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Newsletter – Volume 1, No. 7 – July 6, 2005

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Highlights

1. IRS Guidance on Plan Limits on Benefits and Contributions
2. Impact of Post Year-End Extension of FSAs on HSA Eligibility
3. CMS Guidance under Medicare Part D for Account-Based Health Arrangements

IRS Guidance on Plan Limits on Benefits and Contributions

IRS issued proposed regulations under Internal Revenue Code (Code) section 415 on May 31, 2005. The annual amount that may be paid to a participant in a defined benefit plan starting at ages 62 to 65 is the lesser of a “dollar limit”, i.e., \$170,000 in 2005, or a compensation limit, i.e., 100% of the participant’s average compensation for his/her high 3 years. In defined contribution plans, Code section 415 (c) limits the amounts that may be allocated to a participant’s account each year. For 2005, the maximum amount that may be allocated to a participant’s account is the lesser of \$42,000 (the dollar limit) or 100% of a participant’s compensation.

The last time the IRS issued regulations under Code section 415 was in 1981. Statutory changes that have been made to Code section 415 since 1981 are reflected in IRS notices, revenue rulings and other guidance of general applicability. These notices and releases cover the following items:

- Increased limits on maximum benefits in defined benefit plans and allocations in defined contribution plans
- Adjustments to the dollar limits for benefits paid from defined benefit plans when benefits commence prior to age 62 and after age 65
- Repeal of the combined limit that was applicable when a employer sponsored both a defined benefit and defined contribution plan
- Changes to how cost of living adjustments are made to the annual limits
- Inclusion of certain salary-reduction amounts in determining compensation for limitation purposes
- Rules for phasing in the defined benefit dollar limitation over 10 years of active participation



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IRS has incorporated its past guidance on the above issues in the proposed regulations with some modifications and has incorporated other statutory changes that were not previously addressed by guidance.

Highlights of the New Regulations

The new areas addressed by the proposed regulations include:

1. Military differential pay. This rule allows National Guard and Reserve members who receive differential pay from their employers while they are on active duty to continue to contribute to their employer's retirement plan.
2. Multiple annuity starting dates. Provides new rules for determining the annual benefit under a defined benefit plan where there is more than one annuity starting date. This rule is applicable in situations where benefits under a defined benefit pension plan are aggregated with benefits under another plan under which distributions had already commenced.
3. Determination of high 3 average compensation. The limits payable under a defined benefit pension plan are limited to a specified dollar amount or the participant's average salary for his/her highest three consecutive years. The proposed regulations restrict compensation used for this calculation to compensation earned while the individual was an active participant in the plan. In addition, the regulations clarify that compensation in excess of the compensation limit in Code section 401(a)(17) cannot be used.
4. Social Security supplement. A social security supplement is included in determining the annual benefit without regard to whether it is an ancillary benefit or qualified social security supplement (QSUPP) within the meaning of Treasury Regulations section 1.401(a)(4)-12.
5. Post-employment payments. Amounts that are paid to plan participants generally are not considered compensation for purposes of Code section 415. This means that former employees cannot make salary deferral contributions to 401(k), 403(b) or 457 plans from post-employment payments, e.g. severance. However, there is an exception to this general rule for payments that are made within 2 ½ months following an employee's termination of employment provided that (i) the payments would have been payable if employment had not been terminated and (ii) the payments are with respect to bona fide sick, vacation or other leave that would have been available for use if employment had not terminated.
6. Partial Qualified Joint and Survivor Annuity (QJSA). The proposed regulations clarify that the rule excluding the survivor portion of a QJSA from the limitation on annual benefits applies to the survivor annuity payments under the portion of



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- the benefit that is paid in the form of a QJSA, even if another portion of the benefit is paid in another form.
7. Conversion to a straight life annuity. The annual benefit paid in any form other than a straight life annuity is determined as the greater of the actuarially equivalent straight life annuity determined under the plan's actuarial assumptions or the actuarial assumptions that are specified by statute. Under the proposed regulations, the calculation has been simplified for a form of benefit that is not subject to the minimum present value rules of Code section 417(e)(3) if the straight life annuity is payable at the same age as the optional form. In this case, you can demonstrate compliance with Code section 415 by using the greater of the straight life annuity payable at the same age as the optional form under the terms of the plan or the annuity determined using the statutory assumptions.
 8. Application of the \$10,000 exception. Code section 415(b)(4) provides that payments from a defined benefit plan are deemed to meet the annual benefit limitations if total payments from all defined benefit plans of the employer do not exceed \$10,000 for the plan year or any prior plan year, and the employee has never participated in a defined contribution plan maintained by the employer. The proposed regulations clarify that the \$10,000 limitation is applied to actual distributions made during each year. For example, a single sum distribution that is the actuarial equivalent of an accrued benefit with annual payments that are less than \$10,000 must still be analyzed to determine whether the payments are in compliance with the annual benefit limitations.

Effective Date

The proposed effective date for the new regulations is generally for limitation years beginning on or after January 1, 2007.

Impact of Post Year-End Extension of FSAs on HSA Eligibility

In our last issue, we reported that the IRS had issued a notice permitting an employer to amend its cafeteria plan to provide participants with a 2 ½ month grace period after the close of the plan year to use the monies in their flexible spending accounts for qualified benefits. The 2 ½ month extension may impact an individual's eligibility to make contributions to a Health Savings Account (HSA).

Under the rules governing contributions to an HSA, an individual is prohibited from making contributions to an HSA if he/she is covered under a "general purpose" health FSA. A "general purpose" health FSA is defined as an FSA that provides reimbursements for medical and dental expenses on a first-dollar basis. Revenue Ruling



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2004-45, 2004-22 IRB 971 held that a “general purpose” health FSA provides impermissible other coverage under the HSA rules. It appears that, since the FSA grace period is an extension of an individual’s FSA coverage, which is disqualifying other coverage, an employee would not be eligible to contribute to an HSA in the following year, at least during the three months that include the extended FSA coverage.

It is our understanding that the IRS is working on additional guidance as to possible solutions to this issue. At the present time, it may be prudent to hold off on making any amendments to your cafeteria plan until the IRS guidance is issued.

CMS Guidance under Medicare Part D for Account-Based Health Arrangements

The guidance issued by the Centers for Medicare Services (CMS) addresses the following issues:

1. How to treat account-based health arrangements in determining if individuals are receiving creditable coverage for purposes of Medicare Part D; and
2. Whether the sponsors of those arrangements must provide notices disclosing that coverage is creditable or non-creditable.

Account-based health arrangements include HRAs, HSAs, health FSAs, and Archer MSAs. This guidance also addressed whether the sponsors of these arrangements will qualify for the tax-free drug subsidy under Medicare Part D.

Background

Medicare Part D is intended to subsidize prescription drug costs for retirees by paying directly for some prescription drugs under Medicare Part D or by providing a tax-free subsidy program to employers that provide retiree prescription drug coverage that is actuarially equivalent to Medicare Part D. Under Medicare Part D, a group health plan offering prescription drug coverage must provide disclosure notices to individuals eligible for Medicare Part D who are enrolled in or seeking to enroll in the group health plan’s prescription drug coverage. A copy of the disclosure notice must also be provided to CMS. Disclosure notices must be provided to Part D eligible individuals before November 15, 2005.



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New Guidance

There was some good news in the recently released guidance. The guidance that was released by CMS makes it clear that disclosure notices are not required for health FSAs, HSAs, or Archer MSAs. However, an HRA can be creditable coverage for purposes of Medicare Part D. Therefore, an employer must provide a disclosure notice to Part D eligible individuals, whether the HRA is offered on a stand-alone basis or in conjunction with another plan. In order to determine whether the HRA provides creditable coverage, the guidance confirms that an HRA offered in conjunction with another group health plan, e.g., a high deductible health plan (HDHP), should be combined with that other group health coverage in order to determine whether the combined program meets the actuarial equivalence test for creditable coverage. The CMS guidance also addresses how to determine actuarial equivalence for a stand-alone HRA.

The guidance makes it clear that claims paid from an HRA for Medicare Part D drugs will be eligible for retiree drug subsidy payments on the same terms as claims paid from a typical group health plan. Finally, the guidance provides that contributions to health FSAs, HSAs, and Archer MSAs are disregarded in determining both creditable coverage and eligibility for the retiree drug subsidy.