HEALTH & WELFARE PLAN LUNCH GROUP

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ALSTON & BIRD LLP

One Atlantic Center
1201 W. Peachtree Street
Atlanta, GA 30309-3424
(404) 881-7885
E-mail: john.hickman@alston.com

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ALSTON&BIRD LLP

WWW.ALSTON.COM

Employee Benefits & Executive Compensation ADVISORY ■

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ACA Update: Final Regulations Create New Requirements for Employer Wellness Programs

The Departments of Labor, Treasury, and Health and Human Services (the "Departments") published final wellness regulations this summer (the "Final Wellness Rules")[1] modifying the 2006 HIPAA wellness program regulations (the "2006 Regulations")[2] in light of the changes made to the statutory provisions by the Affordable Care Act (the ACA). These Final Wellness Rules supersede the proposed regulations published on November 26, 2012 (the "Proposed Wellness Rules").[3]

Although there are some welcome changes in the Final Wellness Rules, other changes, particularly those that apply to health-contingent wellness programs (including activity-based programs as described below), will make certain types of wellness programs more difficult to administer. On the plus side, consistent with the statutory provisions, the maximum reward that may be offered under a health-contingent program is increased generally from 20 percent of the cost of coverage (as under the 2006 Regulations) to 30 percent, and up to 50 percent of the cost of coverage for tobacco cessation programs. However, for wellness plans that condition a reward on the satisfaction of a health-contingent standard—e.g., no smoking or attainment of a certain body mass index (BMI)—the Final Wellness Rules change the way such health-contingent wellness incentive programs must be administered by adding new, stricter requirements. The Final Wellness Rules apply to both grandfathered and non-grandfathered plans for plan years beginning on or after January 1, 2014. This advisory discusses key aspects of the Final Wellness Rules as applied to group health plans.

Types of Wellness Programs

Like the 2006 Regulations, the Final Wellness Rules make a distinction between participatory wellness programs and health-contingent wellness programs.

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1 78 Fed. Reg. 33158 (June 3, 2013).

2 71 Fed. Reg. 75014 (December 13, 2006).

3 77 Fed. Reg. 70620 (November 26, 2012). *See* our prior advisory on the Proposed Wellness Rules.

Participatory Wellness Programs

Practice Pointer. The Final Wellness Rules contain different rules for participatory wellness programs and health-contingent wellness programs. Health-contingent wellness programs are subject to stricter requirements, making it critical to correctly categorize the type of wellness program offered.

Participatory wellness programs are programs that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor. Examples cited in the Final Wellness Rules include a fitness center reimbursement program; a diagnostic testing program that does not base rewards on test outcomes; a program that waives cost-sharing for preventive care, such as prenatal or well-baby visits (generally relevant for grandfathered plans only);[4] a program that reimburses employees for the costs of participating in a smoking cessation program regardless of whether the employee quits smoking; and a program offering rewards for attending a free health education seminar.

Participatory programs comply with the HIPAA and ACA non-discrimination requirements as long as participation in the program is available to all similarly situated individuals, regardless of health status. There is no limit on financial incentives for participatory wellness programs and they do not have to meet the requirements for health-contingent wellness programs.

Practice Pointer. "Reward" refers to a discount or rebate of premiums or contributions, a waiver of all or part of other cost-sharing and other financial incentives. It also includes avoiding penalties (such as surcharges).

Health-Contingent Wellness Programs

A "health-contingent wellness program" is a program that bases any portion of a reward on an individual satisfying a standard that is related to a health factor, or requires an individual who fails to satisfy a health standard to "do more" than a similarly situated individual who satisfies the health standard in order to obtain the same reward. This includes performing or completing an activity relating to a health factor, or attaining a specific health outcome (such as attaining certain results on biometric screenings). In a departure from the Proposed Wellness Rules, the Final Wellness Rules divide health-contingent wellness programs into two categories: activity-only and outcome-based programs.

Activity-only wellness programs require individuals to perform or complete activities related to a health factor in order to obtain a reward. However, they do not require an individual to attain or maintain a specific health outcome. Examples of such programs include walking, diet and exercise programs.

Outcome-based programs, in contrast, require individuals to attain or maintain a specific health outcome (such as a certain BMI) in order to obtain a reward. In order for outcome-based programs to satisfy the Final Wellness Rules, the program will generally need to have two tiers. The first is the outcome—e.g., a measure, test or screening that sets the initial standard for obtaining the reward, such as no smoking or a BMI within a certain range. The second tier is a reasonable alternative that must be offered to all individuals who do not meet the specified health outcome (regardless of their medical condition). This second tier could be activity-based (e.g., an exercise program) or outcome-

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[4] Non-grandfathered plans are required to offer certain preventive care services without cost-sharing under the ACA.

based (e.g., an alternative BMI standard and a reasonable time period to meet the standard). Even if the reasonable alternative is activity-only, the program as a whole is considered outcome-based and must satisfy the requirements for outcome-based programs.

Practice Pointer. With an "activity-only" wellness program, such as an exercise or diet program, a reasonable alternative means of obtaining the reward must be offered only to individuals for whom it is unreasonably difficult due to a medical condition to meet the applicable standard, or for whom it is medically inadvisable to attempt to satisfy the standard. In contrast, with an "outcome-based" wellness program (e.g., no smoking), each individual who does not meet the standard must be offered a reasonable alternative to obtain the reward and an opportunity to involve the individual's personal physician to develop an alternative.

Five Requirements for Health Contingent Wellness Programs

The 2006 Regulations and the Proposed Wellness Rules contained five requirements for health-contingent wellness programs. Although the Final Wellness Rules maintain these five categories of requirements, there are some significant changes.

1. Frequency of Opportunity to Qualify

As under the 2006 Regulations and Proposed Wellness Rules, individuals must have the opportunity to qualify for a reward at least once per year in health-contingent programs (both activity-only and outcome-based). Thus, an opportunity to requalify each year must be extended even if a participant has repeatedly failed to meet a goal or complete established requirements.

2. Size of Reward

In general. The total reward for a health-contingent wellness plan—either activity-only or outcome-based—cannot exceed a specified percentage of the total cost of employee-only coverage, taking into account both employer and employee contributions. This is typically referred to as the "COBRA cost" of coverage, less the applicable two-percent administrative charge. If dependents can participate in the program, the reward cannot exceed the applicable percentage of the total cost of coverage in which the employee and dependents are enrolled. In the Proposed Wellness Rules, the Departments requested comments as to whether (and if so, how) a reward should be apportioned among family members if the program is offered to family members and only some qualify for the reward. The Final Wellness Rules do not provide a specific method for apportionment of a reward; thus, there is some flexibility, as long as the solution is reasonable.

The 2006 Regulations capped the permissible reward at 20 percent of the total cost. In accordance with the ACA, the Final Wellness Rules increase the maximum reward to 30 percent for programs other than those related to tobacco use.

Tobacco use. The Departments exercised their regulatory authority by permitting a reward for programs that include tobacco cessation of up to 50 percent. Here's how it works. If the only rewards-based program is tobacco cessation, then the maximum percentage is 50 percent. The 50-percent differential for tobacco use provides consistency with the modified community rating rules, which go into effect in 2014 and permit health insurance issuers in the small and individual market to vary premiums for tobacco use by a similar factor (the modified community rating rules do not apply at this time to the large group market). Insurers that impose such a differential in the small group market must offer a wellness program that meets the requirements of the Final Wellness Rules.

The final regulations under the modified community rating rules define "tobacco use" as use of tobacco products on average four or more times a week in the past six months. This definition has **not** been carried over into the Final Wellness Rules. Thus, outside the fully insured small group market, employers appear to have some flexibility in defining tobacco use. The Final Wellness Rules contain an example of a permissible wellness program that defines tobacco use as use of tobacco in the past 12 months.

If, however, the rewards-based program includes non-tobacco cessation programs and tobacco cessation programs, then the maximum reward for the non-tobacco cessation program cannot exceed 30 percent standing on its own, and the total reward for both cannot exceed 50 percent.

Example. This example, taken from the Final Wellness Rules, demonstrates how the maximum permitted reward is coordinated in a wellness program that provides rewards based on tobacco use and other health factors.

Facts: An employer sponsors a group health plan. The annual premium for employee-only coverage is $6,000 (of which the employer pays $4,500 per year and the employee pays $1,500 per year). The plan offers employees a health-contingent wellness program with several components, focused on exercise, blood sugar, weight, cholesterol and blood pressure. The reward for compliance is an annual premium rebate of $600. In addition, the plan also imposes an additional $2,000 tobacco premium surcharge on employees who have used tobacco in the last 12 months and who are not enrolled in the plans' tobacco cessation program. (Those who participate in the plans' tobacco cessation program are not assessed the $2,000 surcharge.)

Conclusion: The amount of the reward under this program is permissible. The total of all rewards is $2,600 ($600 + $2,000 = $2,600), which does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage ($3,000); and, tested separately, the $600 reward for the wellness program unrelated to tobacco use does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage ($1,800).

3. Reasonable Design

The Final Wellness Rules emphasize that health-contingent wellness programs (both activity-based and outcome-based) must be reasonably designed to promote health or prevent disease. A wellness program is reasonably designed if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals. It must not be overly burdensome, cannot be a subterfuge for discrimination based on a health factor and cannot be highly suspect in the method chosen to promote health or prevent disease. However, it may have more favorable rates for eligibility or premium rates for individuals with an adverse health factor. The determination of whether a wellness program is reasonably designed is based on the relevant facts and circumstances. The Final Wellness Rules provide that in order to satisfy the requirement of reasonable design, ***outcome-based*** wellness programs must provide a reasonable alternative standard to qualify for the reward for all individuals who do not meet the initial standard.

4. Uniform Availability and Reasonable Alternative Standards

Availability of Reasonable Alternative Standards

Activity-only programs (e.g., diet or exercise programs) must make available an alternative means of obtaining the reward only to individuals for whom it is unreasonably difficult due to a medical condition to meet the applicable standard, or for whom it is medically inadvisable to attempt to satisfy the standard. If reasonable under the circumstances, the plan can seek verification, such as from a participant's personal physician, that a health factor creates the need for an alternative standard.

Outcome-based programs must offer each individual who does not meet the initial standard a reasonable alternative to obtain the reward. The plan may not, in general, seek verification under an outcome-based program that an alternative is necessary due to a health factor.

- If the plan offers an alternative to the initial standard that is an ***activity-only program***, then the plan must comply with the requirements applicable to such programs with respect to the alternative. For example, if the plan offers an exercise program as an alternative to having a BMI below a certain level, then the plan must offer an alternative to the exercise program to anyone for whom compliance with the exercise program is unreasonably difficult or medically inadvisable. The plan may, if reasonable under the circumstances, seek verification that a health factor requires an alternative to the exercise program.
- If the plan offers an alternative that is itself an ***outcome-based program***—e.g., satisfaction of a different level of the same standard—then additional requirements apply. The reasonable alternative cannot be a different level of the same standard unless the plan also allows additional time to meet the standard. An example given in the Final Wellness Rules is that if the initial standard is a BMI of less than 30, a reasonable alternative would be to reduce the individual's BMI by a small percentage over a realistic period of time, such as a year. An individual must be given the opportunity to comply with the recommendations of his or her personal physician as a second, reasonable alternative standard to that offered by the plan. An individual may make a request at any time to involve his or her personal physician at any time (if the physician joins in the request) and the physician can change the recommendations at any time consistent with medical appropriateness.

Practice Pointer. Keep in mind that instead of implementing an alternative, a plan can also waive the standard and provide the reward. Waiving the standard will be a more administrable approach, but could lessen the intended effects of the program.

The Final Wellness Rules contain a number of examples that help illustrate how the requirements apply in particular situations.

Other Requirements

In General

Except as otherwise indicated, the following requirements for a reasonable standard apply to both activity-only and outcome-based programs.

Plans do not have to establish an alternative standard in advance of a request, but an alternative must be provided (or the original standard waived) where otherwise required, upon request. Plans have flexibility to determine whether to provide the same reasonable alternative standard to an entire class of individuals (provided it is reasonable) or provide it on a case-by-case basis. Persons who meet the alternative standard must be eligible for the entire reward. If the alternative standard is not met until the end of the plan year, the plan can provide a retroactive payment for the amount of the reward. If a person fails to meet the reasonable alternative for a year, that does not excuse the plan from providing a reasonable alternative for the next plan year.

A person who fails to meet the initial requirement after completing a reasonable alternative may be required to complete the alternative in subsequent years in order to obtain the reward.

Example: For example, suppose a lower premium is offered to individuals who do not use tobacco. As a reasonable alternative, the plan provides the same lower premium to those who complete a smoking cessation education program. At the start of the 2014 plan year, individual A does not qualify for the reward initially (because she smokes), but does complete the smoking education program. A is entitled to the reward for 2014 (which may be paid by the plan after she completes the program). For the 2015 plan year, if A still does not meet the initial standard, the plan may again require A to complete the smoking education program to qualify for the reward for 2015.

If the reasonable alternative standard is the completion of an educational program, the plan must make the program available or assist the employee in finding it, instead of requiring the individual to find one, and it cannot require an individual to pay for it. The time commitment required must be reasonable (e.g., one night a week is not reasonable).

If the reasonable alternative standard is a diet plan, the plan must pay for a membership or participation fee, but does not have to pay for the cost of food.

If a plan makes a recommendation and a participant's personal physician states that such a recommendation is not medically appropriate, the plan must provide a reasonable alternative standard that accommodates the recommendations of the personal physician. The plan may, however, impose standard cost sharing for coverage of medical items and services under the physician's recommendations.

5. Notice of Other Means of Qualifying for the Reward

Finally, the Final Wellness Rules require plans to disclose the availability of other means of qualifying for a reward, including the possibility of a waiver of the otherwise applicable standard, in all plan materials describing the terms of a health-contingent wellness program. This disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. For outcome-based programs, this notice must also be included in any disclosure that an individual did not satisfy an initial standard. A mere mention that a program is available, without describing its terms, does not trigger this disclosure requirement for either activity-based or outcome-based programs.

The Final Wellness Rules include the following updated sample text that plans may use to satisfy this requirement:

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

This advisory was written by **Stacy Clark, Ashley Gillihan, John Hickman** *and* **Carolyn Smith.**

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If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.239.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Stacy C. Clark
404.881.7897
stacy.clark@alston.com

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Emily C. Hootkins
404.881.4601
emily.hootkins@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Johann Lee
202.239.3574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.239.3374
emily.mao@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

Thomas G. Schendt
202.239.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Richard S. Siegel
202.239.3696
richard.siegel@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Daniel G. Taylor
404.881.7567
dan.taylor@alston.com

Laura G. Thatcher
404.881.7546
laura.thatcher@alston.com

Elizabeth Vaughan
404.881.4965
beth.vaughan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON&BIRD LLP

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213-576-1100
NEW YORK: 90 Park Avenue ■ 12th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 275 Middlefield Road ■ Suite 150 ■ Menlo Park, California, USA, 94025-4004 ■ 650-838-2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333
VENTURA COUNTY: 2801 Townsgate Road ■ Suite 215 ■ Westlake Village, California, USA, 91361 ■ 805.497.9474 ■ Fax: 805.497.8804

Modification of "Use-or-Lose" Rule For Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections Under § 125 Cafeteria Plans

Notice 2013 -71

I. PURPOSE

This notice contains modifications to the rules for § 125 cafeteria plans. First, sections II through V of the notice modify the "use-or-lose" rule for health FSAs that is currently set forth in proposed regulations under § 125 of the Internal Revenue Code (the Code). This modification permits § 125 cafeteria plans to be amended to allow up to $500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate the grace period rule. This carryover of up to $500 does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under §125(i) of the Code ($2,500 adjusted for inflation after 2012). This carryover option provides an alternative to the current grace period rule and administrative relief similar to that rule.

Second, section VI of this notice clarifies the scope of the transition relief provided in the preamble to proposed regulations under § 4980H that allows greater flexibility for individuals to make changes in salary reduction elections for accident and health plans provided through § 125 cafeteria plans for non-calendar cafeteria plan years beginning in 2013.

II. BACKGROUND

Section 125(d)(1) defines a § 125 cafeteria plan as a written plan maintained by an employer under which all participants are employees, and all participants may choose among two or more benefits consisting of cash and qualified benefits. Section 125(f) defines a qualified benefit as any benefit which, with the application of § 125(a), is not includable in the gross income of the employee by reason of an express provision of the Code (with certain exceptions). Qualified benefits include employer-provided accident and health plans excludable from gross income under §§ 106 and 105(b), but exclude long term care insurance and certain qualified health plans offered through an Exchange (also referred to as a Marketplace) established under § 1311 of the Patient Protection and Affordable Care Act (the Act).[1]

Pursuant to § 125(d)(2)(A), a § 125 cafeteria plan generally does not include any plan that provides for deferred compensation. Proposed regulations under § 125 that predated the enactment of the Act generally have prohibited participants from using

[1] Public Law 111-148 (124 Stat. 1029 (2010)), amended by § 10104 and § 10203 of the Act.

contributions made for one plan year to purchase a benefit that will be provided in a subsequent plan year. Commonly referred to as the "use-or-lose" rule, this requires that unused benefits or contributions remaining as of the end of the plan year (that is, amounts credited to a health FSA participant's account that remain unused, referred to below as "unused amounts") be forfeited. See Prop. Treas. Reg. §§ 1.125-1(c)(7)(C), 1.125-1(o), and 1.125-5(c).

In 2005, the Treasury Department and the IRS modified the use-or-lose rule by adopting the grace period rule. Under the grace period rule, a § 125 cafeteria plan may permit an employee to use amounts remaining from the previous year (including amounts remaining in a health FSA) to pay expenses incurred for certain qualified benefits during the period of up to two months and 15 days immediately following the end of the plan year. See Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. § 1.125-1(e). This exception was based on other areas of tax law that do not treat certain arrangements as providing for deferred compensation if the compensation payment is made no later than the fifteenth day of the third month after the taxable year in which the services are performed. See, for example, Treas. Reg. § 1.404(b)-1T, Q&A-2.

Section 125(i)[2] provides that, beginning in 2013, a health FSA is not treated as a qualified benefit unless the § 125 cafeteria plan limits each employee's salary reduction contributions to the health FSA to no more than $2,500 per taxable year (as indexed for cost-of-living adjustments). Notice 2012-40, 2012-1 C.B. 1046, provides that the term "taxable year" in § 125(i) refers to the plan year of the § 125 cafeteria plan, so that the limit is applicable only beginning with the first day of the first plan year beginning in 2013.

Notice 2012-40 stated that "[t]he $2,500 limit, while not addressing the 'use-or-lose' rule, limits the potential for using health FSAs to defer compensation and the extent to which salary reduction amounts may accumulate over time. Given the $2,500 limit, the Treasury Department and the IRS are considering whether the use-or-lose rule for health FSAs should be modified to provide a different form of administrative relief (instead of, or in addition to, the current 2½ month grace period rule)." Notice 2012-40 requested comments on whether the proposed regulations under § 125 should be modified to provide flexibility with respect to the operation of the use-or-lose rule for health FSAs in addition to the 2½-month grace period rule. Numerous comments were submitted in response to this request, the overwhelming majority favoring modification of the use-or-lose rule.

III. FURTHER MODIFICATION OF USE-OR-LOSE RULE

The public comments argued for additional flexibility with respect to the operation of the use-or-lose rule for a number of reasons. These included the difficulty for

[2] Section 125(i) was added to the Code by § 9005 of the Act, amended by § 10902 of the Act, and further amended by § 1403(b) of the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152.

employees of predicting their future needs for medical expenditures, the desirability of minimizing incentives for unnecessary spending at the end of a year or grace period, the possibility that lower- and moderate-paid employees are more reluctant than others to participate because of aversion to even modest forfeitures of their salary reduction contributions, and the opportunity to ease and potentially to simplify the administration of health FSAs. In light of these comments, the Treasury Department and the IRS have determined that it is appropriate to modify the use-or-lose rule to permit the use of up to $500 of unused amounts in a health FSA in the immediately following plan year.

Accordingly, an employer, at its option, is permitted to amend its § 125 cafeteria plan document to provide for the carryover to the immediately following plan year of up to $500 of any amount remaining unused as of the end of the plan year in a health FSA. The carryover of up to $500 may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over. For this purpose, the amount remaining unused as of the end of the plan year is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period[3] for the plan year. In addition to the unused amounts of up to $500 that a plan may permit an individual to carry over to the next year, the plan may permit the individual to also elect up to the maximum allowed salary reduction amount under § 125(i). Thus, the carryover of up to $500 does not count against or otherwise affect the indexed $2,500 salary reduction limit applicable to each plan year. Although the maximum unused amount allowed to be carried over in any plan year is $500, the plan may specify a lower amount as the permissible maximum (and the plan sponsor has the option of not permitting any carryover at all).

A plan adopting this carryover provision is not permitted to also provide a grace period with respect to health FSAs. Nor is the plan, for any plan year, permitted to allow an individual to salary reduce for qualified health FSA benefits more than the indexed $2,500 salary reduction limit or permitted to reimburse claims incurred during the plan year that exceed the applicable indexed $2,500 salary reduction limit (and any nonelective employer flex credits) plus the carryover amount of up to $500. If an employer amends its plan to adopt a carryover, the same carryover limit must apply to all plan participants. A § 125 cafeteria plan is not permitted to allow unused amounts relating to a health FSA to be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts relating to a health FSA may be used only to pay or reimburse certain § 213(d) medical expenses (excluding health insurance, long-term care services

[3] A "run-out period" is a period immediately following the end of a plan year during which a participant can submit a claim for reimbursement of expenses incurred for qualified benefits during the plan year. See Prop. Treas. Reg. § 1.125-1(f). By contrast, a grace period is a period of up to two months and 15 days immediately following the end of a plan year during which a participant may use amounts remaining from the previous plan year (including amounts remaining in a health FSA) to pay expenses incurred for certain qualified benefits during that two-month-and-15-day period. See Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. § 1.125-1(e). (A run-out period may also be provided immediately following the end of a grace period instead of immediately following the end of a plan year, so that participants can submit claims for reimbursement of expenses incurred during the grace period or the previous plan year.)

or insurance, see Prop. Treas. Reg. §1.125-1(q)). With respect to a participant, the amount that may be carried over to the following plan year is equal to the lesser of (1) any unused amounts from the immediately preceding plan year or (2) $500 (or a lower amount specified in the plan). Any unused amount in excess of $500 (or a lower amount specified in the plan) that remains unused as of the end of the plan year (that is, at the end of the run-out period for the plan year) is forfeited. Any unused amount remaining in an employee's health FSA as of termination of employment also is forfeited (unless, if applicable, the employee elects COBRA continuation coverage with respect to the health FSA).

The uniform coverage rule requires that the maximum amount of reimbursement from the health FSA (including both salary reduction amounts and any nonelective employer flex credits) be available for claims incurred at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage). That rule continues to apply to § 125 cafeteria plans adopting the carryover of up to $500.

Use of the carryover option permitted under this notice does not affect the ability of a health FSA to provide for the payment of expenses incurred in one plan year during a permitted run-out period at the beginning of the following plan year (just as a run-out period can also be provided when using the grace period rule). Thus, for plans using the new carryover option, a participant's unused health FSA balance at the end of the prior plan year may be used (a) for expenses incurred in the prior plan year, but only if claimed during the plan's run-out period that begins at the end of the prior plan year (in effect retroactively reducing the unused amount as of the end of the prior plan year) or (b) to the extent of the permitted carryover amount of up to $500 from the final prior plan year unused amount, for expenses that are incurred at any time in the current plan year. In contrast, salary reduction or other amounts credited to a health FSA with respect to service in the current plan year may be used only for expenses incurred in the current plan year (unless and to the extent that these current plan year amounts may later be carried over to the following plan year).

For ease of administration, a § 125 cafeteria plan is permitted to treat reimbursements of all claims for expenses that are incurred in the current plan year as reimbursed first from unused amounts credited for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused amounts carried over from the preceding plan year. Any unused amounts from the prior plan year that are used to reimburse a current year expense (a) reduce the amounts available to pay prior plan year expenses during the run-out period, (b) must be counted against the permitted carryover of up to $500, and (c) cannot exceed the permitted carryover. For examples of how the carryover operates, see section V of this notice.

IV. WRITTEN § 125 CAFETERIA PLAN AMENDMENT

To utilize the new carryover option permitted under this notice, a § 125 cafeteria plan offering a health FSA must be amended to set forth the carryover provision. The

amendment must be adopted on or before the last day of the plan year from which amounts may be carried over and may be effective retroactively to the first day of that plan year, provided that the § 125 cafeteria plan operates in accordance with the guidance under this notice and informs participants of the carryover provision, and provided further that a plan may be amended to adopt the carryover provision for a plan year that begins in 2013 at any time on or before the last day of the plan year that begins in 2014.

A § 125 cafeteria plan that incorporates a carryover provision may not also provide for a grace period in the plan year to which unused amounts may be carried over. Accordingly, if, pursuant to the carryover provision, a plan permits amounts that were unused in a plan year to be carried over to the following plan year, the plan is not permitted to provide for a grace period that occurs in that following plan year. For example, a calendar year plan permitting a carryover to 2015 of unused 2014 health FSA amounts (as determined at the end of the run-out period in early 2015) would not be permitted to have a grace period in 2015, but would be permitted to have had a grace period during the first 2 ½ months of 2014.

If a plan has provided for a grace period and is being amended to add a carryover provision, the plan must also be amended to eliminate the grace period provision by no later than the end of the plan year from which amounts may be carried over. The ability to eliminate a grace period provision previously adopted for the plan year in which the amendment is adopted may be subject to non-Code legal constraints.

V. EXAMPLES

The preceding rules of this notice are illustrated by the following examples:

Example 1. Employer sponsors a § 125 cafeteria plan and health FSA with a calendar plan year, an annual run-out period from January 1 through March 31 in which participants can submit claims for expenses incurred during the preceding plan year, and an annual open enrollment season in November in which participants elect a salary reduction amount (not to exceed $2,500) for the following plan year. The plan is timely amended to provide for a carryover that allows all participants to apply up to $500 of unused health FSA amounts remaining at the end of the run-out period to the health FSA for expenses incurred at any time during that plan year. The plan does not provide for a grace period with respect to the health FSA. The plan also does not provide for nonelective employer flex credits.

In November 2014, Participant A elects a salary reduction amount of $2,500 for 2015. By December 31, 2014, A's unused amount from the 2014 plan year is $800. On February 1, 2015, A submits claims and is reimbursed with respect to $350 of expenses incurred during the 2014 plan year, leaving a carryover on March 31, 2015 (the end of the run-out period) of $450 of unused health FSA amounts from 2014. The $450 amount is not forfeited; instead, it is carried over to 2015 and available to pay claims incurred in that year so that $2,950 (that is, $2,500 + $450) is available to pay claims incurred in

2015. A incurs and submits claims for expenses of $2,700 during the month of July 2015, and does not submit any other claims during 2015. A is reimbursed with respect to the $2,700 claim, leaving $250 as a potential unused amount from 2015 (depending upon whether A submits claims during the 2015 run-out period in early 2016).

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 2. The same facts as Example 1, except that A's expenses of $2,700 are incurred and submitted during the month of January 2015 (and not July 2015). The plan may treat $500 of the $800 unused amounts as of December 31, 2014, as available to pay current year expenses. Accordingly, A is reimbursed with respect to the $2,700 claim. The plan treats the first $2,500 of the claim as reimbursed with health FSA contributions for 2015, and the remaining $200 of the claim as reimbursed with the unused amounts as of December 31, 2014. The unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed during the 2014 run-out period in early 2015 is reduced to $600 ($800 - $200). On February 1, 2015, A submits and is reimbursed with respect to $350 of claims for expenses incurred during the 2014 plan year. After the $350 reimbursement, the unused amount remaining for 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed during the 2014 run-out period in early 2015 is reduced to $250 ($600 - $350). A submits no further claims for expenses incurred during the 2014 plan year, so that in addition to the $200 previously used to reimburse the January 2015 claim, $250 is carried over to the 2015 plan year. A submits no further claims for 2015. The amount carried over to 2016 is $250.

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 3. The same facts as Example 2, except that on February 1, 2015, A submits claims with respect to $700 of expenses incurred during the 2014 plan year. Because the unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed has been reduced to $600 prior to February 1, 2015, the plan reimburses A for only $600 of the total $700 of claims. After the $600 reimbursement, the unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed is reduced to zero ($600 - $600). A submits no further claims for expenses incurred during the 2014 plan year, so that the amount carried over to the 2015 plan year is $0 (the entire $800 of unused amounts as of December 31, 2014, having been used to reimburse claims submitted in January 2015 ($200) and February 2015 ($600)).

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 4. The same facts as Example 1, except that, for 2014, A elects a salary reduction amount of $600 and, on December 31, 2014, A still has $600 of unused health FSA amounts.

For 2015, A elects no salary reduction for the health FSA, submits no claims

during the run-out period, and as of the end of the run-out period on March 31, 2015, $600 in unused health FSA amounts remains. Of that amount, $100 is forfeited because it exceeds the $500 carryover limit, and $500 is carried over to the 2015 plan year. A incurs $200 in expenses during the 2015 plan year, which are reimbursed during that plan year. As of December 31, 2015, A has $300 in unused health FSA amounts.

For 2016, A elects no salary reduction for the health FSA but has the $300 carryover from 2015, which is not forfeited. A incurs medical expenses of $300 in 2016, which are reimbursed using the $300 carryover from 2015.

This § 125 cafeteria plan satisfies the preceding rules of this notice.

VI. CLARIFICATION OF SCOPE OF TRANSITION RULE APPLICABLE TO NON-CALENDAR PLAN YEARS BEGINNING IN 2013 FOR PARTICIPANT CHANGES IN SALARY REDUCTION ELECTIONS UNDER HEALTH PLANS PROVIDED THROUGH § 125 CAFETERIA PLANS

A. BACKGROUND

Generally, § 125 cafeteria plan elections must be made before the start of the plan year, and are irrevocable during the plan year, with limited exceptions, including certain changes in status. See Prop. Treas. Reg. § 1.125-2, Treas. Reg. §1.125-4. Under existing regulations, the availability of health plan coverage through an Affordable Insurance Exchange (also referred to in other published guidance as a Marketplace) beginning with calendar year 2014 does not constitute such a change in status. As a result, employees would not be able to change their salary reduction elections for health coverage during a plan year in order to, for example, cease their salary reductions and § 125 cafeteria plan coverage and purchase coverage through an Exchange. However, the Treasury Department and the IRS previously concluded that transition relief is appropriate for individuals with respect to non-calendar § 125 cafeteria plan years beginning in 2013. For individuals eligible for such a plan, health plan coverage through an Exchange will first become available in the middle of the plan's 2013-2014 non-calendar plan year (that is, January 2014). Accordingly, the Treasury Department and the IRS have provided transition relief from the election rules in Prop. Treas. Reg. § 1.125-2 with respect to salary reduction elections under a § 125 cafeteria plan for an employer-provided accident and health plan with a non-calendar plan year beginning in 2013. The transition relief was provided in Section IX.B of the preamble to proposed regulations (issued on December 28, 2012) under § 4980H (referred to below as "Section IX.B"). See 78 Fed. Reg. 218, 237 (Jan. 2, 2013).

Specifically, Section IX.B permits an employer, at its election, to amend one or more of its written § 125 cafeteria plans to allow employees to make either or both of the following changes in salary reduction elections, whether or not the employee experienced a change in status event described in Treas. Reg. § 1.125-4:

1. An employee who elected to salary reduce through the employer's § 125 cafeteria plan for accident and health plan coverage with a non-calendar plan year

beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once during that plan year; and

2. An employee who failed to make a salary reduction election through the employer's § 125 cafeteria plan for accident and health plan coverage with a non-calendar plan year beginning in 2013 before the deadline in Prop. Treas. Reg. § 1.125–2 for making elections for the § 125 cafeteria plan year beginning in 2013 is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the § 125 cafeteria plan.

B. CLARIFICATION OF § 125 CAFETERIA PLAN TRANSITION RULE FOR PARTICIPANT SALARY REDUCTION ELECTIONS AS SET FORTH IN SECTION IX.B

Although the description of the § 125 cafeteria plan transition rule in Section IX.B refers to applicable large employer members (generally meaning a person that, together with one or more other persons, is treated as a single employer that is an applicable large employer), the relief is available, subject to the rules set forth in Section IX.B, to an employer with a § 125 cafeteria plan non-calendar plan year beginning in 2013 whether or not the employer is an applicable large employer or applicable large employer member under § 4980H.

Stakeholders have asked whether employees may use the relief set forth in Section IX.B if their employer amends its § 125 cafeteria plan to allow changes in salary reduction elections but adopts an amendment that is more limited than the two options listed in Section IX.B, as described above. An amendment to a § 125 cafeteria plan adopted pursuant to Section IX.B may be more restrictive than the amendments described in Section IX.B but may not be less restrictive. For example, an employer may amend its § 125 cafeteria plan to allow an employee who elected to salary reduce through the § 125 cafeteria plan to pay for accident and health plan coverage under the § 125 cafeteria plan with a non-calendar plan year beginning in 2013 to prospectively revoke or change his or her election with respect to the accident and health plan once, during a limited period (for example, the first month of 2014 only rather than the entire plan year) without regard to whether the employee experienced a change in status event described in Treas. Reg. § 1.125–4.

VII. EFFECTIVE DATES

An employer may adopt the carryover provision (of up to $500) authorized in this notice to health FSAs for the current § 125 cafeteria plan year (and/or subsequent § 125 cafeteria plan years) by amending the § 125 cafeteria plan document in the manner and within the time frames described in section IV of this notice.

The clarifications described in section VI of this notice of the relief provided in Section IX.B may be applied beginning on or after December 28, 2012 (the date on which the proposed regulations that included Section IX.B were issued).

VIII. EFFECT ON OTHER DOCUMENTS

The Treasury Department and the IRS intend to amend Prop. Treas. Reg. §§ 1.125-1(o) and 1.125-5(c) to reflect the guidance in this notice; taxpayers may rely on the guidance in this notice pending the issuance and effectiveness of those amendments to the regulations.

IX. DRAFTING INFORMATION

The principal author of this notice is Janet A. Laufer of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding the modification of the use or lose rules contained in this notice, contact Ms. Laufer at (202) 927-9639 (not a toll-free call). For further information regarding the clarifications to Section IX.B, contact Ms. Katy Johnson at (202) 927-9639 (not a toll-free call).

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IRS Notice 2013-71
At Last -- Carryover Guidance

JOHN R. HICKMAN, Esq.

Atlanta Office
One Atlantic Center
1201 West Peachtree Street
Atlanta, Georgia 30309-3424
(404) 881-7885
Internet: john.hickman@alston.com

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Use-or-Lose A Historical Context

- Included as Part of Proposed IRS Regulations
- Modified in 2005
  - Significant public pressure
  - IRS indicated constrained by statute
  - Adoption of Grace Period in Notice 2005-42
- Affordable Care Act Adoption
  - $2500 limit on salary reductions limits potential deferral abuse
  - IRS/Treasury solicited input in Notice 2012-40
    - "Overwhelming majority of comments favored modification" (Notice 2013-71)
    - Administrative details (and workload) delayed process

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Notice 2013-71

- In a nutshell
  - Allows optional adoption of $500 (or less) carryover for Health FSA (not DCAP)
    - Does not reduce $2500 salary reduction amount
    - Must be uniformly available
    - In lieu of grace period

Amendment Timing

- Could be effective for 2013
  - Must announce before end of year
  - Must amend plan before end of plan year beginning in 2014
  - If grace period, must amend plan before year-end to eliminate grace period
    - Address any non-Code legal constraints

Administrative Issues

- About the carryover amount
  - Coordination with runout period
    - Carryover determined after any "run-out" period claims (Example 1)
    - Ordering rule: current year claims vs. current year salary reductions first (Example 2)
  - Carryover is indefinite (Example 4)
    - Unless terminate employment
  - Could be capped at less than $500
    - But must be uniformly applied

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Administrative Issues

- Potential impact on HSA eligibility
  - Under IRC 223, individuals with non-excepted health coverage are not HSA eligible
    - Carryover would generally preclude HSA eligibility
    - Existing IRC 223 guidance would allow eligibility for those with zero balance on last day of plan year
  - Possible work-arounds (subject to agency guidance)
    - Allow waiver of carryover
      - Preclude carryover for those who enroll in HSA
      - Convert carryover to limited purpose FSA
    - Allow carryover, but provide for limited duration (e.g., November 30)

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Administrative Issues

- Weighing Grace Period vs Carryover
  - Advantage Grace Period
    - Carryover capped at $500
  - Advantage Carryover
    - Carryover duration not limited

In the Weeds

- Carryover available for those in plan on last day of year (even if do not elect FSA for next year)
  - COBRA continuees would get carryover
    - What is COBRA premium?
  - Absent COBRA election carryover not available for terminated employee
- No permitted election changes due to carryover
  - Changes may be possible if prior to first day of plan year