Benefits and Employment Briefing

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HEALTH CARE REFORM UPDATE: IRS PROVIDES GUIDANCE ON DELAYED ENFORCEMENT OF EMPLOYER PENALTY, RELATED REPORTING

The Internal Revenue Service has released guidance (Notice 2013-45) explaining the transitional relief for 2014 from employer shared responsibility penalties for a failure to offer affordable minimum value health coverage (Internal Revenue Code § 4980H) and related reporting requirements (Code §§ 6055 and 6056).

These penalties and reporting requirements were enacted as part of the 2010 federal health care reform law (Public Law 111-148, commonly referred to as the Patient Protection and Affordable Care Act or PPACA). The transitional relief is limited to the specified penalties and reporting requirements and does not affect other PPACA requirements for employers. Thus, there is no relief from the comparative research (PCORI) fee payment, the prohibition on health plan waiting periods in excess of 90 days and pre-existing condition exclusions, or other compliance obligations.

Under PPACA's employer shared responsibility penalty provisions, an applicable large employer (i.e., an employer with at least 50 full-time or full-time equivalent employees) is subject to penalties for each month in which it fails to offer affordable minimum value coverage to substantially all full-time employees if at least one of its full-time employees obtains subsidized exchange coverage. The IRS will determine whether an employer owes this penalty based on information the employer is required to report under Code § 6056 (and information the IRS has about employees who obtained subsidized exchange coverage). According to Notice 2013-45, these penalties will not be assessed for 2014, meaning that employer shared responsibility penalties will not be imposed until 2015.

The IRS expects to issue proposed regulations on the reporting requirements of Code §§ 6055 and 6056 this summer. The agency plans to use the additional time before implementation to engage in dialogue with employers and other stakeholders to "simplify" the reporting requirements and afford employers more time to develop recordkeeping and reporting systems.

In its Notice, the IRS encourages employers to comply *voluntarily* with the reporting provisions for 2014 — once the reporting rules are issued — and to maintain or expand coverage in 2014. In the agency's view, "[r]eal-world testing of reporting systems and plan designs through voluntary compliance for 2014 will contribute to a smoother transition to full implementation for 2015." Employers also should consider reviewing and commenting on the IRS' information reporting rules when they are issued, especially as the enforcement delay is largely due to input from employers, according to the Obama Administration's announcement.

The Notice leaves many questions unanswered, and the full implications and mechanics of the delay are not yet clear. The Centers for Medicare & Medicaid Services ("CMS") issued a final rule on July 5, 2013, which addresses some aspects of the announced delay. In all cases, the delay brings welcome relief for many employers that have been working diligently to comply with the key PPACA provisions in 2014, under time pressures and with incomplete guidance.

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PCORI FEE JULY 31, 2013, DEADLINE APPROACHING FOR HEALTH INSURANCE POLICY ISSUERS AND SPONSORS OF SELF-FUNDED HEALTH PLANS

The Patient Protection and Affordable Care Act ("PPACA") added Sections 4375-4377 to the Internal Revenue Code ("Code") to require certain issuers of health insurance policies and employers sponsoring self-funded health plans to pay a fee to fund the Patient-Centered Outcomes Research Institute that was established under PPACA ("PCORI Fee"). For plans and policies with years that ended between Oct. 1, 2012, and Dec. 31, 2012, the first PCORI Fee must be paid by July 31, 2013. For other self-funded plans and health insurance policies, the first PCORI Fee payment is due by July 31, 2014. Insurers and plan sponsors with July 31, 2013, payment dates must move quickly to collect the necessary data and determine the applicable PCORI Fee.

Plans and Policies Subject to PCORI Fee

The PCORI Fee applies to "specified health insurance policies" and "applicable self-insured health plans." These policies and plans include most typical self-funded and insured health plans, health maintenance organization contracts ("HMOs"), retiree-only plans and COBRA coverage. However, the PCORI Fee does not apply to the following policies and arrangements:

- Plans and policies that provide "excepted benefits," as defined under the Health Insurance Portability and Accountability Act (HIPAA), such as standalone vision plans, dental plans, and most health flexible spending accounts ("FSAs").
- Health reimbursement arrangements ("HRAs") integrated with a *self-funded* health plan.
- Plans and policies designed primarily to cover employees working and residing outside the U.S.
- Stop loss and indemnity reinsurance policies.
- Employee assistance programs ("EAPs"), disease management programs, or wellness programs, if these programs do not provide significant benefits in the nature of medical care or treatment.
- Certain exempt governmental programs (e.g., Medicare, Medicaid, CHIP, and TRICARE).

See the IRS PCORI applicability chart, at http://www.irs.gov/uac/Application-of-the-Patient-Centered-Outcomes-Research-Trust-Fund-Fee-to-Common-Types-of-Health-Coverage-or-Arrangements, for additional information.

Responsibility for Payment of PCORI Fee

Who pays the PCORI Fee depends on whether a health plan is fully-insured, self-funded, or contains a mix of benefits:

- **Fully-insured health plans.** The PCORI Fee on a fully-insured health plan (i.e., on the underlying insurance policy) is paid by the policy issuer.
- **Self-funded health plans.** The PCORI Fee on self-funded health plans is paid by the employer sponsoring the plan. A single PCORI Fee applies based on the total number of lives covered under all self-

funded benefit programs of one employer with the same plan year.

- **Plans with a mix of self-funded and insured benefits** (where, for example, an employer maintains both an HRA and an insured health plan). The PCORI Fee for the lives covered under the plan's insurance policy are paid by the policy issuer, while the PCORI Fee for the lives covered under the self-funded portion are paid by the plan sponsor. If the same employee is covered under both portions of a plan, the insurer and plan sponsor will both have to pay the PCORI Fee for that employee (because there is no set-off in these circumstances). However, lives covered only under the insured portion are not counted in determining the PCORI Fee for the self-funded portion.

Due Date for PCORI Fee

The PCORI Fee first applies to health insurance policies and self-funded health plans with policy or plan years ending on or after Oct. 1, 2012. It must be reported and paid by July 31 of the calendar year immediately following the last day of the plan or policy year. *Therefore, the PCORI Fee on plans and policies with years that ended between Oct. 1 and Dec. 31, 2012 must be reported and paid by July 31, 2013.*

Calculating PCORI Fee

The PCORI Fee for a plan or policy year is equal to the *applicable dollar amount* for the year multiplied by the *average number of covered lives* during the plan or policy year.

Applicable Dollar Amount

The applicable dollar amount varies year-to-year as follows:

Plan/Policy Year(s) Ending	**Applicable Dollar Amount**
Oct. 1, 2012 – Sept. 30, 2013	$1.00
Oct. 1, 2013 – Sept. 30, 2014	$2.00
Oct. 1, 2014 – Sept. 30, 2019	Adjusted for increases in the projected per capita amount of National Health Expenditures
On or after Oct. 1, 2019	PCORI Fee no longer applies

Number of Covered Lives

Generally, all individuals who are covered during the policy year or plan year (including the covered employee and the employee's covered dependents) must be counted. Three alternative counting methods are available to determine the number of covered lives. A method, once elected, must be used consistently for the duration of the year.

Alternative Counting Methods

- *Actual Count Method.* Add the number of covered lives on each day of the plan or policy year and divide the total by the number of days in the plan or policy year.

- *Snapshot Method.* Add the number of covered lives on a selected day (or days) in each plan or policy quarter and divide the total by the number of days on which the count was made. The count must be performed within three days of the same date(s) in each quarter. Alternatively, a plan may use the "*snapshot factor method*": the number of covered lives on a date is equal to the sum of (1) the number of participants with self-only coverage on that date and (2) the number of participants with coverage other than self-only coverage on the date multiplied by 2.35.
- *Form 5500 Method.* If a plan offers exclusively self-only coverage, add the total number of participants at the beginning and end of the plan year, as reported on the plan's Form 5500, and divide by two. If a plan offers additional coverage options (e.g., employee plus spouse), then simply add the total number of participants covered at the beginning and the end of the plan year, as reported on the plan's Form 5500 (i.e., do not divide by two). The Form 5500 method is not workable for plans that file Forms 5500, on extension, after the PCORI Fee due date.

Special Rule for First Year

For plan years beginning before July 11, 2012, and ending on or after Oct. 1, 2012, any reasonable method may be used to determine the average number of covered lives.

Special Rule for Non-Excepted Health FSAs and HRAs

If a plan sponsor maintains only an HRA or health FSA, then only the covered employees (and not their spouses or dependents) are counted. If another self-funded health plan subject to the PCORI Fee is maintained, in addition to the health FSA or HRA, then this special rule applies only to participants in the health FSA or HRA who do not participate in the other plan.

Reporting and Paying PCORI Fee

Issuers and plan sponsors must file IRS Form 720 by July 31 to report and pay the PCORI Fee. Electronic filing is available. Payment is due on the same date the Form 720 is due. The revised Form 720 and instructions are available, at http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return. The PCORI Fee is a deductible business expense under Code Section 162.

The Internal Revenue Service has provided a Q&A on the PCORI Fee, available at http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers.

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BENEFITS AND TAX CONSEQUENCES OF THE SUPREME COURT DOMA RULING FOR EMPLOYERS

The U.S. Supreme Court's finding that the Defense of Marriage Act (DOMA) provision denying recognition of the marital status of same-sex couples under federal law is unconstitutional leaves many questions about the post-DOMA application of various federal employee benefit and tax rules. (See our previous Compliance Alert, U.S. Supreme Court Rules Legally-Married Same-Sex Spouses Entitled to Federal Recognition and Lifts California Ban on Same-Sex Marriages.) While government guidance is expected, this article explores the implications thus far of the decision on the benefit and tax issues. For this purpose, we consider only benefits that are subject to special federal tax rules and/or the Employee Retirement Income Security Act (ERISA).

Recognition of same sex marriage under federal tax and benefits law primarily affects:

1. Federal tax treatment of benefits provided to eligible spouses, including tax treatment of coverage under group health plans and working condition fringe benefits; and

2. Mandated spousal rights under tax-qualified retirement plans and COBRA continuation coverage.

In the case of other benefits subject to ERISA (and ERISA preemption of state law), principally group health insurance, employers continue to have the right to define the type of spousal relationships (and/or domestic partner relationships) that will be eligible for coverage. (There is one important caveat for benefits provided through insurance discussed in the "Group Health Plans" section below.)

Group Health Plans

Currently, there is no federal law that mandates group health plan coverage based on marital status. Because ERISA preempts state law, a state law definition of spousal status generally will not be relevant and an employer can define spousal status for plan coverage purposes as they choose.

There is one caveat: the rules are somewhat more complicated when an employer provides health benefits through insurance. (Note that benefits provided to a participant in an HMO are considered to be insured.) ERISA permits a state to regulate insurance and benefits provided through insurance — a special exception to the general ERISA preemption of state laws. Based on this exception, if a state requires insurance policies provide coverages or benefits to same-sex spouses or domestic partners, an employer who purchases a policy subject to those requirements will become contractually bound to provide those benefits.

COBRA Coverage

If an employee's spouse is covered under the employee's group health plan immediately prior to a COBRA-qualifying event, then the spouse is entitled to elect COBRA coverage. The COBRA entitlement question is determined by whether or not the spouse was covered under the plan prior to the COBRA-qualifying event.

In addition, an employee who previously elected single coverage under COBRA has the right to change the coverage election at the time of open enrollment. If the plan at that time permits coverage for same-sex spouses of active employees, then the same option will have to be offered to individuals receiving COBRA coverage.

Federal Tax Treatment

The federal tax treatment of certain benefits depends upon spousal status. Most importantly, tax-free treatment of the cost of group health benefit coverage and benefit payments, pre-tax contributions under a Section 125-cafeteria plan and certain working condition fringe benefits depend upon the definition of spouse used in the Internal Revenue Code.

Tax-Qualified Retirement Plans

Generally, tax-qualified retirement plans include 401(k) plans, 403(b) plans, money purchase pension plans and defined benefit pension plans (including cash balance pension plans). The federal law definition of spouse will affect the following areas:

- Spousal consent to payments to a non-spouse beneficiary. This requirement applies to 401(k) plans and all other tax-qualified retirement plans.
- Spousal right to a qualified joint and survivor annuity from a money purchase pension or a defined benefit pension plan. This requirement does not apply to 401(k) or other defined contribution plans unless the plan offers a joint and survivor payment option (this is relatively rare).
- Spousal consent to early payment of plan benefits. Depending on plan design, this requirement typically will not apply to 401(k) or other defined contribution plans.
- Spousal consent to plan loans. As above, depending on plan design, this requirement typically will not apply.
- Somewhat more favorable rules for tax-free rollovers of plan distributions.
- Division of participant retirement benefits in a divorce or legal separation pursuant to a qualified domestic relations order.

Federal Definition of Spouse

As of this writing, neither the Internal Revenue Service, the Department of Labor nor any other federal agency has announced how “spouse” will be defined for purposes of the various federal statutes that include spousal rights.

Prior to the enactment of DOMA, the IRS looked to state law to determine marital status for federal tax purposes. The IRS also recognized common-law marriages that were legal in one state even if the individuals later moved to a state that did not recognize common law marriage.

It would not be surprising if the IRS applies the same rule to same-sex marriages for federal tax and benefit purposes. That is, as long as a couple marries in a state that recognizes same-sex marriage, that marriage would continue to be recognized for federal tax purposes if the couple moved to another state that did not recognize same-sex marriage. The IRS has announced that it would address this issue shortly.

Other Issues

Retroactivity

The most important question is whether the post-DOMA definition of spouse will be applied retroactively for federal tax or benefit purposes.

Given the significant administrative difficulties retroactive application could create, a wait-and-see approach should be considered. However, an employer may wish to file a protective refund claim for the employer

portion of FICA (Social Security and Medicare) taxes. The oldest open tax year currently is 2010.

Employer-Defined Coverage

It is important to note that, other than with respect to retirement plans, and possibly certain insured group health plans, employers remain free under current law to define which type of spousal relationships will be eligible for coverage under plans subject to ERISA. Because of ERISA preemption, an employer is not obligated to adopt state law marital definitions in applying those plans. Since there is no universal definition of spouse, employers should review all benefit plans and policies to determine where the term "spouse" is used and whether it is adequately defined and used consistently (if consistency is desired).

Gross-Up Coverage

Employers who previously "grossed up" employees to cover the additional federal taxes owed for coverage of same-sex spouses should review those policies to adjust to the change in the federal tax treatment. On the other hand, employees who elect coverage for domestic partners who do not meet the requirements to be legally married under state law will still be subject to additional federal taxes for such coverage.

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U.S. DEPARTMENT OF LABOR AUDITS OF HEALTH AND WELFARE PLANS: WHAT TO EXPECT AND HOW TO PREPARE FOR ONE

The Employee Benefits Security Administration ("EBSA") division of the U.S. Department of Labor (the "DOL") is charged with the enforcement of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and other Federal laws and regulations that govern employee benefit plans. EBSA views its mission as "vigorously enforcing the law". Since the enactment of the Patient Protection and Affordable Care Act ("PPACA") in 2010, the DOL has launched the "Health Benefits Security Project", which is a national initiative designed to detect and address compliance shortfalls and deficiencies in health and welfare plans under existing enforcement protocols and PPACA. Recent DOL audits of health and welfare plans have focused on plan operations and required disclosures (such as the notices to participants of the elimination of lifetime limits, the extension of coverage to dependents to age 26, and women's health rights), internal and external claims and appeals procedures, and whether plans electing to defer implementation of certain portions of PPACA under the grandfather provisions thereunder were in place on March 23, 2010.

EBSA has a wealth of information freely available at its website (http://www.dol.gov/ebsa) with respect to EBSA's enforcement activity and to assist employers and their human resources department (or other designated employees in charge of the health and welfare plan) with their compliance efforts, including model notices required under PPACA. In large part due to the DOL's national initiative, we have seen an increase in the number and scope of DOL audits of health and welfare plans.

Upon receipt of notice of a DOL audit of a health and welfare plan, the sponsoring employer should notify its insurance broker and legal counsel and work to ensure that the response is timely and sufficient. In a typical audit of a health and welfare plan, the DOL document request list includes a large

number of categories, most notably the following: plan documents, summary plan descriptions, certificates of coverage, written claims procedures, participant notices, insurance policies and summary payroll registers (for insured plans), plan correspondence files, and the plan's annual returns (generally for the most recent three plan years). While the actual itemized list may appear daunting, most audits are not overwhelming if approached in a methodical and coordinated manner. An organized and comprehensive response (without providing more information and documents than the DOL requests) reflects the employer's good faith efforts to cooperate with the DOL in the audit and may reduce or eliminate the DOL's need to conduct interviews or further investigation of the health and welfare plan. If the DOL investigator identifies compliance concerns during the audit, penalties may be waived or reduced if a settlement (and other corrective measures, as applicable) can be reached.

Whether self-insured or fully-insured, small or large, or the sponsor of a single-employer plan or multiple employer-plan, all employers may take certain measures to be prepared for the increased likelihood of a DOL audit of such employers' health and welfare plans. An employer ideally should designate one or more persons or one department to take charge of the health and welfare plan. Such individual or group should read and be familiar with the plan documents (and policies, as applicable), be familiar with the legal requirements applicable to such plans and the actual plan operations, keep all plan related materials in one location, conduct internal periodic audits of plan operations, seek expert advice as necessary, establish written procedures for plan administration (e.g., procedures to address eligibility disputes), respond to employee questions and furnish required participant notices in a timely manner, and ensure that, if the plan is required to file an annual return (IRS Form 5500 series), that such return is prepared and filed on or before the due date each year (end of the seventh month following the end of the plan year, unless Form 5558 is submitted to obtain an automatic 2.5 month extension). Employers also should maintain adequate insurance (fidelity bonds (as required under ERISA), fiduciary liability insurance, employee benefit plan administration liability insurance, etc.). One of the primary benefits of adopting a proactive approach to plan maintenance is the identification and correction of any compliance concerns before the DOL audits a plan. The DOL offers voluntary correction programs for common plan failures, and such correction programs are no longer available once the DOL notifies an employer of a plan audit.

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USERS TO RECEIVE NEW PASSWORDS FOR EEO-1 REPORTS

The Employer Information Report EEO-1 must be filed annually with the U.S. Equal Employment Opportunity Commission's (EEOC) EEO-1 Joint Reporting Committee. The preferred method for completing the EEO-1 reports is the web-based filing system. The online form is totally web-based. The filing deadline for the 2013 EEO-1 Report is Sept. 30, 2013.

In preparation for the 2013 EEO-1 reporting period, the EEOC has reset the passwords for all users of the online system for security and confidentiality purposes. Reporting companies will receive by mail "notification letters" with the new password. Users who need to access the system prior to receiving the 2013 notification letter may obtain their

new password by sending an e-mail to e1.lostloginpassword@eeoc.gov. The request must come from the company's

EEO-1 contact or certifying official and must contain the company's name and log-in identification. If the certifying official no longer is with the company, the request also should include the name of the former certifying official and a request to transfer access to the new contact.

Who Must File EEO-1 Reports

EEO-1 Reports must be filed by employers subject to Title VII of the Civil Rights Act (and who have at least 100 employees) and by federal contractors and subcontractors with at least 50 employees and a federal contract or subcontract of at least $50,000. The EEO-1 Report requires submission of workforce demographics (race, ethnicity and gender of all employees) by job category.

Single establishment employers file a single EEO-1 Report. However, employers with multiple establishments generally must file several types of reports:

(1) a headquarters report,

(2) separate reports for each establishment of 50 or more employees,

(3) either separate reports for each establishment of less than 50 employees or a list, including name, address, total employment and major activity, of each establishment of less than 50 employees, and

(4) a consolidated report of all employees in the entire organization.

Employers must use employment data from any one payroll period in July, August or September of the current reporting year.

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NLRB HOLDS CONFIDENTIALITY/DISPARAGEMENT PROVISIONS IN EMPLOYMENT AGREEMENTS UNLAWFUL

Applying the principles it has used primarily to evaluate handbook rules and personnel policies, the National Labor Relations Board (NLRB) has held that confidentiality and non-disparagement provisions contained in an employment agreement are unlawful under the National Labor Relations Act. *Quicken Loans, Inc.*, 359 NLRB No. 141 (June 21, 2013). The employer required its mortgage bankers to sign an employment agreement containing a provision about the use and disclosure of "Proprietary/Confidential information." It included among such information:

…all personnel lists, rosters, personal information of co-workers, managers, executives and officers; handbooks, personnel files, personnel information such as home phone numbers, cell phone numbers, addresses and email addresses.

The Agreement also contained a non-disparagement provision:

Non-disparagement. The Company has internal procedures for complaints and disputes to be addressed and resolved. You agree that you will not (nor will you cause or cooperate with others to) publicly criticize, ridicule, disparage or defame the Company or its products, services, policies, directors, officers, shareholders, or employees, with or through any written or oral statement or

image (including, but not limited to, any statements made via websites, blogs, postings to the internet, or emails and whether or not they are made anonymously or through the use of a pseudonym). You agree to provide full cooperation and assistance in assisting the Company to investigate such statements if the Company reasonably believes that you are the source of the statements. The foregoing does not apply to statutorily privileged statements made to governmental or law enforcement agencies.

The NLRB has recently found similar language in handbooks unlawful, and applied its test used to evaluate rules set forth in *Lutheran Heritage Village-Livonia*, 343 NLRB 646 (2004):

"Our inquiry into whether the maintenance of a challenged rule is unlawful begins with the issue of whether the rule explicitly restricts activities protected by Section 7. If it does, we will find the rule unlawful.

If the rule does not explicitly restrict activity protected by Section 7, the violation is dependent upon the showing of one of the following: (1) employees would reasonably construe the language to prohibit Section 7 activity; (2) the rule was promulgated in response to union activity; or (3) the rule has been applied to restrict the exercise of Section 7 rights."

The Board specifically held unlawful language that restricts employees from publicly criticizing, ridiculing, disparaging or defaming the company or its products, because, the Board noted, "Within certain limits, employees are allowed to criticize their employer and its products as part of their Section 7 rights…."

This case underscores that it is not only handbook rules and policies which may come under the scrutiny of the NLRB, but other practices and policies which govern the relationship between an employer and its employees could be found to be overly-broad in their restrictions on employees' rights, and therefore unlawful.

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