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

Compliance Corner

July 30, 2013

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Announcements and Reminders

Final 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 any employer-sponsored group health plan that ended on or after Oct. 1, 2012 through Dec. 31, 2012.

For insured plans, the carrier is responsible for paying the PCOR fee. For self-insured plans, the plan sponsor is responsible. For most single employer plans, the plan sponsor is the employer. Employers should be aware of whether any plans they sponsor are considered self-insured for which the fee may be owed. Most HRAs, for example, are self-insured and are therefore subject to the PCOR fee.

The fee is reported on IRS Form 720. NFP has a quick reference guide summarizing the three fees (the PCOR, the reinsurance fee, and the health insurance tax) that affect employer-sponsored group health plans under PPACA. The guide also summarizes three methods that may be used to calculate the amount of the PCOR fee.

More information on the PCOR fee
Form 720
Final Regulations on PCOR Fee

Reminder: Form 5500 Filing Deadline for Calendar-year Plans is July 31, 2013

Plan sponsors must file Form 5500-series returns on the last day of the seventh month after their plan year ends. Therefore, calendar-year plans must file by July 31, 2013. Plans may request a 2 ½ month extension to file by submitting Form 5558, Application for Extension of Time to File Certain Employee Plan Returns, by that plan's original Form 5500 due date. Form 8955-SSA is also due at the same time, but is filed with the IRS (rather than the DOL).

NFP has vendors available to assist with filings. Ask your advisor if you need assistance.

Form 5500 EFAST2
Form 5558, Extension of Time
Form 8955-SSA

Medical Loss Ratio Rebates: It's That Time Again!

On June 20, 2013, HHS **announced** that issuers will distribute just over $500 million in medical loss ratio (MLR) rebates to individual and group policy holders by Aug. 1, 2013. (**Here is a list** of the rebates by state and market for 2012.) Although the 2013 amount is just a fraction of what it was in 2012 ($1.1 billion), employers who receive a check must be aware of how to

properly distribute rebates to plan participants.

NFP has resources available to assist with processing MLR rebates. Ask your advisor if you need assistance.

Upcoming August Webinars Focus on Benefits Compliance and PPACA

Join NFP Training & Education for the below webinar series that will help keep you in the know on important industry topics. Can't make a live webinar? A recording of each session will be posted to the **NFP Client Learning Portal** within 48 hours of the live webinar. Those listening to a recorded webinar will not be eligible for recertification credit.

Webinars

Same-sex Marriages and Health Plans After *Windsor*
Aug. 7, 2013
3:00 p.m- 4:30 p.m. ET

Register Now

+ Calendar

Complying with Wellness Requirements Under Health Care Reform
Aug. 21, 2013
3:00 p.m- 4:30 p.m. ET

Register Now

+ Calendar

Plan Sponsors Be Aware: DOL Audits on the Rise
Aug. 28, 2013
3:00 p.m- 4:30 p.m. ET

Register Now

+ Calendar

*These programs are pending approval for 1.5 (general) recertification credit hours toward PHR, SPHR and GPHR recertification through the HR Certification Institute. For more information about certification or recertification, visit the HR Certification Institute website at **www.hrci.org**.*

Note: Those listening to a recorded webinar will not be eligible for credit.

The use of this seal is not an endorsement by the HR Certification Institute of the quality of the program. It means that this program has met the HR Certification Institute's criteria to be preapproved for recertification credit.

Health Care Reform Updates

IRS Answers PCOR Questions

On July 25, 2013, the IRS posted answers to several questions on its website regarding the Patient-centered Outcomes Research (PCOR) fee. The guidance does not provide for any changes to the reporting rules, but serves more as a guide for frequently asked questions. The IRS provides:

- The PCOR fee applies to plan years ending on or after Oct. 1, 2012 and before Oct. 1, 2019.
- Stand-alone dental or vision plans are not subject to the fee.
- The fee is due on the average number of lives covered for that plan year, which includes a covered employee, spouse, and children, including those covered under COBRA continuation coverage. An HRA and health FSA need

only count single lives (no spouses or dependents).
- Plans sponsored by tax-exempt organizations and governmental entities are subject to the fee.

PCOR Guidance

DOL Issues Modifiable Notices to Employees of Coverage Options

The DOL has issued modifiable Microsoft Word versions of the model notices that can be used to satisfy the PPACA requirement that employees receive notice of their options under state and federally-facilitated health insurance exchanges (now called "Marketplaces"). This requirement is also commonly referred to as the "Exchange Notice" requirement.

The following modifiable notices are now available:

- **Model notice for employers who offer a health plan to some or all employees**
- **Model notice for employers who do not offer a health plan**

These notices, along with non-modifiable English and Spanish-language PDF versions, are also available on the **DOL Website**

CMS Issues FAQs on FF-SHOP Minimum Participation and COBRA

On July 5, 2013, CMS released a set of selected responses to insurer FAQs relating to the federally-facilitated (FF) small business health options program (SHOP). Employers that may be interested in enrolling in FF-SHOPs will want to be aware of several FAQs relating to FF-SHOP minimum participation requirements and COBRA administration.

On minimum participation, as background, SHOPs may impose minimum participation requirements (default of 70 percent) on employers, so long as the requirements are based on the rate of employee participation in the SHOP as a whole (not on the rate of participation in any particular qualified health plan) of a particular insurer. Regulations describe which employees should be included in the participation rate calculation and also allow health insurers in the small group market to apply minimum participation rules (except during an annual open enrollment period from Nov. 15 to Dec. 15 of each year).

The FAQs clarify that outside the annual open enrollment period, the FF-SHOP will hold an employer's application (and not forward it to an insurer) until the employer meets the 70 percent minimum participation requirement. A group that falls below the minimum participation requirement during a plan year will be allowed to continue participation in the FF-SHOP through the plan year (the FF-SHOP will only check minimum participation rates at initial enrollment and then again at renewal). In addition, retirees offered coverage and COBRA enrollees must be included in the participation rate count. Importantly, the FAQs clarify that employer participating in the FF-SHOP must offer coverage to all full-time employees (those averaging 30 hours or more per week) and cannot vary coverage for different employee classifications (but may impose waiting periods of up to 60 days).

On COBRA, the FAQs clarify that for 2014, current insurance market standards for notifying employees and paying for COBRA coverage will remain unchanged in the FF-SHOP. For 2015, when the FF-SHOP is anticipated to provide billing and payment services for FF-SHOP employers, COBRA premiums will be included on a single employer invoice and employers will be expected to remit the full amount owed by the due date.

CMS FF-SHOP FAQs

Fourth Circuit Rejects Constitutional Challenge to PPACA's Employer Mandate

On July 11, 2013, the U.S. Court of Appeals for the Fourth Circuit, in *Liberty Univ. v. Lew*, 2013 WL 3470532 (4th Cir. 2013), held that PPACA's employer mandate was constitutional. In doing so, the Fourth Circuit affirmed a previous trial court holding, concluding that the employer mandate is a valid exercise of Congress's powers to regulate interstate commerce and to tax. In reaching their decision, the Fourth Circuit also concluded that the U.S. Anti-Injunction Act (AIA)—which generally states that taxes may only be disputed after they are assessed or collected—did not preclude a review of the case, and that the challengers to the mandate did indeed have standing to challenge.

Although the Fourth Circuit's decision deals a loss to those challenging the constitutionality of the employer mandate, the case may eventually find itself before the U.S. Supreme Court, should the case be appealed. In addition, the Fourth Circuit's conclusions on the AIA and on standing may open the door for separate cases challenging another PPACA provision. As background, in at least two other cases, plaintiffs have brought claims alleging that PPACA forbids the federal government to issue premium tax credits in the states that have refused to establish a health insurance exchange. The plaintiffs claim that should the federal government—which is charged with stepping in and establishing such an exchange for those states—choose to issue premium tax credits in those exchanges, it would be a direct violation of PPACA. If that portion of PPACA is held unconstitutional, it would be difficult for the federal government to implement the employer mandate, since employer mandate penalties are triggered by the issuance of a premium tax credit. The government has asked the courts to dismiss those cases on the grounds of the AIA and lack of standing. Relying on the Fourth Circuit's opinion in *Liberty*, those courts would likely have to deny the government's request, thus paving the way for those challenges to proceed.

We will continue to monitor developments related to the Fourth Circuit *Liberty* case, as well as any related developments with respect to other challenges to PPACA.

Liberty Univ. v. Lew

Federal Updates

IRS Releases Video and Transcript on Form 5500 and Form 5558 Filing Tips

On July 19, 2013, the IRS posted a video titled "Forms 5500 and 5558 Filing Tips," which is a less than two minute video describing five tips that plan sponsors should keep in mind when filing Form 5500, or an extension relating thereto (Form 5558). The five tips are also listed on the web page below the video. With the filing deadline for calendar year plans occurring tomorrow, July 31, 2013, plan sponsors may find the video especially timely.

IRS Video

Treasury and IRS Officials Answer Questions, Offer Informal Guidance During Meetings with ABA

The American Bar Association (ABA) recently hosted a meeting of its Joint Committee on Employee Benefits. During the meeting, IRS and Treasury officials provided ABA members an opportunity to ask questions in an informal setting. Although the responses are not binding, they do offer insight on how the IRS would likely resolve such issues if presented. The IRS and Treasury provided comments on a variety of employee benefit issues including performance pay, the short-term deferral rule as applied to severance packages and collateral requirements for plan loans.

On the health and welfare side, ABA members questioned the treatment of automatic adjustments to HDHP out of pocket maximums that begin in 2015. Specifically, members asked what would happen if the HHS adjustment creates a higher out-

of-pocket maximum than the IRS adjustment. In response, the IRS explained that if two different out-of-pocket maximum levels apply to a plan, the plan complies with both if it complies with the lower out-of-pocket maximum.

Transcript

DOL Adjusts 2013 Investment Disclosure Deadline for Retirement Plans

On July 22, 2013, the DOL released Filed Assistance Bulletin (FAB) 2013-02, in which it introduces temporary relief and a one-time "reset" from certain annual participant-disclosure requirements.

As background, under October 2010 DOL regulations, plan administrators were required to disclose comparative charts of plan investment options no later than Aug. 30, 2012, and then at least annually thereafter. Therefore, a plan that initially filed in August 2012 would have the next disclosure due in August 2013. Some plan administrators expressed concern with this timing, as it would preclude this disclosure from being combined with other participant disclosures, resulting in additional costs.
In response to these concerns, under FAB 2013-02, the DOL will allow a plan to align the comparative chart deadline with other plan disclosure and notice deadlines in order to achieve cost efficiencies. Thus, if the plan administrator reasonably determines that it will benefit the plan, participants and beneficiaries, then it may provide the 2013 comparative chart no later than 18 months after the initial chart (as opposed to 12 months, as previously required). For example, a plan that provided the initial chart on Aug. 1, 2012 will have until Feb. 1, 2014 to furnish the next one.

For those plan administrators that already provided the 2013 comparative chart, FAB 2013-02 provides that the same relief is available to them in 2014 (allowing the one-time "reset" and up to 18 months between charts).

Finally, the DOL is considering revising the disclosure requirement to permanently provide more flexibility. Specifically, it is considering whether to allow a 30- or 45-day window within which the annual comparative chart would be provided, rather than the hard deadline of "at least annually" ending on a particular day.

FAB 2013-02
DOL News Release

DOL Offers Guidance on Revenue Sharing Payments as Retirement Plan Assets

On July 3, 2013, the DOL issued Advisory Opinion 2013-03A. While advisory opinions are only controlling as to the entities named, they are illustrative as to how the DOL likely sees an issue. Advisory Opinion 2013-03A describes a common practice by 401(k) plan recordkeepers which involves offering plan clients potential sources of revenue sharing, and concludes that the revenue sharing amounts were not "plan assets" under ERISA.

As background, many plan recordkeeping and administrative service providers provide a variety of investment options to defined contribution plans. These firms receive payments from plan investments through various fees which are generally taken into account in calculating the recordkeeper's fee. The service provider will retain the payments, but will maintain bookkeeping records and credit the plan a portion for such payments. The arrangement allows service providers to deal with these credits in two ways: (1) By applying the credits against plan expenses; or (2) by depositing an amount equal to the credit in the plan's account. Neither approach requires segregation of any amount for the benefit of the plan, nor is such representation to that effect made.

These types of practices are common, but lack formal approval through DOL guidance, leading to the request of this advisory

opinion. The request asks the DOL to confirm that revenue sharing payments received by plan service providers do not constitute plan assets.

As they have with similar plan asset questions, the DOL noted that the assets of a plan are to be identified on the basis of ordinary notions of property rights. Furthermore, the assets of a plan include any tangible or intangible property in which the plan has a beneficial ownership interest. Using this analysis, the DOL concluded that the revenue sharing payments are not plan assets for purposes of ERISA where the plan itself does not actually receive the revenue sharing payments (rather, the plan receives only credits calculated by reference to the amounts received by the service provider). Finally, any credits actually paid into the plan's account would become plan assets once actually placed into the account.

While the revenue sharing amounts themselves are not plan assets, the plan's contractual right to benefit from the payments *would be* a plan asset. Therefore, any claim by the plan for credit or payment due under the contract from the recordkeeper would be a plan asset.

Advisory Opinion 2013-03A

State Updates

Hawaii

On June 26, 2013, Gov. Abercrombie signed HB 848 into law. The new law defines the term "small employer" for all PPACA related provisions implemented in Hawaii. A "small employer" is defined as one with an average of at least one but no more than 50 employees during the preceding calendar year. In addition, the employer must have at least one employee on the first day of the plan year.

The new law also creates a uniform network adequacy standard for all health insurers doing business in Hawaii. Managed care plans must demonstrate the adequacy of their provider network to the commissioner on an annual basis. A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography. HB 848 is effective July 1, 2013.

HB 848

Louisiana

On July 2, 2013, the Louisiana Department of Insurance issued Bulletin No. 2013-05. In this bulletin, the Department referenced DOL FAQs published Jan. 24, 2013. Those FAQs state that hospital indemnity or other fixed indemnity insurance policies under a group health plan provides excepted benefits only when the benefits are paid as a fixed dollar amount per day or other period of hospitalization or illness (regardless of the actual amount of expenses incurred). Generally, most state insurance regulators have not required strict adherence to the fixed dollar amount period referenced in the above FAQ. However, with this bulletin, the Department provides notice to all health insurance issuers in Louisiana that strict compliance with the interpretation in the FAQ will be enforced for all hospital indemnity or other fixed indemnity policies that are issued on or after Jan. 1, 2014.

Bulletin No. 2013-05

Maryland

On May 2, 2013, Gov. O'Malley signed SB 784, “The Deployment of Family Members in the Armed Services Act,” which authorizes leave for employees on the day that an immediate family member is leaving for or returning from active duty outside the U.S. as a member of the armed forces. The law requires Maryland employers to provide employees with one day of unpaid leave, to be used on the day the employee's 'immediate family member' is leaving for or returning from active military duty outside the U.S. as a member of the armed forces. “Immediate family member” is defined as the employee's spouse (including a same-sex spouse), parent, stepparent, child, stepchild or sibling. The law is now known as Chapter 547 and is effective Oct. 1, 2013.

Chapter 547

On May 16, 2013, Gov. O'Malley signed SB 12, “The Reasonable Accommodations for Disabilities Due to Pregnancy Act,” which requires employers to make reasonable accommodations—that do not impose undue hardship on the employer—to allow for pregnant employees to keep their current position or be transferred to a less strenuous position during pregnancy. The law is now known as Chapter 163 and is effective Oct. 1, 2013.

Chapter 163

Massachusetts

On July 12, 2013, Gov. Patrick signed into law H. 3538. The new law repeals the Massachusetts “fair share contribution”, and the health insurance responsibility disclosure (HIRD). As background, under Massachusetts health care reform legislation enacted in 2006, an employer that did not make a premium contribution toward the health insurance costs of its Massachusetts employees was required to pay a fair share contribution—up to $295 per employee—to the Massachusetts Department of Labor, and collect HIRD forms from employees who declined employer health insurance coverage or use of the employer’s cafeteria plan. Under the new law, employers are no longer required to pay that fair share contribution, or collect HIRD forms. However, employers do need to complete fair share contribution filings for periods before July 1, 2013, and do need to continue to make a cafeteria plan available to employees who are not eligible for employer health coverage (which the employee can use to purchase coverage on a pre-tax basis through the Massachusetts health care exchange).

The new law also enacts a separate Employer Medical Assistance Contribution, which is to be used to fund a state trust for uninsured residents. The new contribution is equal to 0.36 percent of the same wage base that applies for Massachusetts unemployment taxation purposes ($14,000)—which is roughly $50 annually. The new contribution is meant to replace a prior assessment used to fund hospitals and other providers of uncompensated health care, and is effective Jan. 1, 2014.

H. 3538
Gov. Patrick’s Press Release

Minnesota

On June 26, 2013, the Minnesota Department of Revenue posted several legislative bulletins describing tax law changes enacted during this year’s sessions, including additional Minnesota state tax withholding. This withholding is now required for certain educational assistance, transit and adoption assistance, despite the fact that these benefits remain exempt from federal taxation. These changes have a retroactive effective date of Jan. 1, 2013.

Specifically in regard to education assistance, Minnesota did not adopt the extension of Internal Revenue Code (IRC) Section 127, under which employers can provide tax-free benefits of up to $5,250 per year. While Section 127 educational assistance benefits are no longer exempt from Minnesota state tax, employers can still provide educational benefits under two other sections of the IRC that remain tax-free: under IRC Sections 132(d) and 117(d).

Regarding transit benefits, Minnesota chose not to match the federal increase in transit pass/vanpool benefits. The federal tax-exempt limit was raised to $245 per month, while the Minnesota level remains at $125 per month. Therefore, any amount of transit pass/vanpool benefit over $125 per month is now subject to Minnesota state tax.

Finally, in regard to adoption assistance, Minnesota did not adopt the federal extension for adoption assistance benefits. Federal law continues to allow employers to exclude up to $12,970 of qualified adoption assistance benefits from an employee's taxable wages in 2013. However, qualified adoption assistance benefits will now be subject to Minnesota state income tax.

Minnesota Department of Revenue Withholding Guidance
Minnesota Department of Revenue Withholding Guidance FAQs

On July 18, 2013, the Minnesota Department of Revenue website was updated to provide additional information about the Minnesota Marriage Equality Act and the recent *Windsor* decision on same-sex marriage from the U.S. Supreme Court. In the update, the Department states that they are awaiting further guidance from the IRS on how the *Windsor* decision will affect federal tax calculations. As Minnesota income tax is based on federal taxable income, IRS guidance will affect Minnesota state income tax calculations for same-sex married couples. For now, employers are advised to continue using the filing status provided by employees to determine Minnesota withholding, which as of Aug. 1, 2014, includes accepting the status of 'married' for same-sex married couples. The Department will release more information as it becomes available.

Minnesota Department of Revenue Website Posting

Missouri

On July 12, 2013, Gov. Nixon signed into law SB 262, which relates to coverage of certain "telehealth" (also referred to as "telemedicine") services.

On telehealth, plans must provide coverage for health care services provided through telehealth, if such services are otherwise covered. The term "telehealth" means exchanging medical information from one place to another using electronic communications. In addition, plans may not apply deductibles, copayments or coinsurance to telehealth services that are greater than those applied to services provided through in-person diagnosis, consultation or treatment. However, plans may (but are not required to) limit coverage for telehealth services to services performed in-network. SB 262 applies to plans that are delivered, issued, continued or renewed on or after Jan. 1, 2014.

SB 262

North Carolina

On July 18, 2013, Gov. McCrory signed into law SB 248, creating SL 2013-296. According to the new law, fully insured plans in North Carolina must provide coverage for services performed by licensed hearing aid specialists if the services are within the specialists' scope of services and those services are otherwise covered by the plan. The new law is effective Oct. 1,

2013.

SL 2013-296

New York

On May 8, 2013, the New York City (NYC) Council passed the Earned Sick Time Act. Mayor Bloomberg vetoed the bill on June 7 before the City Council overrode the veto on June 27, 2013. NYC joins San Francisco, Seattle, Portland, Washington, D.C. and the state of Connecticut in imposing sick leave obligations on employers.

The Act, effective April 1, 2014, requires private-sector employees with 20 or more employees to provide up to five paid sick days per year. Employers with 15 to 19 workers would need to provide the same by October 2015. All other employers need to provide five unpaid sick days a year.

In addition, manufacturing companies are exempt from the paid sick time requirement, as they are struggling. However, such companies would still need to provide unpaid sick time.

NYC Earned Sick Time Act

Puerto Rico

Sponsors of retirement plans covering Puerto Rico residents are reminded of several upcoming deadlines, including:

- July 31, 2013 deadline to comply with the Puerto Rico Treasury Annual Filing Requirement for Trusts Funding Calendar Year Puerto Rico Tax Qualified Plans
- July 31, 2013 deadline to file IRS Form 5500 and 8955-SSA

Form 480.70(OE)
Form SC 2644
Form 5500 EFAST2
Form 5558, Extension of Time
Form 8955-SSA

Vermont

On July 15, 2013, the Vermont Division of Insurance issued Bulletin 178, which provides clarification on the state's time frame requirements for responding to prior authorization requests. Health plans must respond to a completed prior authorization request from a prescribing health care provider within two business days for non-urgent requests. Weekends and legal holidays do not count as business days.

Health plans must respond to a completed prior authorization request within 48 hours for urgent requests. Weekends and holidays are counted within the 48 hours. All requests related to mental health and substance abuse conditions, pharmacy benefit determinations, determinations about whether the use of a prescription drug for the treatment of cancer is medically necessary or requests that are designated as urgent by the member or the member's health care provider are treated as urgent requests. Bulletin 178 clarifies requirements provided for in H 107, which was effective June 7, 2013.

Frequently Asked Question

I have not filed a Form 5500 for my company's health and welfare plans for over ten years. Is there some sort of amnesty program?

There is a correction program—described in more detail below—that allows filing delinquent Forms 5500 with reduced fines, but there is no amnesty program.

As background, under ERISA, DOL penalties can be imposed by the DOL for any refusal or failure to file a required Form 5500, and can be assessed for incomplete or otherwise deficient Forms 5500. Such penalties are generally levied against the plan administrator, and can be up to $1,100 per day starting from the date of the administrator's failure to file a proper Form 5500. In addition, any person who willfully violates the Form 5500 requirement may be subject to a fine of not more than $100,000, imprisonment for not more than 10 years, or both. "Willfully" generally requires a finding of general intent—that is, that the person acted knowingly and voluntarily.

Importantly, the DOL also takes the position that it is not subject to a statute of limitations with respect to the Form 5500, so that it can assess penalties in connection with previous plan years, reaching as far back as the 1988 plan year. This will be a problem if the plan has not filed in years past.

A plan that has not properly adhered to the Form 5500 filing requirement may take advantage of the DOL's Delinquent Filer Voluntary Compliance (DFVC) Program, which is available to plans that voluntarily comply before being notified of a deficiency by the DOL. The DFVC program provides reduced penalties to such plans. Namely, the penalties may be reduced to $10 per day with a maximum limit of $750 for a small plan (one with less than 100 participants) and $2,000 for a large plan (one with 100 participants or more). If the plan is delinquent on multiple years' filings, all filings may be submitted at the same time, including the current year's filing. In this case, the small plan penalty is $1,500 and the large plan penalty is $4,000. Importantly, a failure to file a timely report notice from the DOL will disqualify a plan from using the DFVC program. In effect, if only one year is sent in, and many years are missing, the risk of losing the ability to file under the DFVC program is heightened.

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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