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

# Compliance Corner

**August 27, 2013**

## In This Issue:



## Announcements and Reminders

### Last August Client Training Opportunity! *Plan Sponsors Be Aware: DOL Plan Audits on the Rise*

Join NFP Training & Education for the last compliance-driven client webinar opportunity for August. The final webinar will feature an in-depth look at the DOL plan audits taking place on employers of all sizes (small, mid-market and large), what specific issues DOL auditors are reviewing, as well as proactive steps plan sponsors and administrators can take today to minimize the adverse effects of a DOL audit.

If you missed one of the previous compliance-driven training opportunities held during August, archived calls may continue to be accessed by registering at the links provided below. Note: Those listening to the recorded webinar will not be eligible for HR recertification credit.

**Webinars**

**Same-sex Marriages and Health Plans After *Windsor***
*Now Archived*

**Register to access recording**

**Complying with Wellness Requirements Under Health Care Reform**
*Now Archived*

**Register to access recording**

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

Register Now

+ Calendar

*This program is approved 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**.*

***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.***

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## Upcoming Webinar on PPACA's Exchange Notice Requirement

On Sep. 9, 2013, join NFP Training & Education for a special webinar addressing PPACA's exchange notice requirement. As background, PPACA requires nearly all employers to provide each employee with a new written notice that has never been provided before. There are very few exceptions, so even an employer that does not offer health insurance must still distribute the notice to all employees. The deadline to provide this notice is Oct. 1, 2013, for existing employees (including part-time employees and interns, not just benefits-eligible employees). The notice is important because it describes the existence of the new health insurance exchanges, which are expected to begin enrolling individuals for health insurance coverage on the same date.

Now that this deadline is fast approaching, many employers are wondering what needs to be done. Among the topics that will be addressed include:

- Which employers are subject to the notice requirement?
- To whom does the notice need to be provided?
- Should an employer customize the "specific coverage information" in Part B?
- What content are employers required to complete in this notice?
- Is it acceptable to post the notice on a company intranet, hand-deliver or include in upcoming enrollment packets? What are the penalties if an employer does not comply?

Join Ford Darger, AVP and Counsel with NFP Benefits Compliance, and Jessica Watts, VP with NFP Benefits Compliance, as they delve into this topic and carefully outline the requirement.

Can't make the live webinar? A recording of this 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.

**PPACA's Exhange Notice Requirement**
Sept. 9, 2013
3:00 p.m- 4:30 p.m. ET

Register Now

+ Calendar

*This program is pending approval for 1.0 (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****.*

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## Health Care Reform Updates

### IRS Finalizes Regulations on Disclosure of Tax Return Information for Exchange Income Verification

On Aug. 14, 2013, the IRS finalized regulations and issued frequently asked questions (FAQs) describing the tax return information that it can disclose to HHS in order to assist exchanges in verifying the income of individuals for eligibility determinations. The final regulations adopted the proposed rules issued last year with just two changes.

Individuals seeking premium tax credits or cost-sharing reductions in connection with exchange coverage must have household income below certain thresholds, and the IRS is permitted to disclose to HHS, upon written request, modified adjusted gross income (MAGI) and other specified information about a taxpayer for purposes of making these eligibility determinations and verifying the amount of the credit or reductions. HHS may then disclose the information to the exchange or state agency processing the individual's application. In addition, the FAQs indicate that the return information may also be used for purposes of establishing eligibility for exemptions from PPACA's individual shared responsibility requirement (also known as the "individual mandate").

The regulations elaborate on the information that can be disclosed, including, for example, the amount of social security benefits included in gross income. They also provide that the IRS may disclose information on any individual listed (by name and social security number) on a submitted application for purposes of determining eligibility for an advance payment of a premium tax credit, a cost-sharing reduction or eligibility for certain other programs.

As a reminder, eligibility for the premium tax credit is based on the household income of the applicant, which is the sum of the MAGI of the individuals in the household. Strict privacy and security standards apply to HHS (as well as other entities such as exchanges, state agencies and their contractors), including recordkeeping and handling, storage, and disposal requirements to protect the confidentiality of tax records. Finally, the FAQs explain that the information may not be disclosed to any other entity, including individuals applying for coverage, navigators, agents and brokers, or others assisting in the application process. The regulations became effective Aug. 14, 2013.

**Final regulations**

**IRS FAQs**

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## White House Blog Clarifies Recent Media Activity Relating to "Delay" of PPACA Cost-sharing Limits

NFP Benefits Compliance has received several questions relating to recent media reports on a supposed delay of the provision of PPACA that restricts cost-sharing limits. As background, PPACA restricts out-of-pocket (OOP) maximum limits for non-grandfathered group health plans (including both small and large fully insured plans sold inside and outside the exchanges and self-insured plans) to $6,350 for single coverage and $12,700 for family coverage (those amounts will be adjusted in future years). PPACA also restricts the annual deductible amount for small fully insured group plans (both inside and outside the exchanges) to $2,000 and $4,000 for single and family coverage, respectively. Both limits apply for plan years beginning on or after Jan. 1, 2014.

Last week, several different national publications and media outlets reported that PPACA's cost-sharing limits had been delayed by the government. The White House on its blog responded to the media reports, stating that the government in February "put out public guidance to implement [the PPACA cost-sharing provision], on time," and also indicated that the general requirement has not been delayed.

The supposed and reported delay relates to a transitional relief provision that affects only certain plans. That transitional relief provision was published by the DOL in February 2013, in a set of FAQs titled "FAQs About Affordable Care Act Implementation Part XII," and provides a one-year delay in the effectiveness of the cost-sharing limits for certain plans with multiple service providers. Recognizing the difficulties inherent in such a plan structure (e.g., different levels of OOP maximums, different methods for crediting participants' expenses against such OOP maximums, etc.), the transitional relief was meant to give such plans more time to coordinate communications between service providers.

Specifically, FAQ 2, which outlines the one-year transitional rule, states:

"The Departments have determined that, only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b), the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

1. The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
2. To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1)."

Some news and media outlets reported this as a recent delay in PPACA. While it is a delay in one portion of one provision of PPACA, it is not recent; the special transition relief for multiple service providers was announced in February (and reported in the Feb. 26, 2013 edition of *Compliance Corner*) .

The White House blog confirmed that the February transition relief was meant to allow plans with multiple service providers more time to coordinate communications between such providers, and that the PPACA provision on cost-sharing limits had not otherwise been recently delayed.

**White House Blog**

### IRS Launches New Educational Website on PPACA's Tax Provisions

The IRS has launched a new website addressing tax provisions related to PPACA. The website is meant to educate individuals and businesses on how PPACA may affect them. It is broken into three sections, which explain the tax benefits and responsibilities as it relates to employers, as to individuals and families, and as to other organizations. Links and information pertinent to each group are included. The website has information both about tax provisions that are currently in effect as well as those that will go into effect in future years.

**IRS Educational Website**

### Kaiser Introduces State-by-State Health Exchange Premium Watch List

On Aug. 4, 2013, the Kaiser Family Foundation started tracking premiums and other details about individual and small group insurance plans available through the health insurance exchanges for each state. That information is posted on Kaiser's website and is updated as more states release this information. One of the biggest outstanding questions regarding PPACA is how much coverage will cost. This website provides updated information from the states as it is released. While NFP has not verified the accuracy of this information, it may be a helpful resource to employers.

**Kaiser State Premium Watch**

## Federal Updates

### DOL and DOD Release DOMA-Related Guidance

Since the June 26, 2013 Supreme Court decision striking down Section 3 of the Defense of Marriage Act (DOMA), we have been awaiting guidance from federal agencies on how the decision will impact employer-sponsored benefits. On Aug. 14, 2013, the DOL released a revised version of Fact Sheet #28F, "Qualifying Reasons for Leave under the FMLA." The revised fact sheet defines a spouse as: "a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including "common law" marriage and same-sex marriage." This indicates, that for FMLA purposes, a same-sex spouse residing in a state that recognize same-sex marriage will be eligible for leave under the same conditions as an opposite sex spouse. A same-sex spouse residing in a state that does not recognize same-sex marriage would not be entitled to leave as a spouse under FMLA. This practice is also known as the state of residence rule, meaning that a spouse's obligations and privileges are based on the definition of a spouse in the state in which they reside.

On Aug. 13, 2013, the U.S. Department of Defense (DOD) issued a press release stating that the DOD will extend benefits to same-sex spouses regardless of where the couple is stationed or residing. This is known as the state-of-celebration rule, meaning that a spouse's obligations and privileges are based on the definition of "spouse" in the state in which they were married, regardless of where the spouse now resides.

While the decisions of these agencies seem contradictory, it is important to note that the IRS has not yet published guidance relating to the group health plan eligibility or tax consequences of the recent DOMA decision on same-sex marriage. Until that guidance is received, employers are encouraged to work with legal counsel in determining policies and procedures which are appropriate for the employer.

**DOL Fact Sheet #28F**

**DOD Press Release**

## Health Plan Pays $1.2 Million for HIPAA Violation

On Aug. 14, 2013, HHS announced a resolution agreement with a health plan to settle certain HIPAA violations relating to electronic protected health information (PHI) found on the hard drives of leased photocopiers after the health plan returned them to the leasing company. According to the HHS news release, the health plan submitted a breach notification to HHS after learning of the problem from a television network, which has purchased one of the photocopiers as part of an investigative report. The plan submitted a breach notification to HHS, which in turn investigated the plan. As a result of the investigation, HHS determined that the health plan had failed to properly erase multiple photocopier hard drives prior to returning them to the leasing company. That failure resulted in the impermissible disclosure of electronic PHI of up to 344,579 individuals.

According to the resolution agreement, the health plan also failed to consider the photocopiers in its HIPAA security risk assessment and failed to implement appropriate policies for the disposal of electronic PHI. Accordingly, the agreement requires the health plan to pay over $1.2 million and to comply with a corrective action plan.

The settlement serves as a strong reminder of the importance of HIPAA compliance. Any entity that is considered a 'covered entity' subject to ERISA—which may include an employer in their role as plan sponsor or plan administrator, particularly if PHI is involved—must conduct a thorough security risk assessment and develop proper HIPAA policies and procedures with respect to PHI. PHI can appear in many mediums, including hard drives, computer workstations, photocopiers, fax machines and portable devices, such as a laptop or phone. Importantly, HHS takes the position that electronic PHI stored on these mediums is subject to the HIPAA privacy and security rules, even where the storage is unintentional. Employers should review their policies and determine what HIPAA rules might apply to them as a covered entity (or as a business associate of a covered entity). The HHS news release contains links to resources on media sanitation and safeguarding information stored on electronic devices, including copiers.

**Resolution agreement**
**HHS News Release**

## Employer Ordered to Reinstate COBRA Coverage Following Gross Misconduct Determination

In *Danois v. i3 Archive Inc.*, 2013 WL 3556083 (E.D. Pa. 2013), two employees were on the company's board of directors. The employees were married, but kept that fact a secret from their employer. As part of their duties on the board, the employees made decisions that benefited the other. During a company-wide reduction in force, the employees were terminated upon their own suggestion. Their coverage was terminated under the group health plan and COBRA was offered in a timely manner. A month later, the employer learned of the employee's undisclosed marriage, re-characterized their termination as gross misconduct and withdrew the COBRA offer. The DOL later ruled that the termination had not been for gross misconduct and that the COBRA offer and coverage must be reinstated. This is consistent with case law which requires that the determination of gross misconduct be made at the time of termination. Evidence or proof of gross misconduct cannot be used or obtained following the termination to re-characterize the reason for termination. The employer has asked the court for equitable relief to compensate them for the cost of health insurance they obtained while they were without COBRA coverage. The court has not yet ruled on this ERISA breach of fiduciary duty charge.

***Danois v. i3 Archive Inc.***

## State Updates

### Delaware

On June 30, 2013, Gov. Markell signed HB 149 into law. The law requires insurers to provide payment directly to volunteer fire companies and other certified emergency medical services provider agencies certified by the Delaware State Fire Prevention Commission for covered emergency medical services, including but not limited to basic life support, ambulance service, oxygen and supplies. The payment must be paid directly to the company or agency regardless of whether it has a contract with the insurer or is in the insurer's network. The law is effective for policies issued or renewed on or after July 1, 2013.

**HB 149**

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### District of Columbia

On July 23, 2013, Mayor Gray signed into law the Telehealth Reimbursement Act of 2013. According to the new law, plans issued in D.C. must provide coverage for health care services provided through telemedicine if plans otherwise provide coverage for the same services in-person. Telemedicine—referred to as "telehealth" in the new law—is defined as health care services delivered through interactive audio, video or other electronic media used for the purpose of diagnosis, consultation or treatment. Telehealth does not include services delivered through audio-only telephone conversations, email or fax transmissions. Lastly, under the new law, plans may not apply coinsurance, copayments or deductibles to services provided through telehealth that are greater than coinsurance, copayments or deductibles that apply to in-person services. The new law is effective Aug. 23, 2013.

**D.C. Telehealth Reimbursement Act of 2013**

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### Illinois

On Aug. 6, 2013, Gov. Quinn signed HB 3300 into law. The new law requires insurers to accommodate a reasonable request by a person covered by the policy to receive claims-related communications by alternative means or at alternative locations if the person states that disclosure of all or part of the information could endanger the person. A parent or guardian may make such a request for a covered child. The law is effective Jan. 1, 2014.

**HB 3300**

On Aug. 16, 2013, Illinois Department of Insurance Director Boron issued revised Bulletin #2013-12. While the bulletin addresses filing deadlines for health insurers, it reiterates the requirement of a non-grandfathered small employer group health plan. Such plans must have essential health benefits, limited cost sharing, premium rates that are not discriminatory, guaranteed availability and renewability of coverage and prohibit denial of coverage based on preexisting conditions effective for plan years on or after Jan. 1, 2014.

**Bulletin #2013-12**

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### Maryland

On Aug. 19, 2013, Maryland Insurance Administration (MIA) issued Bulletin 13-27, which summarizes the new insurance laws passed in the 2013 session of the Maryland General Assembly and signed by Gov. O'Malley. A short summary of the laws applicable to the audience of *Compliance Corner* and their respective effective dates is included below.

HB 228 (Chapter 159) –Effective June 1, 2013

- Expands Medicaid eligibility, effective Jan. 1, 2014, to children ages 6 through 18 and adults younger than age 65 with family or household incomes up to 133 percent of Federal Poverty Guidelines and former foster care adolescents up to age 26.
- Provides for Maryland Health Benefit Exchange (MHBE) funding and transition of the Maryland Health Insurance Plan enrollees into the MHBE.
- Provides funding for an establishment and operation of a state reinsurance program to mitigate the impact of excessive healthcare expenses incurred by high-risk individuals in the individual insurance market inside and outside the MHBE. The program will be funded by a hospital assessment.
- Establishes a service center to assist the Small Business Health Options Program (SHOP) and individual exchange.
- Outlines special rules for small employer premium contributions made on behalf of employees.

HB 360 (Chapter 106)—Effective Jan. 1, 2014

- Repeals provisions of insurance law that are obsolete under the ACA or other federal or state law, such as continuation coverage upon death of a group member, conversion coverage for individual policies when group coverage is terminating, and coverage for preexisting conditions.

HB 361 (Chapter 368)—Effective June 1, 2013

- Conformity with and implementation of the federal PPACA, including establishing license and fee requirements for SHOP exchange navigators, removing preexisting condition provisions on policies issued on or after Jan. 1, 2014, amended state law to permit higher incentives for participation in certain wellness programs, amended state law consistent with final Federal rules applicable to association plans.
- For small employers- added new definitions of coverage level, dependent, employee, eligible employee, full-time employee, part-time employee, plan year, qualified employer, qualified health plan, qualifying coverage in an eligible employer-sponsored plan, SHOP Exchange, and small employer that are consistent with the definitions found in the PPACA. Added provisions which establish how small employees will be counted that are consistent with the PPACA. Requires that premium rates for each small employer be set for an entire year both within and outside the exchange consistent with requirements of the PPACA. Requires an annual open enrollment period and special enrollment periods consistent with the PPACA. Extended the grandfathered protection for self-employed individuals in the small employer market by removing the sunset provision.

HB 1216 (Chapter 289)—Effective Oct. 1, 2013

- Requires each health insurer to provide on its website and annually in print to its members and insureds notice about the benefits required under the State mental health and addiction parity law and, if applicable, the Mental Health Parity and Addiction Equity Act (MHPAEA), and that the member may contact the MIA for further information about the benefits.

**Bulletin 13-27**

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## Massachusetts

The Massachusetts Department of Unemployment Assistance (DUA) recently issued an advisory on the effect of the repeal of the Massachusetts Fair Share Contribution (FSC) program. As background (and as covered in the July 30, 2013, edition of *Compliance Corner*), Massachusetts recently repealed the FSC requirement (among other things) that previously applied under Massachusetts health care reform. The advisory clarifies that the last filing period for the FSC program will be 2013 Q3, which is Apr. 1, 2013, through June 30, 2013. FSC filings for that filing period were due Aug. 15, 2013. The advisory provides the web address for online FSC filings, as well as a customer service number, which will remain in place indefinitely, for employers with FSC filing questions.

**DUA Advisory**

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## Minnesota

As previously reported in the July 30, 2013 edition of *Compliance Corner*, Minnesota law was recently amended to allow same-sex couples to marry beginning Aug. 1, 2013. With this change and the U.S. Supreme Court decision in *U.S. v. Windsor*, many people are wondering how to handle pre-tax medical benefits for same-sex spouses in states such as Minnesota that recognize same-sex marriage.

The IRS has yet to issue guidance regarding the federal tax consequences of health insurance premiums for same-sex spouses. However, the Minnesota Department of Revenue has provided interim guidance for Minnesota employers. According to the guidance, effective Aug. 1, 2013, employer-paid health insurance premiums for same-sex spouses should be treated the same as for opposite-sex couples and not considered taxable income for withholding purposes. This treatment also applies for health FSAs.

**Minnesota Department of Revenue Guidance**

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## Oregon

On July 29, 2013, the Gov. Kitzhaber signed HB 2240. Previously Oregon continuation coverage did not include coverage for dental, vision, prescription drug or any other benefits under the policy other than hospital and medical expenses. Pursuant to HB 2240, qualified beneficiaries must be offered continuation coverage in the same manner as provided in their group health insurance plans- which may now include coverage for dental, vision, prescription drug benefits if provided to active employees. The law also made amendments to Oregon insurance law to update the law in accordance with federal PPACA, such as codifying the ten “essential health benefits” and defining the term “employees” for purposes of health insurance. The revisions to the law are effective Jan. 1, 2014.

**HB 2240**

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## South Dakota

On Aug. 13, 2013, the South Dakota Division of Insurance (DOI) published its Summer 2013 Newsletter. The newsletter contains updates from the DOI relating to both insurers and employers. Relevant to employers, the newsletter announces the launch of a new health care reform website, which is meant to help consumers better understand the health insurance exchange (also called “marketplaces”) in South Dakota. According to the newsletter, the new website will direct consumers to information regarding individuals, families, employers and agents, and is available at **www.federalhealthreform.sd.gov**.

## Frequently Asked Question

### Is a Business Associate Agreement needed in the fully insured group health plan context?

The HIPAA privacy rule excepts fully insured group health plans from most of the administrative safeguard requirements if the plans do not create or receive PHI other than summary health information for limited purposes and enrollment/disenrollment information. To take advantage of the exception, some plan sponsors structure the relationship between the plans and the insurers so that the plan does not create or receive PHI, and so that the sponsors take a “hands-off” role in relation to PHI. A fully insured plan sponsor that takes this “hands-off” approach is not required to maintain or provide a privacy notice or to comply with the HIPAA privacy administrative safeguard provisions except for the prohibitions against intimidating or retaliatory acts and against requiring a waiver of HIPAA privacy or security rights. Instead, these and the other privacy and security requirements are imposed upon the insurer. Plan sponsors may engage in the following activities without losing hands-off status:

- *Receive summary health information*. An insurer may provide summary health information (information that summarizes the claims history and expenses of a plan, but does not contain personally identifiable information such as names, emails, addresses, medical record numbers, etc.) to a plan sponsor (electronically or otherwise) for the limited purposes of obtaining premium bids or modifying, amending, or terminating the plan. The information disclosed should be the minimum necessary to accomplish the purpose of the disclosure, and the plan's notice of privacy practices (which should be provided by the insurer) should inform participants that the insurer may disclose this type of information to the plan sponsor.
- *Perform enrollment and disenrollment activities and payroll deductions*. An insurer may provide enrollment and disenrollment information to a plan sponsor (electronically or otherwise). Again, the information disclosed should be the minimum necessary to accomplish the purpose of the disclosure, and the plan's notice of privacy practices (which should be provided by the insurer) should inform participants that the insurer may disclose this type of information to the plan sponsor.

The plan sponsor of a fully insured plan that is “hands-off” PHI will not become subject to HIPAA's privacy and security requirements if, in the course of assisting an employee with a claims dispute, it receives the employee's PHI. A plan sponsor does not become a covered entity simply by advocating on behalf of a participant. Of course, the employer would only be able to obtain PHI or electronic PHI in accordance with the privacy rule—for example, directly from the employee or pursuant to an authorization.

If the sponsor of an insured plan has access to PHI other than summary health information for the limited purposes and enrollment/disenrollment information discussed above, several privacy and security requirements will apply to both the plan and the plan sponsor, including the necessity to get a business associate agreement (BAA) in place with its covered entities, business associates (including advisor/broker, legal counsel, accounting, third-party administrators and consultants on behalf of the plan) and subcontractors of business associates – (assuming, of course, these entities have access to PHI as well).

Importantly, while a fully insured group health plan could avoid most of the privacy and security requirements if the plan and the sponsor were “hands-off,” if the plan sponsor also offers a health FSA, they may still need to have BAAs in place with business associates. This is because health FSAs typically are not fully insured. Thus, unless the health FSA is self-administered and has fewer than 50 participants (so that it is excluded from the definition of “group health plan”), the health FSA will need to comply with HIPAA's privacy rule and, if the health FSA has electronic PHI, with the security rule. This includes implementing a BAA if business associates will have access to PHI as a result of providing assisting in the management/operation of such accounts.

## Acronyms Glossary

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| **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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