THE MELTZER GROUP

Compliance Corner

December 17, 2013

In This Issue:

Health Care Reform Updates

Interim Final Regulations Clarify Marketplace Enrollment Deadline for Jan. 1 Effective Date

On Dec. 17, 2013, HHS published interim final regulations to formalize the extension of the time frame to enroll for coverage with a Jan. 1, 2014, effective date in the health care marketplace. The regulations address coverage through both the federally facilitated individual and small business marketplaces, as well as federal and state partnership individual and small business marketplaces. The previous deadline of Dec. 15, 2013, has now been extended eight days to Dec. 23, 2013, for those attempting to enroll for coverage effective Jan. 1, 2014.

This is a one-time extension that is not intended to apply for coverage effective in future months. For example, if a plan selection is made between Dec. 24, 2013, and Jan. 15, 2014, the coverage effective date will be no later than Feb. 1, 2014, which follows the time frame in the original regulations. That being said, the rule leaves open the possibility for issuers to allow for coverage with an effective date of Jan. 1, 2014, even if it is selected after Dec. 23, 2013, given the newness of the enrollment process. In some cases, this could mean coverage is retroactive. This is a decision left to issuers.

Importantly, the regulations permit state-run health insurance exchanges to select a different deadline for Jan. 1 enrollment.

The regulations further provide that consumers need to pay the initial premium no later than Dec. 31, 2013, to ensure coverage becomes effective on a timely basis, although issuers may again provide more generous policies and allow premiums to be paid after Jan. 1, 2014, for a retroactive effective date. In some cases, a full payment of the total premium due may not be required. Future rulemaking will clarify the payment policies beyond this initial open enrollment period. Finally, this extended deadline has no effect on coverage purchased outside of a publically run marketplace. The regulations are effective Dec. 15, 2013.

Regulations

IRS Releases Final Regulations on PPACA's Health Insurance Tax

On Nov. 29, 2013, the IRS issued final regulations, Rev. Rul. 2013-27 and Notice 2013-76, which all relate to PPACA's health insurance tax (HIT). The HIT is an annual tax that health insurance carriers must pay beginning in 2014. The total HIT amount is $8 billion in 2014 (increasing thereafter), and each carrier is responsible for paying its proportionate share of the total HIT amount (based on the carrier's share of the U.S. health insurance market as expressed in premiums written). As a result, carriers will have to begin paying the HIT in 2014, and will likely pass the related cost on to the policyholders of insured plans (i.e., employers in the group plan context). Self-insured plans are not subject to the HIT.

Back in March 2013, the IRS issued proposed regulations on the HIT (covered in the March 12, 2013, edition of *Compliance Corner*). The final regulations and additional ruling and notice primarily adopt the proposed regulations, but do make some minor modifications as it relates to employers.

Previously, it was not clear whether employee assistance programs, wellness programs and stop-loss insurance policies would be subject to the HIT. The final regulations note that future guidance will address that issue, and that until the future guidance is released, such programs and policies will not be subject to the HIT.

The final regulations and related guidance outline the due date for reporting premiums written and the procedure for determining the fee. Insurers will be notified of their final HIT amount due by Aug. 31 each year, and must pay the HIT by Sept. 30 of that year. Importantly, Rev. Rul. 2013-27 clarifies that carriers must include in their gross income any separate amounts (i.e., line item amounts outside of the premium) that they collect from policyholders to offset the cost of the HIT.

Since the HIT applies directly to the carrier, employers need not concern themselves with calculating, reporting and paying the HIT. But employers will want to be aware of the HIT regulations and how the HIT will affect their fully insured plans.

Regulations
Rev. Rul. 2013-27
Notice 2013-76

Federal Updates

IRS Provides Further Guidance Regarding Cafeteria Plans and Same-sex Spouses

On Dec. 16, 2013, the IRS released IRS Notice 2014-1. The notice builds upon guidance provided in Rev. Rul. 2013-17

regarding cafeteria plans in relation to same-sex spouses. Rev. Ruling 2013-17 was issued following the U.S. Supreme Court decision in *United States v. Windsor*. NFP Benefits Compliance addressed Rev. Ruling 2013-17 in the Sept. 10, 2013, edition of *Compliance Corner*. The notice first establishes the pertinent general cafeteria plan health and dependent care FSA and HSA rules, restates the changes to the Defense of Marriage Act (DOMA) post-*Windsor* and confirms the guidance in Rev. Ruling 2013-17. IRS Notice 2014-1 then provides a set of questions and answers giving further guidance on the application of the *Windsor* decision with respect to certain rules governing the federal tax treatment of certain types of employee benefit arrangements.

The questions and answers are followed by examples used to help demonstrate how the guidance will apply. Of the questions addressed, the first five are about midyear election changes; one is related to health, dependent care and adoption assistance FSA reimbursements; and the final four discuss contribution limits for HSAs and DCAPs. Below are a few highlights of this guidance.

A participant lawfully married to a same-sex spouse as of June 26, 2013 (the date of the *Windsor* decision), or any date thereafter, may make a midyear election change due to a change in legal marital status. However, a plan may not permit a participant to make a midyear election change on the basis that the change in tax treatment resulted in a significant change in cost of coverage. Nevertheless, due to the legal uncertainty, those plans that have already allowed an election change based on significant change in cost since the *Windsor* decision will not be seen as out of compliance for such a period. Also included is information about the effective date for cafeteria plan elections regarding same-sex spouses, the date elections for same-sex spouses must be available pretax, and how the *Windsor* decision affects imputed income.

A cafeteria plan may permit a participant's health, dependent care or adoption assistance FSA to reimburse covered expenses of the participant's same-sex spouse (and dependents) that were incurred not earlier than the first day of the plan year that includes the date of the *Windsor* decision or the date of the marriage, if later. In other words, a calendar-year plan may reimburse covered expenses of same-sex spouses beginning on or after Jan. 1, 2013 (provided that the spouses were married at the time the expense was incurred).

A same-sex married couple is subject to the joint deduction limit of $6,450 (for 2013) for contributions to an HSA with respect to a taxable year (that is, couples who remain married as of the last day of the taxable year). If the combined HSAs of same-sex married couples exceed the HSA contribution limit, contributions for one or both may be reduced for the remaining portion of the tax year to avoid exceeding the applicable contribution limit. Any excess may be distributed from the HSAs no later than the tax return due date for the spouses. This means that the HSAs have the full amount contributed, but income must be attributed for any amount over the limit. Any excess contributions not distributed by that time will be subject to excise taxes.

The same guidance is provided with regard to DCAP contributions exceeding $5,000. Contributions will remain available in the DCAP, yet includable in gross income.

Finally, to the extent that the cafeteria plan sponsor chooses to permit election changes that were not previously provided for in the written plan document, the cafeteria plan must be amended to permit such election changes on or before the last day of the first plan year beginning on or after Dec. 16, 2013. Such an amendment may be effective retroactively to the first day of the plan year including Dec. 16, 2013. This guidance is effective Dec. 16, 2013.

IRS Notice 2014-1

DOL Releases Form 5500, Schedules and Instructions for 2013 Plan Year

The DOL recently released a new version of Form 5500, Annual Return/Report of Employee Benefit Plan, including the related schedule and instructions. The new 2013 Form 5500 is meant to be used for plan years beginning in 2013. There are some minor changes to the 2013 Form 5500. For example, all welfare plans that file a Form 5500 must provide an attachment to Form 5500 labeled "Form M-1 Compliance Information," indicating whether the plan was subject to the Form M-1 filing requirement (which reports various compliance items by a multiple employer welfare arrangement, or MEWA) during the plan year. Failure to provide the attachment may lead to a rejection of the Form 5500 as incomplete (which could result in penalties).

In addition, all plans required to file Form M-1 must file Form 5500. Previously, there was a Form 5500 filing exemption for small MEWAs (those with fewer than 100 participants) that were unfunded or insured. Such MEWAs must also file Schedule G (Financial Transaction Schedule) to report any non-exempt transactions with a party in interest, but do not have to file Schedule I (Financial Information—Small Plan).

Lastly, the Form 5500 Instructions now caution against using any portion of Social Security numbers, since Form 5500 filings are publicly available.

DOL News Release
Form 5500 for 2013 Plan Year
DOL Form 5500 Web Page

IRS Releases 2014 Standard Mileage Rates for Medical Purposes

On Dec. 6, 2013, the IRS issued Notice 2013-80, which announces the 2014 optional standard mileage rates. These rates are used to calculate the deductible costs of operating an automobile to obtain medical care. The same notice also provided the standard mileage rates for use of a car for business, moving or charitable purposes.

Effective Jan. 1, 2014, the standard mileage rates for use of an automobile used for medical purposes will be $0.235 per mile, a one-half cent decrease from the 2013 rate. Notably, this rate can be used for mileage reimbursement from a health FSA, HRA or HSA when such travel is for medically necessary health care as defined by IRC Section 213.

Announcement
Notice 2013-80

IRS Issues FAQS on Treatment of Same-sex Spouses for Certain Taxes

As part of its continued efforts to clarify the taxation of employee benefits in the post-*Windsor* environment, the IRS recently updated its FAQs for married same-sex couples. Of note are FAQs 21–23, which address reimbursement of overpaid Social Security and Medicare taxes.

The FAQs indicate an employee should seek a refund of overpaid Social Security and Medicare taxes from their employer. If the employer indicates an intention not to file a claim or adjust the overpaid Social Security and Medicare taxes, the employee may claim a refund of any overpayment of employee Social Security and Medicare taxes by filing Form 843, Claim for Refund and Request for Abatement. “Windsor Claim” must be clearly written across the top of the form.

Additionally, employers are provided two special alternatives to address overpaid Social Security and Medicare taxes collected during the first three quarters of 2013 prior to *Windsor*. Pursuant to IRS Notice 2013-61, an employer may repay or reimburse an employee for 2013 overpayments of taxes on or before Dec. 31, 2013, and correct the overpayment on the fourth quarter 2013 Form 941. In the alternative, an employer who did not repay the excess withholding to employees by Dec. 31, 2013, may, after receiving written confirmation that the affected employee did not file a claim for refund of the overpaid taxes, make necessary adjustments by filing a single Form 941-X for the fourth quarter to correct overpayments for the entire year.

The rules surrounding post-*Windsor* withholding are complex. Therefore, plan sponsors and employers are encouraged to consult with their tax advisors before implementing a reimbursement strategy.

IRS FAQs

IRS Issues Guidance Regarding Roth In-plan Rollover Rules

On Dec. 11, 2013, the IRS released Notice 2013-74, providing clarification around in-plan Roth conversions. The American Taxpayer Relief Act of 2012 (ATRA) included a modification to the rules associated with Roth conversions within participating defined contribution plans. While certain participants age 59 ? or older (or after separation from service) have always been able to convert distributable pretax plan assets to after-tax savings in a separate Roth account within the plan, the new provision has effectively eliminated the “distributable” requirement. This means that any pretax amount can be converted as long as the plan includes a Roth conversion program and taxes are paid on the converted amount. Notice 2013-74 offers guidance regarding the conversion of otherwise non-distributable amounts, the timing of plan amendments and other matters.

The guidance is effective for in-plan Roth rollovers made after Dec. 31, 2012. Regarding the timing of amendments, the notice says plan sponsors must amend their plans to include the conversions to Roth accounts the later of the last day of the first plan year in which the amendment is effective or Dec. 31, 2014.

The notice illustrates that a plan with in-plan Roth conversions can include elective deferrals, matching and non-elective contributions (both safe harbor and non-safe harbor) and earnings. These remain subject to the distribution restrictions that applied to them before the conversion. However, tax withholding does not apply.

The notice clarifies that a plan with in-plan Roth conversions can limit the frequency of conversions and the type of contributions eligible for conversion. A plan can also eliminate its in-plan Roth conversion feature altogether. However, the limits and choices mentioned above cannot violate nondiscrimination provisions. Finally, the notice addresses general questions related to the top-heavy rules, the tax consequences of conversion and the correction of excess contributions or deferrals.

IRS Notice 2013-74

IRS Issues 2013 Cumulative List of Changes for Use When Requesting Determination Letters

On Dec. 11, 2013, the IRS released Notice 2013-84, cumulatively reporting the changes the IRS will look to when reviewing retirement plan determination letters submitted between Feb. 1, 2014, and Jan. 31, 2015. The groups that submit determination letters during this period will predominantly consist of single employer, individually designed, defined contribution/defined benefit plans in Cycle D and multi-employer plans. An individually designed plan is in Cycle D if the last digit of the plan sponsor's employee identification number is four or nine.

Qualifications that were not on the 2012 Cumulative List are designated on the 2013 Cumulative List as "(New)." Some of the new items on the 2013 list include the U.S. Supreme Court's *U.S. v. Windsor* decision, subsequent guidance related to definitions of "spouse" and "marriage," final regulations regarding reductions of safe harbor contributions and guidance relating to in-plan Roth conversions, among other items.

IRS Notice 2013-84

State Updates

Arizona

On Dec. 6, 2013, Insurance Director Marks announced that Arizona will not adopt the Market Transition Policy that was introduced by CMS on Nov. 14, 2013, and announced in the Nov. 19, 2013, edition of *Compliance Corner*. The Market Transition Policy states that health insurance coverage in the individual or small group market that is renewed for a policy year starting between Jan. 1, 2014, and Oct. 1, 2014, and associated group health plans of small businesses will not be considered out of compliance with market reforms previously required. In the Dec. 3, 2013, edition of *Compliance Corner*, NFP Benefits Compliance highlighted the states that had made a decision about the Market Transition Policy. Arizona now joins the states that will not allow insurers to make the transition policy available to policyholders.

Press Release 13-05

Arkansas

On Nov. 14, 2013, Arkansas Insurance Commissioner Jay Bradford issued a statement clarifying that the Arkansas Insurance Department had previously taken steps, through the issuance of Bulletin 7-2013, to allow carriers the option to extend current plans through calendar year 2014 by adopting one of the changes proposed by the Insurance Department. As a result, the commissioner felt that the recent announcement for transition relief by CMS delaying the enforcement of health care reform's insurance mandates in 2014 would lead to confusion. Issuers in Arkansas would have already taken steps to minimize possible disruptions in the marketplace in 2014.

Statement
Bulletin 7-2013

Delaware

On Nov. 25, 2013, Insurance Commissioner Stewart announced that carriers were permitted to early renew policies that otherwise would have terminated on or before March 31, 2014. Such policies would not be required to be in compliance with 2014 PPACA requirements such as essential health benefits and modified community rating structures. Policies issued on or after Jan. 1, 2014, must be in compliance with federal and state requirements.

Announcement

Hawaii

On Dec. 10, 2013, the Hawaii Insurance Division released a health insurance premium sheet that assists individual and small employer consumers in comparing 2014 policy costs with their existing 2013 health plan. The sheet includes rates for plans both on and off of the exchange, which is called the Hawaii Health Connector.

Press Release and Premium Sheet

On Dec. 1, 2012, the Department of Labor and Industrial Relations announced the 2014 rates for the state disability insurance. Effective Jan. 1, 2014, the maximum weekly benefit amount is $546, an $11 increase from 2013. The maximum employee contribution rate remains 0.5 percent. However, the maximum weekly wage base increases to $940.05 (up from $921.78 in 2013), which means a maximum weekly deduction of $4.70 (up from $4.61 in 2013).

Announcement

Idaho

On Dec. 11, 2013, the Idaho Department of Insurance issued Bulletin 13-05 relating to the recent health insurance policy cancellations. The bulletin states that carriers are permitted to renew non-grandfathered policies that were in existence on Oct. 1, 2013. Such policies will not be required to include essential health benefits or be in compliance with PPACA's modified community rating structure. This decision is in response to President Obama's Nov. 14, 2013, announcement (i.e., that insurers may offer policyholders whose health insurance coverage would otherwise be terminated the opportunity to keep their current plan for another year).

Bulletin 13-05

Iowa

On Nov. 27, 2013, the Iowa Insurance Division issued Bulletin 2013-6 related to hospital indemnity and fixed indemnity

policies. As background, such policies are considered excepted benefits and exempt from many federal and state mandates if they meet certain requirements. On Jan. 24, 2013, the DOL issued an FAQ stating that an indemnity plan would only be considered an excepted plan if benefits are paid as a fixed-dollar amount per day or other period of hospitalization or illness regardless of the amount of expenses incurred. The bulletin explains that the division has historically not enforced the requirement that a plan impose a fixed-dollar amount per day or other period of time. For example, policies may provide benefits on a per-prescription or service provided basis. The division will enforce the requirement beginning with policies issued on or after Jan. 1, 2014. However, there is transitional relief for policies that were issued and in force prior to Jan. 1, 2014. Carriers taking advantage of the transitional relief must issue a notice to all insureds by Feb. 1, 2014. The notice must state that the policy does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and the policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Bulletin 2013-6

Missouri

On Nov. 21, 2013, the Missouri Department of Insurance issued Bulletin 13-07, which permits health insurers to take advantage of the transition relief previously announced by CMS on Nov. 14, 2013. The transition relief allows individual and small group health insurance plans that were previously cancelled due to noncompliance with PPACA insurance mandates in 2014 to be renewed during 2014 without being subject to penalties. The bulletin requires several factors be satisfied for insurers that agree to extend these policies. Small employers who may have received a cancellation notice may be interested in this announcement, and should consult with the insurer on the plan or policy to determine if the insurer will be taking advantage of this transition relief.

Bulletin 13-07

Puerto Rico

On Nov. 18, 2013, the Office of the Commissioner of Insurance issued Ruling Letter CN-2013-161-D permitting health insurers to take advantage of the transition relief previously announced by CMS on Nov. 14, 2013. The transition relief allows individual and small group health insurance plans that were previously cancelled due to noncompliance with PPACA insurance mandates in 2014 to be renewed during 2014 without being subject to penalties. The bulletin requires that several factors be satisfied for insurers that agree to extend these policies. Small employers who may have received a cancellation notice may be interested in this announcement, and should consult with the insurer on the plan or policy to determine if the insurer will be taking advantage of this transition relief.

Letter

South Carolina

On Nov. 19, 2013, the South Carolina Department of Insurance issued Bulletin Number 2013-12, which permits health

insurers to take advantage of the transition relief previously announced by CMS on Nov. 14, 2013. The transition relief allows individual and small group health insurance plans that were previously cancelled due to noncompliance with PPACA insurance mandates in 2014 to be renewed during 2014 without being subject to penalties. The bulletin requires that several factors be satisfied for insurers that agree to extend these policies. Small employers that may have received a cancellation notice may be interested in this announcement, and should consult with the insurer on the plan or policy to determine if the insurer will be taking advantage of this transition relief.

Bulletin Number 2013-12

Frequently Asked Question

When does my benefit plan have to change its waiting period to be no longer than 90 days? How does this apply to a person currently in a waiting period when the change is instituted?

PPACA requires that group health plans and health insurance issuers offering group health insurance cannot apply a waiting period that exceeds 90 days. The waiting period may not extend beyond that 90 days, and all calendar days are counted beginning on the first day of the waiting period, including weekends and holidays. The restriction on waiting periods applies on a plan-year basis. Proposed Treasury Regulation 54.9815-2708(h) states:

“The provisions of this section apply for plan years beginning on or after January 1, 2014. See ?54.9815-1251T providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and health insurance issuers, including grandfathered health plans.”

If an employer’s plan runs on a calendar-year basis, then the waiting period requirement applies as of Jan. 1, 2014. Alternatively, if the plan does not run on a calendar-year basis, the requirement will apply the first day of the plan year beginning after Jan. 1, 2014. For example, a plan with a plan year of June 1–May 30 will need to comply with the waiting period requirement by June 1, 2014.

According to the regulations, if any employee is currently in a waiting period for coverage before the first day of the plan year in 2014, when the requirement goes into effect for the plan, any longer waiting period can no longer apply to the individual. In other words, let’s say the plan is a Jan. 1–Dec. 31 plan year and at the time someone is hired, the plan has the longer waiting period (first of the month following 90 days). An employee hired on Dec. 15, 2013, would actually benefit from the rule even though they were hired before the plan had to comply with the rule. Because the rule went into effect when they were still in a waiting period, the employee would need to be enrolled by the 91st day (March 16, 2014, for this example), and not by the first of the month following 90 days (April 1, 2014, for this example).

Acronyms Glossary

Click here to view a glossary of commonly used acronyms.

Partner. Preserve. Prosper.™

NFP™ Benefits Insurance Wealth Management

National Financial Partners (NFP) and its subsidiaries do not provide legal or tax advice. Compliance, regulatory and related content is for general

informational purposes and is not guaranteed to be accurate or complete. You should consult an attorney or tax professional regarding the application or potential implications of laws, regulations or policies to your specific circumstances.

110701 | 12/13 | BP-15471-12