SCHECHTER BENEFITS ADVISORS | UNCOMMON SOLUTIONS to Design, Educate & Manage

Compliance Corner

June 18, 2013

In This Issue:

Health Care Reform Updates

Additional Guidance Regarding the PCOR Fee

PPACA provides for a new fee that will help fund clinical effectiveness research conducted by the nonprofit Patient-centered Outcomes Research (PCOR) Institute. The carrier is responsible for reporting and paying the PCOR fee for a fully insured plan. The employer plan sponsor is responsible for a self-insured plan including an HRA. For plan years ending between Oct. 1, 2012 and Dec. 31, 2012, the fee is due by July 31, 2013. This is done by filing IRS Form 720, which has now been revised to reflect the fee. Please note that while Form 720 is entitled the Quarterly Federal Excise Tax Return, the PCOR fee is only due annually.

On May 31, 2013, Associate Chief Counsel Andrew Keyso issued guidance related to the PCOR fee in an IRS Memorandum (AM2013-002). The memo states that the PCOR fee will be considered an ordinary and necessary business expense paid or incurred in carrying on a trade or business and, therefore, will be deductible under Section 162 of the Internal Revenue Code. IRS Memorandums, such as this one, do not bind the agency, but do provide helpful insight for plan sponsors of self-insured plans into how the IRS will apply Section 162 to the PCOR fee. The NFP HR and Compliance Solutions website has been updated to reflect this recent guidance.

AM2013-002

Form 720
Form 720 Instructions
NFP HR and Compliance Solutions, Health Care Reform Fees

HHS Releases Final SHOP Regulations

On June 4, 2013, HHS issued final regulations on the Small Business Health Options Program (SHOP) rules. The final rule amends existing regulations regarding triggering events and special enrollment periods for qualified employees and their dependents and implements a transitional policy regarding employees' choice of qualified health plans (QHPs) in the SHOP. Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through an exchange. PPACA contemplates that each exchange will have a SHOP that assists qualified employers in providing health insurance options for their employees. PPACA requires at a minimum that the SHOP must allow employers the option of offering employees one or more QHPs at the level of coverage chosen by the employer. This is called the "employee-choice model" because it gives employees a choice among all QHPs at the metal level chosen by the employer.

The final rule establishes a one-year transitional policy that delays implementation of the employee-choice model for plan years beginning on or after Jan. 1, 2014 and before Jan. 1, 2015. Under the transitional policy, a SHOP is not required, but may permit, qualified employers to offer their employees a choice of QHPs at a single coverage level. Federally-facilitated SHOPs will not exercise this option, but instead allow employers to choose a single QHP from the choices available in the SHOP. The transitional policy is intended to provide additional time to prepare for an employee-choice model and to increase the stability of the small group market during 2014.

Because of the delayed implementation of the employee-choice model, the final rule also delays implementation of the premium aggregation function for the SHOP. Premium aggregation was designed to assist employers whose employees were enrolled in multiple QHPs. Because this function will not be necessary in 2014, the premium aggregation function is now optional for plan years beginning before Jan. 1, 2015.

Finally, PPACA established a special enrollment period for exchanges. Under PPACA's Exchange Establishment Rule, a qualified individual generally has 60 days from the date of the triggering event to select a QHP. This differs from the length of special enrollment periods in group markets provided by HIPAA, which lasts 30 days. Recognizing the lack of rationale to support providing a longer special enrollment period in a SHOP than is provided in the outside group market, the final rule establishes a SHOP special enrollment period of 30 days for most applicable triggering events. For the triggering event of loss of Medicaid/CHIP eligibility or becoming eligible for premium assistance under Medicaid/CHIP, however, the final rule maintains a 60-day special enrollment period, which is consistent with HIPAA's Special Enrollment Right provisions in the group market.

Regulations
Draft Employer Application for SHOP (for those not applying online)
Draft Employee Application for SHOP (for those not applying online)

Federal Updates

Technical Corrections to HIPAA Final Regulations

On June 7, 2013, HHS published technical corrections addressing inadvertent errors and omissions in the HIPAA Privacy, Security and Enforcement Rules that were initially published on Jan. 25, 2013. The corrections address several errors such as incorrect citation references and one typographical error. Importantly, HHS did not waive the effective date of the final regulations as a result of discovering these errors. The effective date of the final regulations remains Sept. 23, 2013.

Federal Register

State Updates

Arizona

On June 13, 2013, the Arizona House and Arizona Senate passed Gov. Brewer's Medicaid Expansion Bill. The Medicaid announcement may prove of interest to employers, because there are concerns in states which reject the expansion of Medicaid. Specifically, individuals with income between 100 and 133 percent of the federal poverty level who may have previously qualified for Medicaid may instead qualify for federal subsidies to purchase health insurance through an exchange. Since the employer mandate penalty affecting employers with over 50 employees is tied to individuals who qualify for a subsidy unless the individuals are Medicaid-eligible, employers with over 50 employees may be subject to more plan affordability penalties than they would were their state to pursue Medicaid expansion. This will no longer be an issue in Arizona due to the passage of this bill.

Press Release

Arkansas

On April 30, 2013, the Arkansas Insurance Department issued Bulletin 11-2013, which pushed the qualified health plan filing deadline for insurance carriers back to June 30, 2013. The Bulletin also provides more detail as to the federal network adequacy standards of qualified health plans to be recommended for approval by the Arkansas Federally-facilitated Partnership Marketplace. Small employers hoping to participate in Small Business Health Options Program (SHOP) coverage should be aware of this delay as they plan for what coverage will be available in 2014.

Bulletin 11-2013

Maryland

On June 13, 2013, the Maryland Insurance Administration issued Bulletin 13-19. The purpose of the bulletin is to clarify that carriers may include alcohol abuse and drug abuse treatment programs certified by the Department of Health and Mental Hygiene under Maryland Health General Article § 8-403 within their provider networks for the delivery of substance use disorder services, including outpatient and intensive outpatient services, for non-grandfathered health benefit plans with plan or policy years that begin on or after Jan. 1, 2014. While primarily of interest to insurance carriers rather than employers, employers may find that they receive communications from their carrier if the policy is adjusted to expand the provider networks. If a significant change is made that will affect the plan's Summary of Benefits and Coverage (SBC), a revised SBC may need to be provided to participants if the change in network is a midyear change.

Bulletin 13-19

On May 2, 2013, Gov. O'Malley signed HB 228, creating Chapter 159. The new law allows qualified employers to enroll in the Small Business Health Options Program (SHOP) operated as part of the Maryland Health Benefit Exchange and offer employee health insurance coverage through either the employer-choice or employee-choice models, among other changes. The law is effective Jan. 1, 2014, for coverage beginning March 1, 2014.

Chapter 159

On May 2, 2013, Gov. O'Malley signed SB 12, creating Chapter 163. The new law requires employers to grant leave to employees on the day that employees' immediate family member is leaving for or returning from active duty outside the United States as a member of the U.S. armed forces. Immediate family member means a spouse, parent, stepparent, child, stepchild or sibling. The law is effective Oct. 1, 2013.

Chapter 163

Oklahoma

On June 13, 2013, the DOL's EBSA issued compliance guidance for employee benefit plans in wake of the Oklahoma tornadoes. The guidance applies to employee benefit plans (including retirement and health plans), plan sponsors and service providers to employers, and is meant to help address some difficulties employers may be having as a result of the tornadoes. On retirement plans, the DOL states that they will not seek to enforce compliance with respect to temporary delays in forwarding participant payments and withholdings to employee pension benefit plans within the prescribed timeframe, so long as the delay is related to disruptions caused by the tornadoes.

Similarly, on health plans, the DOL recognizes that plan participants and beneficiaries may encounter an array of problems due to the tornadoes, such as difficulties meeting certain deadlines for filing benefit claims and COBRA elections. The DOL states that the guiding principle for plans must be to act reasonably, prudently and in the interest of the workers and their families, who rely on their health plans for their physical and economic well-being. Specifically, plan sponsors and fiduciaries should make reasonable accommodations to prevent the loss of benefits in such cases and should take steps to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes.

DOL Oklahoma Guidance

Oregon

On May 31, 2013, the Oregon Insurance Division issued Bulletin INS 2013-3 addressing the standards for group health coverage to be issued to associations, union trust, trust groups or credit unions. In Oregon, association coverage is considered group coverage whether it is purchased by a group or an individual. As a result of PPACA, the small group rating exemption for associations in Oregon will be eliminated. Further, non-grandfathered small group association coverage will be pooled with non-grandfathered small group market coverage under the federal definition of small group. Finally, the offering and issuance of association coverage in the small group market will need to be updated for PPACA compliance regardless of association membership. Large association groups will need to ensure that they qualify as a true large group as defined in federal law before coverage will be issued, but the Oregon Insurance Division will not assist with this determination. Such large associations will need to contact the U.S. DOL. These changes are effective for plan years on or after Jan. 1, 2014, but the bulletin is effective immediately.

Bulletin INS 2013-3

Puerto Rico

On May 29, 2013, Gov. Padilla signed into law SB 238 prohibiting workplace discrimination based on sexual orientation or gender identity. The law prohibits all employers in the public and private sector from suspending, refusing to hire, firing or otherwise discriminating against an employee on the basis of sexual orientation or gender identification. Certain churches

and faith-based organizations are exempted from the nondiscrimination law.

SB 238- (available in Spanish only)

Vermont

On May 20, 2013, Gov. Shumlin signed H. 315 into law. The law requires, "to the extent permitted under federal law," out-of-state employers to provide health insurance coverage to the same-sex spouse or civil union partner of an employee who resides in Vermont. The law is effective July 1, 2013. Employers which are domiciled outside of Vermont and have employees who reside in Vermont should consult with their attorney to determine how the new mandate will impact their group health plan eligibility in light of the Defense of Marriage Act and ERISA.

H. 315

Washington

On May 31, 2013, the Washington Health Benefit Exchange reported that nine health insurance issuers have filed with the Office of the Insurance Commissioner to provide 57 qualified health plans totaling 229 plan options for individuals and families through Washington Healthplanfinder, the state's new online health insurance marketplace. The exchange also announced that the Small Business Health Options Program (SHOP) exchange will only offer coverage in some – not all – counties in the state when open enrollment begins on Oct. 1, 2013.

Healthplanfinder
Press Release

West Virginia

On May 2, 2013, Gov. Tomblin announced the decision to expand Medicaid in West Virginia. The governor has the authority to expand Medicaid without legislative approval. The Medicaid announcement specifically may prove of interest to employers, because there are concerns in states which reject the expansion of Medicaid, individuals with income between 100 and 133 percent of the federal poverty level who may have previously qualified for Medicaid may instead qualify for federal subsidies to purchase health insurance through an exchange. Since the employer mandate penalty affecting employers with over 50 employees is tied to individuals who qualify for a subsidy unless the individuals are Medicaid-eligible, employers with over 50 employees may be subject to more plan affordability penalties than they would were their state to pursue Medicaid expansion. This will no longer be an issue in West Virginia as a result of the governor's announcement.

Press Release

Frequently Asked Question

We contribute to a multiemployer union plan for our unionized employees. With respect to the employer mandate, must we include those union employees in our employee count? If so, must we offer health insurance to those union members that work for us for 30 or more hours per week?

There is no specific exemption under the employer mandate for union members. Therefore, the question becomes whether

the union members constitute “employees” under the common law standard. Because an employer typically controls the hours the union members work as well as pays wages to the union members, union members will likely be considered employees of the employer as opposed to the union. As such, you must include those union members in your employee count when determining the applicability of the employer mandate.

If the employer mandate applies, you must provide all full-time union employees (and their dependents) minimum essential coverage that is both affordable and of minimum value (or pay a penalty). In considering the employer mandate, it is important to remember the obligations under the employer mandate rest with the employer, not the plan--so you will be required to comply regardless of which plan options are currently offered (and regardless of how those plan options--including employer contribution levels--were negotiated). In other words--the employer mandate applies regardless of any other collective bargaining agreements that may be in place.

A transition rule is in place for 2014, however. Under this rule you will not be subject to a penalty with respect to a full-time union employee if:

1. You are required to make a contribution to a multiemployer plan pursuant to a collective bargaining agreement or an appropriate related participation agreement; and
2. Coverage under the multiemployer plan is offered to the full-time union employee (and his or her dependents); and
3. The coverage offered to the full-time union employee is affordable and provides minimum value.

For purposes of determining whether coverage under the multiemployer plan is affordable, you may use any of the affordability safe harbors. Coverage under a multiemployer plan will also be considered affordable if the employee’s required contribution, if any, toward self-only health coverage under the plan does not exceed 9.5% of the wages reported to the qualified multiemployer plan, which may be determined based on actual wages or an hourly wage rate under the applicable collective bargaining agreement.

Acronyms Glossary

ADA	Americans with Disabilities Act
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
DOL	U.S. Department of Labor
EBSA	Employee Benefits Security Administration
EEOC	Equal Employment Opportunity Commission
ERISA	Employee Retirement Income Security Act
FLSA	Fair Labor Standards Act
FMLA	Family and Medical Leave Act
FSA	Flexible Spending Arrangement
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account

IRC	Internal Revenue Code
IRS	Internal Revenue Service
MLR	Medical Loss Ratio
OTC	Over-the-counter Item or Drug
PPACA	Patient Protection and Affordable Care Act (aka health care reform)

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