January 2014 Employee Benefits Update

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UNITED STATES SUPREME COURT UPHOLDS PLAN PROVISION SHORTENING LIMITATIONS PERIOD

On December 16, 2013, the Supreme Court settled a long-standing split among various Circuit Courts of Appeals, holding that an ERISA plan may impose a limitation on the time period during which a participant can sue for benefits that begins to run prior to the date on which the participant's final appeal is denied. *See Heimeshoff v. Hartford Life & Accident Insurance Co*.

ERISA section 502(a)(1)(B) allows participants in ERISA benefit plans to sue to recover benefits under the plan that are wrongfully denied. Unlike ERISA claims for breach of fiduciary duty, ERISA itself does not provide a limitation period for a claim under ERISA section 502(a)(1)(B). Rather, courts have looked to plan documents themselves, when applicable, or to analogous state statutes to determine the applicable limitation periods. Additionally, courts have held that a claim under ERISA section 501(a)(1)(B) does not "accrue" until a participant exhausts all administrative remedies available under a plan and the plan issues a final claim denial. This means that a participant may not file suit under ERISA section 501(a)(1)(B) until using all appeals available under the plan.

Heimeshoff allows a plan to implement a limitation period that begins to run prior to the accrual of the ERISA section 501(a)(1)(B) claim even though participants will have no way of knowing how long they have to file a claim until final denial is issued. This is true as long as (1) the limitations period is of reasonable length and (2) there is no controlling statute to the contrary.

Background

Wal-Mart provides long-term disability benefits to qualifying employees through a group insurance policy (Policy) issued by the Hartford Life & Accident Insurance Co. (Hartford). The Policy required a participant to provide written proof of loss "within 90 days after the start of the period for which Hartford owes payment." In accordance with ERISA, the Policy also provided an administrative appeals process through which a participant could appeal a denial of benefits, including the right to sue. Finally, the Policy also provided that "Legal action cannot be taken against The Hartford . . . [more than] 3 years after the time written proof of loss is required to be furnished according to the terms of the policy."

In mid-2005, Heimeshoff was diagnosed with lupus and fibromyalgia and filed a claim with Hartford for long-term disability benefits. Later that year, Hartford denied Heimeshoff's claim because both Heimeshoff and her physician failed to respond to Hartford's request for additional information. In accordance with the Policy and ERISA, Hartford's notice of denial informed Heimeshoff that she had 180 days to appeal the denial. In mid-2006, Hartford reopened Heimeshoff's claim to allow her to supplement it with the information Hartford had requested prior to the first denial. After reviewing the newly submitted report, Hartford again denied Heimeshoff's claim. Heimeshoff appealed and, following the review of two additional physicians, Hartford denied the appeal in November 2007.

In November 2010 (nearly three years after the final denial), Heimeshoff filed suit in federal district against Hartford and Wal-Mart (pursuant to ERISA section 501(a)(1)(B)) claiming that Hartford abused its discretion in denying her claim. Hartford and Wal-Mart moved to dismiss the complaint as untimely under the Policy's three-year limitations period. The district court granted the motion. Heimeshoff appealed the district court's decision to the Court of Appeals for the Second Circuit. The Second Circuit upheld the district court's decision.

Moving Forward

Heimeshoff's potential effect on ERISA plans is somewhat unclear. For example, the Court did not explain what constitutes a "reasonable limitation period." The Court assumed that claims and appeals requirements placed on Hartford by ERISA generally result in a final decision being issued within one year. Thus, under a limitations period similar to that in Heimeshoff, a participant would have two years following the accrual of the cause of action in which to file suit. In *Heimeshoff*, delays in review resulted in the participant having approximately one year in which to file suit following final denial. This appears to indicate that the Court views a limitation period that extends one year beyond the final appeal denial as reasonable. Additionally, the Court positively cites a Seventh Circuit case where a participant was effectively left with seven months after the final appeal denial in which to file suit. Beyond these references, however, the Court does not give any guidance as to the "reasonableness" of a plan's limitations period.

Additionally, the Policy at issue in *Heimeshoff* was insured. As such, the Policy arguably fell within ERISA's saving clause and was subject to state insurance laws, including a state-mandated statute of limitations. In *Heimeshoff*, the relevant state statute only required a limitations period that provided the participant with at least one year to bring suit "from the time when the loss insured against occurs."

The Policy's limitation period of three years provided a considerably longer period.

Self-insured plans are not generally subject to state insurance laws. However, many courts look to the most analogous state limitations law. It is unclear how an analogous state statute of limitations that is longer than a plan's limitations period would impact how *Heimeshoff* applies to that plan.

SELECT COMPLIANCE DEADLINES AND REMINDERS

Determination Letters Update

Cycle C Remedial Amendment Period individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2014. Cycle C plans include those sponsored by employers with tax identification numbers (EINs) ending in a three or an eight, as well as governmental plans.

Additionally, Cycle D Remedial Amendment Period opens February 1, 2014. Cycle D plans include those sponsored by employers with EINs ending in a four or a nine, as well as nongovernmental multiemployer plans. Cycle D closes on January 31, 2015.

IRS Form 1099-R Must Be Distributed by January 31, 2014

IRS Form 1099-R, *Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.*, must be sent to recipients of retirement plan distributions during the prior plan year by January 31, 2014.

RETIREMENT PLAN DEVELOPMENTS

IRS Releases 2014 Form 1099-R and Instructions for Completing Form 1099-R

On December 6, 2013, the IRS released the final version of the 2014 *Instructions for Forms*

1099-R and 5498, following the release of the 2014 Form 1099-R in late November. Although both the Form 1099-R and accompanying Instructions contain some changes, those changes affect only reporting related to IRAs and should not have an effect on employer-sponsored plans.

Bipartisan Budget Act Affects Single Employer Pension Plans

On December 26, 2013, President Obama signed into law the Bipartisan Budget Act of 2013 (the Act). The Act, among other things, includes an $8 billion increase in PBGC premiums for single employer pension plans. The Act also restricts access to the Social Security Administration's death master file (DMF), which some pension plans have historically used to determine when an annuitant has died.

PBGC Rate Increase. Following closely on the heels of PBGC premium rate increases included in prior legislation, the Act further increases flat rate PBGC premiums for single employer pension plans by $8 in 2015 (to $57) and by another $7 in 2016 (to $64). The Act also includes similar rate increases for plans paying variable rate premiums. Importantly, the Act does not affect PBGC premiums for multiemployer pension plans.

Social Security Administration (SSA) Death Master File. Historically, pension plan administrators have been able to use the DMF to determine the date of an annuitant's death. Because the DMF is generally updated weekly, this information was typically available within a short period of time following an annuitant's death. It remains unclear how the Act may impact this access.

The Act restricts access to the DMF during the three years following a person's death. During this restriction period, only persons with "a legitimate fraud prevention interest, or a business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty" will have access to a person's DMF information. Plan administrators arguably fall under the "fiduciary duty" exception, but the Act provides no examples of those who will be granted access. Future guidance may be issued to clarify who may continue to access the DMF.

IRS Provides Frozen Defined Benefit Plans with Temporary Nondiscrimination Relief

On December 13, 2013, the IRS issued an advance copy of Notice 2014-5, temporarily allowing some employers sponsoring both a frozen defined benefit (DB) plan and a defined contribution (DC) plan to aggregate the DB and DC plans to demonstrate compliance with the nondiscrimination requirements of ERISA sections 401(a)(4) and 410(b) on the basis of equivalent benefits, even if the aggregate plan does not meet current statutory requirements for aggregated testing.

Importantly, this temporary relief is available only if the DB plan was amended prior to December 13, 2013 to prohibit employees hired after a certain date from participating in the plan (even if the amendment takes effect at a later date). It is

unclear from the guidance whether this temporary relief would also extend to a plan in which accruals are also frozen. The DB plan must also meet one of the following conditions:

1. For the plan year beginning in 2013, the DB plan must have been part of an aggregated plan that either was primarily defined benefit in character or consisted of broadly available separate plans, as those terms are defined by regulation; or

2. In the case of a DB plan that was frozen by an amendment adopted prior to December 13, 2013, the DB plan was not part of an aggregated plan for the plan year beginning in 2013 because the DB plan satisfied the coverage and nondiscrimination requirements without aggregation with any DC plan.

This relief is temporary and will only apply to plan years beginning before January 1, 2016. Additional guidance is expected to provide permanent rules.

HEALTH AND WELFARE PLAN DEVELOPMENTS

IRS Releases Post-Windsor Guidance Regarding Same-Sex Spouses and Cafeteria Plans

On December 16, 2013, the IRS issued Notice 2014-1 (the Notice) clarifying the application of the Supreme Court's decision in *US v. Windsor* to the rules under Code Section 125 (relating to cafeteria plans) and Code Section 223 (relating to health saving accounts (HSAs)).

Mid-Year Elections. The Notice confirms that a cafeteria plan that covers same-sex spouses of employees may treat a participant who was married to a same-sex spouse as of the date of the Windsor decision (June 26, 2013) as if the participant experienced a change in legal marital status on that date and allow a participant to revoke an existing election and make a new election if the new election is filed at any time during the cafeteria plan year that includes June 26, 2013 (the date of the Windsor decision) or December 16, 2013 (the date of the Notice). These elections must also satisfy the general regulation requirements regarding election changes.

The Notice also clarifies that, although a change in the tax treatment of a benefit offered under a cafeteria plan generally does not constitute a significant change in the cost of coverage for purposes of mid-year election changes, a cafeteria plan may allow a participant with a same-sex spouse to make a mid-year election

change as a result of the plan's interpretation that the change in tax treatment resulted in a significant change in the cost of health coverage.

A change in status election made in connection with *Windsor* must become effective no later than the date that coverage under the cafeteria plan would be added under the plan's usual procedures for change in status elections, or if later, a reasonable period of time after December 16, 2013.

Written Plan Amendments. If a cafeteria plan already permits a change in election upon a change in legal marital status, the plan need not be amended to specifically permit a change in status election with regard to same-sex spouses in connection with Windsor. However, if a plan did not previously allow election changes for a change in marital status, the cafeteria plan must be amended to permit such election changes on or before the last day of the first plan year beginning on or after December 16, 2013. The amendment may be retroactive to the first day of the plan year including December 16, 2013, provided the cafeteria plan operates in accordance with the guidance in the Notice.

After-Tax Salary Reductions. The Notice provides that employers that receive notice that a participant is married to a same-sex spouse receiving health coverage under the employer's plan before the end of the cafeteria plan year, must begin treating the amount the participant pays for spousal coverage as a pre-tax salary reduction under the plan. This change must be made no later than the date that a change in legal marital status would be required to be reflected for income tax withholding purposes or, if later, a reasonable period of time after December 16, 2013. Additionally, for a participant who elected to pay for health coverage for a same-sex spouse on an after-tax basis, the participant's salary reduction election is deemed to include the employee cost of spousal coverage even if the employer reports the amounts as taxable income and wages to the participant. Therefore, the after-tax amount that the participant pays for spousal coverage is excluded from the gross income of the participant and is not subject to federal income or federal employment taxes.

FSA Reimbursements. Pursuant to the Notice, participants in a cafeteria plan may use their Health Flexible Spending Account (FSA) to be reimbursed for covered expenses of the participant's same-sex spouse or same-sex spouse's dependent incurred during the period beginning on a date that is not earlier than the beginning of the cafeteria plan year that includes June 26, 2013 or the date of the marriage, if later. A same-sex spouse may be treated as covered by the FSA during the current plan year, even if the participant initially elected coverage under a

self-only FSA.

Contribution Limits. Same-sex spouses are subject to the joint deduction limit for contributions to an HSA ($6,450 for 2013) and the exclusion limit for contributions to a dependent care FSA ($5,000). Some same-sex spouses may have made contributions exceeding these limits. Therefore, any excess contributions must be distributed from the applicable HSA no later than the date the spouses' tax return is due or the excess contributions will be subject to excise taxes. For dependent care FSAs, to the extent the contributions exceed the limit, the amount of excess contributions are includable in the spouses' gross income.

REINHART COMMENT

We note that neither Windsor nor the Notice require an employer's health plan or cafeteria plan to cover same-sex spouses. Rather, the IRS limits its guidance to plans that previously did, or post-Windsor elect to, cover same-sex spouses.

Departments Issue Proposed Regulations Expanding the Definition of Excepted Benefits

On December 24, 2013, the IRS and the Department of Health and Human Services (Departments) released proposed regulations expanding the definition of "excepted benefits" under both the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA). Excepted benefits are generally exempt from some requirements under HIPAA and most mandates of the ACA. The proposed regulations are effective December 24, 2013 and provide that, should final regulations prove more restrictive than the proposed regulations, the final regulations will take effect prior to January 1, 2015.

Dental and Vision Benefits. Dental or vision benefits were previously considered "excepted benefits" only if participants have both the right to elect whether to receive the benefit and pay an additional premium for the benefit. The proposed regulations remove the requirement that a participant must pay an additional premium for these benefits to be considered "excepted." As a result, the proposed regulations provide that a dental or vision plan will be considered "excepted" if participants are given the right to opt-out of the coverage, regardless of whether the participant is required to pay any premium for the coverage.

Wraparound Coverage. The proposed regulations also provide that certain wraparound coverage will be considered excepted benefits. As the result of ACA-

mandated changes, some employers have found that their employees cannot actually afford the employer plan, even though the plan is "affordable" under ACA rules. In response, these employers may choose to offer wraparound coverage that supplements any coverage the employee buys on any exchange so that the aggregate coverage is equal to the coverage the employee would have received had the employee been able to afford the employer-sponsored coverage. The proposed regulations provide that this supplemental coverage will be considered excepted benefits.

Employee Assistance Programs. In a prior notice, the Departments provided that until the issuance of final regulations, employee assistance programs (EAP) would be considered excepted benefits if the EAP did not provide "significant benefits in the nature of medical care or treatment." The proposed regulations provide that EAPs will be considered excepted benefits only if:

- The program cannot provide significant benefits in the nature of medical care;
- The benefits cannot be coordinated with benefits under another group health plan;
- No employee premiums or contributions are required to participate in the EAP; and
- There is no cost sharing under the EAP.

HHS Clarifies that the Individual Mandate Hardship Exemption Includes Some Individuals Whose Insurance Policies Have Been Cancelled

In a December 19, 2013 letter to various United States senators, Kathleen Sebelius, Secretary of the Department of Health and Human Services (HHS), clarified that HHS interprets the "hardship exemption" from the ACA's individual mandate to include some individuals whose insurance policies have recently been cancelled. As a result, these individuals will be permitted to comply with the ACA's requirement to purchase health insurance by purchasing catastrophic coverage.

IRS Clarifies that Health Insurance Tax Does Not Apply to Multiemployer Plans

On November 29, 2013, the IRS released final regulations further clarifying the application of the ACA-imposed tax on health insurance issuers. Among other clarifications, the final rule specifically provides that neither a multiemployer plan

nor its underlying tax-exempt trust are considered "covered entities" subject to the health insurers tax.

GENERAL DEVELOPMENTS

Federal District Court Permanently Enjoins Utah Laws Banning Same-Sex Marriage

On December 20, 2013, a Utah federal district court permanently enjoined Utah's ban on same-sex marriage, immediately allowing same-sex couples there to marry. However, on January 6, 2014, the United States Supreme Court stayed the district court's injunction, halting further same-sex marriages in Utah pending an appeal of the initial ruling.

Although the state of Utah clarified that while it still considers the marriages to be valid, it will not recognize the marriages of those married prior to the stay for purposes of receiving state benefits reserved for married couples. However, on January 10, United States Attorney General Eric Holder advised that "for purposes of federal law, these marriages will be recognized as lawful and considered eligible for all relevant federal benefits on the same terms as other same-sex marriages." The section within this Employee Benefits Update titled IRS Releases Post-Windsor Guidance Regarding Same-Sex Spouses and Cafeteria Plans, as well as the September 2013 and October 2013 EB Updates, discuss the treatment of same-sex marriages in retirement and health plans.

Sixth Circuit Expands Scope of Relief Available Upon Unlawful Denial of Benefits

On December 6, 2013, the Sixth Circuit held that ERISA allows a participant to recover a dual award consisting of both denied benefits under ERISA section 502(a)(1), as well as the disgorgement of profits resulting from the denial of benefits pursuant to the equitable relief available under ERISA section 502(a)(3). *See Rochow v. Life Insurance Co. of North America*, No. 12-2074 (6th Cir. Dec. 6, 2013).

Although both prior Supreme Court and Sixth Circuit precedent held that relief was not available under both sections 502(a)(1) and 502(a)(3) of ERISA, the Sixth Circuit held that *Rochow* was distinguishable because "complete relief" was not available unless the plaintiff received both awards.

The Sixth Circuit's ruling in Rochow appears to be a broad expansion of a participant's ERISA recovery rights. It is unclear whether other circuits would

follow this ruling.

DOL Issues Expanded Form 5500 for Use In Reporting for 2013 Plan Year

On December 5, 2013, the DOL issued advance copies of the 2013 Form 5500 and accompanying instructions. The new instructions:

- Require Multiple Employer Welfare Arrangements (MEWA) and entities claiming certain exceptions to file both a Form 5500 and a Form M-1, regardless of size or funding status;
- Require all welfare plans to include an attachment to the Form 5500 labeled "Form M-1 Compliance Information." Failure to include the Form M-1 Compliance Information attachment will result in the Form 5500 submission being deemed incomplete and may result in penalties under ERISA;- The Form M-1 Compliance Information attachment must state whether the plan was subject to the Form M-1 filing requirements for the plan year. Additionally, if the plan was subject to the Form M-1 filing requirements, the attachment must state whether the plan is currently in compliance with the Form M-1 filing requirements and provide the Receipt Confirmation Code for the 2013 Form M-1 annual report. If the plan is not currently subject to the Form M-1 filing requirements, but was in the past, the plan must include the Receipt Confirmation Code for the most recently submitted Form M-1.
- Include a new element 5c (added to Line 5 of Schedules H and I) asking defined benefit plans whether the plan is covered under the PBGC insurance program; and
- Have been updated to reflect provisions of the Moving Ahead for Progress in the 21st Century Act.