features should not be submitted under the pre-approved program. The extended deadline did not apply to sponsors of individually designed Cycle C plans that intended to file determination letters as individually designed plans. These plans still had to be filed by January 31, 2014.

Deadline Extended for Filing Form 8905. The IRS also extended the Form 8905 filing deadline from January 31, 2014, to March 31, 2014, for plan sponsors of Cycle C individually designed retirement plans that do not intend to file determination letters as individually designed plans but intend to adopt a pre-approved defined benefit plan document. As background, plan sponsors may submit the Form 8905 in lieu of an application for an individually designed determination letter (IRS Form 5300) if they intend to adopt a pre-approved defined benefit plan document in the future and wish to preserve (or in the case of new plans, obtain) reliance on the terms of the pre-approved plan.

PBGC Changes Flat-Rate Premium Due Date for Large Plans; Not Currently Accepting 2014 Filings

The Pension Benefit Guaranty Corporation (PBGC) recently published a final rule implementing part of its July 2013 proposal to simplify the premium payment process and ease the administrative burden on large plans by eliminating the estimated flat-rate premium requirement for large single employer and multiemployer plans (500 or more participants). In accordance with the final rule, the PBGC has moved the flat-rate premium due date for large plans to the variable-rate due date for single employer plans, beginning with the 2014 plan year. As a result, the 2014 flat-rate premium for large calendar-year plans will be due October 15, 2014, instead of February 28, 2014. Unlike single employer plans, multiemployer plans do not pay a variable-rate premium.

Small and Mid-Size Plans. The final rule does not impact mid-size plans (100-499 participants) or small plans (fewer than 100 participants). The final rule addresses only the large plan early filing date because the February 28 deadline is fast approaching. In the PBGC's July 2013 proposal, however, small calendar-year plans that currently have an extended 2014 premium filing date of April 30, 2015, will instead submit their 2014 premium on October 15, 2014; mid-size calendar-year plans will continue to submit their 2014 premium on October 15, 2014. The PBGC will address small and mid-size plans in a future final rule.

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PBGC Not Accepting 2014 Filings. The PBGC expects to publish a final rule addressing the rest of its premium simplification proposal, post the 2014 premium payment instructions and make My Plan Administration Account (My PAA) available for 2014 filings well before the first filing deadline of October 15, 2014. Until then, the PBGC is not accepting any 2014 filings (2013 filings must continue to be filed.)

RETIREMENT PLAN DEVELOPMENTS

President Obama Unveils a New Retirement Savings Account in State of the Union Address

In his State of the Union Address on January 28, 2014, President Obama announced a new retirement savings account, myRA (My Retirement Account), designed to help millions of Americans who lack access to employer-sponsored retirement accounts. MyRA accounts are similar to Roth Individual Retirement Accounts, but also include principal protection by the government, a low but steady variable interest rate return and no tax penalty for amounts withdrawn.

Employers are not required to administer or contribute to myRA accounts, but the White House says it will strongly encourage employers to offer the program and distribute information to employees. On paydays, participating employers will send a direct deposit to each participating employee's myRA account.

Bypassing Congress, President Obama has signed an executive memorandum directing the Treasury Department to administer the new myRA accounts and finalize the program by December 31, 2014.

IRS Releases 2013 Form 8955-SSA and Instructions

The IRS has released the 2013 version of Form 8955-SSA and instructions. Retirement plans must generally file Form 8955-SSA to report information about separated participants with deferred vested benefits under the plan. In addition, plan administrators must also provide each participant listed on the Form 8955-SSA with an individual statement setting forth the information reported on the form.

The 2013 Form 8955-SSA remains unchanged from the 2012 version. The instructions, however, note for the first time that the Schedule SSA (Form 5500) should no longer be used under any circumstances. Instead, Form 8955-SSA should be filed for all plan years, including delinquent returns for plan years before 2009.

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PBGC Issues Proposed Rule Reducing Reporting Obligations for Certain Multiemployer Plans

The PBGC recently issued a proposed rule that would amend its multiemployer regulations to make providing information to the PBGC and plan participants more efficient and effective, and reduce the burden on plan sponsors. The amendments would reduce the number of actuarial valuations required for certain small terminated (but not insolvent) plans, shorten the advance notice fling requirement for merger transactions and remove certain notice requirements for insolvent multiemployer plans.

IRS Releases Revised Forms 5300 and 5310; Increases User Fees

The IRS recently released finalized, revised versions of Form 5300 and Form 5310. Form 5300 (Application for Determination for Employee Benefit Plan) is generally used to request an IRS determination letter qualifying an individually designed retirement plan under sections 401(a) and 501(a) of the Internal Revenue Code (the Code). Form 5310 (Application for Determination for Terminating Plan) is used to request an IRS determination letter in connection with the termination of a plan.

In addition, the IRS increased some user fees on requests for determination letters and other rulings, beginning with submissions made as of February 1, 2014.

The revised Form 5300 and Form 5310 ask for additional information that was not requested on the previous versions of these forms, so plan sponsors and plan administrators should carefully review the instructions before filing.

The IRS has stated that it will continue to accept the prior versions of Form 5300 (Rev. 4-2011) and 5310 (Rev. 4-2006) through June 30, 2014.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Finally Issues Employer Shared Responsibility Regulations

The IRS issued final regulations on the Affordable Care Act's (ACA) employer shared responsibility rules. This ACA mandate was originally intended to be effective in 2014, but was previously delayed until 2015. The regulations contain further transitional relief for employers with 50 to 99 full-time employees. We are preparing a separate e-alert explaining the highlights of these rules that will be sent out shortly.

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DOL Releases ACA FAQ Addressing Coverage of Preventative Services, Wellness Programs and Mental Health Parity

The Departments of Labor, Health and Human Services and the Treasury (collectively, the Departments) have issued additional Frequently Asked Questions (FAQs) addressing questions related to implementation of the ACA and Mental Health Parity. Specifically, the FAQs address the following topics: coverage of preventative services, limitations on cost sharing, expatriate health plans, wellness programs, fixed indemnity insurance, and the effect of the ACA on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Because implementation of the ACA is ongoing, these FAQs remind employers and plan sponsors of important compliance requirements and deadlines.

Coverage of Preventative Services. For plan or policy years beginning on or after September 24, 2014, non-grandfathered group health plans and non-grandfathered health insurance coverage offered in the individual or group market must cover risk-reducing breast cancer medications for applicable women without cost-sharing subject to reasonable medical management.

REINHART COMMENT: The list of recommended preventive services changes from time to time as best practices for disease and condition prevention and discovery are reviewed and updated. For new recommendations, non-grandfathered plans must cover the service for the first plan year that begins on or after the one-year anniversary of the published recommendation. Plan sponsors should review the list of recommended preventive services annually to determine any additional preventive services that must be covered and any that are no longer required to be covered.

Limitations on Cost Sharing. For plan years beginning on or after January 1, 2015, non-grandfathered group health plans and group health insurance coverage must have an out-of-pocket maximum that limits participants' overall out-of-pocket costs for essential health benefits (EHBs). Because cost-sharing limits in ACA section 1302(c) apply only to EHBs, plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not EHBs.

Additionally, a plan may, but is not required to, count out-of-pocket spending for out-of-network and non-covered items and services towards the plan's annual maximum out-of-pocket limit.

Expatriate Health Plans. The FAQs provide additional clarification regarding the definition of an insured expatriate health plan for purposes of applying the

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temporary transitional relief.

Wellness Programs. The FAQs clarify that, if a participant is provided a reasonable opportunity to enroll in a tobacco cessation program at the beginning of the plan year and qualify for the reward (i.e., avoiding the tobacco premium surcharge) under the program, the plan is not required to provide another opportunity to avoid the tobacco premium surcharge until renewal or re-enrollment for coverage for the next plan year. Nothing, however, prevents a plan or issuer from allowing rewards (including pro-rated rewards) for mid-year enrollment in a wellness program for that plan year.

Fixed Indemnity Insurance. The FAQs clarify that coverage supplementing other group health plan coverage may nonetheless qualify as supplemental excepted benefits even though such coverage does not meet the definition of fixed indemnity excepted benefits.

ACA's Effect on MHPAEA. The FAQs reiterate that, for plan years beginning on or after January 1, 2014, all non-grandfathered individual market coverage and all nongrandfathered small market group coverage that is not otherwise subject to the Department of Health and Human Services (HHS) transitional policy must include coverage for mental health and substance use disorder benefits. Moreover, that coverage must comply with the federal parity requirements set forth in the interim final regulations issued by the Departments in February 2010. The final regulations issued by the Departments on November 13, 2013, apply to plan years beginning on or after July 1, 2014 (which, for calendar year plans, is January 1, 2015).

IRS Issues Proposed Regulations on ACA's Individual Mandate Addressing Treatment of HRAs and Wellness Initiatives

The IRS has issued proposed regulations on the ACA's individual mandate, which penalizes individuals who lack "minimum essential coverage" under the ACA. The penalty is known as the "shared responsibility payment." Specifically, the proposed regulations address how health reimbursement arrangements (HRAs) and wellness incentives are treated for purposes of the individual mandate's affordability exemption for individuals who are otherwise eligible for employer-provided coverage. The affordability exemption excuses individuals from the shared responsibility payment if the lowest priced coverage available under the employer's plan would cost more than 8% of total household income.

In addition, the proposed regulations clarify the definition of excepted benefits,

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hardship exemptions that may be claimed on a federal income tax return and the computation of the monthly penalty amount.

The proposed regulations would, if finalized as proposed, retroactively apply as of January 1, 2014.

HRA Contributions. Under the proposed regulations, new amounts made available for the current year under an integrated Health Reimbursement Accounts (HRA) would be taken into account in determining an employee's or a related individual's required contributions under the affordability exemption, as long as the amounts can be used to pay premiums. Conversely, HRA amounts that may be used only for cost-sharing are not taken into account for purposes of determining affordability.

Wellness Incentives. The proposed regulations provide that wellness program incentive amounts are taken into account in determining required contributions under the affordability exemption only if the incentives relate to tobacco use.

Impact on Employers. The IRS has previously issued regulations addressing the treatment of HRAs and wellness incentives as they apply to the employer mandate to offer affordable coverage that provides minimum value. These proposed regulations address HRAs and wellness incentives as they apply to the individual mandate to obtain minimum essential coverage. Although not directly applicable to employers, employers are advised to understand how employer-provided coverage impacts their employees and family members in light of the individual mandate rules.

HHS Releases Proposed Rule Requiring Health Plans to Demonstrate Compliance with HIPAA Electronic Transaction Requirements

The HHS has published a proposed rule to implement the ACA requirement that "controlling health plans" (CHP) certify compliance with certain electronic transaction standards adopted under the Health Insurance Portability and Accountability Act (HIPAA). A CHP is defined to mean a health plan that controls its own business activities, actions or policies, or a health plan that is controlled by a non-health plan entity. This definition is quite broad and likely includes most health plans covered by HIPAA.

The proposed rule would require CHPs, and business associates performing transactions on behalf of CHPs, to certify compliance with the standards and operating rules regarding three electronic transactions under HIPAA: eligibility for

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a health plan, health care claim status, and health care electronic funds transfers and remittance advice. CHPs would certify compliance to the HHS by obtaining one of two credentials from the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

REINHART COMMENT: All HIPAA Covered Entities, including health plans, were required to be in compliance with the eligibility for a health plan and health care claim status requirements as of January 1, 2013, and the health care electronic funds transfers and remittance advice requirements by January 1, 2014. Most health plans delegate these transactions to administrators and other service providers, and the certification required by these proposed regulations will require health plans to ensure that their service providers are in compliance with these requirements.

The proposed rule would require a CHP that obtains a Health Plan Identifier (HPID) before January 1, 2015, to submit documentation of its credentials to the HHS by December 31, 2015. A CHP that obtains an HPID on or after January 1, 2015, would have to submit documentation of its credentials within 365 days of receiving its HPID.

REINHART COMMENT: Under the HPID final rule, existing health plans (other than certain health plans that meet the definition of "small health plan") must obtain an HPID by November 5, 2014. Small health plans have until November 5, 2015 to obtain an HPID. The proposed rule, in accordance with the ACA's penalty provisions, would assess the following penalties on CHPs that fail to comply with certification and documentation submission requirements: $1 per covered life per day, assessed each day until certification is completed, limited to $20 per covered life. If a CHP knowingly or recklessly provides inaccurate or incomplete information regarding its certification, then the $20 cap is increased to $40 per covered life.

GENERAL DEVELOPMENTS

Seventh Circuit Denies Health Plan's Claim of Entitlement to Refund of $1.7 Million Payment to Hospital

On February 5, 2014, the Seventh Circuit upheld a lower court's decision denying a health plan's claim of entitlement to a refund of payments of $1.7 million to a hospital, despite the plan ultimately discovering that the patient was not covered under the plan. *See Kolbe & Kolbe Health and Welfare Benefit Plan v. Medical College of Wisconsin, Inc.* and *Children's Hospital of Wisconsin, Inc.* (7th Cir. 2014).

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The employer-sponsored health and welfare plan in this case provided health benefits to employees and employees' dependents. In 2007, a covered employee notified the plan that his newborn daughter had a serious medical condition requiring medical treatment. Despite receiving insufficient information to determine whether the child was covered under the terms of the plan, the plan began paying the child's medical bills submitted by the treating hospital. After almost a year of protracted efforts to determine the child's status under the plan, the plan administrator determined that the child was ineligible for benefits. By that time, the plan had paid the hospital almost $1.7 million. The plan demanded that the money be refunded, but the hospital refused.

Upholding the district court's earlier decision, the Seventh Circuit held that the plan was not entitled to a refund of the $1.7 million. The Court noted that the provider agreement that governed the relationship between the plan and the hospital did not contain a provision granting refunds, and the Court refused to read one into the agreement. The Court also pointed out that the plan took almost 11 months to determine that the child was not eligible under the plan and, during this time, the hospital had no reason to believe it was receiving the payments erroneously.

In what could be described as a cautionary tale for plan sponsors and plan administrators, this case reminds plan administrators to carefully and promptly review an individual's eligibility for benefits. In the event of wrongful payment, the Seventh Circuit does not require a health care provider to refund the payment to the plan unless an agreement between the parties specifically states otherwise.

In Multiemployer Plan Case, Supreme Court Rules that a Decision on the Merits Triggers Time Limit to Appeal Regardless of a Pending Decision on Claim for Attorneys' Fees

Resolving a split among the federal circuit courts, the U.S. Supreme Court held that a decision on the merits of a case always triggers the time limit to appeal to a federal appellate court, regardless of the pendency of an unresolved claim for attorneys' fees. *See Ray Haluch Gravel Co. v. Central Pension Fund of Operating Engineers* (U.S. 2014).

In the case before the Court, several multiemployer plans affiliated with the International Union of Operating Engineers (the Plans) brought suit under ERISA and applicable collective bargaining agreement against the Ray Haluch Gravel Company (the Company) for delinquent contributions, attorneys' fees and costs.

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The lower court had issued an order on June 17, 2011, on the merits of the contribution claim, and issued a second order on July 25 on the Plans' motion for fees and costs. The Plans appealed both decisions on August 15. On appeal, the Company argued that the decision on the merits was final and the appeal was therefore untimely because the Plans failed to appeal within the required 30 days of the decision. The Plans argued that the final decision on the merits came July 25 because entitlement to fees and costs was an element of damages and thus part of the case's merits. The First Circuit agreed with the Plans and, viewing the appeals as timely, addressed both of the Plans' claims on appeal.

The Supreme Court reversed the First Circuit, holding that the appeal of the June 17 order was untimely. Reiterating its decision in *Budinich v. Becton Dickinson & Co.* and pointing to the need for operational consistency and predictability of a uniform rule, the Court concluded that a decision on the merits is final for purposes of appeal even if the issue of attorneys' fees remains unresolved or entwined with the merits of the case.

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