2013 Legislative and Regulatory Year in Review

An Overview of Policy Related to HR and Employee Benefits
Enacted in 2013

February 2014
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This report was compiled by the Legislative Reporting Team.
2013 Legislative and Regulatory Year in Review

This report summarizes key legislative and regulatory activity at the federal level in 2013 and highlights some significant federal court cases, all from the perspective of employer-sponsored employee benefit and human resources (HR) programs. The following report was compiled by the Legislative Reporting Team. If you have questions or for more information, please contact us here.
Federal Legislative Activity in 2013

Highlights of Federal Legislation Enacted in 2013

2013 can best be described as a year of congressional gridlock. As with 2012, little progress was made in policymaking, especially in the areas of employee benefits and HR. During 2013, nearly 60 bills were enacted into law.

Some of the enacted bills focused on extending government funding, temporarily raising the debt ceiling, and ultimately ending the shutdown that halted government operations for two weeks this past October. One piece of legislation, the American Taxpayer Relief Act (ATRA) (enacted in January 2013), did include employer-provided fringe benefits, a “Doc Fix,” and Roth provisions.

During 2013, the Senate passed an immigration bill and the Employment Non-Discrimination Act (ENDA). The House passed several bills that would have either repealed or defunded the Patient Protection and Affordable Care Act (Affordable Care Act) or placed other limitations on the health care reform law. None of these bills are expected to pass both chambers and become law. The 113th Congress will continue to convene through January 3, 2015.

President Obama Signs Budget Deal Into Law

On December 26, 2013, President Obama signed into law a two-year budget deal (Bipartisan Budget Act of 2013 – H.J. Res. 59). The bipartisan agreement sets discretionary spending at more than $1 trillion for the next two fiscal years and replaces sequester cuts beginning in January 2014. The budget includes a temporary, three-month “Doc Fix,” which delays a 20.1% reduction in Medicare payments (beginning January 1, 2014) under the Sustainable Growth Rate (SGR) formula. Legislators are hoping to permanently repeal the SGR before the temporary “patch” expires in March 2014. Additionally, the budget compromise increases defined benefit pension plan insurance premiums for the second time in two years. (The flat-rate per-participant premium for single employers will increase to $57 for plan year 2015 and to $64 for plan year 2016. Flat-rate premiums will then be indexed to the growth in wages thereafter. Variable-rate premiums will increase by $5 per $1,000 of unfunded vested benefits in plan year 2015 and an additional $5 in plan year 2016. Variable-rate premiums will also be indexed to increases in wages thereafter. They will be capped at $500 per participant for plan years beginning after 2015.)

The budget agreement does not include any new tax increases, nor does it contain provisions to extend emergency unemployment benefits or target the debt ceiling.

President Enacts Law Ending Government Shutdown; Temporarily Raises Debt Ceiling

On October 17, 2013, President Obama signed into law H.R. 2775 (Continuing Appropriations Act, 2014 – P.L. 113-46). The legislation, passed by Congress in a last-minute voting frenzy, ended the partial government shutdown and temporarily extended the nation’s federal borrowing capacity. The law funded the government until January 15, 2014 and raised the debt ceiling through February 7, 2014. The only Affordable Care Act provision included in the legislation requires income verification for anyone applying for federal subsidies in the health insurance Exchanges (marketplaces).
President Obama Signs Bill to Continue Government Funding Into Law

On March 26, 2013, President Obama signed into law the “Consolidated and Further Continuing Appropriations Act, 2013” (H.R. 933). The law provided for continued government spending, which included funding for various government agencies. The legislation also included budget reductions required under sequestration. The law became effective after the previous stopgap funding measure expired on March 27 and provided funding through the fiscal year ending September 30, 2013.

President Obama Signs No Budget, No Pay Act Into Law

On February 4, 2013, President Obama signed into law the No Budget, No Pay Act of 2013 (P.L. 113-3). The law extended the debt ceiling until May 19 and contained a provision that required each chamber of Congress to pass a budget by April 15 or have members’ pay suspended.

President Signs ATRA Into Law; Includes Employer-Provided Fringe Benefits, “Doc Fix,” and Roth Provision

On January 2, 2013, President Obama signed ATRA into law. The law contained a number of tax provisions for businesses and individuals, including: increased taxes on individuals with taxable income of more than $400,000 (or more than $450,000 for married individuals filing jointly); increased tax rates on capital gains and dividends; a permanent patch to the alternative minimum tax (AMT); and a one-year extension to unemployment insurance. The law also included another “Doc Fix” by avoiding a 27% reduction to Medicare physician reimbursements for 2013. In addition, the new law allowed Section 401(k), 403(b), and 457(b) plans to be amended to permit the conversion of taxable vested amounts (e.g., elective deferrals, matching contributions, and nonelective employer contributions) to a designated Roth account maintained within the plan. Previously, in-plan Roth conversions were only permitted for participants who were eligible for a distribution from the plan (e.g., for participants who were age 59½ or older). The newly expanded Roth conversion provisions apply to requests made after December 31, 2012.

Other employer-provided fringe benefits in the legislation included education assistance, adoption assistance, the employer-provided child care credit, and qualified transportation expenses.
Judicial Activity

The biggest and most anxiously-awaited judicial news came during the summer of 2013, when the U.S. Supreme Court struck down a key section of the federal Defense of Marriage Act (DOMA). In the *United States v. Windsor*, the Court held that the section in the federal DOMA defining “marriage” as a legal union between one man and one woman and “spouse” as only to a person of the opposite sex is unconstitutional. The Court’s decision generated a number of legal and business implications for employers. Government agencies have responded to the decision by issuing a variety of guidance on same-sex marriage.

**U.S. Supreme Court**

**Supreme Court Strikes Down Key Section of DOMA and Dismisses Prop 8 Case for Lack of Jurisdiction . . .**

By a 5-4 decision, the U.S. Supreme Court has ruled in *United States v. Windsor* that a key section of the federal DOMA defining marriage as the union of one man and one woman for purposes of federal law is unconstitutional as a deprivation of the equal protection guaranteed by the Fifth Amendment. The opinion and its holding are confined to lawful marriages.

In the *Windsor* decision, the Court addressed the impact of Section 3 on spousal entitlement to benefit programs sponsored by the federal government and private employers:

> [The Defense of Marriage Act] prevents same-sex married couples from obtaining government healthcare benefits they would otherwise receive…It forces them to follow a complicated procedure to file their state and federal taxes jointly…It raises the cost of health care for families by taxing health benefits provided by employers to their workers’ same-sex spouses…And it denies or reduces Social Security benefits allowed to families upon the loss of a spouse and parent, benefits that are an integral part of family security.

The Court stated that the Court’s opinion and the holding striking down Section 3 of DOMA applied only to “lawful marriages.” As a result, federal law will now defer to state law in determining whether a couple is legally married for purposes of federal laws defining terms such as “marriage” and “spouse.”

Also by a 5-4 decision, the Supreme Court ruled in *Hollingsworth v. Perry* that the petitioners in the Proposition 8 case did not have standing to contest the district court’s decision overturning California’s ban on same-sex marriage. The Court vacated the Ninth Circuit decision, effectively leaving in place the district court’s ruling and reinstating California’s recognition of same-sex marriage.

**. . . And Tightens Employment Discrimination Claims in Two Other Cases**

In addition to the landmark DOMA and Proposition 8 rulings released by the Supreme Court during the summer, the Court issued two important employment law cases involving Title VII employment discrimination claims. In *Vance v. Ball State University*, an employee of Ball State University filed a lawsuit against her employer, claiming that she had been subjected to a racially hostile work environment in violation of Title VII of the Civil Rights Act as a result of alleged harassment by another employee. The liability of an employer for workplace harassment may depend on whether an alleged harasser is a
co-worker of an employee or a supervisor. Where a harasser meets the definition of a "supervisor," an employer may have vicarious liability for his or her actions. The Court upheld the Seventh Circuit’s judgment that the harasser in this case was not a “supervisor” for purposes of vicarious liability under Title VII because there was no evidence that she was empowered by Ball State University to take any tangible employment actions against the plaintiff. Tangible employment actions, the Court explained, effect a “significant change in employment status” and include actions such as “hiring, firing, failing to promote, reassignment with significantly different responsibilities, or a decision causing a significant change in benefits.” In reaching its conclusion, the Court rejected what has been a broader approach to supervisor status taken by the Equal Employment Opportunity Commission (EEOC).

In *University of Texas Southwestern Medical Center v. Nassar*, the Court raised the bar for plaintiffs with retaliation claims under Title VII. In this case, a staff physician and faculty member alleged that he had been retaliated against by his employer in violation of Title VII for having made earlier claims of racial and religious harassment. In its ruling, the Court determined that an employee who claims retaliation under Title VII must prove “that the desire to retaliate was the but-for cause of the challenged employment action,” not merely a motivating factor. In rejecting the lower standard for retaliation claims, Justice Kennedy, writing for the majority, commented on the importance of properly interpreting the antiretaliation section of Title VII and noted the ever-increasing number of retaliation claims. Such claims have nearly doubled in the past 15 years, from a little over 16,000 such claims in 1997 to over 31,000 in 2012.
Federal Regulatory Activity

Most of the federal regulatory activity in 2013 by far was centered on compliance with the Affordable Care Act. Over 80 different items for employers to track, comprehend, and sometimes implement were released under the Affordable Care Act in 2013, over 20 of which were regulations that were finalized.

While health plans stole the spotlight, retirement plans had a quieter year. Among notable regulatory developments, the Internal Revenue Service (IRS) issued temporary nondiscrimination relief for certain closed pension plans and the Department of Labor (DOL) continued to pursue more extensive disclosures to participants, including illustrations of potential monthly lifetime income amounts in defined contribution plans.

In addition, a number of federal guidance documents on same-sex marriage applicable to employee benefits, payroll, and other aspects of employment were released after the Supreme Court’s ruling in the landmark United States v. Windsor case in June 2013.

All of these regulatory developments are included below in the summaries of regulatory activity. Related Aon Hewitt bulletins are also noted.

Health Care

Affordable Care Act Guidance

Please note that some of the regulatory documents issued under the Affordable Care Act in 2013 were broad in their scope and extended, on occasion, beyond the single subject areas identified by the headings below.

Basic Health Program

On September 20, 2013, the Centers for Medicare and Medicaid Services (CMS) released proposed regulations that would establish the Basic Health Program, as required by the Affordable Care Act. The Basic Health Program provides states with the flexibility to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the state Exchanges. The Basic Health Program would complement and coordinate with enrollment in a qualified health plan (QHP) through the Exchanges, as well as with enrollment in Medicaid and the Children’s Health Insurance Program (CHIP). The proposed regulations would establish a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. Additionally, the regulations would amend other rules issued by the Secretary of Health and Human Services (HHS), in order to clarify the applicability of those rules to the Basic Health Program.

Compliance Tools and Websites

In 2013, the Employee Benefit Security Administration (EBSA) made available two Affordable Care Act self-compliance tools on its website. The tools were developed to assist group health plans, plan sponsors, plan administrators, health insurance issuers, and other parties in understanding and complying with the health care reform law. The first tool (Health Insurance Portability and Accountability Act (HIPAA) and Other Health Care-Related Provisions) includes 57 questions to determine whether a group health plan is in compliance with some of the provisions of Part 7 of ERISA. The second tool
(Affordable Care Act Provisions) discusses Affordable Care Act compliance and provisions, as well as recent regulations, and the document includes a list of questions to help determine whether group health plans and health insurance issuers are in compliance with the law. The DOL stated that these tools will be updated in the future to address additional requirements as they become applicable, as enforcement grace periods expire, or as government agencies issue additional guidance.

On August 15, 2013, the IRS released a new website detailing the tax provisions of the Affordable Care Act. The website has separate sections for employers, individuals, families, and other organizations. Topics include premium tax credits, benefits and responsibilities for employers, and tax provisions for insurers and other types of businesses. Additionally, the agency released Publication 5093 (Health Care Law Online Resources). The publication provides a listing of online Affordable Care Act government resources that are available for individuals and employers.

The Obama Administration launched a new website called Business.USA.gov on August 1, 2013. The website, designed for employers of all sizes and plans, is meant to provide educational materials on how the Affordable Care Act may “affect businesses and help them compete.” Business.USA.gov will also act as a user-friendly hub that can connect employers to informational content on tax credits and other provisions of the law from the Small Business Administration, HHS, and the Treasury.

HHS updated its HealthCare.gov website at various times in 2013, providing more consumer-focused resources and educational tools to help individuals prepare for implementation of the Affordable Care Act. In addition to the website, HHS began to provide a 24-hour-a-day consumer call center to help individuals prepare for enrollment in the Exchanges and sign up for private health insurance. The Exchange, created as part of the Affordable Care Act, is intended to provide individuals and small businesses with “one-stop shopping” to purchase affordable, quality health insurance options. Additionally, HHS renamed the former “Exchanges” as the “health insurance marketplace” and allowed consumers to sign up for updates via text or email. Federal and state Exchanges become operational in 2014 and are intended to provide individuals and small businesses with the opportunity to purchase affordable, quality health insurance options as part of the health care reform law. Open enrollment in the new Health Insurance Exchange began October 1, 2013.

EAPs, HRAs, Health FSAs, Vision Plans, and Dental Plans

On December 20, 2013, the IRS, EBSA, and CMS released proposed regulations that would amend the regulations on excepted benefits. The proposed regulations state that “Excepted benefits are generally exempt from the health care reform requirements that were added to those laws by HIPAA and the Affordable Care Act.” The agencies indicated that after the enactment of the health care reform law, stakeholders asked the government to amend the regulations on excepted benefits to remove conditions for limited-scope vision and dental benefits as excepted benefits. The proposed regulations would also establish the criteria for employee assistance programs (EAPs) to qualify as excepted benefits beginning in 2015.

The DOL, Treasury, and HHS issued technical guidance on September 13, 2013 that clarified the application of the Affordable Care Act’s group market reforms to health reimbursement arrangements (HRAs), employer payment plans, health flexible spending accounts (health FSAs), and EAPs. The guidance focused, in particular, on the application of the rules prohibiting annual dollar limits on essential health benefits (EHBs) and prohibiting cost sharing for certain preventive health services on an in-network basis. The guidance—DOL Technical Release 2013-03 and IRS Notice 2013-54—applies to plan years beginning on and after January 1, 2014, but the guidance can also be applied for all prior periods.
See the Aon Hewitt bulletin titled “So Complex It’s Scary: Friday the 13th Affordable Care Act Guidance on HRAs, Health FSAs, and EAPs” (September 2013) under “2013 Developments: A Closer Look” for a discussion of how this guidance affects employer-provided health care plans.

Early Retiree Reinsurance Program

On April 19, 2013, CMS issued a notice providing termination dates for several processes under the Early Retiree Reinsurance Program (ERRP) in preparation for the January 1, 2014 program sunset date. The ERRP secure website was in the process of being phased down. It will eventually be taken offline and archived. Specifically, the notice indicated that the last day upon which plan sponsors were required to update information contained in either their paper application or the ERRP secure website was December 31, 2013. In addition, the last day for submitting an ERRP reimbursement request was July 31, 2013; the last day for submitting corrections to data inaccuracies was July 31, 2013 (i.e., the last day upon which a plan sponsor may have submitted an ERRP reimbursement request); and the last day for submitting an ERRP reopening request was December 31, 2013. In addition, the notice indicated that plan sponsors do not need to notify CMS of a change of ownership in instances where the anticipated effective date of the change would occur after December 31, 2013. The notice does not limit the requirements in the ERRP regulations that plan sponsors (and subcontractors, if applicable) must maintain and furnish to the HHS Secretary, upon request, certain records. Such records must be maintained for six years after the expiration of the plan year in which the costs were incurred, or longer if otherwise required by law.

Employer Mandate and Minimum Value

The Obama Administration announced on July 2, 2013 that the employer mandate under the Affordable Care Act will be delayed until 2015, thus giving employers an extra year to comply with the law’s complicated hours-tracking and related reporting rules. On July 9, the IRS followed up with a Notice (2013-45) spelling out the specifics of the delay. Under the Affordable Care Act, an employer with 50 or more full-time equivalent employees is liable for monetary penalties if the employer does not offer affordable, minimum value health care coverage to a full-time employee and that employee obtains subsidized health care coverage from a health insurance Exchange. Those penalties, along with the insurance reporting requirements imposed on employers under the Affordable Care Act, will not be enforced against employers until 2015. The delay means that employers will have an additional year to offer health insurance coverage to their full-time employees before the IRS will assess penalties, known as the employer shared responsibility payment. Employers also will have an additional year to comply with the information reporting provisions that require employers to provide information to the IRS regarding the health insurance coverage offered to their full-time employees. That information will, in part, determine whether those employees are entitled to subsidized health insurance and whether employers are liable for an employer shared responsibility payment. The transition relief did not delay the effective date for other provisions of the Affordable Care Act, such as the requirement that individuals purchase health insurance or pay a penalty.

See the Aon Hewitt bulletins titled “Affordable Care Act’s Employer Mandate Goes to the Waiting Room” (July 2013) and “Summer Arrives—Administration ‘Beaches’ Employer Shared Responsibility Payments for 2014” (July 2013) under “2013 Developments: A Closer Look.”

The Treasury and IRS issued proposed regulations relating to the health insurance premium tax credit enacted by the Affordable Care Act on April 30, 2013. The proposed regulations affect individuals who enroll in QHPs through Exchanges and claim the premium tax credit and Exchanges that make QHPs available to individuals and employers. The proposed regulations also provided guidance on determining
whether health coverage under an eligible employer-sponsored plan provides minimum value and affect employers that offer health coverage and their employees. In addition, under the proposed regulations, employers may only take into account whether a plan participant qualifies for an incentive or reward under a group health plan’s wellness program that is designed to prevent or reduce tobacco use when determining the plan’s affordability and minimum value under the Affordable Care Act. In calculating a plan’s affordability and minimum value, wellness program incentives and rewards that do not relate to tobacco use are not taken into account and are treated as not earned. The April 30 proposed regulations, which would become effective in plan years beginning after 2014, provide a transition rule for affordability and minimum value determinations made by plans with wellness programs in plan years beginning in 2014. The proposed regulations also address contributions to HRAs and health savings accounts (HSAs) for purposes of determining affordability and minimum value and discuss the impact of COBRA coverage and retiree medical coverage on an individual’s ability to obtain a premium tax credit through an Exchange.

See the Aon Hewitt bulletin titled “Up in Smoke?—IRS Filters Out Most Wellness Programs From Affordability and Minimum Value Tests and Clears the Air on COBRA and Retiree Medical Coverage” (May 2013) under “2013 Developments: A Closer Look.”

Employers received an unwelcome answer from HHS when the department provided that out-of-pocket (OOP) limits up to the HSA OOP limit will apply to all non-grandfathered group health plans in the self-insured and large group markets. The final rule also sets forth the methods for employer-sponsored self-insured group health plans to determine whether their plans provide minimum value. However, the new rule provides little clarification on the determination of EHBs for purposes of complying with the prohibition on annual and lifetime dollar limits on EHBs. The final rule, implemented by the Affordable Care Act, was published in the Federal Register on February 25, 2013 and became effective on April 26, 2013.

See the Aon Hewitt bulletin titled “Final Rule Limits Out-Of-Pocket Maximums; Addresses Minimum Value and Essential Health Benefits” (March 2013) under “2013 Developments: A Closer Look” for a discussion of the application of the OOP limit to self-insured and large group health plans, calculation of MV for self-insured and fully insured plans in the large group market, and determination of EHBs for purposes of the prohibition on annual and lifetime dollar limits.

Exchanges
HHS Secretary Kathleen Sebelius announced on December 12, 2013, a number of new steps that are being implemented to help ensure consumers have health care access and coverage as of January 1, 2014. The steps are specifically targeted for those who are seeking to obtain coverage as part of the Affordable Care Act implementation. As part of the effort, HHS issued interim final regulations that formalized a previously announced decision that gave individuals until December 23, instead of December 15, to select a QHP through any Exchange for an effective coverage date of January 1, 2014. State Exchanges are allowed to select a different date. The regulations also established a related policy regarding the date by which an individual needs to pay any applicable initial premium to ensure timely effectuation of coverage. The regulations apply to the individual market and Small Business Health Options Program (SHOP) in both the federally facilitated and state Exchanges. The regulations do not change the plan selection or premium payment dates for coverage offered outside of the Exchanges. The regulations were effective as of December 15, 2013. Other HHS steps included requiring insurers to accept payment through December 31 for coverage that will begin January 1 and urging issuers to give consumers additional time to pay their first month’s premium and still have coverage beginning...
January 1, 2014. In addition, HHS offered individuals enrolled in the federal Pre-Existing Condition Insurance Plan (PCIP) the chance to extend their coverage through January 31, 2014 if they have not already selected a new plan. PCIP is “a transitional bridge program that provides people with health conditions who could otherwise be shut out of the insurance market or charged more because of their pre-existing condition quality, affordable health insurance until options become available in the [Exchanges].” HHS also strongly encouraged insurers to treat out-of-network providers as in-network to ensure continuity of care for acute episodes or if the provider was listed in their plan’s provider directory as of the date of an enrollee’s enrollment. Furthermore, HHS strongly encouraged insurers to refill prescriptions covered under previous plans during January 2014.

On November 27, 2013, HHS issued a statement on the Healthcare.gov blog (A Direct New Path to Marketplace Coverage) outlining changes to the 2014 enrollment process for the federally facilitated SHOP. Specifically, in 2014, small employers will be able to enroll their employees in “direct enrollment” coverage through an agent, broker, or insurer that offers a certified SHOP plan and has agreed to conduct enrollment according to HHS standards.

On November 25, 2013, CMS released proposed regulations that would establish payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and reductions; and user fees for federally facilitated Exchanges, as required by the Affordable Care Act. The regulations also propose additional standards with respect to composite rating, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for QHPs offered through a federal Exchange, patient safety standards for issuers of QHPs, and the SHOP.

CMS announced late on November 14, 2013, that small group health insurance policies, as well as individual health insurance policies, that are currently in place can remain in effect for one year without having to comply with the Affordable Care Act Exchange rules that start in 2014. The CMS announcement followed the President’s press conference that same day, announcing the fix. CMS issued a letter to state insurance commissioners informing the commissioners that the “transition policy” applies to both small group and individual policies that have changed since the law took effect, as well as to policies that individuals and small groups purchased after the law was enacted. The definition of a “small group” varies from state to state, but generally does not exceed 100 employees.


On October 24, 2013, CMS released final regulations implementing provisions of the Affordable Care Act. According to CMS, the final provisions are basically unchanged from previous proposed regulations and guidance documents. The final regulations outlined financial integrity and oversight standards with respect to the health insurance Exchanges, QHP issuers in federally facilitated Exchanges, and states with regard to the operation of risk adjustment and reinsurance programs. The regulations established additional standards for special enrollment periods, survey vendors that may conduct enrollee satisfaction surveys on behalf of QHP issuers, and issuer participation in a federally facilitated Exchange. In addition, the regulations made certain amendments to definitions and standards related to the market reform rules. The regulations also amended and adopted as final interim provisions set forth in the “Amendments to the HHS Notice of Benefit and Payment Parameters for 2014” interim final rule (published March 11, 2013) relating to risk corridors and cost-sharing reduction reconciliation. The interim rule adjusted risk corridor
calculations to align with the single risk pool provision of the Affordable Care Act. HHS is also allowing QHP issuers to use an optional simplified methodology for calculating the amounts of cost-sharing reductions provided during a transition period. The provisions of the final interim rule were effective as of April 30, 2013.

CMS published draft guidance on the federally facilitated Exchanges. The “Federally Facilitated Marketplace Enrollment Operational Policy and Guidance” (dated October 3, 2013), went into effect with “minimal changes” as of October 1. According to CMS, “All enrollments made on or after October 1, 2013, must be processed in accordance with these requirements.” CMS stated that this guidance will be a “living document, updated regularly, and supported by clarifying bulletins in the interim between updates.”

On September 26, 2013, HHS announced that small businesses would have to wait until November 1, 2013, to electronically enroll in the federally facilitated SHOP Exchange. The SHOP is designed to offer small businesses a choice of health insurance options for employees beginning in 2014. Through the SHOP, small employers will be able to compare prices, coverage, and plan options. Enrollment in the “SHOP Marketplace for Federally-facilitated Marketplace” program was to begin October 1, 2013. In its press release, HHS stated that “all functions for SHOP will be available in November and if employers and employees enroll by Dec. 15, 2013, coverage will begin Jan. 1, 2014.” (Secondary sources indicated that most states managing their own Exchanges were still on target to open their SHOP Exchanges October 1.)

On September 25, 2013, HHS released a report indicating that, on average, consumers will be able to choose from 53 health plans in the health insurance Exchanges. Additionally, the agency indicated that most consumers will have a choice of at least two (or more) different health insurance companies. Premiums are estimated to be approximately 16% lower than originally expected, with “about 95 percent of eligible uninsured living in states with lower than expected premiums—before taking into account financial assistance.” The federal and state Exchanges are to become operational in 2014 (with enrollment generally beginning October 1, 2013) and are intended to provide individuals and small businesses with the opportunity to purchase affordable, quality health insurance as part of the Affordable Care Act.

On August 28, 2013, HHS and CMS released final regulations that outline Exchange standards with respect to eligibility appeals, agents and brokers, privacy and security, issuer direct enrollment, and the handling of consumer cases. The regulations also set forth standards with respect to a state’s operation of the Exchange and the SHOP. The regulations finalize policies generally without change to previously proposed regulations released in January and June of 2013. The final regulations became effective on September 30, 2013.

CMS released additional Exchange guidance in the form of a frequently asked question (FAQ) on August 5, 2013. Federal and state Exchanges are to become operational in 2014 (with enrollment beginning October 1, 2013) and are intended to provide individuals and small businesses with the opportunity to purchase affordable, quality health insurance options as part of the health care reform law. The FAQ clarifies the agency’s policy on the consumer income verification process when applying for Exchange eligibility. Specifically, it addresses the circumstances when the state-based Exchanges would be allowed to accept less than full income verification from consumers applying for federal subsidies to help them purchase health coverage. CMS states that the Exchanges “would always use data from tax filings and Social Security data to verify household income information provided on an application, and in many cases, will also use current wage information that is available electronically.” The latest guidance is
in response to a final rule that was issued by CMS in July 2013 outlining Exchange eligibility determinations. The final rule triggered some concerns about potential fraud, so the agency responded with this FAQ.

On July 12, 2013, CMS released final regulations addressing various requirements applicable to Navigators and non-Navigator assistance personnel in federally facilitated and state Exchanges, as required by the Affordable Care Act. Navigators are organizations that are charged with providing unbiased information to consumers about health insurance, the new health insurance Exchanges, QHPs, and public programs, including Medicaid and CHIP. Additionally, the regulations also finalized the requirement that Exchanges must have a certified application counselor program and establish the standards for related consumer assistance tools. The final regulations became effective on August 12, 2013.

On July 5, 2013, CMS released final regulations implementing provisions of the Affordable Care Act. The regulations outlined new Medicaid eligibility provisions; finalized changes related to electronic Medicaid and CHIP eligibility notices and delegation of appeals; streamlined existing Medicaid eligibility rules; revised CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amended requirements for benchmark and benchmark-equivalent benefit packages consistent with Sections 1937 of the Social Security Act (referred to as “alternative benefit plans”) to ensure that these benefit packages include EHBs and meet certain other minimum standards. The final regulations also implemented specific provisions, including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Exchanges, and updated Medicaid premium and cost-sharing requirements. The regulations included transition policies for 2014 as applicable.

CMS released final regulations on May 31, 2013, which implemented provisions of the Affordable Care Act related to the SHOP. The final regulations amended existing regulations regarding triggering events and special enrollment periods for qualified employees and their dependents and implemented a transitional policy regarding employees’ choice of QHPs in the SHOP. Federal and state Exchanges are to become operational in 2014 and are intended to provide individuals and small businesses with the opportunity to purchase affordable, quality health insurance options. As part of the Affordable Care Act, each state will have a SHOP that assists qualified employers in providing health insurance options for their employees. The final regulations became effective on July 1, 2013.

See the Aon Hewitt bulletin titled “New HHS Regulations Make “SHOP”-ping Easy in 2014” (April 2013), which discusses the regulations as they were originally proposed, under “2013 Developments: A Closer Look.”

On May 31, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) issued a progress update (Federal Marketplace Progress Fact Sheet) related to the building of Exchanges. Included in the overview was an Exchange timeline, a narrative description of the Exchange timeline, as well as SHOP employee and employer applications.

On May 14, 2013, CMS released FAQs on health insurance Exchanges. The FAQs addressed: the oversight of premium stabilization programs, advance payments of the premium tax credit, and cost-sharing reductions; issuers’ ongoing compliance with Exchange-specific standards and oversight; state-based Exchange reporting requirements; privacy and security standards for state-based Exchanges and
non-Exchange entities (e.g., Navigators, agents, brokers, etc.); cost-sharing reductions and HSAs; eligibility and enrollment; and issuer withdrawal from the small group or large group market.

On March 11, 2013, the Office of Personnel Management (OPM) published a final rule establishing the Multi-State Plan Program (MSPP). The Affordable Care Act directs the OPM to establish the MSPP to foster competition among plans competing in the individual and small group health insurance markets on the Exchanges. Through contracts with OPM, health insurance issuers will offer at least two multi-state plans (MSPs) on each of the Exchanges. One of the issuers must be non-profit. Under the law, an MSPP issuer may phase in the states in which it offers coverage over four years, but it must offer MSPs on Exchanges in all states and the District of Columbia by the fourth year in which the MSPP issuer participates in the MSPP. The final rule (with the exception of Section 800.503) was effective as of May 10, 2013.

HHS Secretary Kathleen Sebelius, on January 17, 2013, announced $1.5 billion in establishment grants to support states in building their Exchanges. Six states (Delaware, Iowa, Michigan, Minnesota, North Carolina, and Vermont) received Level One establishment grants, which are one-year grants used to build Exchanges. Five states (California, Kentucky, Massachusetts, New York, and Oregon) received Level Two establishment grants, which are multi-year awards used to further develop states’ existing Exchanges. In total, 34 states and the District of Columbia have received grants to build their Exchanges. States may apply for grants through the end of 2014.

On January 3, 2013, HHS Secretary Kathleen Sebelius announced that additional states received conditional approval to operate their health insurance Exchanges. The Exchanges, created as part of the Affordable Care Act, are intended to provide individuals and small businesses with “one-stop shopping” to purchase affordable, quality health insurance options. Coverage through the Exchanges will begin on January 1, 2014. HHS will operate a federally facilitated Exchange in states that are not ready or unwilling to operate an Exchange or partner with HHS in operating one. California, Hawaii, Idaho, Nevada, New Mexico, Vermont, and Utah received conditional approval to operate a state-based Exchange, and Arkansas was conditionally approved to operate a state partnership Exchange. As of January 3, 19 states and the District of Columbia received conditional approval from HHS (two to operate a state partnership Exchange and the rest to operate a state-based Exchange). In addition, HHS issued guidance that provides a framework and basic roadmap for states considering a state partnership Exchange. The state partnership Exchange is a hybrid model through which states may assume primary responsibility for many of the functions of the federally facilitated Exchange permanently or as they work toward running a state-based Exchange. The guidance indicated states can choose to carry out plan management functions (state plan management partnership Exchange) or to assume responsibility for in-person consumer assistance and outreach (state consumer partnership Exchange). States also have the option to assume responsibility for a combination of these main Exchange activities.

Health Care Reform Study
Health Insurance Market Rules

On February 22, 2013, HHS issued a final rule that implemented provisions related to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, and catastrophic plans, as required by the Affordable Care Act. The final rule clarified the approach used to enforce the applicable requirements of the Affordable Care Act with respect to health insurance issuers and group health plans that are nonfederal governmental plans. The rule also amended the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under the federal rate review program, and revised the timeline for states to propose state-specific thresholds for review and approval by CMS. The final rule was effective April 29, 2013 (some provisions took effect March 29, 2013). In coordination with the final rule, HHS also issued a report, “Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act.”

Individual Mandate

Individuals with cancelled insurance policies can obtain a temporary “hardship exemption” under the Affordable Care Act. Those who qualify for the hardship exemption will be able to purchase a less-expensive catastrophic insurance policy, allowing them to be exempt from the Affordable Care Act’s individual mandate requirement to obtain minimum coverage. The policy change was first communicated in a December 19, 2013 letter to six legislators written by HHS Secretary Kathleen Sebelius. The CMS followed the Secretary’s announcement with an official bulletin later that evening. The CMS bulletin detailed all the options available for consumers with cancelled policies, including the new hardship exemption.

On October 28, 2013, CMS issued an FAQ providing additional guidance on the Affordable Care Act enrollment and deadlines. Individuals now have until March 31, 2014, to enroll in the health insurance Exchanges without incurring any tax penalty under the individual mandate. While the open enrollment period for the Exchanges runs through the end of March 2014, consumers originally had to enroll by February 15, 2014 to avoid a penalty under the health care reform law.

On August 27, 2013, the Treasury and IRS issued final regulations on the individual shared responsibility provision under the Affordable Care Act. The individual shared responsibility provision takes effect in 2014 and requires individuals to have basic health insurance coverage (minimum essential coverage) to qualify for an exemption or to make a shared responsibility payment when filing a federal income tax return. Minimum essential coverage includes coverage under eligible employer-sponsored plans (including self-insured group health plans, COBRA coverage, and retiree coverage) and coverage that is purchased in the individual market. The final regulations largely finalize the proposed regulations that were issued in January 2013.

See the Aon Hewitt bulletin titled “How ‘Minimum’ Is Your Health Insurance Coverage? IRS Proposes Regulations on Offering and Maintaining Minimum Essential Coverage Starting in 2014” (February 2013), which discusses the regulations as they were originally proposed, under “2013 Developments: A Closer Look.”

HHS issued final regulations on June 26, 2013, on the individual shared responsibility payments required under the Affordable Care Act to be paid on federal income tax returns by people who do not have minimum essential coverage. The final regulations address exemptions available to persons for whom obtaining coverage under a QHP constitutes a hardship. HHS developed a list of certain circumstances that will always be treated as constituting a hardship. For example, hardship exemptions will be available
to individuals for whom an Exchange projects that no offer of coverage that meets the minimum value standard will be affordable. Hardship exemptions will also be available on a case-by-case basis. Specific rules for receiving an exemption are explained in the final regulations. In addition, the final regulations designate types of coverage as minimum essential coverage. For example, self-insured student health coverage is designated as minimum essential coverage only for 2014. After 2014, sponsors of self-funded student health plans may apply to be recognized as minimum essential health coverage through a process outlined in the final regulations.

The IRS on June 26, 2013, provided transition relief in Notice 2013-42 from the individual mandate for employees who are eligible for an employer-sponsored group health plan that operates on a non-calendar year. The individual mandate generally requires all taxpayers to maintain minimum essential coverage beginning January 1, 2014. Under the transition relief, the IRS will allow employees and their spouses or dependents who are eligible to enroll in a non-calendar year employer-sponsored health plan to avoid individual mandate tax penalties for the months between January 1, 2014 and the month that the employer’s 2013-2014 plan year ends.

Jointly Issued FAQs

Over the course of 2013, the DOL, Treasury, and HHS (the departments) jointly issued various sets of FAQs that spanned multiple subject areas related to the Affordable Care Act. The 2013 FAQs built upon earlier FAQs under the Affordable Care Act. Only those FAQs that were jointly issued appear below; FAQs issued by a single department or agency appear elsewhere in this section.

Set 11—The eleventh set of FAQs on administration of the Affordable Care Act, issued January 24, 2013, offered a range of guidance to employers sponsoring group health plans: from the “good”—easing the rules on Exchange notices and employer group waiver plan (EGWP) supplemental benefits; to the “bad”—tighter rules on Affordable Care Act exemptions for fixed indemnity benefits; and the “ugly”—the application of rules on EHBs to HRAs.

See the Aon Hewitt bulletin titled “Affordable Care Act FAQs Offer Employers the Good, the Bad, and the Ugly on Notices, EGWPs, Fixed Indemnity, and HRAs” (January 2013) under “2013 Developments: A Closer Look.”

Set 12—The twelfth set of FAQs issued on February 20, 2013 by the departments provided employers with a transition rule in 2014 for complying with a provision in the Affordable Care Act that imposes annual limits on OOP maximums for all non-grandfathered self-insured and large group health plans. The final rule, issued by HHS on February 25, 2013, stated that the annual limits for high-deductible health plans (HDHPs) on OOP maximums apply to self-insured and large group health plans. The annual OOP maximum may not exceed the limits for HDHPs as issued annually by the IRS ($6,250 single/$12,500 family in 2013). The FAQs also provide additional guidance on complying with the Affordable Care Act provision requiring all non-grandfathered group health plans and health insurance issuers to provide certain preventive services with no cost sharing.


Set 13—On March 8, 2013, the departments released an FAQ that clarifies the extent to which expatriate group health insurance coverage is subject to the provisions of the Affordable Care Act. Though it was only a single question and answer, it is referred to by the departments as the thirteenth set of FAQs. In
the guidance, the departments recognize that expatriate health plans may face special challenges when complying with certain provisions of the Affordable Care Act—specifically, challenges in “reconciling and coordinating the multiple regulatory regimes that apply to expatriate health plans that might make it impracticable to comply with all the relevant rules at least in the near term.” While the departments gather further information to determine what actions may be appropriate regarding the current requirements under the Affordable Care Act, they have determined that, for plans with plan years ending on or before December 31, 2015, with respect to expatriate health plans, they will consider the requirements of subtitles A and C of Title I of the Affordable Care Act satisfied if the plan and issuer comply with the pre-Affordable Care Act version of Title XXVII of the Public Health Service Act (PHS Act). For purposes of the temporary transitional relief, an expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage.

**Set 14**—Plan sponsors must add a statement to the summary of benefits and coverage (SBC) for the 2014 plan year regarding whether the plan provides minimum essential coverage and whether the plan meets the minimum value requirements, according to the fourteenth set of FAQs released by the departments on April 23, 2013. The FAQs require very few additional changes for SBCs for the 2014 plan year and extend for another year the safe harbors and enforcement relief provided for in previous guidance. The SBC requirements were established by the Affordable Care Act.


**Set 15**—The departments indicated that plan sponsors will not receive guidance on provisions requiring the coverage of clinical trials or provider nondiscrimination, as these provisions are self-implementing, according to the fifteenth set of FAQs issued by the departments on April 29, 2013. Furthermore, coverage reporting requirements will not begin until 2015. If a plan received an annual dollar limit waiver for a mini-med plan, a change in the plan year will not change the expiration date of the waiver.

*See the Aon Hewitt bulletin titled “That’s All Folks?—Agencies Say Some Affordable Care Act Rules Will Be Implemented Without Guidance” (May 2013) under “2013 Developments: A Closer Look.”*

**Set 16**—On September 4, 2013, the departments issued two additional FAQs on implementation of the Affordable Care Act. The first FAQ explained that an employer will have satisfied its obligation to provide the required Notice of Coverage Options to an individual if another party (such as an issuer, multiemployer plan, or third-party administrator) provides a timely and complete notice. However, an employer is not relieved of its statutory obligation to provide the notice if the third party fails to provide the notice to all of the employer’s employees. The requirement that the notice be provided to all employees means that the notice must be provided to not only participants enrolled in a group health plan, but also employees who are not eligible for coverage under the plan and/or employees who are not enrolled in the plan. The second FAQ discussed the 90-day waiting period limitation. In March 2013, the departments issued proposed regulations providing guidance on the 90-day rule. A group health plan or health insurance issuer offering group health insurance coverage may not impose a waiting period that exceeds 90 days. In this FAQ, the departments state that they will issue final regulations that will give plans and issuers sufficient time to comply with the waiting period limitation. The final regulations, to the extent they are more restrictive than the proposed regulations, will not take effect prior to 2015, and the March 2013 proposed regulations may be relied on by plans and issuers until at least through 2014. The FAQ also
provides an example of how a particular kind of eligibility provision in a multiemployer plan would be seen as being “designed to accommodate a unique operating structure” and not in violation of the 90-day limitation.

**Medical Loss Ratio Requirements**
On May 17, 2013, CMS released a final rule that implements new medical loss ratio (MLR) requirements for the Medicare Advantage (MA) Program and the Medicare Prescription Drug Benefit Program (Part D) established under the Affordable Care Act. The MLR represents the percentage of revenue used for patient care, rather than administrative expenses or profit. Under the final rule, MA and Part D sponsors are subject to financial and other penalties for failing to meet an MLR of at least 85%. The final rule primarily follows the proposed rule released in February 2013. However, CMS did agree with commenters on the proposed rule who recommended that the reporting deadline should be December, not July. In the final rule, CMS states that “We agree with the commenters that the best balance between beneficiary protection and calculating MLRs based on the most complete data is to require that, in general, MLR reporting for a contract year will occur in the December following the contract year, on a date and in a manner specified by CMS.” The final rule became effective on July 22, 2013.

On May 10, 2013, the IRS released proposed regulations that provide guidance to Blue Cross and Blue Shield organizations, and certain other health care organizations, on computing and applying the MLR added to the Internal Revenue Code (Code) by the Affordable Care Act.

**Mental Health and Substance Use**
On February 20, 2013, HHS published a report, “Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans,” on how EHBs for mental health and substance use disorder services will be covered at parity with medical and surgical benefits.

**Nondiscrimination**
On August 1, 2013, HHS and the Office for Civil Rights published a request for information (RFI) on Section 1557 of the Affordable Care Act. Specifically, Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The RFI sought feedback on a variety of issues related to Section 1557 to better understand individuals’ experiences with discrimination in health programs or activities and covered entities’ experiences in complying with federal civil rights laws.

**Penalties, Fees, and Taxes**
HHS provided additional guidance on the transitional reinsurance fees that group health plans must pay beginning in 2014, on December 2, 2013. The proposed regulations set the reinsurance fee for 2015 at $44 per covered life; adjust the timing for the collection of reinsurance contributions, starting in 2014; exclude self-insured and self-administered group health plans from having to pay the reinsurance fee in 2015 and 2016; include a specific definition of major medical coverage; clarify how certain covered lives are counted; describe audits of contributing entities subject to the fee; and propose the 2015 maximum cost-sharing amounts.

*See the Aon Hewitt bulletin titled “Guidance on Transitional Reinsurance Fees Brings Holiday Gifts for Some Employers and Coal for Others” (December 2013) under “2013 Developments: A Closer Look.”*
On November 26, 2013, the Treasury and IRS released final regulations relating to the additional hospital insurance tax on income above threshold amounts (Additional Medicare Tax), as added by the Affordable Care Act. Specifically, the final regulations provide guidance for employers and individuals relating to the implementation of the Additional Medicare Tax, including the requirement to withhold Additional Medicare Tax on certain wages and compensation, the requirement to file a return reporting Additional Medicare Tax, the employer process for adjusting underpayments and overpayments of Additional Medicare Tax, and the employer and individual processes for filing a claim for refund for an overpayment of Additional Medicare Tax. The regulations became effective on November 29, 2013.

The Treasury and IRS issued final regulations on the health insurance providers fee, IRS Notice 2013-76, and IRS Revenue Ruling 2013-27 on November 26, 2013. The final regulations relate to the annual fee imposed on covered entities engaged in the business of providing health insurance for U.S. health risks. This fee is imposed by Section 9010 of the Affordable Care Act. The regulations affect persons engaged in the business of providing health insurance for U.S. health risks. The regulations became effective on November 29, 2013. IRS Notice 2013-76 provides guidance on the time and manner for submitting Form 8963 (Report of Health Insurance Provider Information), notifying covered entities of their preliminary fee calculation, submitting a corrected Form 8963 for the error correction process, and the time for notifying covered entities of their final fee calculation. IRS Revenue Ruling 2013-27 explains income tax treatment of amounts a covered entity collects from policyholders to offset the cost of the annual fee imposed under the Affordable Care Act.

On June 7, 2013, the IRS posted to its website a chief counsel advice memorandum (AM 2013-002). The memorandum states that fees paid by health insurance companies and health insurance plan sponsors to fund the Patient-Centered Outcomes Research (PCOR) Trust Fund, as required as part of the Affordable Care Act, are tax deductible as ordinary and necessary business expenses. According to the May 31 memorandum, the “required PCOR fee will be an ordinary and necessary business expense paid or incurred in carrying on a trade or business.”

Without much fanfare, the IRS published the long-awaited update to Form 720 (Quarterly Federal Excise Tax Return) on June 3, 2013. Plan sponsors of applicable self-insured health plans and health insurance issuers were required to pay the first annual Patient-Centered Outcomes Research Institute (PCORI) fee by July 31, 2013 for the plan year ending in 2012. The annual fee, which is paid using IRS Form 720 “Quarterly Federal Excise Tax Return,” helps finance the PCORI Trust Fund. The Trust Fund will fund the PCORI's research into the comparative effectiveness of medical treatments.

See the Aon Hewitt bulletin titled “PCORI Fee Due July 31; IRS Updates Form 720” (June 2013) under “2013 Developments: A Closer Look.”

Under a final rule issued on March 1, 2013, a transitional reinsurance fee is being added to the penalties and taxes imposed on employers and their fully insured and self-insured group health plans by the Affordable Care Act. Effective April 30, 2013, and applicable for plan years beginning on or after January 1, 2014, self-insured and fully insured group health plans will have to pay a transitional reinsurance fee—$63 per capita in 2014—to fund the first year of a three-year reinsurance program to help stabilize premiums for individuals and small groups in the Exchanges.

See the Aon Hewitt bulletin titled “HHS Final Rule on Transitional Reinsurance Fee Adds to Employer Costs” (March 2013) under “2013 Developments: A Closer Look.”
Pre-Existing Condition Insurance Plan
On May 17, 2013, HHS and CMS released an interim final rule on the PCIP, as established under the Affordable Care Act. The interim final rule establishes the payment rates for covered services furnished to individuals enrolled in the PCIP program administered by HHS beginning with covered services furnished on June 15, 2013. The interim final rule also prohibits facilities and providers who, with respect to dates of service beginning on June 15, 2013, accept payment for most covered services furnished to an enrollee in the federally-administered PCIP from charging the enrollee an amount greater than the enrollee’s OOP cost for the covered service as calculated by the plan.

CCIIO published a list of all states enrolled in the PCIP on January 18, 2013. The PCIP is a temporary program established under the Affordable Care Act that provides coverage to eligible uninsured individuals with pre-existing conditions until 2014. Beginning in 2014, individuals will have access to coverage through the health insurance Exchange. The Exchange, also created as part of the Affordable Care Act, is intended to provide individuals and small businesses with “one-stop shopping” to purchase affordable, quality health insurance options. The PCIP program is administered by either the state or federal government. Currently, 23 states and the District of Columbia elected to have their PCIP program administered by the federal government, while 27 states have chosen to run their own programs. The state listing detailed the date when each state began providing benefits to individuals accepted into the program and the number of people enrolled in the program by each state as of October 31, 2012.

Premium Tax Credits and Subsidies
The budget deal that reopened the partially shutdown United States government in October 2013 contained a directive to the Secretary of HHS to “verify” that individuals applying for subsidies in the public health insurance Exchanges meet the income requirements set forth in the Affordable Care Act. The law, however, contains no details on the verification procedures that must be adopted or their impact, if any, on employers and group health plans. The law orders the HHS Secretary to “ensure” that the public Exchanges “verify” that individuals applying for premium tax credits and cost-sharing reductions meet the eligibility requirements of the Affordable Care Act. The HHS Secretary was required to submit a report to Congress by January 1, 2014, that details the procedures employed by the public Exchanges to verify eligibility for the subsidies. By July 1, 2014, the HHS Inspector General is required to report to Congress on the effectiveness of the procedures and safeguards in preventing the submission of inaccurate or fraudulent information by applicants for coverage in the public Exchanges.

See the Aon Hewitt bulletin entitled “Debt Deal Contains Verification Requirement for Affordable Care Act Exchange Subsidies” (October 2013) under “2013 Developments: A Closer Look.”

On August 23, 2013, the IRS released proposed regulations providing guidance on the tax credit available to certain small employers that offer health insurance coverage to their employees under Section 45R of the Code, enacted by the Affordable Care Act. These proposed regulations affect certain taxable employers and certain tax-exempt employers. According to the IRS, the proposed regulations apply to small employers with no more than 25 full-time employees who each annually earn less than $50,000 for the taxable year. The employers must also have a qualifying arrangement in effect that requires them to pay a percentage of the premium cost of a QHP offered to their employees through the SHOP Exchange. For taxable years beginning January 1, 2014, the maximum credit for an eligible small employer, other than a tax-exempt one, is 50% of the premium payments made on behalf of its employees under the QHP. For tax-exempt small employers, the maximum credit is 35%.
On June 28, 2013, the IRS released proposed regulations on the reporting of information on premium tax credits by new Exchanges. The Exchanges would be required to report the information to the IRS on a monthly basis and to the recipient on an annual basis under the proposals. Electronic delivery of statements to recipients would be permitted if consent is obtained. The proposed regulations cover the type of information to be reported, the time and manner of reporting, and the statements to be furnished to taxpayers or responsible adults.

On June 26, 2013, the IRS provided guidance on when, for purposes of the premium tax credit, an individual is eligible for minimum essential coverage under Medicaid, Medicare, CHIP, and the TRICARE government-sponsored health program. In Notice 2013-41, the IRS also provided guidance on eligibility for minimum essential coverage through self-funded student health plans and state high-risk pools.

The IRS issued final regulations relating to the health insurance premium tax credit enacted by the Affordable Care Act on January 30, 2013. The final regulations provide guidance to individuals related to employees who may enroll in eligible employer-sponsored coverage and who wish to enroll in QHPs through Exchanges and claim the premium tax credit. The regulations became effective on February 1, 2013.

Preventive Care and Contraceptive Coverage
On September 9, 2013, the IRS released Notice 2013-57. The Notice clarified that a health plan will not fail to qualify as an HDHP under Section 223(c)(2) of the Code merely because it provides without a deductible the preventive health services required under Section 2713 of the PHS Act to be provided by a group health plan or a health insurance issuer offering group or individual health insurance coverage. The IRS defines an HDHP as a health plan that satisfies certain requirements with respect to minimum deductibles and maximum OOP expenses. Notice 2013-57 specifies that preventive care for purposes of the safe harbor provided in Section 223(c)(2)(C) of the tax code will be considered anything that qualifies as preventive care under Notice 2004-23 and Notice 2004-50, regardless of whether it would constitute preventive care for purposes of Section 2713 of the PHS Act. The two 2004 Notices provided guidance on preventive care benefits that are allowed to be provided by an HDHP without satisfying the minimum deductible requirement of Section 223(c)(2)(A). Additionally, Notice 2013-57 provided information about the definition of preventive care for purposes of HDHPs associated with HSAs.

The HHS, IRS, and EBSA jointly published final regulations on the coverage of particular preventive services under the Affordable Care Act on July 2, 2013. The final regulations address providing women with access to contraceptive coverage without cost sharing in a way intended to protect certain nonprofit religious organizations that have religious objections to providing contraceptive coverage from being required to contract, arrange, pay, or refer for such coverage. They also establish accommodations for student health coverage arranged by eligible organizations that are institutions of higher education.

See the Aon Hewitt bulletin titled “Obama Administration Modifies Rules on Religious Organizations and Coverage of Contraceptives” (February 2013), which discussed the regulations in their previous proposed stage, under “2013 Developments: A Closer Look.”

Reporting, Disclosure, Notices, and Forms
On September 11, 2013, EBSA released an FAQ indicating that there is no penalty for employers who fail to issue the Notice regarding Exchanges. However, the agency indicated that employers should still continue to distribute the Notice. The federal and state Exchanges are to become operational in 2014 and
are intended to provide individuals and small businesses with the opportunity to purchase affordable, quality health insurance options as part of the Affordable Care Act. According to EBSA, the Notice should inform employees about the Exchanges and that, depending upon income and what coverage may be offered by the employer, employees may be able to receive lower-cost private insurance through the Exchanges. It should also inform employees that if employees purchase insurance through the Exchanges, they may lose the employer contribution (if any) to their health benefits. There are two model Notices to assist employers with compliance.

On September 5, 2013, the Treasury and IRS released proposed regulations on health insurance reporting requirements applicable to large employers (generally, employers with 50 or more full-time employees). Under the Affordable Care Act (Section 6056 of the Code), large employers must report detailed information on employee health care coverage to the IRS. Large employers must also provide statements to employees about their coverage that will help them determine whether they can claim a premium tax credit on their tax returns. The proposed regulations specify the substantial amount of information to be reported on the extent of health insurance coverage provided to employees and would provide a general method and simplified methods for reporting. The Treasury and IRS are considering the use of codes on Form W-2 for some of the required reporting.

The Treasury and IRS issued proposed regulations on September 5, 2013, on the required reporting of minimum essential coverage under the Affordable Care Act (Section 6055 of the Code). Health insurance issuers and sponsors of self-insured health plans must report information on the type and period of coverage to the IRS, including the name of each person enrolled in minimum essential coverage and the months the person was covered. They must also furnish information to employees on the coverage provided to them and their dependents. The proposed regulations would permit issuers and plan sponsors to transmit this information to employees electronically, but the recipient would have to consent to the electronic delivery.

On August 14, 2013, the Treasury and IRS published final regulations on the disclosure of return information under Code Section 6103(l)(21) to carry out eligibility requirements under the Affordable Care Act. The regulations define certain terms and prescribe certain items of return information in addition to those items prescribed by statute that will be disclosed, upon written request, under Section 6103(l)(21). Section 6103(l)(21) permits the disclosure of return information to assist Exchanges in performing certain functions established in the Affordable Care Act for which income verification is required, as well as to assist state agencies administering state Medicaid programs, state CHIPs, or basic health programs. Section 6103(l)(21) identifies specific items of return information that will be disclosed and authorizes the disclosure of the following items of return information: taxpayer identity information, filing status, the number of individuals for whom a deduction is allowed, the taxpayer's modified adjusted gross income, and the taxable year to which any such information relates or, alternatively, that such information is not available. Section 6103(l)(21) also authorizes the disclosure of such other information prescribed by regulation that might indicate whether an individual is eligible for the premium tax credit or cost-sharing reductions under the health care reform law. The Treasury and IRS released proposed regulations in April 2013. The final regulations became effective on August 14, 2013.

Beginning October 1, 2013, all employers subject to the Fair Labor Standards Act (FLSA) must provide a notice to new and current employees regarding coverage options available through an Exchange, as part of the Affordable Care Act. Employers also have the option of providing this notice before October, according to Technical Release 2013-02 issued by EBSA on May 8, 2013. Technical Release 2013-02 provides temporary guidance related to this notice. EBSA also released a model notice to employees of
coverage options, as well as an updated model election notice for group health plans for purposes of COBRA, which includes additional information regarding health coverage alternatives offered through an Exchange.

*See the Aon Hewitt bulletin titled “Have You Heard? Employers Must Notify Employees of Exchange Option” (May 2013) under “2013 Developments: A Closer Look.”*

On April 29, 2013, CMS released shortened health insurance application forms that are to be used for the federal Exchanges. The application for individuals without health insurance has been reduced from 21 to three pages, and the application for families is now seven pages. Additionally, CMS released an “Individual Without Financial Assistance” form (three pages). This form determines eligibility status and can be completed by any individual who requires health coverage. CMS stated that consumers will be able to fill out one application and see an entire range of health insurance options, including plans offered in the Exchange markets, Medicaid, and CHIP, as well as information on financial assistance (tax credits) to help pay premiums. Applications could be submitted beginning October 1, 2013. The initial open enrollment period will last six months.

CCIIO released a technical fact sheet on the 2014 Notice of Benefit and Payment Parameters (Payment Notice) on March 11, 2013. The fact sheet follows the release of an interim final rule and a proposed rule amending certain provisions of the Payment Notice by HHS. Provisions of the Payment Notice and amendments to the Payment Notice are summarized in the technical fact sheet. Topics include the state notice of benefit and payment parameters state notice timing; provisions and parameters for the permanent risk adjustment program; provisions and parameters for the transitional reinsurance program; provisions for the temporary risk corridors program; provisions for the advance payments of the premium tax credit and cost-sharing reductions programs; new standards related to cost-sharing reductions; provisions for the SHOP; and provisions for MLR requirements.

**State Reviews and Evaluations**

The DOL, HHS, and Treasury jointly released Technical Release 2013-01, which extends until 2016 the use of temporary standards for state external review processes for health care claims and appeals that non-grandfathered group health plans and health insurance issuers must comply with under the Affordable Care Act. The release, released on March 15, 2013, updates earlier guidance (Technical Release 2011-02, released June 2011) which included a set of temporary standards that would apply until January 1, 2014. The new technical release states that until January 1, 2016, issuers will be considered to be in compliance with regulations on standards for state external review processes if they comply with the temporary standards established in the 2011 guidance.

On February 20, 2013, CCIIO issued an FAQ addressing state evaluation of plan management activities of health plans and issuers. According to the FAQ, states can evaluate whether health plans and issuers meet certification standards and conduct other specified plan management activities for the Exchanges without submitting a “blueprint” application to HHS. Blueprints are applications states must submit to HHS to be approved to operate state-based Exchanges or to participate in state partnership Exchanges under the Affordable Care Act.

**Waiting Periods**

Grandfathered and non-grandfathered group health plans and health insurance issuers may not impose any waiting period that exceeds 90 days, for plan years beginning on or after January 1, 2014, according
to proposed regulations issued March 18, 2013 by the DOL, HHS, and Treasury. In addition, the proposed regulations provide that for plan years beginning after 2014, the Affordable Care Act’s prohibition on pre-existing condition exclusions would supersede the HIPAA creditable coverage rules, with the result that group health plans would no longer have to issue certificates of creditable coverage to participants and beneficiaries who lose health care coverage.

See the Aon Hewitt bulletin titled “Proposed Regulations Implement 90-Day Waiting Period and End HIPAA Creditable Coverage Certificates” (March 2013) under “2013 Developments: A Closer Look.”

Wellness Programs
Employer group health plans that offer health-contingent wellness programs must provide employees who fail to meet the health contingency with a reasonable alternative in order to receive the full amount of any reward or incentive, according to final regulations released May 29, 2013 by the DOL, HHS, and Treasury. However, the conditions under which a wellness program must offer a reasonable alternative to an individual who fails to meet the health contingency will now depend on whether the wellness program requires the employee to engage in an activity or to achieve a specific health outcome. The final regulations, which are applicable in plan years beginning after 2013, apply to all group health plans, whether or not grandfathered. They also increase the maximum possible rewards that a wellness program may provide to employees as amended by the Affordable Care Act.

See the Aon Hewitt bulletin titled “If at First You Don’t Succeed, Try, Try Again: Agencies Require Reasonable Alternatives for Individuals Who Fail Health-Contingent Wellness Programs” (June 2013) under “2013 Developments: A Closer Look.”

Whistleblowers
The Occupational Safety and Health Administration (OSHA) on February 22, 2013, issued an interim final rule outlining procedures for the handling of retaliation complaints under the Affordable Care Act. The rule implemented the employee protection (whistleblower) provision of the Affordable Care Act, which added Section 18C of the FLSA, to provide protections to employees of health insurance issuers or other employers who may have been subject to retaliation for reporting potential violations of the law’s consumer protections (e.g., the prohibition on denials of insurance due to pre-existing conditions) or affordability assistance provisions (e.g., access to health insurance premium tax credits). The interim final rule was effective as of February 27, 2013.

Other Health Care Guidance
Health FSAs, Dependent Care FSAs, and HSAs
On December 16, 2013, the IRS released guidance (Notice 2014-01) on the application of the rules under Section 125 of the Code (relating to cafeteria plans, including health and dependent care flexible spending arrangements (FSAs)) and Section 223 of the Code (relating to HSAs), with respect to elections and reimbursements for same-sex spouses following the Supreme Court decision in United States v. Windsor. In June 2013, the Supreme Court struck down a key section of the federal DOMA that defined marriage as the union of one man and one woman for purposes of federal law. The IRS guidance, primarily in the form of questions and answers, addresses: midyear election changes; FSA reimbursements; and contribution limits for HSAs and dependent care assistance programs. The guidance became effective on December 16, 2013.
The Treasury and IRS issued Notice 2013-71 on October 31, 2013, which modifies the rules for Code Section 125 cafeteria plans. Specifically, the guidance changes the longstanding “use-or-lose” rule for health FSAs. For the first time, at the plan sponsor’s option, employees participating in health FSAs will be allowed to carry over, instead of forfeiting, up to $500 of unused amounts remaining at the end of a plan year. According to the Treasury, some plan sponsors may be eligible to take advantage of the option to adopt a carryover provision as early as plan year 2013. In addition, the existing option for plan sponsors to allow employees a grace period after the end of the plan year remains in place. However, a health FSA cannot have both a carryover and a grace period; it can have one or the other or neither. Additionally, the Notice clarifies the scope of the transition relief provided in the preamble to proposed regulations under Section 4980H that allows greater flexibility for individuals to make changes in salary reduction elections for accident and health plans provided through Section 125 cafeteria plans for non-calendar cafeteria plan years beginning in 2013.


On May 2, 2013, the IRS issued inflation-adjusted limits for contributions to an HSA for calendar year 2014 (Revenue Procedure 2013-25). For calendar year 2014, the limit on contributions for an individual with self-only coverage under an HDHP is $3,300 ($6,550 for family coverage). An HDHP for calendar year 2014 is defined as a health plan with an annual deductible that is not less than $1,250 for self-only coverage ($2,500 for family coverage). The limit on annual OOP expenses is $6,350 for self-only coverage ($12,700 for family coverage). The limit on catch-up contributions for individuals age 55 or older is $1,000.

HIPAA

On January 17, 2013, the Office for Civil Rights released a final rule that updated privacy and security protections for health information as established by HIPAA. The final rule modified HIPAA privacy, security, and enforcement rules mandated in the Health Information Technology for Economic and Clinical Health (HITECH) Act to strengthen the privacy and security protection for individuals’ health information. It also modified the rule for breach notification for unsecured protected health information under the HITECH Act to address public comments received on the interim final rule and strengthened the privacy protections for genetic information by implementing provisions in the Genetic Information Nondiscrimination Act (GINA). Among other provisions, the final rule expanded many of the requirements for business associates of entities that receive protected health information, such as contractors and subcontractors. According to HHS, some of the largest reported breaches have involved business associates. Penalties were increased for noncompliance based on the level of negligence with a maximum penalty of $1.5 million per violation.


Medicare

CMS announced on October 28, 2013, the 2014 Medicare Part A and Part B premium, deductible, and coinsurance amounts to be paid by Medicare beneficiaries. The standard monthly Medicare Part B premium will not increase in 2014 and will remain at the 2013 rate of $104.90. Higher-income
beneficiaries (those with incomes over $85,000 single/$170,000 joint) will pay higher premiums. According to CMS, the past five years have been among the slowest periods of average Part B premium growth in Medicare’s history. The Medicare Part B deductible will also remain unchanged at $147. The 2014 Medicare Part A deductible will increase to $1,216, up from $1,184 in 2013. The Part A deductible is paid by the beneficiary per “spell of illness” for covered inpatient hospital services. After the first 60 days of hospitalization, the 2014 coinsurance will be $304 per day for days 61 through 90 ($296 in 2013), and $608 per day ($592 in 2013) for the 91st and later days. The daily coinsurance for the 21st through 100th day in a skilled nursing facility will be $152 in 2014, up from $148 in 2013.

On September 19, 2013, CMS announced that enrollment in the MA program is projected to increase for the fourth straight year. The average MA premium in 2014 is projected to increase by only $1.64 from last year, coming to $32.60. According to CMS, 99.1% of beneficiaries will have access to a plan. The average number of plan choices will remain about the same in 2014, and access to supplemental benefits remains stable. Since the passage of the Affordable Care Act, average MA premiums are down by 9.8%.

On February 15, 2013, CMS released its 2014 Advance Notice and draft Call Letter. According to the agency, the Advance Notice and draft Call Letter take “important steps to improve payment accuracy for MA (Part C) and in Part D plans for 2014, without shifting costs to beneficiaries.” For example, the standard Part D deductible will be $310 in 2014 (down from $325 in 2013), and cost-sharing amounts will be reduced.

Since 2006, employers have been subject to an annual (and in limited instances, more frequently than annual) disclosure requirement applicable to most employers providing prescription drug coverage to individuals who are Part D-eligible. This disclosure is not new and should have occurred each year since 2006. The disclosure applies regardless of whether an employer provides retiree prescription drug benefits. An employer that has been approved for the retiree drug subsidy (RDS) is exempt from filing the notice with CMS with respect to those qualified covered retirees for whom the employer is claiming the RDS. For this group, the employer’s RDS application serves as the disclosure to CMS. As noted below, even if the employer is approved for RDS for some groups, the notice will be required for all groups other than those for which the employer is claiming the RDS. For example, an employer that applies for the RDS must still disclose this information for any active employee who is Part D-eligible. Due to tax changes under the Affordable Care Act, some employers that sponsor retiree prescription drug plans moved to a Part D EGWP in 2013 instead of applying for the RDS. An EGWP is a Part D plan and therefore, is not required to issue notices of creditable coverage or disclose the creditable status of the coverage to CMS. Employers should keep this in mind when gathering the data for the disclosure.

See the Aon Hewitt bulletin titled “Medicare Part D Disclosure Reminder and a Tip for EGWPs” (February 2013) under “2013 Developments: A Closer Look.”

Mental Health and Substance Use
On November 8, 2013, three federal agencies—CMS, EBSA, and the IRS—jointly issued long-awaited final mental health parity regulations. The interim regulations were originally published in January 2010. The final regulations implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical and surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. The final regulations also contain a technical amendment relating to external review with respect to the multistate plan program administered by the OPM. Private employers with fewer than 50 employees are exempt from the law. The
mental health parity provisions of the final regulations apply to group health plans and health insurance issuers for plan years (or, in the individual market, policy years) beginning on or after July 1, 2014. According to the agencies, until the final regulations become applicable, plans and issuers must continue to comply with the mental health parity provisions of the interim final regulations.

See the Aon Hewitt bulletin titled “Government Modifies Mental Health and Substance Use Disorder Parity Rules” (December 2013) under “2013 Developments: A Closer Look.”

TRICARE
On May 28, 2013, the Department of Defense (DOD) published a final rule implementing Section 702 of the Ike Skelton National Defense Authorization Act for Fiscal Year 2011. (An interim final rule was released in April 2011.) It establishes the TRICARE Young Adult (TYA) program to provide an extended TRICARE program coverage opportunity to most unmarried children under the age of 26 of uniformed services sponsors. TYA is a premium-based program that provides TRICARE program coverage to unmarried children under the age of 26 of TRICARE-eligible sponsors who no longer meet the age requirements for TRICARE eligibility (age 21, or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and the sponsor provides more than 50% of the student’s financial support), and who are not eligible for medical coverage from an eligible employer-sponsored plan based on their individual employment status. If qualified, they can purchase TRICARE Standard/Extra or TRICARE Prime benefits coverage. The particular TRICARE option available depends on the uniformed service sponsor’s eligibility and the availability of the TRICARE option in the dependent’s geographic location. TYA is similar to young adult coverage under the Affordable Care Act, but reflects a number of differences between TRICARE, a statutorily created DOD health benefits program and typical civilian health care plans. Among these is that TYA is a full cost premium-based program; it is limited to unmarried dependent children of TRICARE-eligible sponsors; and the dependent child must not be eligible for medical coverage from an eligible employer-sponsored plan based on their individual employment status (an exclusion that does not expire on January 1, 2014, but is permanent).
Retirement

Correction and Compliance Programs

On January 24, 2013, the IRS announced that model documents used for the Voluntary Correction Program (VCP) for submissions under Revenue Procedure 2013-12 are also available on the agency’s website. Electronic links are available for a model VCP compliance statement, Appendix C schedules (Part II), and Forms 8950 and 8951. The IRS stated that practitioners are not allowed to modify the forms or content of the schedules.


On January 18, 2013, the IRS released revised Forms 8950 and 8951 to be included with all new applications submitted as part of the Employee Plans Compliance Resolution System’s (EPCRS) VCP. Revenue Procedure 2013-12 updated the EPCRS for sponsors of retirement plans that have not met the requirements of tax code Sections 401(a), 403(a), 403(b), 408(k), or 408(p) for a period of time. Through EPCRS, plan sponsors can correct plan failures and continue to provide employees with retirement benefits on a tax-favored basis. The forms requirement is an integral component of new submission procedures for the VCP.

Defined Benefit Plans

On December 13, 2013, the IRS released temporary nondiscrimination relief for certain closed defined benefit pension plans. These are plans that provide ongoing accruals but that have been amended to limit those accruals to some or all of the employees who were participating in the plan on a specified date. Such plans may increasingly have trouble satisfying nondiscrimination testing over time as the proportion of plan participants who are highly compensated employees (HCEs) increases. This may happen for a number of reasons, such as higher rates of turnover among nonhighly compensated employees (NHCEs) than HCEs and the tendency of NHCEs participating in the closed defined benefit plan to become HCEs as they continue in their employment. Notice 2014-5 allows certain employers that sponsor both a closed defined benefit plan and a defined contribution retirement plan to demonstrate that the aggregated plans comply with the nondiscrimination requirements of Section 401(a)(4) on the basis of equivalent benefits, even if the aggregated plans do not satisfy the current conditions for testing on that basis.

The Pension Benefit Guaranty Corporation (PBGC) published a final rule on December 2, 2013, which updates the early retirement probability table. Specifically, the rule amends PBGC’s regulation on allocation of assets in single-employer plans by substituting a new table for determining expected retirement ages for participants in pension plans undergoing distress or involuntary termination with valuation dates falling in 2014. This table is needed in order to compute the value of early retirement benefits and, thus, the total value of benefits under a plan. The final rule became effective on January 1, 2014.

On November 15, 2013, PBGC issued its Annual Report for Fiscal Year 2013. The report noted that PBGC’s deficit increased to approximately $36 billion, due largely to the declining financial condition of multiemployer plans. Additionally, the report noted PBGC’s high customer satisfaction scores. The deficit in the program for single-employer pension plans narrowed to about $27.4 billion, down from $29.1 billion in 2012. The program insures the pensions of nearly 32 million workers and retirees in 23,000 ongoing
plans sponsored by private-sector employers. The single-employer program’s potential exposure to future pension losses from financially weak companies was estimated at about $292 billion, compared to about $295 billion last fiscal year. Multiemployer plans provide lifetime income to more than 10 million people in 1,400 plans. According to the agency, because more plans will fail within the next decade, PBGC’s multiemployer insurance program’s deficit rose to more than $8.2 billion, compared with $5.2 billion in 2012.

On November 7, 2013, PBGC announced the 2014 flat-rate premiums for single-employer and multiemployer plans. For the 2014 plan year, the per-participant flat-rate premium for single-employer plans is $49.00 (up from $42.00 in 2013) and $12.00 for multiemployer plans (no change from last year). Adjustments to the premium rates are based upon inflation, changes resulting from the Moving Ahead for Progress in the 21st Century Act (MAP-21), and the national average wage index.

On November 6, 2013, PBGC announced that the 2014 maximum yearly guarantee for a 65-year-old retiree will increase to $59,318.16 (a 3.2% increase from the $57,500 2013 rate). The maximum guaranteeable monthly benefit for a 65-year-old beneficiary for 2014 is $4,943.18 (as compared to $4,789.77 in 2013). The PBGC maximum guarantee is based on a formula prescribed by federal law. Yearly amounts are higher for people older than age 65 and lower for those who retire earlier or choose survivor benefits. The guarantee increase only applies to single-employer pension plans. The maximum guarantee limit for participants in multiemployer plans is $12,870 with 30 years of service, which has been in place since 2001.

On July 22, 2013, PBGC released proposed regulations to make the agency’s premium rules more effective and less burdensome. Based upon regulatory review under Executive Order 13563 (Improving Regulation and Regulatory Review), PBGC proposed to amend its regulations on premium rates and payment of premiums to simplify due dates, coordinate the due date for terminating plans with the termination process, make conforming and clarifying changes to the variable-rate premium rules, provide for relief from penalties, and make other changes. Large plans would no longer have to pay flat-rate premiums early; small plans would get more time to value benefits. These amendments would be effective beginning 2014. PBGC also proposed to amend its regulations in accordance with the MAP-21.

PBGC issued a proposed rule on April 2, 2013, on reportable events and certain other notification requirements. Under ERISA, pension plans and the companies that sponsor them are required to report to PBGC a range of corporate and plan events. In 2009, PBGC proposed to increase reporting requirements by eliminating most reporting waivers. Plan sponsors and pension practitioners objected, saying that PBGC would have required reports where the actual risk to plans and PBGC is minimal. In the new proposed rule, the agency states its agreement. The new proposal would exempt most companies and plans from many reports and would target requirements to the minority of companies and plans that are at substantial risk of default.

On March 11, 2013, PBGC announced updates to the e-4010 instructions to reflect PBGC’s guidance on the effect of MAP-21 on 4010 reporting. The agency noted that other minor modifications were also made to the application.

On March 8, 2013, the DOL released a Field Assistance Bulletin (FAB) 2013-01 concerning new disclosure requirements mandated by MAP-21. MAP-21 amended Section 101(f) of ERISA to require plan administrators of single-employer defined benefit pension plans to provide participants and others additional information regarding the impact of MAP-21’s interest rate stabilization rules on the plan’s
funding status. According to the DOL, an estimated 12,000 single-employer plans covering approximately 33.5 million participants and beneficiaries are subject to the new disclosure requirements. FAB 2013-01 addressed a need for interim guidance pending the adoption of regulations or other guidance under Section 101(f) of ERISA, as amended by MAP-21. The FAB set forth technical questions and answers and provided a model supplement that plan administrators may use to discharge MAP-21 disclosure obligations.

PBGC released its annual pension insurance data tables on February 27, 2013. The tables captured statistical trends in private defined benefit plans. Additionally, PBGC announced its plans to update the tables on a more frequent basis. Rather than wait to publish a full annual update, the agency will provide users access to the most recently published data for each of about 70 topics. As updates become available, users will have the option of choosing “Most Current Data” or the complete set for any given year. Users can subscribe to PBGC’s Open Government page to receive notifications when new data becomes available.

On February 11, 2013, the IRS issued guidance (Notice 2013-11) on the 25-year average segment rates that are applied to adjust the otherwise applicable 24-month average segment rates that are used to compute the minimum contribution requirements for single-employer defined benefit plans under Section 430 of the Code and Section 303 of ERISA for plan years beginning in 2013. The guidance reflects the changes made to the Code and ERISA by MAP-21.

On January 30, 2013, PBGC issued Technical Update 13-1, which provided guidance for plan years beginning after 2012 on compliance with the reportable events requirements of Section 4043 of ERISA and PBGC’s regulation on Reportable Events and Certain Other Notification Requirements. Technical Update 13-1 addressed two topics: funding-related determinations for purposes of waivers, extensions, and the advance reporting threshold test and missed quarterly contributions.

Defined Contribution Plans

On December 12, 2013, the IRS issued guidance (Notice 2013-74) on in-plan rollovers to designated Roth accounts. The guidance, which was in Q&A form, covers in-plan Roth rollovers of otherwise nondistributable amounts and also provides rules that are applicable to all in-plan Roth rollovers. ATRA expanded in-plan Roth rollovers to include rollovers of “otherwise nondistributable amounts,” effective for in-plan Roth rollovers made after December 31, 2012. Previously, in-plan Roth rollovers could only be made for “otherwise distributable amounts,” such as amounts eligible for distribution due to severance from employment or attainment of age 59½. Thus, beginning in 2013, a Section 401(k) plan can allow an individual to roll over an amount from a non-Roth, regular (pretax) account into a designated Roth account in the same plan at a time when the individual is not eligible for a distribution. Similar rules apply to Section 403(b) and governmental Section 457(b) plans. With respect to rollovers of otherwise nondistributable amounts, Notice 2013-74 addressed prior guidance, eligible rollover amounts, withholding, and plan amendments. With respect to all in-plan Roth rollovers, the Notice addressed the types of contributions eligible for rollovers, a plan’s discontinuance of such rollovers, the requirement of five taxable years of participation, net unrealized appreciation, top-heavy plans, and excess amounts.

On November 14, 2013, the IRS released final regulations that included amendments to regulations relating to certain cash or deferred arrangements under Section 401(k) and matching contributions and employee contributions under Section 401(m). The regulations provide guidance on permitted midyear reductions or suspensions of safe harbor nonelective contributions in certain circumstances for
amendments adopted after May 18, 2009. These regulations also revised the requirements for permitted
midyear reductions or suspensions of safe harbor matching contributions for plan years beginning on or
after January 1, 2015. The regulations affect administrators of, employers maintaining, participants in,
and beneficiaries of certain defined contribution plans that satisfy the nondiscrimination tests of Section
401(k) and Section 401(m) using one of the design-based safe harbors.

The DOL, on August 9, 2013, extended the time period for submitting comments on an information
collection request issued on January 22 regarding a survey that will ask respondents to answer questions
related to information found in their retirement plan benefit statements. The DOL intends to survey
participants involved in an existing household Internet panel called the American Life Panel (ALP) and
also plans to conduct four focus groups consisting of nonpanel members to explore whether information
presented in retirement plan benefit statements is understandable and assists in retirement planning.

The DOL on July 22, 2013 released FAB 2013-02. The bulletin announced a temporary enforcement
policy that will allow Section 401(k)-type plans to reset the timing for the annual distribution of the
investment comparative chart that they are required to furnish to plan participants. Under the enforcement
policy contained in FAB 2013-02, plan administrators may reset the deadline one time, for either the 2013
or the 2014 comparative chart, if the responsible plan fiduciary determines that doing so will benefit the
plan’s participants and beneficiaries and provided that no more than 18 months may pass before
participants receive their next comparative chart. The DOL stated that this enforcement policy does not
alter a plan administrator’s obligations under the regulation to timely update the investment information
that is available at the plan’s Internet web address or to notify participants about changes to investment
information, such as a new plan investment option.

On May 8, 2013, the DOL published an Advance Notice of Proposed Rulemaking (ANPRM) that
described requirements the DOL is considering for defined contribution plans to provide illustrations of
potential monthly lifetime income amounts (i.e., hypothetical annuity payments) based on actual
participant account balances. An ANPRM is not equivalent to the issuance of proposed regulations;
instead, the DOL is still in the policy-making stages and is seeking input from plan sponsors and service
providers on their current thinking of what upcoming proposed regulations may be. These pre-proposed
regulations would apply only to defined contribution plans subject to ERISA and are, in part, a result of
numerous responses received with respect to the joint DOL and Treasury RFI regarding lifetime income
options issued back in February 2010.

See the Aon Hewitt bulletin titled “DOL Seeks Comments on Proposed Lifetime Income Illustrations for

On April 2, 2013, the IRS released a report summarizing results from the Section 401(k) Compliance
Check Questionnaire responses received from a random sample of plan sponsors that filed Form 5500
for the 2007 plan year. The final report (91 pages) summarized the results that are both generalized to
the Section 401(k) plan population that files Form 5500; and stratified to highlight the differences in the
results by plan size. The Section 401(k) Compliance Check Questionnaire requested information in the
following areas: demographics, plan participation, contributions, designated Roth features, distributions,
top-heavy and nondiscrimination testing, IRS correction programs, and plan administration.

On February 28, 2013, the DOL issued tips on target date retirement funds (TDFs) for ERISA plan
fiduciaries. The DOL provided the general guidance to assist plan fiduciaries in selecting and monitoring
TDFs and other investment options in Section 401(k) and similar participant-directed individual account
plans. The document provided an overview of TDFs, which automatically rebalance to become more conservative as an employee gets closer to retirement. The DOL’s tips for plan fiduciaries included recommendations to establish a process for comparing and selecting TDFs; establish a process for the periodic review of selected TDFs; understand the fund’s investments—the allocation in different asset classes (stocks, bonds, cash), individual investments, and how these will change over time; review the fund’s fees and investment expenses; inquire about whether a custom or non-proprietary target date fund would be a better fit for a plan; develop effective employee communications; take advantage of available sources of information to evaluate the TDF and recommendations received regarding the TDF selection; and document the process.

On February 21, 2013, the IRS posted a Section 403(b) Plan Fix-It Guide. The resource was the latest in a series of electronic employee plans compliance tools available for practitioners and plan sponsors. The chart included 10 mistakes that can occur in Section 403(b) plans and contained information describing how to find, fix, and avoid such mistakes in the future.

On January 22, 2013, the DOL issued an information collection request regarding a survey that will ask respondents to answer questions related to information found in their retirement plan benefit statements. The DOL intends to survey participants involved in an existing household Internet panel called the ALP and also plans to conduct four focus groups consisting of nonpanel members to explore whether information presented in retirement plan benefit statements is understandable and assists in retirement planning. Survey topics include participants’ current allocations to their retirement accounts, their expectations for how long they will need to keep working, their financial goals for retirement, the basis for calculating those goals, how frequently they view their current benefits statement, whether they receive benefit statements in paper or electronic format, and what information from the statements do they primarily focus on. Participants will then be provided with two different benefits statements that provide slightly different information and will be asked to answer several questions based on those statements to better assess what they understand about the statements. The study results will be used to support the DOL’s rule making related to ERISA, as amended by the Pension Protection Act (PPA), which requires administrators of ERISA-covered individual account plans to furnish periodic benefit statements to participants and beneficiaries.

Mass Submitter Plans

On July 30, 2013, the IRS released Announcement 2013-37, which extends to January 31, 2014 the deadline to submit on-cycle applications for opinion and advisory letters for sponsors and practitioners maintaining defined benefit mass submitter lead plans for the plans’ second six-year remedial amendment cycle. The original deadline was October 31, 2013.

Missing Participants and Lost Pensions

On June 20, 2013, PBGC released an RFI asking for input about the agency’s plans to implement a new program to deal with benefits of missing participants in terminating individual account plans. The agency is interested in stakeholders’ views on topics such as the extent of the demand for such a program, the demand for a database of missing participants, the availability of private-sector missing participant services, potential program costs and fees, electronic filing, and the contours of diligent search requirements.
PBGC announced on March 18, 2013, that the lockbox addresses for sending payment of designated benefits and/or other amounts due missing participants with a completed payment voucher have changed. The new addresses for the U.S. Postal Service and other mail delivery services, as well as for wire transfers, are available on page 5 of the PBGC’s “Missing Participants Filing Instructions.” The address for sending the Schedule MP (including any required attachments) along with the post-distribution certification has not changed.

PBGC updated “Finding a Lost Pension” in 2013. This guide assists employees who believe they have a pension, but who cannot find their pension plan or former employer to begin receiving their benefits. The booklet was produced in partnership with the Gerontology Institute of the University of Massachusetts Boston.

Pre-Approved Plans

On March 28, 2013, the IRS released Revenue Procedure 2013-22, which establishes the procedures for issuing opinion and advisory letters for Section 403(b) pre-approved plans. Under the program, pre-approved plan sponsors may apply to the IRS for an opinion letter (for prototype plans) or an advisory letter (for volume submitter plans). Revenue Procedure 2013-22 establishes the new program and explains certain requirements that pre-approved Section 403(b) plans must satisfy; responsibilities of pre-approved plan sponsors; procedures for applying for opinion and advisory letters; and conditions under which an eligible employer that adopts a pre-approved Section 403(b) plan has reliance that the form of the plan meets Code Section 403(b) and the final Section 403(b) regulations.

Qualification and Covered Compensation Tables

The IRS released Revenue Ruling 2014-03 on December 19, 2013, which provides the 2014 compensation tables for calculating certain benefits under qualified pension, profit sharing, and stock bonus plans. The tables list the rounded amounts of covered compensation for various birth years and Social Security retirement years. The IRS stated that plan administrators may use the covered compensation tables to determine permitted disparity when integrating retirement plan benefits with Social Security benefits.

On December 11, 2013, the IRS released Notice 2013-84, which contained the 2013 Cumulative List of Changes in Plan Qualification Requirements (2013 Cumulative List) described in Section 4 of Revenue Procedure 2007-44, 2007-2 C.B. 54. The 2013 Cumulative List is to be used by plan sponsors and practitioners submitting determination letter applications for plans during the period beginning February 1, 2014 and ending January 31, 2015. According to the IRS, plans using this 2013 Cumulative List will primarily be single employer individually designed defined contribution plans and single employer individually designed defined benefit plans that are in Cycle D and multiemployer plans as described in Section 414(f). Generally, an individually designed plan is in Cycle D if the last digit of the employer identification number of the plan sponsor is four or nine. The list of changes in Section 4 of the Notice does not extend the deadline by which a plan must be amended to comply with any statutory, regulatory, or guidance changes. The general deadline for timely adoption of an interim or discretionary amendment can be found in Section 5.05 of Revenue Procedure 2007-44. The IRS stated that the 2013 Cumulative List reflects changes under a variety of laws, including the MAP-21, ATRA, and PPA.
Reporting and Disclosure

On August 29, 2013, the Treasury and IRS issued proposed regulations relating to the requirements for filing certain employee retirement benefit plan statements, returns, and reports on magnetic media. Plan administrators that file at least 250 returns in a calendar year would be required to file electronically. The term magnetic media includes electronic filing, as well as other magnetic media specifically permitted under applicable regulations, revenue procedures, publications, forms, instructions, or other guidance on the IRS.gov website. The regulations would affect plan administrators and employers maintaining retirement plans that are subject to various employee benefit reporting requirements under the Code.
Other HR-Related Topics

The following section provides an overview of other HR-related regulations, guidance, and updates by the following topics:

- Discrimination;
- EEOC Guidance;
- FMLA;
- Immigration: E-Verify/I-9;
- IRS Guidance: Business Related, Taxation, and Tables;
- Other;
- Regulatory Agenda and Priority Guidance Plans;
- Same-Sex Marriage; and
- Wage.

Discrimination

On February 27, 2013, the Office of Federal Contract Compliance Program (OFCCP) announced that it rescinded two 2006 enforcement guidance documents on pay discrimination, commonly known as the “Compensation Standards” and “Voluntary Guidelines.” The action became effective on February 28, 2013, and intends to “protect workers and strengthen OFCCP’s ability to identify and remedy different forms of pay discrimination.” The rescission enables the OFCCP to conduct investigations of contractor pay practices consistent with the Civil Rights Act of 1964. The Notice of final rescission withdrawing the two documents also includes new guidance for employers establishing the procedures as well as analysis and protocols OFCCP will utilize going forward when conducting compensation discrimination investigations. OFCCP will supplement the guidance with FAQs, technical assistance, webinars, and other resources and materials to ensure that contractors have adequate information about how to comply with the law.

EEOC Guidance

On May 15, 2013, EEOC issued four revised documents on protection against disability discrimination, pursuant to the goal of the agency’s strategic plan to provide current guidance on the requirements of antidiscrimination laws. The documents address how the Americans with Disabilities Act (ADA) applies to applicants and employees with cancer, diabetes, epilepsy, and intellectual disabilities. The documents are available on the EEOC’s website, under “Disability Discrimination, The Question and Answer Series.” The revised documents reflect the changes to the definition of disability made by the ADA Amendments Act (ADAAA) that make it easier to conclude that individuals with a wide range of impairments, including cancer, diabetes, epilepsy, and intellectual disabilities, are protected by the ADA. Each of the documents also answers questions about topics such as: when an employer may obtain medical information from applicants and employees; what types of reasonable accommodations individuals with these particular disabilities might need; how an employer should handle safety concerns; and what an employer should do to prevent and correct disability-based harassment.
FMLA

The DOL revised its model FMLA forms and notice poster in February 2013. The DOL amended the forms’ expiration dates to February 28, 2015; made other changes to forms WH-384 and WH-385; and introduced WH-385-V, which is a new form for military caregiver leave to care for veterans. The DOL provides the following model forms:

- WH-380-E Certification of Health Care Provider for Employee’s Serious Health Condition;
- WH-380-F Certification of Health Care Provider for Family Member’s Serious Health Condition;
- WH-381 Notice of Eligibility and Rights & Responsibilities;
- WH-382 Designation Notice;
- WH-384 Certification of Qualifying Exigency For Military Family Leave;
- WH-385 Certification for Serious Injury or Illness of Covered Servicemember—For Military Family Leave; and
- WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave.

The DOL requires all covered employers to display a poster summarizing the major provisions of the FMLA and how employees may file a complaint.

On February 5, 2013, the DOL released final regulations amending certain FMLA regulations. The final regulations implement amendments to the military leave provisions of the FMLA made by the National Defense Authorization Act for Fiscal Year 2010 (2010 NDAA), which extended qualifying exigency leave to family members of servicemembers in the Regular Armed Forces, redefined the deployments that allow qualifying exigency leaves, and extended military caregiver leave to family members of certain veterans with serious injuries or illnesses. The final regulations also include provisions to implement the Airline Flight Crew Technical Corrections Act (AFCTCA), which established new leave eligibility requirements for airline flight crewmembers and flight attendants. In addition, the final regulations clarify changes concerning the calculation of intermittent or reduced schedule FMLA leave; the reorganization of certain sections to enhance clarity; the removal of the forms from the regulations; and technical corrections to the current regulations. The final regulations became effective on March 8, 2013.

See the Aon Hewitt bulletin titled “Department of Labor Issues FMLA Regulations on Family Military Leaves, Airlines Flight Crews, and Other Topics” (February 2013) under “2013 Developments: A Closer Look.”

The DOL released its FMLA in 2012: Final Report on February 4, 2013. The DOL published the survey the same week the law celebrated its 20th anniversary. Survey respondents consisted of 1,812 worksites and 2,852 employees. All respondents were asked about leave taken for FMLA-covered reasons. Some findings are highlighted below:

- 85% of employers found it easy to comply with the law, and misuse of the FMLA by employees was rare (fewer than 2% of covered worksites);
- 91% of employers reported that complying with the FMLA had either a positive effect or no noticeable effect on employee absenteeism, turnover, and morale;
- 90% of employees returned to work after FMLA leave;
24% of leave taken for FMLA reasons was intermittent leave and fewer than 2% of employees who took intermittent leave were off for a day or less; and

13% of all employees reported taking leave for a FMLA reason in the past 12 months.

On January 14, 2013, the DOL issued guidance in the form of an Administrator’s Interpretation (AI 2013-1) regarding caring for an adult child under FMLA. AI 2013-1 determines that “additional guidance is needed regarding the definition of ‘son or daughter’ as it applies to an employee seeking to take leave under the FMLA to care for a son or daughter with a disability who is 18 years of age or older.” The guidance clarifies that the age of a son or daughter at the onset of a disability is not relevant in determining a parent’s entitlement to FMLA leave. In addition, the interpretation provides guidance on the impact of the ADAAA on a parent’s ability to take FMLA leave to care for an adult son or daughter with a disability. The ADAAA made significant changes to the definition of the term “disability” under the ADA, which is administered by EEOC. According to the DOL, the Wage and Hour Division has received requests for guidance regarding the impact of the ADAAA on determinations of whether a parent may take leave under the FMLA to care for a son or daughter 18 years of age or older with a disability. The interpretation also discusses the impact of this guidance on the availability of FMLA leave for parents to care for a son or daughter who becomes disabled during military service.

See the Aon Hewitt bulletin titled “New DOL Guidance on FMLA Leave to Care for Adult Children” (January 2013) under “2013 Developments: A Closer Look.”

Immigration: E-Verify and I-9 Form

On November 27, 2013, the U.S. Citizenship and Immigration Services (USCIS) announced that it was updating its Memorandums of Understanding (MOUs) for the E-Verify electronic eligibility verification program. The latest MOUs were released by USCIS on December 8, 2013, and became effective on that date. The MOUs that were changed include the MOU for employers using E-Verify, the MOU for third parties using E-Verify on an employer’s behalf, and the MOU for employers that use third parties to input information into E-Verify.

New users will now need to submit one of the new or revised MOUs to enroll. According to USCIS, the MOUs are tailored to each access method and are easier to read and understand. As part of the changes, USCIS retitled and revised three current MOUs for E-Verify browser users and also added three new MOUs for web services users and developers.

USCIS announced the newly revised Employment Eligibility Verification Form I-9 on March 8, 2013. Employers are required to use the I-9 form to verify the identity and employment authorization eligibility of their employees. The revisions to the I-9 form contain formatting changes and the inclusion of additional data fields. According to USCIS, the revised I-9 form does not need to be completed for existing employees who already have a form on file, unless employment eligibility needs to be reverified.

The Federal Register notice instructed employers to immediately begin using the new I-9 form with a revision date of “(Rev. 03/08/13) N.” However, USCIS stated that the older version of the form would be accepted until May 7, 2013.

See the Aon Hewitt bulletin titled “USCIS Issues Revised I-9 Form” (March 2013) under “2013 Developments: A Closer Look.”
IRS Guidance: Business Related, Taxation, and Tables

The IRS issued Information Release 2013-95 and Notice 2013-80 on December 6, 2013, announcing the optional standard mileage rates for use in computing the deductible costs of operating an automobile for business and other purposes beginning January 1, 2014. The standard mileage rates are: 1) $0.56 per mile for business miles; 2) $0.235 per mile for medical or moving purposes; and 3) $0.14 per mile in service of charitable organizations. According to the IRS, the rates for both business miles and medical and moving purposes decreased by half of $0.01 from the 2013 rates. The rate for service of charitable organizations remained the same.

On November 26, 2013, the Treasury and IRS issued final regulations on net investment income tax. These final regulations provide guidance on the general application and computation of the 3.8% Medicare contribution tax on the unearned income of individuals, estates, and trusts whose incomes meet certain income thresholds. The regulations became effective on December 2, 2013. The net investment income tax was one of three new federal taxes added by the Affordable Care Act.

The IRS issued Notice 2013-65 on September 25, 2013. This annual Notice provides the 2013-2014 special per diem rates for taxpayers to use in substantiating the amount of ordinary and necessary business expenses incurred while traveling away from home, specifically: 1) the special transportation industry meal and incidental expenses (M&IE) rates; 2) the rate for the incidental expenses only deduction; and 3) the rates and list of high-cost localities for purposes of the high-low substantiation method. Procedure 2011-47 provides rules for using a per diem rate to substantiate, under Section 274(d) of the Code and Section 1.274–5 of the Income Tax Regulations, the amount of ordinary and necessary business expenses paid or incurred while traveling away from home. Taxpayers using the rates and list of high-cost localities provided in Notice 2013-65 must comply with Revenue Procedure 2011-47.

The per diem rate for travel to high-cost localities is $251; the rate for all other sites within the continental United States (CONUS) is $170. The amount of the $251 high rate and $170 low rate that is treated as paid for meals for purposes of Section 274(n) is $65 for travel to any high-cost locality and $52 for travel to any other locality within the CONUS. The special M&IE rates for taxpayers in the transportation industry are $59 for any locality of travel within the CONUS and $65 for any locality of travel outside the continental United States (OCONUS). The Notice also lists the cities that are considered high-cost localities for all or a portion of the calendar year with a federal per diem rate of $210 or more (e.g., Chicago, Illinois).

The per diem allowances became effective on October 1, 2013.

The Treasury and IRS released final regulations updating employer identification numbers (EINs) on May 3, 2013. The regulations require any taxpayer assigned an EIN to provide updated information to the IRS in the manner and frequency prescribed by forms, instructions, or other appropriate guidance. According to the agency, the final regulations will enhance the IRS’s ability to maintain accurate information on the assigned EINs, which are also known as federal tax identification numbers, used to identify a business entity. EINs are used by employers, sole proprietors, corporations, partnerships, nonprofits, trusts, estates, and government agencies. The final regulations follow proposed regulations that were issued in March 2012 that required anyone issued an EIN to provide updated information in a manner and frequency that had not been determined at the time. The final regulations became effective on May 6, 2013.
The IRS released Notice 2013-27 on April 29, 2013, that provides the maximum vehicle values for 2013 that taxpayers need to determine the value of personal use of employer-provided vehicles under the special valuation rules provided under Section 1.61-21(d) and (e) of the income tax regulations.

On April 18, 2013, the IRS released Notice 2013-17, which addresses circumstances in which an Employee Stock Option Plan (ESOP) that satisfied the diversification requirements of Section 401(a)(28)(B)(i) by allowing distribution of a portion of a participant’s account has become subject to the diversification requirements of Section 401(a)(35). The Notice provides relief from the anti-cutback requirements of tax code Section 411(d)(6) for ESOPs that hold, or are treated as holding, publicly traded employer securities.

The IRS released Notice 2013-14 on March 8, 2013, which provides guidance on Section 309 of ATRA, enacted January 3, 2013. The law amended the Code to extend the Work Opportunity Tax Credit through December 31, 2013, for taxable employers and for qualified tax-exempt organizations. The Notice provides employers that hire members of targeted groups additional time beyond the 28-day deadline in Section 51(d)(13) for submitting Form 8850, Pre-screening Notice and Certification Request for the Work Opportunity Credit, to designated local agencies.

On February 27, 2013, the IRS announced (IR 2013-23) that it expanded its Voluntary Classification Settlement Program (VCSP). The program provides partial relief from federal payroll taxes for eligible employers that are treating their workers or a class or group of workers as independent contractors or other nonemployees and now want to treat them as employees. The IRS is modifying several eligibility requirements for the VCSP, allowing more employers (including large-size) to apply for the program. Additionally, businesses, tax-exempt organizations, and government entities may qualify. Under the revised program, employers under IRS audit, other than an employment tax audit, can qualify for the VCSP. These and other permanent modifications to the program are described in IRS Announcement 2012-45 and in FAQs posted on the agency website.

On February 25, 2013, the IRS released Revenue Procedure 2013-21, which reflects the inflation-adjusted limitations on depreciation deductions and lease rates for cars, trucks, and vans first placed in service in calendar year 2013.

The IRS released its 2013 Employer’s Tax Guide, along with two affiliated publications: Publication 15-A (Employer’s Supplemental Tax Guide) and Publication 15-B (Employer’s Tax Guide to Fringe Benefits) on February 1, 2013. The 2013 Employer’s Tax Guide contains the federal income tax percentage method and wage bracket withholding tables and employer instructions on accounting for taxable and nontaxable items. Publication 15-A supplements the Employer’s Tax Guide with detailed guidance on employee status, third-party sick pay, and includes alternative 2013 federal income tax withholding tables. Publication 15-B includes descriptions of most fringe benefit issues that often cross into payroll administration.

On January 25, 2013, the IRS released proposed regulations under Section 3504 of the Code providing circumstances under which a person (payor) is designated as an agent to perform the acts required of an employer and is liable for employment taxes with respect to wages or compensation paid by the payor to individuals performing services for the payor’s client pursuant to a service agreement between the payor and the client.
On January 16, 2013, the IRS released guidance (Notice 2013-8) with respect to issues related to the enactment of Section 203 of ATRA, which increased the monthly transit benefit exclusion under Section 132(f)(2)(A) of the Code from $125 per participating employee to $240 per participating employee for the period of January 1, 2012 through December 31, 2012.

On January 11, 2013, the IRS released Revenue Procedure 2013-15, which provides the 2013 cost-of-living adjustments for inflation for certain items, including the tax tables. Revenue Procedure 2013-15 also includes items whose values were specified in ATRA, such as the beginning of the 39.6% income tax brackets, the beginning income levels for the limitation on certain itemized deductions, and the beginning income levels for the phase-out of the personal exemptions. The guidance also provides information about the adoption credit, child tax credit, and modifies Revenue Procedure 2011-52 to reflect an amendment to Section 132(f)(2) made by ATRA concerning qualified transportation fringe benefits.

On January 3, 2013, the IRS released updated income tax withholding tables for 2013, due to the enactment of ATRA.

Other

The DOL launched the CareerOneStop Business Center for employers on March 25, 2013. The online Business Center provides one-stop access to information and state and local resources to assist employers in recruiting, hiring, and training skilled workforces. The Business Center is one of the CareerOneStop suite of web products sponsored by the DOL’s Employment and Training Administration.

On January 28, 2013, EBSA released a notice which describes changes to the Delinquent Filer Voluntary Compliance Program (DFVC Program). Administrators of employee benefit plans subject to ERISA that fail to file annual reports on a timely basis can be subject to civil penalties under the law. The DFVC Program is intended to encourage delinquent plan administrators to comply with their annual reporting obligations under ERISA through the assessment of reduced civil penalties. The DFVC Program was initially adopted in 1995 and was last updated in 2002. Most recently, the DFVC Program website was updated to reflect the DOL’s final regulation mandating electronic filing of annual reports as part of the implementation of a wholly electronic ERISA Filing Acceptance System (EFAST2) for those reports. In addition, the notice also describes an existing online penalty calculator and Internet-based payment system for the DFVC Program. The notice became effective immediately upon publication in the Federal Register.

Regulatory Agenda and Priority Guidance Plans

On November 26, 2013, federal departments and agencies (the DOL, EEOC, IRS, HHS, PBGC, etc.) released their Fall 2013 Semiannual Regulatory Agendas. The agendas include regulatory plans and priorities for 2014, as well as regulations that were completed during 2013. A variety of regulations are expected to be issued in the upcoming months, impacting health care, retirement, executive compensation, immigration, and employment. Some of the expected regulations include, but are not limited to:

- A number of tax-related provisions, as required by the Affordable Care Act;
- The re-proposal of the definition of fiduciary rule;
- Rules regarding hybrid retirement plans;
Accrual rules for defined benefit plans;
Guidance on the application of Section 409A to nonqualified deferred compensation plans;
Pension benefit statements; and
Revising the definition of a spouse under the FMLA.

On November 20, 2013, the Treasury released its first quarter update to the 2013-2014 Priority Guidance Plan. The 2013-2014 plan contains 324 projects that are priorities for allocation of the resources of the Treasury offices during the twelve-month period from July 2013 through June 2014 (the plan year). The plan represents projects the Treasury intends to actively work on during the plan year and does not place any deadline on completion of projects. Projects on the 2013–2014 plan provide guidance on a variety of issues important to individuals and businesses, including international taxation, health care, and implementation of legislative changes. In addition to the items on the 2013–2014 plan, the Appendix lists the more routine guidance that is generally published each year.

The first quarter update to the 2013-2014 plan reflects five additional projects that have become priorities and/or guidance that has been published during the period from July 16, 2013 through September 30, 2013 of the plan year. The Treasury intends to update and republish the 2013–2014 plan during the plan year.

On August 9, 2013, the Treasury and IRS released the fourth quarter update of the 2012-2013 Priority Guidance Plan. The 2012–2013 Priority Guidance Plan (published November 19, 2012) contained the 317 original projects that were priorities for allocation of the resources of the Treasury and IRS offices during the twelve-month period from July 2012 through June 2013.

Same-Sex Marriage

On September 23, 2013, the IRS released Notice 2013-61, which provides guidance to employers and employees to make claims for refunds or adjustments of overpayments of Federal Insurance Contributions Act (FICA) taxes and federal income tax withholding (employment taxes) resulting from the Supreme Court decision in United States v. Windsor. In Windsor, the Court held that the section in the federal DOMA defining “marriage” as a legal union between one man and one woman and “spouse” as only a person of the opposite sex is unconstitutional. The Notice adds to the guidance in IRS Revenue Ruling 2013-17 (released August 29) that announced that the IRS will recognize all legally married same-sex couples for federal tax purposes regardless of where the couple lives.

Notice 2013-61 also provides special administrative procedures that can be used by employers to claim refunds or make adjustments of overpayments of employment taxes paid with respect to same-sex spouse benefits for 2013 and a special administrative procedure that can be used with respect to overpayments of FICA taxes for years before 2013. According to the IRS, the two special administrative procedures provided in the Notice are optional and are intended to “reduce filing and reporting burdens associated with the optional retroactive application of the holdings” in Revenue Ruling 2013-17.

See the Aon Hewitt bulletin titled “IRS Issues Post-Windsor Refund Guidance” (September 2013) under “2013 Developments: A Closer Look.”

On September 18, 2013, EBSA issued guidance in which it states that the terms “spouse” and “marriage” in Title I of ERISA and related regulations should generally be treated as including “same-sex couples legally married in any state or foreign jurisdiction that recognizes such marriages, regardless of where
they currently live.” “State” means any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and any other territory or possession of the United States. The guidance reflects the U.S. Supreme Court's ruling in United States v. Windsor, in which the Court held that the section in the federal DOMA defining “marriage” as a legal union between one man and one woman and “spouse” as only to a person of the opposite sex is unconstitutional. “Marriage” and “spouse” do not include individuals in formal relationships not “denominated” as marriages under state law, such as domestic partnerships or civil unions, whether or not individuals in those relationships have the same rights and responsibilities as individuals married under state law. EBSA also stated that it plans to issue guidance in the future that will address specific provisions of ERISA and its regulations.

The Treasury and IRS released much-anticipated guidance (Revenue Ruling 2013-17 and in FAQs) as to how same-sex marriages, domestic partnerships, and civil unions will be treated under federal tax law on August 29, 2013. The guidance implements federal tax aspects of the June 2013 Windsor Supreme Court decision. The Treasury and IRS have specified that same-sex couples will be treated as married for all federal tax purposes, including income and gift and estate taxes. The ruling applies to all federal tax provisions where marriage is a factor, including filing status, claiming personal and dependency exemptions, taking the standard deduction, employee benefits, contributing to an individual retirement account (IRA), and claiming the earned income tax credit or child tax credit.


On August 14, 2013, the DOL updated “Fact Sheet #28F: Qualifying Reasons for Leave Under the Family and Medical Leave Act” to include same-sex spouses. The Fact Sheet was updated to reflect the Supreme Court's recent decision in Windsor. Fact Sheet #28F updates the definition of 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.”

See the Aon Hewitt bulletin titled “DOL Issues New FMLA Guidance on Same-Sex Marriage” (August 2013) under “2013 Developments: A Closer Look.”

Wage

On September 17, 2013, the DOL announced a final rule that extends the FLSA minimum wage and overtime protection to most direct care workers who provide essential home care assistance to elderly people and people with illnesses, injuries, or disabilities. The final rule becomes effective January 1, 2015. The DOL has also created a new web portal with fact sheets, FAQs, and other materials to assist families, employers, and workers.
2013 Developments: A Closer Look

The following Aon Hewitt bulletins provide in-depth analysis and insights for many of the legislative and regulatory developments in 2013.

Annual Aon Hewitt Publications

Aon Hewitt’s 2014 Limits for Benefit Plans Now Available

Each year, the U.S. government adjusts the limits for retirement plans, Social Security, Medicare, and other benefit programs to reflect price and wage inflation and changes in the law. As a result, employee benefit plans must be adapted annually to accommodate the new limits. All of the numbers in this report are official unless otherwise indicated. The Aon Hewitt 2014 Limits for Benefit Plans is available here.

Aon Hewitt Compliance Calendar—Significant Compensation and Benefit Due Dates for 2014

Aon Hewitt is pleased to present its 2014 Compliance Calendar to help plan sponsors identify the significant compensation and benefit due dates for 2014. This Compliance Calendar includes relevant dates involving plan disclosures, contribution and distribution requirements, and dates for various regulatory filings involving retirement and health and welfare plans. This Compliance Calendar assumes a plan administered on a calendar year basis by an employer with a calendar fiscal year. In general, the information for pension plans applies to single employer plans; other plans, such as multiemployer plans (e.g., Taft-Hartley plans) or government plans, may be subject to different requirements and are not included in this Compliance Calendar. Additionally, compliance dates related to group health care coverage or retiree prescription drug coverage have been included where applicable. The 2014 Compliance Calendar is intended to alert the reader to some of the more significant dates for 2014 and is not intended to identify all compliance obligations or due dates. The 2014 Aon Hewitt Compliance Calendar is available here.

Aon Hewitt Publications on Federal Developments

January 2013

Affordable Care Act FAQs Offer Employers the Good, the Bad, and the Ugly on Notices, EGWPs, Fixed Indemnity, and HRAs

An Aon Hewitt bulletin on FAQ guidance issued by the DOL, Treasury, and HHS on Exchange notices; HRAs and the rules on dollar limits for EHBs; the application of certain Affordable Care Act rules to EGWP supplemental benefits; the payment of the PCORI fee for multiemployer plans; and whether fixed indemnity policies are “excepted benefits” from Affordable Care Act compliance is available here.

IRS Updates Guidance on the Employee Plans Compliance Resolution System (EPCRS)

This Aon Hewitt bulletin on Revenue Procedure 2013-12, which updates the EPCRS for employers’ corrections of certain plan failures, is available here.

New DOL Guidance on FMLA Leave to Care for Adult Children

On January 14, 2013, the DOL issued an Administrator’s Interpretation with guidance on FMLA leave to care for adult children. An eligible employee can take FMLA leave to care for a child age 18 and older if the child has a disability within the meaning of the ADA and is incapable of self-care because of that
disability. This is in addition to the requirement that a child have a serious health condition and the employee being needed to care for the child.

This Aon Hewitt bulletin provides an overview of the three main topics found in the DOL guidance:

- Age of the child at the start of the disability;
- Impact of the ADAAA, specifically the new broader definition of “disability” in the ADA, on leaves to care for adult children; and
- FMLA leave to care for an adult child wounded in military service.

The Aon Hewitt bulletin on the DOL guidance is available here.

February 2013

Department of Labor Issues FMLA Regulations on Family Military Leaves, Airline Flight Crews, and Other Topics
On February 6, 2013, the DOL published revised FMLA regulations. The regulations implement amendments to the family military leave provisions of the FMLA made by 2010 NDAA, which extended qualifying exigency leave to family members of servicemembers in the Regular Armed Forces, redefined the deployments that allow qualifying exigency leaves, and extended military caregiver leave to family members of certain veterans with serious injuries or illnesses. Other regulations implement the AFCTCA, which established new leave eligibility requirements for airline flight crewmembers and flight attendants. Additional regulations address GINA, the Uniform Services Employment and Reemployment Rights Act (USERRA), and the use and measurement of intermittent leaves. The regulations became effective on March 8, 2013. This Aon Hewitt bulletin summarizes the qualifying exigency leave, military caregiver leave, airline flight crew, and other changes. It also contains Aon Hewitt commentary. The Aon Hewitt bulletin is available here.

An Aon Hewitt bulletin on minimum essential coverage proposed regulations issued on February 1, 2013, discusses the definition of minimum essential coverage, including what types of employer-sponsored group health coverage meet the definition, and individuals who must maintain minimum essential coverage or pay a shared responsibility payment. The bulletin is available here.

Medicare Part D Disclosure Reminder and a Tip for EGWPs
This Aon Hewitt bulletin reminding employers of an annual disclosure requirement applicable to most employers that provide prescription drug coverage to individuals that are eligible for Part D is available here.

Obama Administration Modifies Rules on Religious Organizations and Coverage of Contraceptives
This Aon Hewitt bulletin on proposed rules that would require an insurance carrier or third-party administrator of a religious organization to facilitate coverage for contraceptive items and services at no cost to participants or the religious organization is available here.
March 2013

Agencies Release 12th Set of FAQs on Health Care Reform Transition Rule
FAQs issued on February 20, 2013 provide employers with a transition rule in 2014 for complying with a provision in the Affordable Care Act that imposes annual limits on OOP maximums for all non-grandfathered, self-insured, and large group health plans. An Aon Hewitt bulletin that summarizes the information in this twelfth set of FAQs is available here.

Final Rule Limits Out-Of-Pocket Maximums; Addresses Minimum Value and Essential Health Benefits
Employers received an unwelcome answer from the HHS when the department issued a final rule providing that OOP limits up to the HSA OOP limit will apply to all non-grandfathered group health plans in the self-insured and large group markets. The Aon Hewitt bulletin discussing the final rule is available here.

GINA, HIPAA, and Your DNA: A Privacy Love Story
This Aon Hewitt bulletin on the HHS’s final regulations regarding the protection of genetic information that is protected health information is available here.

HHS Final Rule on Transitional Reinsurance Fee Adds to Employer Costs
This Aon Hewitt bulletin discusses the amount of a transitional reinsurance fee added to the penalties and taxes imposed on employers and their fully insured and self-insured group health plans by the Affordable Care Act. HHS issued a final rule on March 1, 2013, providing details on the fee. The bulletin is available here.

New Rules, New Notices, New Agreements—Final HIPAA/HITECH Act Regulations Require Action by Employer-Sponsored Group Health Plans
Self-insured employer group health plans must revise HIPAA Notices of Privacy Practices, amend business associate agreements, and take other steps under final regulations issued by HHS. This Aon Hewitt bulletin on the final regulations under HIPAA and the HITECH Act is available here.

Proposed Regulations Implement 90-Day Waiting Period and End HIPAA Creditable Coverage Certificates
The Aon Hewitt bulletin on proposed regulations issued by the DOL, Treasury, and HHS on the maximum 90-day waiting period for group health plan coverage and HIPAA creditable coverage certificates is available here.

USCIS Issues Revised I-9 Form
The USCIS has revised the Employment Eligibility Verification Form I-9. The new form is nine pages—six pages of instructions, two pages for Sections 1, 2, and 3 that are completed by the employee and employer, and one page with the lists of acceptable documents for identity and employment authorization. The following Aon Hewitt bulletin discusses the additional instructions and data fields, lists of documents, E-Verify, and also includes Aon Hewitt commentary. The Aon Hewitt bulletin on the revised I-9 form is available here.

What to Expect When You Violate HIPAA’s Privacy Rules
This Aon Hewitt bulletin on guidance in final regulations on HIPAA/HITECH Act enforcement and civil money penalties is available here.
April 2013

**FAQs Provide Guidance on 2014 SBCs: You Get What You Get and You Don’t Get Upset**
The Aon Hewitt bulletin on SBC disclosures for the 2014 plan year regarding whether the plan provides minimum essential coverage and whether the plan meets the minimum value requirements as discussed in the fourteenth set of FAQs about Affordable Care Act requirements issued by the DOL, Treasury, and HHS is available [here](#).

**New HHS Regulations Make “SHOP”-ping Easy in 2014**
The HHS delayed the implementation of the SHOP for state and federal Exchanges until 2015, according to proposed regulations issued by HHS on March 11, 2013. The SHOP had been designed to offer small businesses a choice of health insurance for their employees beginning in 2014. Under the HHS regulations, the full range of plan choices under the SHOP will not be required until plan years beginning in 2015. This Aon Hewitt bulletin discussing the HHS proposed regulations is available [here](#).

May 2013

**DOL Seeks Comments on Proposed Lifetime Income Illustrations for Defined Contribution Plans**
This Aon Hewitt bulletin on proposals for plan sponsors to provide participants in defined contribution retirement plans with illustrations of potential monthly lifetime income amounts under consideration at EBSA is available [here](#).

**Have You Heard? Employers Must Notify Employees of Exchange Option**
This Aon Hewitt bulletin on Technical Release 2013-02, which provides guidance on notices required to be provided to participants of coverage options available to them under an Exchange, is available [here](#).

**That’s All Folks?—Agencies Say Some Affordable Care Act Rules Will Be Implemented Without Guidance**
The Aon Hewitt bulletin on FAQs on the Affordable Care Act that cover such topics as self-implementing provisions, expiration of the mini-med annual dollar limit waivers, and transparency reporting is available [here](#).

**Up in Smoke?—IRS Filters Out Most Wellness Programs From Affordability and Minimum Value Tests and Clears the Air on COBRA and Retiree Medical Coverage**
This Aon Hewitt bulletin on IRS proposed regulations on when an employer may take into account a participant’s qualification for an incentive or award under a group plan’s wellness program that is designed to reduce or prevent tobacco use and on the impact of COBRA and retiree health coverage on available premium tax credits is available [here](#).

June 2013

**If at First You Don’t Succeed, Try, Try Again: Agencies Require Reasonable Alternatives for Individuals Who Fail Health-Contingent Wellness Programs**
This Aon Hewitt bulletin on final regulations released by the DOL, Treasury, and HHS on health-contingent wellness programs is available [here](#).
**PCORI Fee Due July 31; IRS Updates Form 720**
This Aon Hewitt bulletin on an IRS update to Form 720 (Quarterly Federal Excise Tax Return) as it relates to payment by employers of the PCORI fee is available [here](#).

**July 2013**

**Affordable Care Act’s Employer Mandate Goes to the Waiting Room**
This Aon Hewitt bulletin on an announcement by the Obama Administration on July 2, 2013 that the employer mandate under the Affordable Care Act will be delayed until 2015, thus giving employers an extra year to comply with the law’s complicated hours-tracking and health insurance reporting rules, is available [here](#).

**Microhistory of Employee Benefits and Compensation, 1636-2013**
This Aon Hewitt bulletin presents a comprehensive timeline of the development of employee benefits and compensation in the U.S., starting with the first pension law enacted by the Plymouth Colony in 1636. Covering over 350 years, the "Microhistory of Employee Benefits and Compensation" provides a bird's-eye view of how various events and legislation have shaped compensation practices, pension and Section 401(k) plans, health plans, Social Security, and other aspects of employment affecting workers today. The Aon Hewitt bulletin is available [here](#).

**Summer Arrives—Administration “Beaches” Employer Shared Responsibility Payments for 2014**
The Obama Administration delayed the employer shared responsibility provisions (often referred to as the “employer mandate”) under the Affordable Care Act until 2015. The official announcement, Notice 2013-45, was released by the IRS on July 9, 2013. This transition relief is discussed in an Aon Hewitt bulletin available [here](#).

**August 2013**

**DOL Issues New FMLA Guidance on Same-Sex Marriage**
The DOL has confirmed that a spouse for purposes of the FMLA is based on the law of the state of the employee’s residence. This position is consistent with current FMLA regulations, and was issued in the wake of the U.S. Supreme Court’s *United States v. Windsor* ruling. In the *Windsor* case, the Supreme Court invalidated a provision in the federal DOMA that excluded same-sex marriages from the federal definition of marriage. DOMA prevented employees from being able to take FMLA leaves for their same-sex spouses. This Aon Hewitt bulletin addresses the updated DOL guidance and is available [here](#).

**Treasury and IRS Release Guidance on Same-Sex Marriage, Domestic Partnerships, and Civil Unions**
On August 29, 2013, the Treasury and IRS released Revenue Ruling 2013-17 and related FAQs on the topic of same-sex marriage, domestic partnerships, and civil unions and how these relationships will be treated under federal tax law. The much-awaited guidance was in response to the June 2013 Supreme Court *United States v. Windsor* ruling. In *Windsor*, the Supreme Court struck down a key section of the federal DOMA that defined marriage as the union of one man and one woman for purposes of federal law. However, the extent of the impact of *Windsor* on same-sex spouses in the context of federal tax law was unclear until this guidance was issued. Under the guidance, the Treasury and IRS have announced that all legal same-sex marriages will be recognized for federal tax purposes. The Aon Hewitt bulletin is available [here](#).
September 2013

**IRS Issues Post-Windsor Refund Guidance**
The IRS issued guidance on September 23, 2013, for employers and employees on how to file claims for refunds or adjustments for excess FICA taxes (Social Security and Medicare taxes) and federal income tax withholding (collectively, “employment taxes”) related to benefits provided to same-sex spouses following the Supreme Court’s decision in *United States v. Windsor* striking down Section 3 of the federal DOMA. Under *Windsor*, employers can use this special administrative guidance to correct overpayments of employment taxes for 2013 and prior years with respect to certain benefits for same-sex spouses. The Aon Hewitt bulletin providing an overview of the guidance, issued as Notice 2013-61, is available [here](#).

**OFCCP Issues Final Regulations on Federal Contractors’ Obligations Regarding Veterans and Individuals with Disabilities**
On September 24, 2013, OFCCP published new regulations regarding the affirmative action and nondiscrimination obligations of federal contractors and subcontractors. One set of regulations updates obligations to veterans under the Vietnam Era Veterans’ Readjustment Assistance Act (VEVRAA), and another set updates obligations to disabled individuals under Section 503 of the Rehabilitation Act. Both sets of regulations become effective March 24, 2014. This Aon Hewitt bulletin summarizes some of the primary changes to the VEVRAA and Section 503 regulations, as well as a federal contractor’s obligations. The Aon Hewitt bulletin is available [here](#).

**So Complex It’s Scary: Friday the 13th Affordable Care Act Guidance on HRAs, Health FSAs, and EAPs**
The DOL, Treasury, and HHS issued technical guidance on September 13, 2013, that clarified the application of the Affordable Care Act’s group market reforms to HRAs, employer payment plans, health FSAs, and employee assistance plans. This Aon Hewitt bulletin discusses the guidance issued in DOL Technical Release 2013-03 and IRS Notice 2013-54 and is available [here](#).

October 2013

**Debt Deal Contains Verification Requirement for Affordable Care Act Exchange Subsidies**
This Aon Hewitt bulletin on the part of the budget deal that reopened the partially shut down United States government that contained the directive to the Secretary of HHS to “verify” that individuals applying for subsidies in the public health insurance Exchanges meet the income requirements set forth in the Affordable Care Act is available [here](#).

November 2013

**CMS Says Obama Fix Applies to Small Group and Individual Policies**
This Aon Hewitt bulletin on the announcement by CMS on November 14, 2013, that small group health insurance policies, as well as individual health insurance policies, that are currently in place, can remain in effect for one year without having to comply with the Affordable Care Act Exchange rules that start in 2014 is available [here](#).

**IRS’s Halloween Guidance “Treats” Health FSAs to $500 Carryover “Trick”**
This Aon Hewitt bulletin on Notice 2013-71, which allows sponsors of health FSAs to amend their plans to allow for a $500 carryover of unused amounts into the next year, is available [here](#).
December 2013

**Government Modifies Mental Health and Substance Use Disorder Parity Rules**
This Aon Hewitt bulletin on final regulations requiring parity in the treatment of mental illnesses and substance use disorders is available [here](#).

**Guidance on Transitional Reinsurance Fees Brings Holiday Gifts for Some Employers and Coal for Others**
An Aon Hewitt bulletin on additional guidance issued by HHS on the transitional reinsurance fees that group health plans must pay starting in 2014 is available [here](#).
Resources

To stay current with the latest HR-related legislative and regulatory updates in 2014, read the Aon Hewitt Washington Report: 2014 Aon Hewitt Washington Report Index

If you would like to subscribe to the weekly Aon Hewitt Washington Report (published on Mondays), please email us at: research.washingtonreport@aonhewitt.com

Aon Hewitt’s Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon Hewitt bulletins on Affordable Care Act guidance and regulations, is available here.

The link to the Current Unified Agenda of Regulatory and Deregulatory Actions (i.e., the Fall 2013 Semiannual Agendas and Regulatory Plans, searchable by agency) is available here.

The U.S. House of Representatives website is available here.

The U.S. Senate website is available here.

The U.S. Supreme Court website is available here.

The White House website is available here.
About Aon Hewitt

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