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

# Compliance Corner

**July 2, 2013**

## In This Issue:



## Announcements and Reminders

### Training Now Available for HHS' Minimum Value Calculator

On April 11, 2013, HHS released the final version of the minimum value calculator. To use the calculator, an employer would simply input the plan's characteristics, such as deductibles, co-payments and coinsurance, and the minimum value calculator will determine whether or not a large, self-insured health plan meets the 60 percent minimum value as required by PPACA.

#### Minimum Value Calculator

To access the calculator:

- Scroll down about half-way to the section entitled, "Plan Management"
- Click on the link entitled, "Minimum Value Calculator (XLSM - 598 KB)"
- Do not use the Actuarial Value Calculator! This is a different tool specifically meant to be used for small group and individual plans.
- Make sure macros are enabled in Excel or the calculator will not function

---

### Reminder: PCOR Fee Payable by July 31

A new fee, funding the Patient-centered Outcomes Research Institute and commonly referred to as the PCOR fee, is payable by July 31, 2013 for many employer-sponsored group health plans.

As a general rule, the fee is due by July 31 of the calendar year following the plan or policy year ending on or after Oct. 1, 2012. This means that for plan years ending from Oct. 1, 2012 through Dec. 31, 2012, the first due date is July 31, 2013.

The next due date will be July 31, 2014 and will apply to plan years ending from Jan. 1, 2013 through Dec. 31, 2013. The fee is payable annually, and runs through 2019.

For insured plans, the carrier is responsible for paying the PCOR fee. However, for self-insured plans, the plan sponsor (generally the employer) is responsible. Employers should be aware of whether any plans they sponsor are considered self-insured for which the fee may be owed, such as a self-insured prescription drug-plan. Most HRAs, in addition, are self-insured and are subject to the PCOR fee. There are three methods to be used to determine the number of covered lives under a plan in order to calculate the amount of the PCOR fee. The fee is reported on IRS Form 720 (which has recently been updated for the PCOR fee).

NFP has a quick reference guide summarizing the three fees that affect employer-sponsored group health plans under PPACA. Ask your advisor for a copy.

**More information on PCOR Fee**
**Form 720**
**Final Regulations on PCOR Fee**

## Health Care Reform Updates

### Departments Issue Final Regulations Related to Contraceptive Coverage and Religious Organizations

On June 28, 2013, HHS, IRS and EBSA issued final rules related to contraceptive coverage and religious organizations. As background, PPACA required non-grandfathered group health plans to provide coverage for women's preventive services effective for plan years beginning on or after Aug. 1, 2012. The coverage must be provided with no cost to the participant. One of the categories of services that must be provided is contraceptive services.

Under the previously issued proposed regulations, non-grandfathered group health plans sponsored by religious employers were exempt from providing coverage for contraceptive services for plan years beginning on or after Aug. 1, 2012. The new regulations extend that exemption for plan years starting on or after Aug. 1, 2013. For this purpose, a religious employer is defined as a nonprofit entity referred to in Section 6033(a)(3)(A)(i) and (ii) of the IRC. This generally includes churches, conventions or associations of churches and other houses of worship.

The earlier proposed regulations also provided a safe harbor for non-grandfathered group health plans sponsored by other

religiously affiliated nonprofit entities, such as hospitals and educational institutions. Such plans were given a one-year delay under the requirement to provide coverage for contraceptive coverage if the nonprofit employer sponsoring the plan met certain requirements. Those requirements were that the organization holds itself as a religious organization, it has not offered coverage for contraceptive coverage since February 2013 on account of religious objections and it maintains on file a self-certification in accordance with the regulations. The final regulations extend the safe harbor for plan years starting on or after Aug. 1, 2013 through Dec. 31, 2013.

Effective for plan years starting on or after Jan. 1, 2014, the final regulations provide an accommodation for group health plans sponsored by the religiously affiliated nonprofit entities defined above. Such nonprofit entities are not required to arrange or pay for contractive services coverage on account of religious objections. However, women enrolled under the plan will still be eligible for contraceptive coverage at no cost. The insurer or third party administrator (TPA) will provide the coverage to the insureds with no cost to the nonprofit entity.

A nonprofit entity wanting to take advantage of this accommodation should complete a self-certification and provide it to the plan's insurer or TPA. The new certification applies to plan years beginning on or after Jan. 1, 2014, and must be completed prior to the first day of the applicable plan year. The DOL has provided a model notice for this purpose. The insurer or TPA will then notify the participants of the plan's certification and the availability of coverage through the insurer or TPA.

**Final Regulations**
**Safe Harbor Extension for Plan Years beginning before Jan. 1, 2014**.
**Model Certification Form, for Plan Years beginning on or after Jan. 1, 2014**.
**CMS Fact Sheet**
**HHS Press Release**

---

## Final HHS Rule Regarding Exchange Functions Released: Discusses Exemptions from the Individual Mandate Penalty

On June 26, 2013, HHS released a final rule on Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions. This rule finalizes a proposed rule published Jan. 30, 2013 (and discussed in the Feb. 12, 2013, edition of *Compliance Corner)*. The analogous IRS proposed rule was released at the same time (also discussed in the same *Compliance Corner* article). While there is not a final IRS rule, on June 26, 2013, the IRS published Notices 2013-41 and 2013-42, which address issues raised by this HHS final rule. As a reminder, the Secretary of HHS has joint responsibility of these matters with the Secretary of Treasury. Also released by HHS was a fact sheet explaining the new rule, and guidance addressing criteria for determining whether a hardship exists. The final rule outlines when an individual is exempt from PPACA's individual mandate and includes several provisions regarding minimum essential coverage.

PPACA recognizes nine exemptions from the individual mandate. Eligibility for the hardship exemption and the religious conscience exemption will be determined exclusively by the exchange. Applicants who file for any of the following four exemptions-- lack of affordable coverage, income below the tax filing limit, unlawful presence in the United States or short term (three months) gaps in coverage-- will claim such exemption at the time of filing for taxes (if at all). For the remaining three categories of individuals eligible for exemptions--members of health care sharing ministries, members of Indian tribes, or persons who are incarcerated-- an exemption can be obtained through the exchange or, alternatively, at the time they file their taxes. An applicant can apply for multiple exemptions simultaneously.

The end of the final rule addresses minimum essential coverage, which is the type of coverage an individual must have to avoid the individual mandate penalty. The proposed rule recognized self-insured student health plans as minimum essential coverage. However, after substantial feedback that some student health plans may offer inadequate coverage, the final rule only recognizes self-insured student health plans as minimum essential coverage through Dec. 31, 2014. State high-risk pools will similarly only be recognized as minimum essential coverage through Dec. 31, 2014. Foreign health coverage, multi-

share plans and AmeriCorps coverage will not generally be recognized as minimum essential coverage. However, coverage that does not otherwise qualify as minimum essential coverage can qualify if it meets specific criteria set out in the rule. These criteria include "substantially" complying with the insurance reform requirements of PPACA that pertains to non-grandfathered, individual coverage (although the rule does not specify which insurance reform requirements are included).

**Final Rule**
**Fact Sheet**
**Guidance of Hardship Exemption Criteria and Special Enrollment Periods**.

---

## Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit

On June 26, 2013, the IRS issued Notice 2013-41, which provides guidance on when certain individuals are eligible for minimum essential coverage under certain government-sponsored health programs (i.e., Medicaid, Medicare, CHIP or TRICARE) or through self-funded student health plans and state high risk pools for purposes of the premium tax credit. The notice specifically addresses disenrollment from CHIP or Medicaid for nonpayment of premiums, CHIP waiting period, eligibility based on agency determination and eligibility based on enrollment to indicate circumstances when individuals may or may not be eligible for subsidized exchange coverage during these periods.

The notice reiterates guidance issued by HHS on the same day (see previous article above), providing for a one-year transitional relief period in 2014 whereupon self-funded student health plans and state high risk pools will be considered minimum essential coverage. These plans will not be permanently designated as minimum essential coverage and starting with plan years beginning on or after Jan. 1, 2015, they will have to apply to HHS to be so recognized.

Although the specifics of the individual shared responsibility penalty are not of direct significance to employers, familiarity with these provisions will help employers appreciate the indirect impact on employees of their failure to offer an affordable employer-sponsored plan. There is still more detail to come as the IRS finalizes its regulations on the individual mandate penalty.

**IRS Notice 2013-41**

---

## IRS Provides Transitional Relief Regarding Individual Mandate Penalty

On June 26, 2013, the IRS released IRS Notice 2013-42, which provides transitional relief for certain individuals under the individual mandate penalty. Specifically, the transitional relief applies to uncovered individuals who are eligible to enroll in a non-calendar year plan that begins in 2013 and ends in 2014. The individual, and eligible family members, would not be liable for a penalty under the individual mandate for any month before the plan year begins in 2014. For example, if an individual is eligible for an employer-sponsored plan, with a plan year that runs June 2013 through May 2014, the individual and eligible family members would not be subject to a penalty under the individual mandate for January 2014 through May 2014.

**IRS Notice 2013-42**

---

## DOL Releases Spanish Version of the Exchange Notice

The DOL has released a Spanish version of the model Exchange Notice. As a reminder, employers, who are subject to the FLSA, must distribute the notice to existing employees by Oct. 1, 2013, and to subsequent new employees within 14 days of

the hire date. The notice informs employees of the availability of the health insurance exchange and their possible eligibility for a premium tax credit. The new version will be helpful for employees whose primary language is Spanish. The NFP HR and Compliance Solutions website has been updated to reflect these additions.

**Model Exchange Notice (Spanish) for Employers Who Offer A Health Plan**
**Model Exchange Notice (Spanish) for Employers Who Do Not Offer A Health Plan**
**NFP HR and Compliance Solutions, Model Notices**

---

### Tenth Circuit Ruling Results in Temporary Order Barring Enforcement of Contraceptive Mandate

On June 28, 2013, two Oklahoma corporations run by religious families were granted a temporary restraining order by the District Court for the Western District of Oklahoma, temporarily barring the government from enforcing the mandate to provide birth control at zero cost-sharing as required for non-grandfathered plans under PPACA (known as the "contraceptive mandate"). The temporary order was a result of a ruling by the U.S. Court of Appeals for the Tenth Circuit the day before, on June 27, 2013, in which the Circuit Court issued six separate opinions after hearing the case of *Hobby Lobby Stores, Inc. v. Sebelius*, 12-6294, 2013 WL 3216103 (10th Cir. June 27, 2013). The Circuit Court ruled that some for-profit corporations can be considered "persons" that can have their own religious beliefs and exercise them. The decision is significant because this was the first ruling by a federal appeals court on the contraceptive mandate, and is one of the few being filed by a for-profit corporation. Nearly 60 other lawsuits are pending nationwide challenging the mandate, but most are being filed by non-profit colleges, schools and other institutions.

The Tenth Circuit Court split five to three with respect to the treatment of for-profit corporations as religious persons. The decision found that corporations, if they are owned by religiously devout individuals who control the company's affairs, are protected by the federal Religious Freedom Restoration Act. The Circuit Court returned the case to a federal district judge in Oklahoma, to weigh whether to bar the government from enforcing the mandate against the two Christian-oriented corporations. The district judge issued a temporary restraining order, barring the government from enforcing the mandate – and collecting federal fines of approximately $1.3 million per day ($475 million per year), until a hearing can be held, set for July 19, 2013, on whether to impose a more lasting order.

Importantly, this case does not relieve nongrandfathered plans of the obligation to comply with the contraceptive mandate as required under PPACA.  Employers considering noncompliance with this mandate must consult legal counsel.

***Hobby Lobby Stores, Inc. v. Sebelius***
**Temporary Restraining Order**

## Federal Updates

### U.S. Supreme Court Same-sex Marriage Decision Raises Employer-sponsored Employee Benefit Plan Considerations

On June 26, 2013, the U.S. Supreme Court let stand a lower court ruling overturning California's Proposition 8 and struck down Section 3 of the Defense of Marriage Act (DOMA). While the decision results in significant uncertainty for employer-sponsored employee benefit plans, federal agencies have announced guidance is forthcoming.

As background, Proposition 8 is a 2008 California voter initiative that banned same-sex marriage in California by defining a marriage as between only a man and a woman. A lower court overturned the proposition to which the proponents of Proposition 8 appealed. In the first decision, *Hollingsworth v. Perry*, No. 12-144, the Court held that the proponents of Proposition 8 did not have the legal rights to defend the law. Therefore, the decision by the U.S. Court of Appeals for the Ninth Circuit, from which the U.S. Supreme Court appeal was born, has no legal force. The court sent the case back to the

Ninth Circuit with instructions to dismiss the case. This means that the California ruling striking Proposition 8 down stands, and same-sex marriage is now legal in California. State officials ordered all counties in California to begin issuing marriage licenses on June 28, 2013.

For purposes of federal law, DOMA Section 3 defines marriage as between only a man and a woman. In the second decision, *United States v. Windsor*, No. 12-307, the court ruled that Section 3 is unconstitutional. As background, this challenge was brought by a woman considered married under New York state law who paid more than $350,000 in estate taxes because her deceased partner was not recognized as her spouse for federal tax purposes. By overturning Section 3, the court opens up to same-sex spouses more than 1,100 federal benefits, rights and burdens linked to marital status. Section 2 of DOMA, allowing states to refuse to recognize same-sex marriages from other states, was not before the court as part of this case. Therefore, states still have the option of refusing to recognize such out-of-state unions. Ultimately, the *Windsor* decision means that same-sex couples who are legally married must now be treated the same under federal law as married opposite-sex couples. (Please note that domestic partnership may be different than same-sex marriage, and the tax consequences relating to domestic partnership remain unchanged by the *Windsor* decision—for more on this see the FAQ at the end of *Compliance Corner*.)

**Implications for Employer-sponsored Employee Benefit Plans**

The Supreme Court rulings have major implications for employer-sponsored employee benefit plans. Specifically, for all purposes under ERISA and the IRC, employers and plans will now be required to recognize a same-sex spouse as a spouse, at least in states that allow same-sex marriage. The following states currently issue same-sex marriage licenses: CA, CT, DE, IA, MA, MD, ME, MN (8/1/2013), NH, NY, RI (8/1/2013), VT, WA and DC. This generally means that employers in these states will no longer be required to impute income for coverage or benefits provided to a same-sex spouse. This is because a same-sex spouse may be covered on a tax-free basis the same as any opposite-sex spouse, although IRS guidance would be welcomed on this point (specifically on when an employer should discontinue the practice of imputing income: prospectively or retroactively).

Some states specifically prohibit the recognition of same-sex marriages performed in other states. Employers in these states will not be required to recognize same-sex marriages, although employers may choose to do so on a voluntary basis (please note that there may be tax consequences): AK, AL, AR, AZ, FL, GA, HI, ID, IN, KS, KY, LA, MI, MO, MS, MT, NC, ND, NE, NM, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV, WY, and Puerto Rico.

Finally, six states provide for civil unions or domestic partnerships that offer spousal-equivalent protections for same-sex couples, which may include same-sex couples married in other states. These states are: CO, HI, IL, NV, NJ and OR.

From a retirement plan perspective, there will be implications regarding spousal rights in relation to areas such as annuities, required minimum distributions(RMDs), hardship withdrawals, loan, rollovers and Qualified Domestic Relations Orders (QDROs). From a health and welfare benefits perspective, there will be implications regarding pre-tax eligibility (such as allowing a qualifying event under Section 125 for mid-year enrollment in the health plan), COBRA rights, FMLA, HIPAA, consumer driven reimbursement plans (i.e. HRAs, FSAs and dependent care flexible spending accounts) and use of HSA funds to pay qualified medical expenses of a same-sex spouse. Significantly, self-insured plans that currently define a "spouse" as defined under federal law will need to revise the plan eligibility language accordingly. Fully insured plans should contact the insurance carrier to determine what action, if any, is needed.

The President issued a press release, directing the Attorney General to review affected federal statutes. On June 27, 2013, both the IRS and HHS announced they are working with the Department of the Treasury and Department of Justice and expects to provide revised guidance in the near future. Finally, in a memo issued by the federal government's Office of Personnel Management, federal agencies were told to allow health coverage to begin immediately to the spouses and children of married same-sex employees, and to set the stage for more to gain that coverage within 60 days. The memo also covered other forms of insurance and retirement benefits. Private employers should wait for further guidance prior to implementing plan changes and revising payroll practices.

**White House Press Release**
**California Press Release**
**IRS Announcement**
**HHS Announcement**
**OPM Memo**
***Hollingsworth v. Perry***
***United States v. Windsor***

---

### DOL Issues FAQs for Participants and Beneficiaries Following the Oklahoma Tornadoes

On June 25, 2013, the DOL's EBSA issued a set of 22 FAQs for health and retirement plan participants and beneficiaries in conjunction with the Oklahoma tornadoes. The FAQs provide guidance on certain questions that participants and beneficiaries may be facing following the tornadoes in Oklahoma. For example, one FAQ asks how an employee should proceed in filing a claim for benefits or obtaining replacement identification cards if the employer is closed as a result of the tornadoes. Other FAQs address how an employee should proceed if an affected employer has failed to pay their portion of an employee's health insurance premium, where a COBRA participant should send a COBRA premium payment if the prior location for sending the COBRA premium is closed, and an employee's rights when it comes to promised benefits in the event that the employer shuts down. The FAQs also include additional resources for more information.

Employers with Oklahoma ties should be aware of the FAQs, both to educate themselves and to help address any questions that may arise from employees and others affected by the Oklahoma tornadoes.

**DOL FAQs for Participants and Beneficiaries Following the Oklahoma Tornadoes.**

## State Updates

### Alaska

On June 24, 2013, Gov. Parnell signed into law HB 125, creating Chapter 38. The new law relates to insurance coverage of prescription eye drops. Specifically, plans that provide for prescription topical eye medications must permit plan participants to refill prescriptions to treat conditions before the last day of prescribed dosage periods, without regard to coverage restrictions. Plan participants may request early refills at certain times, depending on the length of dispensed supplies (30-, 60-, or 90-day supplies). Chapter 38 is effective for plan years that are offered, issued, delivered or renewed on or after Jan. 1, 2014.

**Chapter 38**

---

### California

On June 17, 2013, Insurance Commissioner Dave Jones announced that emergency regulations had been approved which would bring state insurance law in alignment with PPACA requirements. As background, PPACA requires non-grandfathered individual and small group plans to cover ten categories of essential health benefits. The new regulations amend state insurance law to require the same of non-grandfathered policies issued or renewed in California on or after Jan. 1, 2014. They apply to individual and small group policies issued both inside and outside of the exchange.

Such policies must mirror the coverage for essential health benefits as provided by the state's benchmark plan. The new regulations identify several services and items as essential health benefits. This means that non-grandfathered small group

plans will be required to provide coverage for such services. The services and items include: diabetic shoes and inserts, glucose monitors, infusion pumps, respiratory drug delivery devices, canes, crutches, IV poles, enteral formula, hospital grade breast pumps, compression burn garments, prosthetic devices related to mastectomies, acupuncture services, bone marrow transplant donation services, adult incontinence garments and skilled nursing facility services. Additionally, medically necessary orthodontic services for children to age 19 must be provided under the essential health benefit category of pediatric oral care.

**Press Release**
**Regulations**

On June 27, 2013, Gov. Brown signed into law ABX1-1 and SBX1-1. Effective Jan. 1, 2014, ABX1-1 will expand eligibility under Medi-Cal, the state's Medicaid program, to individuals under age 65 with income up to 133 percent of the federal poverty level. Also effective Jan. 1, 2014, SBX1-1 supplements Medi-cal coverage to include mental health and substance abuse disorder benefits.

**ABX1-1**
**SBX1-1**
**Press Release**

On June 26, 2013, the U.S. Supreme Court issued a decision in *Hollingsworth v. Perry*, No. 12-144, which was related to Proposition 8's prohibition of same-sex marriage in California. The court sent the case back to the Ninth Circuit Court with instructions to dismiss the case. This effectively strikes down Proposition 8, which means that same-sex marriages will be permissible in California. We expect guidance from the Department of Insurance regarding the impact on employer-sponsored benefit plans and the effective date. Until then, the understanding is that fully insured group health insurance policies issued in California will be required to offer coverage for same-sex spouses under the same terms and conditions as opposite-sex spouses. The term "spouse" in written documents and policies will be interpreted to include both same-sex and opposite sex legally married spouses. Plan documents for self-insured plans should be reviewed by legal counsel and amended as necessary.

***Hollingsworth v. Perry***
**Press Release**

---

## Colorado

On June 5, 2013, Gov. Hickenlooper signed into law SB 13-180. According to the new law, for purposes of health insurance policies issued in Colorado, therapeutic care for treatment of autism spectrum disorders includes treatment provided by licensed occupational therapy assistants. The new law is effective June 30, 2013.

**SB 13-180**

On May 13, 2013, Gov. Hickenlooper signed into law SB 13-1266. The new law is meant to align Colorado's health insurance laws with PPACA, including PPACA's requirements for plan enrollment, children's preventive and primary care, early intervention services, mammography, preventive health care and autism spectrum disorders. SB 13-1266 is effective for group health plans issued or renewed on or after Jan. 1, 2014.

**SB 13-1266**

---

## Connecticut

On June 5, 2013, SB 1029 was signed by Gov. Malloy, creating Public Act No. 13-84. The law requires employers that have insured group health plans to maintain benefit coverage levels for certain plan participants diagnosed with autism spectrum disorders. The law was effective the date it was signed, on June 5, 2013.

**Public Act No. 13-84**

On June 18, 2013, HB 5767 was signed by Gov. Malloy, creating Public Act No. 13-131. The law requires employers that have insured group health plans and provide coverage for prescription drugs must provide coverage for prescription drug refills to treat chronic illnesses under certain circumstances. The law is effective Jan. 1, 2014.

**Public Act No. 13-131**

---

## Florida

On June 14, 2013, Gov. Scott signed HB 655, which prohibits “political subdivisions” in the state from requiring employers to provide employment benefits not otherwise required under state or federal law, including benefits for health, disability, death, group accidental death and dismemberment, paid or unpaid days for holidays, sick leave, vacation, retirement and profit-sharing benefits.

**HB 655**

---

## Kentucky

On May 31, 2013, the Kentucky Department of Insurance issued Bulletin 2013-3. The bulletin summarizes legislation adopted during the 2013 General Assembly Regular Session. Included in the summary is HB 366, which requires health benefit plans that provide prescription drug coverage to provide coverage for milk fortifiers as prescribed by a physician up to $15,000 per infant per plan year.

**Bulletin 2013-3**

The Kentucky Department of Insurance has posted a series of frequently asked questions (FAQs) related to PPACA. The FAQ's are addressed to insurance companies, but include information that is also of interest to employers who sponsor group health plans. The first set of FAQ's, issued on April 17, 2013, clarify that group policies continue to be subject to state continuation provisions and conversion privileges. These requirements were not pre-empted by PPACA.

The second set of FAQ's, issued on May 22, 2013, provide information regarding essential health benefits. To comply with the essential health benefits requirement, a non-grandfathered small group policy will be required to provide coverage for one pair of frames and lenses per year per child. Additionally, if determined to be medically necessary, the plan must also provide coverage for one replacement pair of frames and lenses. The requirement applies to non-grandfathered small group policies issued or renewed on or after Jan. 1, 2014.

The third set of FAQ's, issued June 17, 2013, addresses questions related to dependent coverage to age 26, the employer mandate and the Summary of Benefits and Coverage.

**FAQ's #1**
**FAQ's #2**
**FAQ's #3**

## Massachusetts

On June 19, 2013, the Massachusetts Division of Insurance issued Bulletin 2013-07. The bulletin is addressed to Massachusetts insurers, but is of interest to small employers as well. The bulletin relates to pediatric dental benefits within plans offered to eligible small employers outside the Massachusetts exchange. Specifically, plans offered outside the Massachusetts exchange must include (either within the policy itself or as a rider to the policy) coverage for pediatric dental benefits (as required under the essential health benefits (EHB) requirement of PPACA). In addition, insurers must provide a notice at the time of solicitation on whether a plan covers dental benefits at the pediatric dental EHB. Small Massachusetts employers should be aware of the pediatric dental EHB requirement for plans offered outside the exchange.

**Bulletin 2013-07**

## Nevada

On June 2, 2013, Gov. Sandoval approved SB 266. The law prohibits plans that provide coverage for prescription drugs for cancer chemotherapy from applying cost-sharing provisions that exceed $100 per prescription for orally administered chemotherapy drugs. In addition, plans cannot apply monetary limits to coverage for orally administered chemotherapy drugs that are less favorable than limits that apply to injected or intravenously administered chemotherapy drugs. The law is effective for group health plans delivered, issued, or renewed on or after Jan. 1, 2015.

**SB 266**

## Oregon

On June 10, 2013, the Oregon Insurance Division adopted permanent rules to amend the definition of "Mental or Nervous Condition" for the purpose of specifying treatment required for such conditions. The change was needed because the current rules allow carriers to exclude treatment of gender identity disorder in adults over the age of 18. This rule excludes gender identity disorder in adults from the definition of a mental or nervous condition (and thus the coverage mandated in ORS 743A.168). This exclusion appears to violate the prohibition against discrimination on the basis of gender identity and therefore must be removed from the rules, according to the new rules. The rulemaking is effective June 17, 2013.

**Rule**

On June 6, 2013, Gov. Kitzhaber signed HB 2903, which revises the employee eligibility requirements for taking crime victim leave. In addition, employers must post in conspicuous and accessible locations in the workplace summaries of the crime victim leave provisions and any rules administered by the Oregon Bureau of Labor and Industries that are related to the enforcement of such provisions. The law is effective Jan. 1, 2014.

**HB 2903**

**South Carolina**

On June 7, 2013, Gov. Haley signed into law S465, creating Act. No. 48. The new law relates to the definition of "eligible employee" for purposes of small group health insurance in South Carolina and for small employers (defined in South Carolina as those with fewer than 50 eligible employees) that use the South Carolina federally-facilitated health insurance exchange to provide health insurance coverage. Specifically, an eligible employee is one who normally works 30 hours or more per week or who is licensed as a real estate agent working on a straight commission basis. Act. No. 48 is effective immediately.

**Act. No. 48**

## Frequently Asked Question

### Does the U.S. Supreme Court's decision on DOMA affect the taxation of an employee's coverage of a domestic partner?

No. The U.S. Supreme Court's decision on DOMA does not affect domestic partner coverage. Rather, it impacts benefits related only to married same-sex spouses. Specifically, the decision states that for purposes of federal law (including federal income tax rules and other benefits), same-sex spouses who are legally married (according to state law) are now treated the same as opposite-sex spouses. States generally do not define "marriage" to include a domestic partnership. Thus, domestic partnership status does not rise to the level of a legal marriage, and therefore a domestic partner (same- or opposite-sex) would not be considered a "spouse" entitled to tax and other benefits.

For purposes of federal taxation and benefits, only an employee, an employee's spouse (which per the Supreme Court's decision now includes a same-sex spouse), an employee's child under age 26, and an employee's financial dependent may receive tax-free coverage under the employee's group health plan. Anyone who is covered under the group health plan but who is not the employee's tax dependent would result in imputed tax to the employee. So, if the domestic partner (same- or opposite-sex) is not a tax dependent of the employee, then there are adverse federal tax consequences, as follows:

1. The portion of the employee's premiums that pay for the partner's coverage must be paid with after-tax dollars (i.e., this amount cannot be paid pre-tax through a section 125 plan); AND
2. The fair market value of the coverage itself must be added to the employee's gross income and taxed as normal wages (including employment taxes). There is no specific federal guidance on specifying how to calculate the value, but there are generally two acceptable methods. The first is to use the incremental amount that the employer pays towards the partner's coverage (e.g., use the employee-plus-spouse employer contribution minus the employer's contribution for employee only). The second (and more conservative) is to use the employee-only COBRA rate (minus the two percent administrative fee) and subtract the amount that the employee contributed towards the premium on a post-tax basis.

Ultimately, employers should engage outside counsel to assist with any federal taxation issues, including the determination of whether an individual (including a domestic partner) is a "dependent" for purposes of tax-advantaged coverage and which method to use in calculating the fair market value of coverage that must be imputed to the employee on account of a non-tax-dependent.

## 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) |

Partner. Preserve. Prosper.™

NFP™ Benefits Insurance Wealth Management



102107 | 6/13 | BP-15463-12