

Hamilton News

Guidance Issued on “Grandfathering”

Joint guidance was issued on June 23, 2010, by the Departments of Labor, Treasury, and Health and Human Services regarding how the requirements in health care reform apply to “grandfathered” plans (those in use at the time the law was enacted on March 23, 2010), clarifying what constitutes such a plan, and defining how the status is maintained.

The regulations define a grandfathered plan as “health coverage provided by a group health plan or an insurance issuer in which an individual was enrolled on March 23, 2010...and the status of the coverage is maintained as long as the plan continuously covers at least one person (not necessarily the same person) since that date.” Renewal of an insurance policy that was in effect on the date the law was enacted does not affect the plan’s status nor does the enrollment of newly-eligible employees or family members of participants. Interestingly, the status is generally determined separately for each benefit option, so a plan may have some options that are grandfathered while others are not.

The plan will lose its grandfathered status if it:

- Switches to a new insurer;
- Eliminates all or substantially all benefits to diagnose or treat a particular condition;

- Increases a percentage cost sharing requirement, such as co-insurance, above the level in effect on March 23;
- Increases a fixed-cost requirement other than co-payments, like a deductible or out-of-pocket limit, by more than medical inflation plus 15%;
- Increases co-pays by the greater of (1) medical inflation plus 15% or (2) medical inflation plus \$5; OR
- Decreases the employer contribution rate by more than 5% of the March 23 rate.

The regulations clearly state that certain changes *can* be made without threatening the grandfathered status, as long as they are within the standards just described. These include changes to premiums, to comply with federal or state laws, or to voluntarily comply with health reform law early and switching third-party administrators.

An additional requirement to maintain the grandfathered status of a plan is the imposition of a notice requirement. A plan must include a statement in any plan materials notifying participants that the plan is considered grandfathered and contact information for questions or concerns.

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HIRE Act—IRS Sees Errors on Tax Returns

The Hiring Incentive to Restore Employment (HIRE) Act, signed into law in March of this year, provides tax incentives to employers who hire unemployed workers and extends deduction limits for capital improvements. With the filing of some of the first quarterly returns claiming the tax credit, an IRS spokesperson has noted that a number of returns were filed with errors.

The most frequently noted error is employers including a dollar value on lines that require a count of the qualified employees. This is the most problematic error noted, though returns have also include computational errors, or an inaccurate employer identification number. Returns filed with errors that the IRS is not allowed to correct are placed in a “suspense” status until the information can be clarified with the employer. If the necessary information is not received during the appropriate correspondence period, the IRS will process the return without the tax exemption or credit.

In addition to the errors already noted, the IRS is developing a compliance plan for the HIRE Act and has provided guidance on the documentation and information it may request in audit situations. While there is no limit to what may be requested, employers should have a ready list of employees who were included in the tax credit computation, a valid and timely signed affidavit for each employee claimed, confirmation that those claimed are “employees” and not in some other form of work relationship, and any additional information regarding employees hired to replace another employee (including the termination reason for the original employee).

Some employers have opted not to file for the HIRE Act tax credit for all their qualified employees, instead claiming the work opportunity tax credit (WOTC). Employers may not claim both credits for the same employee, but should elect the credit most beneficial for them. If an employer claims the HIRE Act exemption and later determines that the WOTC would have been more beneficial, the company can elect out of the exemption later on the Form 941X for each impacted quarter, and include the eligible WOTC income on its income tax return.

“Interim Final Rules” Issued on PPACA

The Departments of Treasury, Labor, and Health and Human Services jointly issued Interim Final Rules on June 28 related to key provisions of the recently-enacted Patient Protection and Affordable Care Act (PPACA), known commonly as health care reform. These rules cover pre-existing condition exclusions, annual and lifetime coverage limits, and rescissions, and apply both to new and grandfathered plans.

Pre-existing Conditions: Group health plans and health insurance issuers may not impose pre-existing condition exclusions for individuals under the age of 19 regardless of whether the individual has prior creditable coverage, for plan years beginning on or after September 23, 2010. This will be extended to all plan participants as of January 1, 2014. The regulations explain that plans may still exclude select benefits as long as the exclusion applies regardless of when the condition arose.

Lifetime Limits: Plans and issuers are prohibited from applying lifetime dollar limits on “essential health benefits” under PPACA, for plan years beginning on or after September 23, 2010.

Annual Limits: Beginning January 1, 2014, plans and issuers may not impose annual limits on essential health benefits but under the Rules, the implementation of this ban is phased into effect, beginning this year. Plans may have annual limits as long as they are at least the annual maximums shown in the schedule to the left. In addition, the Rules make clear that the annual limits apply on an *individual* basis, and may not be used on a family basis to deny coverage to an individual. Also, these limits apply to essential health benefits only, allowing plans and issuers to retain lifetime

Plan Year	Min. Annual Limit
On or after 9/23/10 (2011 CY)	\$750,000
On or after 9/23/11 (2012 CY)	\$1,250,000
On or after 9/23/12 (2013 CY)	\$2,000,000

and annual limits on benefits that are not considered essential health benefits and as long as they are permitted by other federal or state law. Plans must provide a special enrollment for individuals who were previously ineligible for coverage due to a lifetime or annual limit exclusion. This Rule does not apply to certain “mini-med” plans, flexible spending arrangements, medical savings accounts, and health savings accounts.

Essential Health Benefits: Crucial to decision making regarding annual and lifetime limits is the definition of essential health benefits. These include ambulatory and emergency services, hospitalization, maternity and newborn care, prescription drugs, mental health and substance use disorder treatment, rehabilitative services and devices, chronic disease management, preventive and wellness services, laboratory services, and pediatric (including oral and vision) care.

Rescissions: Under the Act, plans and issuers may not rescind coverage once a participant has become covered, except in the case of an individual whose act, practice or omission constitutes fraud or who has made an intentional misrepresentation of material fact. This standard applies to all rescissions, including group or individual coverage and whether insured or self-insured. The Rules clarify that a plan may *proactively* cancel coverage when it is determined that a participant has been ineligible for some time (e.g., the employee changed to an ineligible part-time status several months prior) as long as a 30-day notice of the rescission is provided.

Simple Cafeteria Plans

For plan years after December 31, 2010, some small employers’ cafeteria plans can qualify as “simple cafeteria plans” allowing them a safe harbor from the nondiscrimination requirements under Section 125(b) of the Internal Revenue Code. These provisions normally apply to all cafeteria plans and prohibit discrimination in favor of highly compensated individuals or key employee regarding their eligibility to participate, levels of contributions, or actual benefits received. Any employee who is not classified as highly compensated or key is considered a “qualified employee.”

An employer is eligible to establish a simple plan if, during either of the two preceding years, it employed an average of 100 or fewer employees. This provision is intended to allow small but growing employers to offer the pre-tax contribution and cafeteria plan benefits to its employees without the concern of having to meet the nondiscrimination testing requirements.

A simple cafeteria plan must contribute a uniform amount equal to at least 2% of each employee’s compensation for the year, allow any employee who worked 1,000 or more hours in the preceding year to participate, and permit all eligible employees to elect any benefit available under the plan. Employers may elect to exclude employees who will still be under the age of 21 at the end of the plan year, have less than one year service on any day during the plan year, are covered by a collective bargaining agreement, or non-resident aliens working outside the United States.



A recent workers’ comp study completed by Johns Hopkins School of Medicine reviewing five years of data from a Louisiana provider found that 3.7% of physicians accounted for a whopping 72% of workers’ comp costs in the state. These “cost-intensive providers” had average claims that were:

- four times higher than other doctors,
- took twice as long to settle, and
- had more than twice as many with claims cost of \$50,000 or greater.

Interestingly, the majority of high cost claims were involved in pain management. This study was published in *Journal of Occupational and Environmental Medicine*.

“National Research Program” or Compliance Study?

In March, the IRS began its largest tax compliance study in 25 years, the National Research Program (NRP) focusing on employment tax practices. Since business practices and IRS regulations have changed significantly, the IRS felt that this study is necessary. Examinations are being conducted to “help the IRS understand the compliance characteristics of employment tax filers,” according to a Spring 2010 IRS newsletter. The two main goals of the NRP are:

- To secure statistically valid information for computing the Employment Tax Gap; and
- To determine compliance characteristics so the IRS can focus on employment tax areas with the most compliance problems.

The IRS will select 2,000 taxpayers each year for the next three years, for a total of 6,000 employers. Faris Fink, deputy commissioner for the IRS Small Business / Self-employed Division, noted that 90% of the first phase employers have been notified and about one-third of the 2,000 first-year audits are underway.

At a recent American Bar Association event, two senior IRS officials answered questions about the NRP. They noted that the original list of employers was selected based on their 2008 Form 941 filings and future employers will be selected based on their 2009 filings. While the selection was “generally random,” the process was “tweaked a little bit.” Other than saying that the IRS excluded companies with two or fewer employees, no further specification of the “tweaks” was provided. The audits were also selected to be geographically random. Questions were asked whether small employers are targeted. Less than 3% of the first phase audits were for large or mid-sized companies, but the Small Business Administration notes that 99.7% of all US employers are considered small (less than 500 employees). The IRS representatives noted that these audits will be more invasive than what is called a traditional or

“targeted” audit. The IRS is trying to learn what non-compliance areas are a problem, causing the exams to take longer and be more comprehensive.

One topic that will receive specific attention is the proper handling of the tax status of fringe benefits (personal use of company vehicle, club memberships, etc.). Auditors are expected to use a number of methods for identifying concerns, such as “flipping checks” from payroll and accounts payable and reviewing insurance policies or other documents that might indicate the existence of fringe benefits. Auditors may walk through the parking lot to see what type of car is parked in the president’s spot, check to see if its company-owned or insured, then verify that its personal use is reflected as taxable income. Auditors are trained to look into 70 different types of fringe benefits and will be looking for accounts payable checks that indicate the company is paying for something, such as boat slips, residential properties, or other red-flags indicating a situation that may warrant further review.

A second critical component of the audit will be the correct classification and tax treatment of independent contractors versus employees. Employers should carefully comply with the IRS’s tests for a contractor, focusing on (1) which party maintains primary control of how and when work is performed, (2) who bears the financial risk and pays the business expenses associated with performing a job, and (3) does the relationship “look” like an employee-type relationship, including payment of benefits or the performance of work critical to the company’s operation. IRS officials expect to find a significant number of employee misclassifications.

The IRS plans to use the results of this “research program” to develop tools for future compliance efforts, including revised audit techniques, education initiatives and enforcement efforts.

DID YOU KNOW?

...that the Department of Labor announced in April of this year that it would no longer issue Opinion Letters to employers’ specific questions. Long a useful guidance tool for employers, Opinion Letters are published anonymously on the DOL website and can be the basis for other employers’ efforts to comply with federal wage and hour (and other) regulations. The last Opinion Letters issued by the DOL were in January 2009, prior to the Obama administration. There have now been several “Administrator’s Interpretations” issued, most conflicting or rescinding previously-issued DOL guidance. Guidance will now be provided in response to employer requests in the form of references to applicable statutes, but without analysis of the specifics of their situation. To date, the DOL has withdrawn 14 existing Opinion Letters for “further consideration.” The first Administrator’s Interpretation, regarding Mortgage Loan Officers, overturned previously issued guidance, claiming that these jobs should now be non-exempt. Employers should take a careful approach to wage and hour interpretation and compliance.

Expanded FMLA Definition of “Son or Daughter”

The Department of Labor (DOL) issued Administrator’s Interpretation 2010-3 regarding a “clarification” of the definition of “son or daughter” under the Family and Medical Leave Act (FMLA). Currently, FMLA allows eligible employees to take up to 12 workweeks of job-protected leave to care for the birth, adoption or care of a son or daughter with a serious health condition. It has defined this to include a “biological, adopted, or foster child, stepchild, a legal ward, or a child of a person standing *in loco parentis*” to a minor or mentally- or physically-disabled adult.

In its June 22, 2010 guidance, the DOL expands the definition who might qualify as a one serving *in loco parentis* (e.g., in place of the parent). Current regulations include those with both day-to-day responsibilities to care for and financially support a child, including employees with no biological or legal relationship to a child. Now, the DOL has said that if an adult either provides day-to-day care or financial support, he or she may be eligible for leave under FMLA. In particular, this might include an unmarried partner who assists with either the care or financial support of a partner’s child, but does not bear the responsibility for both.

Also, the regulations do not restrict the number of “parents” who may request leave to care for a child or bond following birth or adoption, though the same principles apply if multiple parents are employed by the same employer (limits to a total of 12 weeks leave, split among the parents).

To request this leave, an employee may be asked to provide reasonable documentation or, in cases where no legal or biological relationship exists, a statement asserting the relationship to support the desired leave.



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