Reinhart

November 2013 Employee Benefits Update

On October 31, 2013, the Internal Revenue Service (IRS) released Notice 2013-71 (Notice), modifying the "use-or-lose" rules applicable to Flexible Spending Accounts (FSAs) contained in Internal Revenue Code (Code) section 125 cafeteria plans. Currently, plans may either impose a use or lose rule requiring all amounts in the FSA be used by the last day of the plan year, or plans may include a "grace period" that permits a plan to allow a participant to use funds remaining in an FSA to cover medical expenses incurred during the first two and one-half months of the next plan year. Plans may now allow participants to carry over to the subsequent plan year up to $500 of unused amounts remaining in a participant's account at the end of a plan year. However, a plan may not allow participants to utilize both the grace period rule and the new $500 "carryover" rule.

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Action Steps and Considerations

Plans may implement the carryover rule retroactively for the 2013 plan year or prospectively for future plan years. For a calendar year plan that wishes to implement the new rule for the 2013 plan year, the plan sponsor must:

- Amend its cafeteria plan document before the end of the 2013 plan year to remove the grace period rule, if applicable;
- Amend its cafeteria plan document before the end of the 2014 plan year to adopt the new carryover rule; and
- Communicate the change to participants in time for participants to plan expenses for the remainder of the 2013 plan year and to make FSA deferral elections for next year.

For a calendar year plan that wishes to implement the carryover rule for the 2014 plan year, the plan sponsor would need to:

- Amend its cafeteria plan document before the end of the 2014 plan year to remove the grace period rule, if applicable, and to adopt the new carryover rule; and
- Communicate the change to participants in time for participants to make FSA deferral elections.

Plan sponsors should take other factors into consideration when deciding whether to
implement this change, especially with regard to a 2013 retroactive change. If a

plan
sponsor's cafeteria plan currently uses the grace period rule but the plan sponsor decides to implement the new carryover rule for 2013, some participants may be adversely affected.

For example, assume a participant in a calendar year plan schedules a procedure for
January 2014 that will cost $1,000. Under the grace period rule, the participant could have planned to use $1,000 of 2013 funds to pay for the procedure. Under the carryover rule, the participant will not be able to reserve sufficient funds from 2013 to pay for the procedure because he can only carry over $500 of 2013 funds.

In addition, implementing the carryover rule may make a participant ineligible to participate in a health savings account (HSA) for the next plan year. Under the grace period rule, participants who move to an HSA-based plan are ineligible to contribute to the HSA for three months if they had assets remaining in the FSA at the end of the plan year. Because the amounts carried over under the carryover rule are available for the entire following year, the carryover rule could result in the participant not being able to make HSA contributions for the entire year. In the absence of additional guidance from the IRS on this issue, it appears that such a participant would have to exhaust his or her FSA account by the end of the year before moving to an HSA plan.

Background - Carryover Rule

The Notice specifies that the carryover rule is not mandatory. A cafeteria plan may allow carryovers in compliance with the rules, but it is not required to do so. Additionally, the Notice provides that $500 is the maximum amount that may be carried over from one year to the next. The plan sponsor is free to set its own limit on maximum carryover, not to exceed $500. However, the same carryover limit must apply to all plan participants. In effect, the rule provides that a plan may allow a participant to carry over the lesser of (1) the amount remaining in a participant's account following a plan year, or (2) $500. Importantly, the amount available for carryover in a participant's account is determined after all reimbursements from the still permitted run-out period.

The Notice also clarifies that the amount of a participant's carryover will not affect the participant's ability to defer the maximum $2,500 into the participant's FSA during a plan year. During any year in which a participant's FSA contains both carryover funds and current employee contributions, a cafeteria plan is permitted

to treat reimbursements for claims incurred during the current plan year as being paid first from current year contributions and, only after complete exhaustion of current contributions, use carryover contributions.

Select Compliance Deadlines and Reminders

Market Reforms Affecting Cafeteria Plans and FSAs

Last month, we reported on the impact of the Patient Protection and Affordable Care Act (ACA) market reforms on health reimbursement accounts (HRAs), the primary component of the guidance. We now address two minor components of Technical Release 2013-03 and Notice 2013-54 affecting FSAs and "employer payment plans."

- FSAs that do not qualify as excepted benefits and that are not grandfathered are essentially prohibited for plan years beginning on or after January 1, 2014.
- FSAs qualify as an excepted benefit if they are structured so that the maximum benefit payable to any participant does not exceed two times the participant's salary reduction election for the health FSA for the year or, if greater, $500 plus the amount of the participant's salary reduction election.

"Employer payment plans" that consist of employer pre-tax reimbursement of individual health insurance premiums will essentially be prohibited for plan years beginning on or after January 1, 2014 because they cannot be integrated with individual market coverage. However, pre-tax reimbursements for dental, vision and other voluntary benefits will still be permissible. The rules related to this guidance are extremely complex.

Plan sponsors that currently offer FSAs and pre-tax reimbursement of individual health insurance premiums must review their plan documents and determine whether the structure is compliant and what changes, if any, are necessary before December 31, 2013.

2013 End-of-Year Compliance Checklist

Reinhart has prepared a 2013 end-of-year compliance checklist that provides an overview of new compliance items for health and retirement plans that should be addressed before 2014. The checklist also includes important ongoing year end requirements.

Summary of Benefits and Coverage

Group health plans are required to issue a summary of benefits and coverage (SBC) to participants and beneficiaries covered under the plan. For plans that do not require annual enrollment, the SBC must be provided no later than 30 days prior to the first day of the new plan year. Therefore, calendar year plans without open enrollment should issue their SBCs by November 30, 2013.

ERRP Website to Be Taken Offline

The Early Retiree Reimbursement Program (ERRP) website will be taken offline during the first week of January 2014, coinciding with the sunset of the ERRP program. Plan sponsors of plans that participated in ERRP should access the ERRP website prior to January 1, 2014 to print and save the plan's information and data for their files.

Internal Revenue Code Section 436 Amendments

Code section 436, as added by the Pension Protection Act of 2006, sets limits on benefit payments and pension accruals for defined benefit plans that are "underfunded." As discussed in the December 2012 EB Update, the IRS issued Notice 2012-79 again extending to the last day of the first plan year that begins on or after January 1, 2013 (i.e., December 31, 2013 for calendar year plans) both the deadline to amend a plan to satisfy Code section 436 and the period during which such an amendment is eligible for relief from the anti-cutback requirements of Code section 411(d)(6). The current extension to amend was granted to allow more time to provide additional guidance. No additional guidance has been issued to date, but the IRS has not yet issued an additional extension. Accordingly, calendar year plans subject to Code section 436 should proceed to adopt plan amendments for Code section 436 by December 31, 2013.

Cycle C Determination Letter Filings Due January 31, 2014

Remedial Amendment Period Cycle C individually designed plans must be submitted for a favorable 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.

Retirement Plan Developments

IRS Published Retirement Plans' 2014 Dollar Limits

On October 31, 2013, the IRS announced the 2014 cost of living adjustments affecting
dollar limitations for qualified retirement plans. The highlights are as follows:

- Elective Deferrals. The elective deferral (contribution) limit for employees who participate in 401(k), 403(b), most 457 plans and the federal government's Thrift Savings Plan remains unchanged at $17,500.
- Catch-Up Contributions. The catch-up contribution limit for employees aged 50 and over who participate in 401(k), 403(b), most 457 plans and the federal government's Thrift Savings Plan remains unchanged at $5,500.
- Annual Compensation Limit. The annual compensation limit under Code sections 401(a)(17), 404(l), 408(k)(3)(C) and 408(k)(6)(D)(ii) is increased from $255,000 to $260,000.
- Annual Additions Limit. The annual additions limitation for a defined contribution plan under Code section 415(c)(1)(A) is increased in 2014 from $51,000 to $52,000.
- Annual Benefit Limit. The limitation on the annual benefit under a defined benefit plan under Code section 415(b)(1)(A) is increased from $205,000 to $210,000.
- Definition of Highly Compensated Employee. The limitation used in the definition of highly compensated employee under Code section 414(q)(1)(B) remains unchanged at $115,000.
- Definition of Key Employee. The dollar limitation under Code section 416(i)(1)(A)(i) for defining a key employee in a top-heavy plan is increased from $165,000 to $170,000.

A comprehensive list of changes can be found at IRS Announces 2014 Pension Plan Limitations.

IRS Issues Informal Guidance on Automatic Beneficiary Revocations upon Legal Separation

As part of Issue 2013-3 of the Employee Plans News, the IRS provided guidance clarifying the application of automatic beneficiary revocations to legal separations. Qualified retirement plans may not automatically revoke a participant's beneficiary designation of his or her spouse as beneficiary when the participant and spouse become legally separated rather than divorced. However, the plan may allow the participant to change his or her beneficiary designation without spousal consent while legally separated. Qualified plans may still provide for automatic revocation of a participant's beneficiary designation upon divorce.

International Paper Settles Breach of Fiduciary Duty Claim

International Paper Co. (International Paper) recently negotiated what is likely the second largest negotiated settlement with respect to a 401(k) fee case. In 2006, a group of plaintiffs filed a class action lawsuit on behalf of participants and beneficiaries against International Paper and other defendants in an Illinois district court. In their lawsuit, the plaintiffs claimed that International Paper violated ERISA with respect to a number of issues, such as paying excessive fees for recordkeeping and investment management, including its own publicly traded stock as an investment option in the plan, fraudulently reporting investment histories for the plan's funds, improperly delaying contributions to the plans, and improperly retaining interest earned on contributions for corporate accounts.

On October 1, 2013, the plaintiffs and defendants reached a preliminary settlement
agreement for $30 million. International Paper denied any breach of fiduciary duty or other wrongdoing but nonetheless agreed to distribute the money among some 70,000 current and former participants. The company also agreed to undergo four years of monitoring of its 401(k) plans, receive new bids for its recordkeeping functions and improve its plan offerings for current and future employees.

Health and Welfare Plan Developments

HHS Issues Reinsurance Fee Guidance, Indicating Additional Changes Forthcoming

On October 24, 2013, the Department of Health and Human Services (HHS) released a Final Rule amending the HHS Notice of Benefit and Payment Parameters for 2014. The Final Rule briefly addresses a few issues related to the Reinsurance Fee that will begin on January 1, 2014, with first payments due in late 2014 or early 2015. Of note, three of the four issues are addressed only in the Preamble, indicating additional guidance may follow.

- The Preamble to the Final Rule indicates HHS's intent to exempt self-insured, self-administered plans from the Reinsurance Fee for 2015 and 2016. However, plans will still be responsible for a Reinsurance payment for 2014. The Preamble gives no indication of when it intends to issue the Rule, nor does it give an indication of what requirements, if any, self-insured, self-administered plans will be required to meet.

- The Preamble also provides that HHS intends to propose in future rulemaking that Reinsurance Fees be collected in two installments. HHS did not provide whether this proposed rule change will apply only to 2015 and 2016, or whether it will apply beginning in 2014.
- The Preamble provides that HHS intends to provide a more specific definition of "major medical coverage" in the 2015 Notice of Benefit and Payment Parameters. As previously interpreted by HHS, the definition of "major medical coverage" would exclude, for example, stand-alone vision coverage, stand-alone dental coverage, self-insured prescription drug coverage, HSAs and FSAs, as well as integrated HRAs. Additionally, for participants who have both employer-provided major medical coverage as well as Medicare coverage, the fee will apply only to the extent that Medicare is the individual's secondary payer under the Medicare Secondary Payer rules.
- The Final Rule requires contributing entities to maintain records relating to the Reinsurance payments for ten years to be provided upon request from HHS for purposes of verification, investigation, audit or other review of reinsurance contribution amounts.

The Reinsurance program requires all insurance providers and sponsors of self-insured plans to pay a yearly fee for each life covered by major medical coverage. The money collected will then be disbursed to qualifying insurers covering high-risk individuals. The program begins on January 1, 2014 and runs through the end of 2016.

CMS Releases FF-SHOP Technical Guidance on Premiums

HHS released Frequently Asked Questions #6 applicable to the Federally-Facilitated Small Business Health Options Program (FF-SHOP). Employers with an average of 50 or fewer employees doing business in those states that have elected not to implement their own SHOP system may participate in the FF-SHOP system. For example, the FF-SHOP system will operate in Wisconsin, Illinois, Indiana and Michigan, while Minnesota will operate its own SHOP.

The FAQs discuss:

- How premiums will be calculated, including for employers with employees in multiple states;
- Whether a small employer's premium rate may be changed during the employer's plan year;
- Whether composite (or average) premiums may be used in the FF-SHOPs;

- How employers may contribute to employee and dependent premiums in an FF-SHOP;
- How employees will be allowed to contribute to their premiums in an FF-SHOP;
- What happens if an employer's estimate of the number of employees who elect coverage is different from actual participation, and the impact on premiums; and
- Examples of contribution calculations.

General Developments

New Jersey Extends Marriage Rights to Same-Sex Couples

In October, New Jersey became the 14th state to allow same-sex couples to marry following a state trial court decision and the state's withdrawal of its challenge. The trial court in Garden State Equality v. Dow, 2013 WL 5687193 (N.J. 2013), overturned the state's ban on same-sex marriage, leading to the change. Accordingly, same-sex couples can now marry in New Jersey and will be treated as married for federal tax purposes. Reinhart's September 2013 and October 2013 Employee Benefits Updates discuss the treatment of same-sex marriages in retirement and health plans.