2014 Legislative and Regulatory Year in Review

An Overview of Policy Related to HR and Employee Benefits Enacted in 2014

January 2015
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Resources
2014 Legislative and Regulatory Year in Review

This report summarizes key legislative, judicial, and regulatory activity at the federal level in 2014 from the perspective of employer-sponsored employee benefit and human resources (HR) programs. As we issue this report in January 2015, changes are already underway. See the “Resources” section at the end of this report for information on how to stay current with the latest updates in 2015. The following report was compiled by the Legislative Reporting Team. If you have questions or for more information, please contact us here.

Acronyms and Other Terms Used in This Report

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<th>Description</th>
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<td>ADA</td>
<td>Americans with Disabilities Act</td>
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<td>ATIN</td>
<td>adoption taxpayer identification number</td>
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<td>CCIIO</td>
<td>Center for Consumer Information and Insurance Oversight</td>
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<td>Children’s Health Insurance Program</td>
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<td>Defense of Marriage Act</td>
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<td>Employee Benefits Security Administration</td>
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Federal Legislative and Executive Activity in 2014

Highlights of Legislation and Executive Orders

No major legislation in the area of HR or employee benefits was enacted in 2014, though certain federal law requirements were modified (e.g., pension smoothing was extended and the Medicare physician pay rate reduction temporarily patched). In the State of the Union address early in the year, the Administration introduced a new retirement savings plan for employees of small employers not currently sponsoring a retirement plan (“myRA”). Members of Congress proposed other retirement savings plans also targeting small employers, but they were not enacted in 2014.

For more information on the retirement proposals, see the Aon Hewitt bulletin titled “Retirement Savings Proposals—Summary of Key Provisions” (February 2014) under “2014 Developments: A Closer Look,” near the end of this report.

While it was a relatively quiet year in terms of actual legislation, there were a number of new developments from the executive branch, especially with regard to federal contractors. Several new executive orders added requirements for federal contractors that sought to address discrimination based on sexual orientation or gender identity, prohibit employer retaliation against employees who discuss their compensation, enforce equal pay laws, and require employer disclosure of labor violations. In addition, beyond federal contractors, the Administration directed the Department of Labor (DOL) to revamp existing overtime regulations.

Extenders Bill Signed Into Law; Includes Multiemployer Plan and Fringe Benefit Provisions

On December 19, 2014, President Obama signed into law the “Tax Increase Prevention Act of 2014” (H.R. 5771). The Senate approved the legislation on December 16, and the House passed the measure on December 3. The law included a few employer-related provisions. It extended through 2015 special funding rules under the Pension Protection Act of 2006 (PPA) that seek to bolster the funding of multiemployer plans that are in certain categories of underfunding, beginning with plans that are either less than 80% funded or projected not to meet minimum required contributions within seven years. It also extended through 2015 the ability of multiemployer plans to take an additional five years to amortize funding shortfalls.

The law also extended parity for employer-provided mass transit and parking benefits. The maximum monthly exclusion amount for transit passes and van pool benefits was extended through 2014. Also, the employer wage credit for employees who are active duty members of the uniformed services was extended through 2014. In addition, the law extended through 2014 tax-free distributions from individual retirement accounts (IRAs) for charitable purposes.

President Signs Into Law Trillion Dollar Funding Bill; Includes Multiemployer Pension Provisions

On December 16, 2014, President Obama signed into law a $1.1 trillion spending package to continue to fund government operations (Consolidated and Further Continuing Appropriations Act, 2015—H.R. 83). The Senate approved the legislation on December 13, and the House approved the measure on December 11. The law included 11 appropriations bills that funded most government agencies, such as
the Internal Revenue Service (IRS), through September 30, 2015. However, the Department of Homeland Security was only funded through February 27, 2015. The law also allowed trustees of certain underfunded multiemployer pension plans to adjust benefits. Among other provisions, the law designated financial support of ongoing military operations; provided emergency funding for the Ebola epidemic; increased federal limits on individual contributions to national political parties; and repealed part of the Dodd-Frank Act, allowing banks to directly engage in derivatives trading.

President Signs Short-Term Continuing Resolution to Fund Government Into Law; Includes Internet Tax Provision

On September 19, 2014, President Obama signed into law a $1 trillion short-term continuing resolution (H.J. Resolution 124) that funded government operations through mid-December. The Senate passed the bill on September 18, and the House approved the legislation September 17. Government funding was set to expire September 30. Among other budgetary provisions, included in the measure is a temporary extension of the moratorium on taxing Internet access to December 11, 2014, previously scheduled to expire November 1, 2014.

President Signs Highway Bill With Pension Smoothing Provisions Into Law

On August 8, 2014, President Obama signed into law the Highway and Transportation Funding Act of 2014 (HAFTA) (H.R. 5021). The law provided approximately $10.8 billion for the Highway Trust Fund through May 2015. The pension smoothing provision included in the law extended the Moving Ahead for Progress in the 21st Century Act (MAP-21) stabilization provisions for five years. Increased Pension Benefit Guaranty Corporation (PBGC) premiums were not included in the law.

President Signs Executive Order Requiring Violation Disclosures by Prospective Federal Contractors

On July 31, 2014, President Obama signed an Executive Order (Fair Pay and Safe Workplaces) that required prospective federal contractors to disclose labor law violations and gave federal agencies more guidance on how to consider labor violations when awarding federal contracts. Prospective contractors will be required to disclose labor violations from the past three years before they can get a contract. The types of violations subject to disclosure include wage and hour, safety and health, collective bargaining, family and medical leave, and civil rights protections. Contractors will also be required to collect similar information from some subcontractors. The Order will apply to new federal procurement contracts valued at more than $500,000. Implementation of the Order will be done in stages, applying to new contracts on a prioritized basis during 2016. The Order also added other requirements, such as requiring contractors to provide their employees with particular pay documents, eliminating mandatory arbitration requirements for some workers, and requiring contractors to periodically update their violations history after a contract is awarded.

President Signs Workforce Innovation and Opportunity Act Into Law

President Obama signed the Workforce Innovation and Opportunity Act (H.R. 803) into law on July 22, 2014. The House approved the legislation on July 9, and the Senate approved the bill in late June. The law reauthorized 33 DOL job training programs, streamlined the job training system, and provided a single set of outcome metrics for every federal workforce program under the Act. Among the many provisions, the law included changes to the workforce development system, training and employment services, Job Corps, adult education, and state vocational and rehabilitation services.
President Signs Executive Order Prohibiting Federal Contractors From Discriminating Based on Sexual Orientation or Gender Identity


President Obama Issues Two Executive Actions on Pay Discrimination and Equal Pay Laws for Federal Contractors

President Obama announced two new executive actions addressing pay discrimination and enforcement of equal pay laws on April 8, 2014:

- The President issued an Executive Order prohibiting federal contractors from retaliating against employees who choose to discuss their compensation with one another.
- The President issued a Presidential Memorandum instructing the Secretary of Labor to establish new regulations requiring federal contractors to submit to the DOL summary data on compensation paid to their employees, including data by sex and race.

President Obama Signs Into Law Bill Providing One-Year Patch for Medicare Physician Pay Rates

On April 2, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014 (H.R. 4302). The Senate passed the bill on March 31, and the House approved the legislation on March 27. The legislation provided a one-year patch (through March 31, 2015) for Medicare physician pay rates under the current sustainable growth rate system, thus avoiding a 24% reduction that was scheduled to go into effect April 1, 2014. H.R. 4302 also extended other health-related provisions set to expire and made other changes to current-law health provisions.

President Instructs DOL to Modernize Overtime Regulations

President Obama issued a Memorandum on March 13, 2014, instructing the DOL to propose revisions to modernize and streamline existing overtime regulations. In the Memorandum, the President stated that existing "white collar” regulations (for executive, administrative, and professional employees) regarding exemptions from the Fair Labor Standards Act (FLSA) are outdated and need to be reviewed. The Memorandum asked the DOL to “consider how the regulations could be revised to update existing protections consistent with the intent of the Act; address the changing nature of the workplace; and simplify the regulations to make them easier for both workers and businesses to understand and apply.”

President Obama Releases 2015 Budget

On March 4, 2014, President Obama released his Fiscal Year 2015 Budget that proposed $3.9 trillion in spending funded through a number of measures, including increased taxes on corporations and high-income individuals. Passage of the President’s budget was considered to be unlikely, as proposals are typically intended as a framework for discussion. Additionally, the budget agreement passed in
December 2013 established most of the funding levels for 2014 and 2015. However, the President’s proposal did provide a framework for priorities in the upcoming year and offered insight regarding future legislative and/or regulatory actions.

The 2015 budget included a number of provisions impacting employee benefits in the areas of health, retirement, and employment. As with previous budgets, the 2015 blueprint also focused on continued investment in education, infrastructure, research, development, climate change, manufacturing, job creation, and training. Tax reform continued to remain a priority, with the budget including provisions to close a number of tax “loopholes” and again minimizing deductions for high-income individuals, as well as providing tax credits for lower-income employees and the middle class.

**President Signs Debt Ceiling Bill Into Law**

On February 15, 2014, President Obama signed into law the Temporary Debt Limit Extension Act (S. 540). The law suspended the debt ceiling through March 2015 and allowed the Treasury to borrow additional money to fund spending previously approved by Congress. The House passed the measure on February 11, 2014, and the Senate cleared the bill on February 12.

**President Signs Spending Bill Into Law; Government Funded Through September 30, 2014**

President Obama signed into law a 2014 omnibus appropriations bill (H.R. 3547—Consolidated Appropriations Act of 2014) on January 17, 2014. The $1.01 trillion spending measure funded the government through September 30, 2014. The bill provided $12 billion in funding for various federal health programs and agencies (e.g., the DOL, Health and Human Services (HHS), IRS, etc.). The Senate passed the bill on January 16, and the House approved the bill on January 15. Before finalizing H.R. 3547, the House and Senate in the prior week had to first approve a short-term extension (H.J. Res. 106) of the continuing appropriations legislation that Congress originally passed in October 2013. The short-term continuing resolution extended the government funding deadline to January 18. Without the short-term resolution, government funding would have expired on January 15.

**Judicial Activity**

Many lawsuits have been filed in the last four years challenging the validity of all or parts of the Affordable Care Act, which was enacted in 2010. In 2014, the U.S. Supreme Court issued a ruling in a case involving the Affordable Care Act’s contraceptive coverage provision, as described below. In 2015, it will rule on whether federal subsidies may be provided to taxpayers buying health insurance through the federal Affordable Care Act Exchange (marketplace).

Many in the benefits community also expected the U.S. Supreme Court to take up one or more cases involving state laws on same-sex marriage, but the Court declined to review any of those cases in 2014. In 2015, however, the Court will issue a ruling on state same-sex marriage laws.
U.S. Supreme Court

U.S. Supreme Court Rules Contraceptive Mandate as Applied to Closely Held Corporations Unlawful

On June 30, 2014, the U.S. Supreme Court ruled in *Burwell v. Hobby Lobby Stores* that the regulations issued by HHS under the Affordable Care Act that impose a contraceptive mandate, as applied to closely held corporations, violate the Religious Freedom Restoration Act of 1993.

Federal Regulatory Activity

In 2013, most of the federal regulatory activity by far was centered on compliance with the Affordable Care Act, and 2014 was no different, with a similarly large number of regulatory documents issued, some of them consisting of vitally important Affordable Care Act guidance. Approximately 80 different regulatory documents, forms, tools, and other items for employers to track, comprehend, and sometimes implement were released under the Affordable Care Act in 2014.

While far less regulatory guidance was issued on the retirement plan side than the health plan side in 2014, the year still saw a considerable uptick in the amount of retirement plan guidance coming from the agencies as compared with the prior year. This increase was said to be attributable at least in part to the gradual winding down of work on guidance that was required to be issued under the Affordable Care Act and an overall shifting of agency personnel out of Affordable Care Act work and back to their normal areas, which is expected to continue into 2015.

With respect to other HR-related topics, the DOL developed a number of new regulations applicable to federal contractors that followed up on Executive Orders issued by President Obama in 2014. The federal contractor regulations addressed discrimination on the basis of sexual orientation and gender identity, pay secrecy policies, employee compensation reporting, and minimum wage.

Regulatory developments in 2014 are summarized below, generally in reverse chronological order under each heading, with the most recent issuances appearing first. Related Aon Hewitt bulletins that provide further analysis of the guidance are also noted in the summaries.

Health Care

Affordable Care Act Guidance

Please note that some of the regulatory documents issued under the Affordable Care Act in 2014 were broad in their scope and extended, on occasion, beyond the subject areas identified by the headings below.

Basic Health Program

On October 21, 2014, the Centers for Medicare and Medicaid Services (CMS) released the proposed methodology and data resources necessary to determine federal payment amounts made in program year 2016 to states that elect to establish a Basic Health Program under the Affordable Care Act. The Basic Health Program is a voluntary option under the health care reform law offering coverage to certain
low-income individuals outside the Exchanges. The Basic Health Program was scheduled to begin in 2014, but CMS delayed implementation until 2015.

**On March 7, 2014,** CMS released final regulations and a final methodology establishing 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 complements and coordinates 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 final regulations, which are effective as of January 1, 2015, set forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. The final methodology, which also took effect on January 1, 2015, provides the methodology and data sources to determine the federal payment amounts made to states in program year 2015 that elect to establish a Basic Health Program.

**Cafeteria Plans**

**On September 18, 2014,** the Treasury and IRS released Notice 2014-55. Notice 2014-55 expands the permitted election rules for health coverage under a Section 125 cafeteria plan and addresses two specific situations in which a Section 125 cafeteria plan participant is permitted to revoke his or her election under the Section 125 cafeteria plan during a period of coverage. The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer’s group health plan. The second situation involves an employee participating in an employer’s group health plan who would like to cease coverage under the group health plan and purchase coverage through a competitive Exchange established under Section 1311 of the Affordable Care Act.

*See the Aon Hewitt bulletin titled “IRS Issues New Affordable Care Act Guidance for Cafeteria Plans, PCORI Fees, and FTE Status” (September 2014) under “2014 Developments: A Closer Look.”*

**COBRA**

**On May 2, 2014,** the government announced updates to model notices informing workers of their eligibility to continue health-care coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). The updates clarify that if workers are eligible for COBRA continuation coverage when leaving a job, they may choose to instead purchase coverage through the Exchange, as created by the Affordable Care Act.

Individuals and families who are eligible for employer-sponsored coverage generally must be informed of their right to COBRA continuation coverage at the start of employment. They must also be informed of their right to purchase COBRA coverage when separating from a job. The proposed changes to the model notices would offer information on more affordable options available through the Exchange, where those individuals and families may be eligible for financial assistance that would not otherwise be available for COBRA continuation coverage. In most cases, workers and their families eligible for, but not enrolled in, COBRA continuation coverage would be able to enroll in Exchange coverage outside of the normal open enrollment period.

In coordination with this announcement, the government agencies released a frequently asked question (FAQ) (see the section “Jointly Issued FAQs”), a clarifying bulletin, and proposed regulations. The
clarifying bulletin, published by HHS’s Center for Consumer Information and Insurance Oversight (CCIIO), discussed a special enrollment period in the Exchanges for individuals already enrolled in COBRA continuation coverage. The proposed regulations related to COBRA notification requirements were released by the DOL’s Employee Benefits Security Administration (EBSA) on May 2, 2014. The proposed regulations contained amendments to notice requirements of the health care continuation coverage provisions of Part 6 of Title I of ERISA to better align the provision of guidance under the COBRA notice requirements with the Affordable Care Act provisions already in effect, as well as any provisions of federal law that will become applicable in the future.

See the Aon Hewitt bulletin titled “It’s Time for Spring Cleaning: Agencies Provide Needed Cleanup on COBRA, CHIP, Health FSA Rollovers, and Group Market Reforms” (June 2014) under “2014 Developments: A Closer Look.”

Compliance Tools and Websites

On November 19, 2014, EBSA updated its online health benefit “Compliance Assistance Guide—Health Benefits Coverage Under Federal Law.” EBSA updated the section of the guide’s Self-Compliance Tool pertaining to provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and also included updates on Affordable Care Act and mental health parity provisions. Additionally, EBSA provided a document with questions and answers on mental health parity requirements.

On September 9, 2014, the IRS announced the availability of several new YouTube videos to help taxpayers get important information about the Affordable Care Act and tax return filing. The videos, which are part of a series on the IRS YouTube channel, feature IRS Commissioner John Koskinen discussing the premium tax credit and the individual shared responsibility provision. These Affordable Care Act provisions could impact an individual’s tax return in 2015 when filing a 2014 return.

On May 1, 2014, in the IRS’s Outreach Corner, the agency provided a sample article for organizations and businesses to use to reach customers about retirement savings. This midyear retirement savings checkup discusses retirement savings options and provides links to helpful retirement information on IRS.gov.

Contraceptive Coverage

On August 22, 2014, the Departments of Labor, Treasury, and Health and Human Services (the Departments) issued regulations on contraceptive coverage under the Affordable Care Act. The regulations were in response to the June 30, 2014 U.S. Supreme Court ruling (Burwell v. Hobby Lobby Stores) that held that the regulations by HHS under the Affordable Care Act that impose a contraceptive mandate, as applied to closely held corporations, violate the Religious Freedom Restoration Act of 1993. The regulations address both nonprofits and closely held for-profit entities.

The interim final regulations for nonprofits provided an additional way for organizations eligible for an accommodation to provide notice of their religious objection to providing coverage for contraceptive services. The regulations allow these eligible organizations to notify HHS in writing of their religious objection to providing contraception coverage. HHS and the DOL will then notify insurers and third-party administrators so that enrollees in plans of such organizations receive separate coverage for contraceptive services, with no additional cost to the enrollee or the employer. The regulations became effective on August 27, 2014.

On the same day, the Treasury also released proposed regulations cross-referencing the interim final
regulations providing guidance to employers, group health plans, and health insurance issuers providing group health insurance coverage.

**EAPs, Vision Plans, Dental Plans, and Wraparound Coverage**

On December 19, 2014, the Departments issued proposed regulations that would amend the definition of excepted benefits (as required under the Affordable Care Act) to include certain limited wraparound coverage. According to the Departments, the proposed regulations would allow group health plan sponsors, in limited circumstances, to offer wraparound coverage to employees who are purchasing individual health insurance in the private market, including through the health insurance Exchange. The regulations propose two pilot programs for wraparound coverage. One pilot would allow wraparound benefits only for multi-state plans in the health insurance Exchange, and another would allow wraparound benefits for part-time workers who could otherwise qualify for a flexible savings arrangement who enroll in an individual market plan.

On September 26, 2014, guidance released by the Departments provided that employers can add certain Employee Assistance Programs (EAPs), dental plans, and vision plans to the list of excepted benefits that are exempt from requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act. The final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

See the Aon Hewitt bulletin titled “Final Regulations Exempt Some EAPs, Dental Plans, and Vision Plans From Affordable Care Act and HIPAA” (October 2014) under “2014 Developments: A Closer Look.” For information on earlier proposed regulations on excepted benefits, and see “Yes, Employers, There Is an Escape Clause!—Christmas Eve Guidance Exempts Some EAPs and Limited Scope Dental and Vision Plans From HIPAA and Affordable Care Act” (January 2014) under “2014 Developments: A Closer Look.”

On March 14, 2014, CMS released an interim final rule that requires issuers of QHPs, including stand-alone dental plans, to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program; other federal and state government programs that provide premium and cost-sharing support for specific individuals; and Indian tribes, tribal organizations, and urban Indian organizations. The interim final rule became effective March 14, 2014.

**Employer Mandate and Minimum Value**

On November 4, 2014, the Treasury and HHS released Notice 2014-69, which advises employers and other taxpayers that employer-sponsored health plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services do not provide minimum value within the meaning of Section 36B. The Notice also advises that the Treasury and HHS are considering whether the continuance tables underlying the Minimum Value Calculator produce valid actuarial results for plans with these designs. Employers offering plans that fail to cover in-patient hospitalization or physician services should “exercise caution in relying on the Minimum Value Calculator to demonstrate that these plans provide minimum value for any portion of a taxable year after publication of final regulations.”


On September 18, 2014, the Treasury and IRS issued Notice 2014-49, which describes a proposed approach to the application of the look-back measurement method, which may be used to determine if an
employee is a full-time employee (FTE) for purposes of the Affordable Care Act’s employer mandate (Section 4980H of the Internal Revenue Code (Code)), in situations in which the measurement period applicable to an employee changes. This Notice is intended to address the topics for which guidance was anticipated in Section VII.G of the preamble to the final Section 4980H regulations issued in February 2014. The Treasury and IRS indicated that “taxpayers may rely on the approach in the Notice until further guidance is issued, and in any case through the end of the 2016 calendar year.”

On February 10, 2014, the Treasury and IRS issued final regulations implementing employer shared responsibility provisions under Section 4908H of the Code, as part of the Affordable Care Act. The final regulations state that beginning January 1, 2015, the employer mandate will apply to employers with more than 100 FTEs. Under the Affordable Care Act, employers with fewer than 50 employees are not required to provide coverage or complete any forms in 2015, or in any year. Employers with 50-99 employees that do not yet provide health insurance coverage to their FTEs will report on their workers and coverage in 2015, but will have until 2016 before any employer responsibility payments will apply. The final regulations clarify that to avoid a payment for failing to offer coverage, large employers (those with 100 or more employees) will need to offer coverage to 70% of their FTEs in 2015 and 95% in 2016 and beyond. Other items addressed in the final regulations include:

- Clarifications regarding various employee categories (i.e., volunteers, educational employees, seasonal, student work-study programs, and adjunct faculty);
- Provisions to assist businesses to comply in 2015;
- FTE status determinations; and
- Affordability safe harbors.

In related news, the IRS published 46 “Questions and Answers” on its website to provide additional information about the regulations. The questions address:

- Basics of the employer shared responsibility provisions;
- Which employers are subject to the employer shared responsibility provisions;
- Identification of FTEs;
- Liability for the employer shared responsibility payment;
- Calculation of the employer shared responsibility payment;
- Making an employer shared responsibility payment;
- Transition relief;
- Basics for small employers; and
- Additional information.

The final regulations became effective on February 12, 2014.

See the Aon Hewitt bulletins titled “IRS Eases Employers Into Employer Mandate” (February 2014) and “Treasury and IRS Issue Final Regulations for Reporting Compliance With Affordable Care Act Mandates” (April 2014) under “2014 Developments: A Closer Look.”

Exchanges

On September 2, 2014, CMS released final regulations specifying the additional options for annual eligibility redeterminations, renewal, and reenrollment notice requirements for QHPs offered through the
federally facilitated Exchanges, beginning with annual redeterminations for coverage for benefit year 2015. The final regulations provide additional flexibility for state health insurance Exchanges, including the ability to propose unique approaches that meet the specific needs of each state.

CMS also released a fact sheet providing additional details about the renewal process in the federally facilitated Exchanges, as required as part of the Affordable Care Act. Generally, consumers who did not take any action on their own by December 15, 2014, will automatically be enrolled in the same plan, premium tax credit, and any other financial assistance as in the 2014 plan year.


**On June 26, 2014**, CMS released proposed regulations on the procedures that health insurance Exchanges would use in redetermining the annual coverage eligibility for individuals enrolled in health insurance through the health insurance Exchanges under the Affordable Care Act. The Exchanges would be able to use proposed additional options for eligibility redeterminations beginning with redeterminations for coverage for the 2015 plan year. The proposed rules would also provide standard notices for issuers to use when discontinuing or renewing coverage.

**On June 3, 2014**, CCIIO released an FAQ on QHPs and guaranteed availability standards. The question asks what actions are issuers required to take to ensure that QHPs intended for the health insurance Exchanges meet the guaranteed availability standards, consistent with the May 16, 2014 FAQs on health insurance market reforms and marketplace standards. In the response, CCIIO states that all non-grandfathered individual Exchange health insurance products must be guaranteed available to all individuals, unless an exception applies.

**On May 16, 2014**, CMS released final regulations addressing various requirements applicable to health insurance issuers, health insurance Exchanges, Navigators, non-Navigator assistance personnel, and other entities under the Affordable Care Act. The final regulations establish standards related to product discontinuation and renewal, quality reporting, nondiscrimination standards, minimum certification standards and responsibilities of QHP issuers, the Small Business Health Options Program (SHOP), and enforcement remedies in the federally facilitated Exchanges.

The final regulations also finalize: a modification of HHS’s allocation of reinsurance collections if those collections do not meet the department’s projections; certain changes to allowable administrative expenses in the risk corridors calculation; modifications to the way HHS calculates the annual limit on cost sharing; an approach to index the required contribution used to determine eligibility for an exemption from the shared responsibility payment under Section 5000A of the Code; grounds for imposing civil money penalties on persons who provide false or fraudulent information to the Exchange and on persons who improperly use or disclose information; updated standards for the consumer assistance programs; standards related to the opt-out provisions for self-funded, non-federal governmental plans and those related to the individual market provisions under HIPAA, including excepted benefits; standards regarding how enrollees may request access to non-formulary drugs under exigent circumstances; amendments to Exchange appeals standards and coverage enrollment and termination standards; and time-limited adjustments to the standards relating to the medical loss ratio program. The majority of the provisions in the regulations were finalized as proposed.
On May 16, 2014, CMS issued 12 FAQs regarding the implementation of certain health insurance market reforms and Exchange standards established in the Affordable Care Act. The document includes guidance on essential health benefits and actuarial value, guaranteed availability, minimum essential coverage, and transitional policy extensions.

On May 1, 2014, HHS released the sixth in a series of Issue Briefs which highlights national and state enrollment-related information for the Exchanges created by the Affordable Care Act. The latest brief indicates that over eight million people have chosen a health plan through the Exchanges through the March 31, 2014 enrollment period.

The brief includes data for states that are implementing their own Exchanges and states with Exchanges that are supported by or fully run by HHS (including those run in partnership with states). The brief also includes updated data on the characteristics of persons who have selected an Exchange plan (by gender, age, and financial assistance status) and the plans that they have selected (by metal level).

On March 14, 2014, CMS posted proposed regulations on various requirements applicable to health insurance issuers, Exchanges, Navigators, non-Navigator assistance personnel, and other entities under the Affordable Care Act. Specifically, the regulations proposed standards related to product discontinuation and renewal, quality reporting, nondiscrimination standards, minimum certification standards and responsibilities of QHP issuers, SHOP, and enforcement remedies in federally facilitated Exchanges. They also proposed: a modification of HHS’s allocation of reinsurance contributions collected if those contributions do not meet projections; certain changes to the ceiling on allowable administrative expenses in the risk corridors calculation; modifications to the way the agency calculates certain cost-sharing parameters so that they are rounded to the nearest $50 increment; certain approaches in how the agency may index the required contribution used to determine eligibility for an exemption from the shared responsibility payment; grounds for imposing civil money penalties on persons who provide false information to the Exchange; updated standards for the consumer assistance programs; standards related to the opt-out provision for self-funded, non-Federal governmental plans and the individual market provisions under HIPAA; standards for recognition of certain types of foreign group health coverage as minimum essential coverage; amendment to Exchange appeals standards and coverage enrollment and termination standards; and time-limited adjustments to the standards relating to the medical loss ratio program.

On March 14, 2014, CMS issued an FAQ on the coverage of same-sex spouses as related to the Affordable Care Act. In the FAQ, CMS states that a health insurance issuer in the group or individual market may not refuse to offer coverage of a same-sex spouse if the health insurance issuer offers coverage to an opposite-sex spouse.

The FAQ follows up on final regulations released in February 2013, which require health insurance issuers offering non-grandfathered health insurance coverage in the group or individual markets (including QHPs offered through Exchanges) to guarantee the availability of coverage unless one or more exceptions apply. The preamble to the final regulations indicates that discriminatory marketing practices or benefit designs represent a failure by health insurance issuers to comply with the guaranteed availability requirements, and the final regulations establish certain marketing and nondiscrimination standards in the regulation text. The FAQ is provided to clarify the meaning of the terms used in the regulations for the purposes of describing the requirements health insurance issuers must meet to ensure guaranteed availability of coverage and reinforce the current regulations’ prohibition against discrimination based on sexual orientation. However, the prohibition is not intended to interfere with a plan sponsor’s ability to define a dependent spouse for purposes of coverage eligibility, according to the
FAQ. On the same day, HHS restated this nondiscriminatory guidance in a blog posting: “Beginning next year, if an insurance company offers coverage to opposite-sex spouses, it cannot choose to deny that coverage to same-sex spouses. In other words, insurance companies will not be permitted to discriminate against married same-sex couples when offering coverage.”

Health Plan Identifiers

On October 31, 2014, CMS announced a delay, until further notice, in enforcement of the requirement for HIPAA-covered entities (including employer plan sponsors of large self-insured group health plans) to obtain a unique Health Plan Identifier (HPID) for “controlling health plans.” If employer plan sponsors do not, or are unable to, obtain HPIDs for their self-insured group health plans that are “controlling health plans” by the deadline of November 5, 2014, no enforcement action will be taken by HHS against those health plans. This delay applies to enforcement of the regulations pertaining to health plan enumeration (obtaining an HPID), as well as use of the HPID in HIPAA transactions adopted in the HPID final rule.

On October 27, 2014, CMS released an FAQ addressing which group health plans must obtain an HPID. In the FAQ, CMS announced a simplified procedure for a group health plan to use if the plan comprises of several component benefits. Such a plan, often referred to as an ERISA “wrap” plan, now has the option of obtaining a single HPID for the entire arrangement or separate HPIDs for the component benefits.

For additional details about the new guidance, please see the Aon Hewitt bulletin titled “One HPID to a Customer—CMS Okays One HPID for an ERISA ‘Wrap’ Plan” (October 2014) under “2014 Developments: A Closer Look.”

On September 24, 2014, CMS launched a new quick reference guide Web page with step-by-step instructions for obtaining a controlling health plan HPID under HIPAA. As explained in the guide, users that need to obtain a controlling health plan HPID will go through the CMS Enterprise Portal, access the Health Insurance Oversight System, and apply for the HPID.

See the Aon Hewitt bulletin titled “Better Late Than Never—CMS Issues HPID Guidance for November 5th Deadline” (October 2014) under “2014 Developments: A Closer Look.”

Individual Mandate

On November 21, 2014, the Treasury and IRS released final regulations relating to the requirement to maintain minimum essential coverage enacted by the Affordable Care Act. These final regulations provide individual taxpayers with guidance under Section 5000A of the Code on the requirement to maintain minimum essential coverage and rules governing certain types of exemptions from that requirement. The final regulations became effective on November 26, 2014.

On November 21, 2014, the IRS released additional Affordable Care Act guidance. In Notice 2014-76, the IRS provided a list of the Section 5000A hardship exemptions that taxpayers may claim on a federal income tax return without obtaining a hardship exemption certification from the health insurance Exchange. In Revenue Procedure 2014-62, the IRS announced the indexed applicable percentage table in Section 36B(b)(3)(A) of the Code, which is used to calculate an individual’s premium tax credit for taxable years beginning after calendar year 2015. It also announced the indexed required contribution percentage in Section 36B(c)(2)(C)(i)(II) used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage for purposes of Section 36B for plan years beginning after calendar year 2015. Finally, Revenue Procedure 2014-62 cross-references the required contribution percentage, as determined under guidance issued by HHS, used to determine whether an individual is
eligible for an exemption from the individual shared responsibility payment because of a lack of affordable minimum essential coverage under Section 5000A(e)(1)(A) for plan years beginning after calendar year 2015.

On October 6, 2014, CCIIO released guidance regarding catastrophic coverage for canceled health plans. Under the guidance, individuals whose plans were canceled for not being compliant with the Affordable Care Act will continue to be eligible for enrollment in or renewal of catastrophic coverage with a plan year that begins on or before October 1, 2016. However, the majority of hardship exemptions granted to individuals in 2014 expired on December 31, 2014 and individuals will not be able to use them to enroll or re-enroll in catastrophic coverage in 2015 (with the exception of the hardship exemption for individuals who are eligible for services through the Indian Health Service).

On September 18, 2014, CCIIO released shared responsibility guidance in regard to filing a threshold hardship exemption. The individual shared responsibility provision of the Affordable Care Act requires individuals to have qualifying health care coverage (known as minimum essential coverage), qualify for an exemption, or make a shared responsibility payment when filing their federal income tax returns. The Affordable Care Act provides nine categories of exemptions. Among these are an exemption for individuals with household income below the applicable return filing thresholds and an exemption for individuals who experienced a hardship, as determined by the Secretary of HHS, with respect to the capability to obtain coverage under a QHP. CMS published final regulations on exemptions from the shared responsibility payment in July 2013. The Secretary, in coordination with the IRS and Treasury, has determined that any individual who does not have enough gross income to meet the minimum threshold for having to file a tax return also should be entitled to a hardship exemption. This guidance provided additional details about the hardship exemption.

On March 26, 2014, the Obama Administration confirmed that individuals who were unable to enroll in Affordable Care Act health insurance coverage by the March 31, 2014 deadline would have additional time to do so. In connection with the announcement, CCIIO released guidance detailing the extension opportunities. The first CCIIO document (Guidance for Issuers on Special Enrollment Periods for Complex Cases in the federally facilitated Exchange after the Initial Open Enrollment Period) provided descriptions of scenarios in which individuals will be granted additional time to enroll. Reasons included: exceptional circumstances (e.g., natural disasters); enrollment, system and display errors; unresolved casework; and victims of domestic abuse. The second document (Guidance for Issuers on People "In Line" for the federally facilitated Exchange at the End of the Initial Open Enrollment Period) detailed special enrollment periods for individuals "in line" to purchase coverage using either paper or electronic applications.

On March 5, 2014, CCIIO offered an extension to individuals who had a health insurance plan that does not comply with the Affordable Care Act. The extension allowed those insurance plans that do not meet the Affordable Care Act’s minimum requirements to continue for an additional two years. States and health care plans did have the option of choosing whether to provide any extension. The CCIIO bulletin noted that in November 2013, CMS issued a letter to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. CMS announced in the letter that if permitted by applicable state authorities, health insurance issuers could choose to continue certain coverage that would otherwise be cancelled, and affected individuals and small businesses could choose to re-enroll in such coverage. Under this transitional policy, “non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2014 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met.”

The latest
guidance extended the “transitional policy for two years,” to policy years beginning on or before October 1, 2016.

**On January 23, 2014,** the IRS released proposed regulations relating to the requirement to maintain minimum essential coverage enacted by the Affordable Care Act. The proposed regulations would affect individual taxpayers who may be liable for the shared responsibility payment for not maintaining minimum essential coverage. Section 5000A of the Code, as added by the Affordable Care Act, provides that for months beginning after December 31, 2013, a nonexempt individual must maintain minimum essential coverage or make a shared responsibility payment. (The IRS published final regulations on the shared responsibility provisions on August 30, 2013.)

On the same day, in tandem with the release of the proposed regulations, the IRS released Notice 2014-10. The Notice provides relief guidance relating to the individual shared responsibility payment required under Section 5000A of the Code for months in 2014 in which individuals have, under Medicaid and Chapter 55 of Title 10, U.S.C. (medical and dental care for members and certain former members of the uniformed services and for their dependents), limited-benefit health coverage that is not minimum essential coverage.

The Notice and proposed regulations clarified that the Section 5000A shared responsibility payment would not be imposed with “respect to an individual for months in 2014 when the individual has coverage under family planning services Medicaid, tuberculosis-related services Medicaid, pregnancy-related Medicaid, emergency medical conditions Medicaid, a Section 1115 demonstration project authorized under Section 1115(a)(2) of the Social Security Act (42 U.S.C. 1315(a)(2)), coverage for medically needy individuals, uniformed services space available care, or uniformed services line-of-duty care.”

**Jointly Issued FAQs**

Over the course of 2014, the Departments jointly issued various sets of FAQs that spanned multiple subject areas related to the Affordable Care Act. The 2014 FAQs continued the line of jointly issued FAQs released in earlier years. Only those FAQs that were jointly issued appear below; FAQs issued by a single department or agency appear elsewhere in this “Health Care” section. The FAQs are listed in numerical order.

**Set 18**—On January 9, 2014, the Departments released the 18th set of FAQs on the Affordable Care Act implementation. The guidance addressed a number of issues, including the Affordable Care Act’s impact on the MHPAEA, stating that the health care reform law “builds on MHPAEA and provides that mental health and substance use disorder services are one of ten essential health benefits categories.” In addition to the MHPAEA, the FAQs also addressed:

- The coverage of preventive services (for plan years beginning on or after January 1, 2015, plans and issuers subject to Public Health Service Act Section 2707 are required to apply all out-of-pocket maximums across all essential benefits);
- The definition of insured expatriate health plans; and
- Wellness programs.

*See the Aon Hewitt bulletin titled “Into the Woods—Latest Round of FAQs Addresses Details of Cost Sharing, Wellness, Preventive Services, and Transitional Reinsurance Fee” (January 2014) under “2014 Developments: A Closer Look.”*
Set 19—On May 2, 2014, the Departments published FAQs about Affordable Care Act implementation related to the proposed changes to the model notices. The Departments provided guidance on the following:

- Coverage of Preventive Services—A group health plan or health insurance issuer will be considered to be in compliance with the requirement to cover tobacco use counseling and interventions if, for example, the plan or issuer covers, without cost sharing, screening for tobacco use and, for those who use tobacco, at least two tobacco cessation attempts per year (as defined in the FAQs).
- Limitations on Cost Sharing—The FAQs discuss what costs a plan may count towards the out-of-pocket (OOP) maximum where an individual pays more for out-of-network services or for brand-name prescription drugs. They also discuss how the OOP limit applies in health plans that use reference-based pricing structures.
- Health FSA Carryover and Excepted Benefits—Unused carryover amounts in a health FSA that satisfy the modified “use-or-lose” rule should not be taken into account when determining if the health FSA satisfies the maximum benefit payable limit prong under the excepted benefits regulations.
- Summary of Benefits and Coverage—The FAQs also provide guidance on templates for summaries of benefits and coverage (SBCs) and on the continued application of previously issued enforcement and transition relief guidance, including specific safe harbors, with respect to the requirements to provide an SBC and a uniform glossary.

See the Aon Hewitt bulletin titled “It’s Time for Spring Cleaning: Agencies Provide Needed Cleanup on COBRA, CHIP, Health FSA Rollovers, and Group Market Reforms” (June 2014) under “2014 Developments: A Closer Look.”

Set 20—On July 17, 2014, the Departments issued guidance in the form of an FAQ stating that closely held corporations that eliminate some or all contraceptive services from their group health plans based on religious beliefs will trigger notice requirements under ERISA. The guidance follows the June 30, 2014, U.S. Supreme Court ruling in Burwell v. Hobby Lobby Stores, Inc. that closely held, nonprofit companies do not have to provide contraceptive services that are against the owners’ religious beliefs. The guidance, posted by the departments on the DOL’s EBSA website, states that for “plans subject to [ERISA], ERISA requires disclosure of information relevant to coverage of preventive services, including contraceptive coverage.”

Set 21—On October 10, 2014, the Departments released guidance on the application of maximum out-of-pocket (MOOP) limits and reference-based pricing structures under the Affordable Care Act.

See the Aon Hewitt bulletin titled “Right Before Columbus Day, Look What’s Been Discovered—New FAQ on Reference-Based Pricing and MOOP Limits” (October 2014) under “2014 Developments: A Closer Look.”

Set 22—On November 6, 2014, the Departments issued guidance on premium reimbursement under the Affordable Care Act. The guidance addressed three separate situations in which an employer assists employees with the purchase of individual policies on the insurance Exchanges by providing a cash subsidy. The Departments responded to the following questions:

- My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?
- My employer offers employees with high-claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?
A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code Section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Exchange coverage. Is this permissible?

Penalties, Fees, and Taxes

On November 21, 2014, CMS released proposed regulations that would establish payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for federally facilitated Exchanges, as required by the Affordable Care Act. The regulations would provide additional standards for the annual open enrollment period for the individual market for benefit years beginning on or after January 1, 2016, essential health benefits, QHPs, network adequacy, quality improvement strategies, the SHOP, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics. The regulations also propose that the annual open enrollment period for 2016 and beyond begin on October 1 and run through December 15 of the year prior to the benefit year.

On November 14, 2014, CMS announced that the deadline for contributing entities to submit their 2014 enrollment counts for the transitional reinsurance program contributions was extended from November 15, 2014 to 11:59 p.m. on December 5, 2014. The transitional reinsurance program was established under the Affordable Care Act to stabilize premiums in the individual market inside and outside of the Exchanges. The January 15, 2015 and November 15, 2015 payment deadlines remain the same.

On October 31, 2014, the IRS published FAQs on the Affordable Care Act transitional reinsurance program. Section 1341 of the Affordable Care Act establishes the transitional reinsurance program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. The statute requires all health insurance issuers and third-party administrators on behalf of self-insured group health plans to make contributions under this program to support payments to individual market issuers that cover high-cost individuals (payment-eligible issuers). Regulations proposed by HHS to implement the reinsurance program specify that self-insured group health plans are liable for the contributions, although a plan may utilize a third-party administrator or administrative-services-only contractor for transfer of the contributions. In the guidance, the IRS indicated that sponsors of self-insured group health plans and health insurance issuers can treat contributions under the Affordable Care Act’s transitional Reinsurance Program as ordinary and necessary business expenses for tax purposes.

Also in 2014, to navigate what is expected to be the biggest compliance year of the Affordable Care Act, Aon Hewitt prepared a 2014 “To Do” list to help employers prepare for 2015.


On September 18, 2014, the Treasury and IRS released Notice 2014-56, which provides the applicable dollar amount for determining the Patient-Centered Outcomes Research Institute (PCORI) fee for policy years and plan years ending on or after October 1, 2014, and before September 30, 2015. The applicable dollar amount used to calculate the fee is $2.08. Section 4375 imposes a fee on the issuer of a specified health insurance policy for each policy year ending after September 30, 2012, and before October 1, 2019. Section 4376 imposes a fee on the plan sponsor of an applicable self-insured health plan for each plan year ending after September 30, 2012, and before October 1, 2019. The fee imposed by Sections
4375 and 4376 help fund the PCORI, as created as part of the Affordable Care Act. The fee is calculated using the average number of lives covered under the policy or plan and the applicable dollar amount.

**On September 18, 2014,** the IRS released final regulations on the application of the $500,000 deduction limitation for remuneration provided by certain health insurance providers under Section 162(m)(6) of the Code. These regulations affect certain health insurance providers providing remuneration that exceeds the deduction limitation. The regulations became effective on September 23, 2014. For dates of applicability, please refer to Section 1.162031(j) of the final regulations.

**On August 13, 2014,** the IRS released Notice 2014-47. The Notice provided guidance for the 2014 fee year on how the IRS will administer the definition of a “covered entity” for purposes of the health insurance fee under Section 9010 of the Affordable Care Act. The Notice applied only to the 2014 fee year. The IRS stated that the Notice resolves confusion as to the scope of the exclusions in Section 9010(c)(2) from the general definition of the term covered entity. Additionally, Notice 2014-47 clarified that a controlled group does not have to report for a controlled group member who would not qualify as a covered entity in the 2014 fee year if it were a single-person covered entity.

**On March 5, 2014,** CMS released final regulations on the notice of benefit and payment parameters for 2015 as part of the Affordable Care Act. The final regulations establish payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for federally facilitated Exchanges. The regulations also provide additional standards with respect to composite premiums, 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 federally facilitated Exchange, patient safety standards for issuers of QHPs, and the SHOP. The regulations became effective on May 12, 2014.


**Pre-Existing Condition Insurance Plan**

**On March 14, 2014,** the Obama Administration announced that enrollees in the federally run Pre-Existing Condition Insurance Plan (PCIP) who had not yet found new health insurance coverage through the Exchanges could purchase an additional month of PCIP coverage through April 30, 2014. The PCIP program makes health coverage available to individuals with pre-existing conditions.

**On January 14, 2014,** HHS announced that individuals enrolled in the PCIP had the option of remaining in the program through March 31, 2014. (HHS originally made an announcement in December 2013 that allowed participants to maintain coverage through January 31, 2014.) The PCIP program was created as a transitional health plan as part of the Affordable Care Act for people with chronic health conditions. According to HHS, the latest extension will allow PCIP enrollees additional time to review health insurance Exchange plan options and “enroll in the coverage that best meets their needs before open enrollment closes in March.”

The PCIP expired on April 30, 2014. It was originally scheduled to run through 2013, but HHS extended the program for those individuals unable to find coverage through the Exchanges. On April 24, 2014, CCIIO announced a special enrollment period for individuals losing coverage through the PCIP at the end of the month. Enrollees who did not have other coverage that began May 1, 2014 were eligible for a
60-day special enrollment period that began on May 1, 2014 (ending June 30, 2014) to enroll in new coverage through the federally facilitated Exchange.

Premium Tax Credits and Subsidies

On July 24, 2014, the IRS issued final and temporary regulations relating to the health insurance premium tax credit enacted by the Affordable Care Act. The regulations affect individuals who enroll in QHPs through health insurance Exchanges and claim the premium tax credit and Exchanges that make QHPs available to individuals. The regulations address a number of issues related to tax code provisions under the Affordable Care Act in situations such as domestic abuse, spousal abandonment, divorce, separation, custody disputes, and self-employment (e.g., tax filing for those claiming the health insurance premium tax credits, reconciling advance payments of health insurance premium tax credits, and deductions of health insurance costs for the self-employed). The regulations were effective July 28, 2014. For applicability dates, please refer to the regulations.

On the same day, the IRS also released three related revenue procedures with the issuance of the final and temporary regulations, as highlighted below:

- Revenue Procedure 2014-37 provided the methodology to determine the applicable percentage table in Section 36B(b)(3)(A) of the Code used to calculate an individual's premium assistance credit amount for taxable years beginning after calendar year 2014. It also provides the methodology to determine the required contribution percentage in Section 36B(c)(2)(C)(i)(II) used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage for purposes of Section 36B for plan years beginning after calendar year 2014. Additionally, Revenue Procedure 2014-37 reproduces the required contribution percentage, as determined under guidance issued by HHS, used to determine whether an individual is eligible for an exemption from the individual shared responsibility payment because of a lack of affordable minimum essential coverage under Section 5000A(e)(1)(A) for plan years beginning after calendar year 2014.

- Revenue Procedure 2014-41 provided calculation methods a taxpayer may use to resolve the interrelationship between the Section 162(l) deduction and the premium tax credit under Section 36B. It provides an iterative calculation and alternative calculation taxpayers may use, as well as examples demonstrating the calculations.

- Revenue Procedure 2014-46 provided the 2014 monthly national average premium for QHPs that have a bronze level of coverage for taxpayers to use in determining their maximum individual shared responsibility payment under Section 5000A(c)(1)(B) of the Code and Section 1.5000A-4 of the Income Tax Regulations. The revenue procedure also provides an explanation of the methodology used to determine the monthly national average premium amount.

On July 22, 2014, two U.S. appeals courts issued contradictory rulings on the health insurance subsidies (i.e., premium tax credits) that are provided as part of the Affordable Care Act. The U.S. Court of Appeals for the D.C. Circuit ruled 2-1 (Halbig v. Burwell) that the IRS incorrectly allowed individuals to receive subsidies in states that use the federal insurance Exchange. The court did not order that the subsidies immediately cease, as it expected a continuing legal battle. (The Department of Justice did indicate it planned to appeal the decision.) Later that same day, a three-judge panel of the U.S. Court of Appeals for the 4th Circuit in Richmond unanimously ruled (King v. Burwell) that the IRS had acted correctly in allowing Affordable Care Act subsidies to go to all federal and state Exchanges, despite unclear wording in the health care reform legislation. The U.S. Supreme Court will issue a ruling in King v. Burwell in 2015. The Halbig v. Burwell case is on hold pending disposition of King v. Burwell by the Supreme Court.

Reporting, Disclosure, Notices, and Forms

On December 22, 2014, the Departments issued proposed regulations regarding the SBC and the Uniform Glossary for group health plans and health insurance coverage in the group and individual markets under the Affordable Care Act. The regulations proposed changes that implement the disclosure requirements under Section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. The regulations also proposed changes to the documents required for compliance, including a template for the SBC, instructions, sample language, a guide for coverage example calculations, and the Uniform Glossary.

On October 20, 2014, CCIIO announced that the form for submitting the transitional reinsurance program annual enrollment count is available on Pay.gov. The Affordable Care Act established the transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Exchanges. The transitional reinsurance program will collect contributions from health insurance issuers and certain self-insured group health plans (contributing entities) in the 2014, 2015, and 2016 benefit years to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the Treasury. Using Pay.gov, filers will be able to complete all of the informational requirements: registration, submission of the Annual Enrollment Count, and remittance of contributions.

The form became available on Pay.gov on October 24, 2014 in time for the 2014 benefit year’s annual enrollment count submission deadline of November 15, 2014. However, CCIIO noted that reinsurance contribution payments were not due on November 15, 2014. Contributing entities have the option to pay: 1) the entire 2014 benefit year contribution in one payment no later than January 15, 2015, reflecting $63.00 per covered life or 2) in two separate payments for the 2014 benefit year, with the first remittance due by January 15, 2015 reflecting $52.50 per covered life, and the second remittance due by November 15, 2015, reflecting $10.50 per covered life.

Also in 2014, the IRS updated the following draft forms required for Affordable Care Act reporting:

- Form 1095-A, Health Insurance Marketplace Statement;
- Form 1095-B, Health Coverage;
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage; and
- Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns.

Forms 1095-A, 1095-B, and 1095-C were updated to include an “Instructions for Recipient” page. The instructions are meant to assist individuals in determining whether they are eligible for a premium tax credit through the Affordable Care Act.

The IRS released draft instructions for two new forms related to individual taxpayer obligations under the Affordable Care Act. Draft instructions for Form 8962 (Premium Tax Credit) were released on September 17, 2014, and draft instructions for Form 8965 (Health Care Coverage Exemptions) were released on September 15, 2014.

On August 28, 2014, the IRS posted draft instructions to accompany the draft forms that employers will use to report health coverage offered to employees. The instructions provided assistance to filers who must complete the forms as required by the Affordable Care Act. The instructions were directed at
Exchanges that must report enrollees in QHPs, as well as employers and others that provide minimum essential coverage or are subject to the employer mandate.

The draft instructions were for the following forms:

- Form 1095-A, Health Insurance Marketplace Statement;
- Forms 1094-B and 1095-B; and
- Forms 1094-C and 1095-C.

On July 24, 2014, the IRS released draft forms that employers were to use to report on health coverage that they offer to their employees. According to the IRS, these draft forms were provided to help stakeholders, including employers, tax professionals, and software providers, prepare for these new reporting provisions. The following draft forms were posted to the IRS website, among others:

- Form 1094-B, Employer Transmittal of Health Coverage Information Returns;
- Form 1094-C, Employer Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Return;
- Form 1095-B, Health Coverage; and
- Form 1095-C, Employer Provided Health Insurance Offer and Coverage.

See the Aon Hewitt bulletin titled “Maybe They’re in the Box?—IRS Issues Draft Reporting Forms (But Not the Instructions) for Individual and Employer Mandates Under the Affordable Care Act” (July 2014) under “2014 Developments: A Closer Look.”

On May 2, 2014, the IRS issued final regulations on requirements for Exchanges to report information relating to the health insurance premium tax credit as enacted by the Affordable Care Act. The final regulations apply to Exchanges that offer QHPs to individuals. The final regulations became effective on May 7, 2014 and apply to tax years ending after December 31, 2013.

On March 28, 2014, the IRS issued Notice 2014-24. The Notice provides a temporary safe harbor for covered entities that report direct premiums for expatriate plans on a Supplemental Health Care Exhibit. A covered entity may apply this temporary safe harbor for purposes of reporting direct premiums written on Form 8963, Report of Health Insurance Provider Information, which is used to calculate the fee imposed by Section 9010 of the Affordable Care Act. For the 2014 and 2015 fee years, it allows such an entity to exclude 50% of its direct premiums written for expatriate plans in reporting total direct premiums to the IRS for purposes of determining its health insurance providers fee.

On March 5, 2014, the Treasury and IRS released final regulations providing guidance to providers of minimum essential health coverage that are subject to the information reporting requirements of Section 6055 of the Code, enacted by the Affordable Care Act. Health insurance issuers, certain employers, and others that provide minimum essential coverage to individuals must report to the IRS information about the type and period of coverage and furnish the information in statements to covered individuals. These final regulations affect health insurance issuers and carriers, employers, governments, and other persons that provide minimum essential coverage to individuals. The regulations were effective as of March 10, 2014. For applicability dates, refer to Sections 1.6055-1(j) and 1.6055-2(b).

On March 5, 2014, the Treasury and IRS released final regulations providing guidance to employers that are subject to the information reporting requirements under Section 6056 of the Code, enacted by the Affordable Care Act (generally employers with at least 50 FTEs, including full-time equivalent employees).
Section 6056 requires those employers to report to the IRS information about the health care coverage, if any, they offered to FTEs, in order to administer the employer-shared responsibility provisions of Section 4980H of the Code. Section 6056 also requires those employers to furnish related statements to employees that may use to determine whether, for each month of the calendar year, they may claim on their individual tax returns a premium tax credit under Section 36B (premium tax credit). The regulations provide for a general reporting method and alternative reporting methods designed to simplify and reduce the cost of reporting for employers subject to the information reporting requirements under Section 6056. The regulations were effective as of March 10, 2014. For dates of applicability, readers should refer to Sections 301.6056-1(m) and 301.6056-2(b).

On March 4, 2014, the IRS updated its website to include instructions for Form 8963, Report of Health Insurance Provider Information. This form allows employers to report net premiums written “for health insurance of United States health risks.” The IRS will use this information to calculate the annual fee on health insurance providers as required by the Affordable Care Act.

Small Business Health Care Tax Credit

On June 26, 2014, the IRS issued final regulations on the tax credit available to certain small employers that offer health insurance coverage to their employees. The credit is provided under Section 45R of the Code, enacted by the Affordable Care Act. The regulations affect small employers, both taxable and tax-exempt, that are eligible for the tax credit. The regulations, which were effective as of June 30, 2014, include guidance on the definition of eligible small employers, the calculation of full-time equivalent employees and the credit amount, filing requirements, the uniform percentage requirement, and other related matters.

On March 10, 2014, the IRS issued an information release encouraging small employers that provide health insurance coverage to their employees to investigate the small business health care tax credit. The small business health care tax credit was included in the Affordable Care Act. Eligible small employers could claim the credit for 2010 through 2013 and for two additional years beginning in 2014. For 2010 through 2013, the maximum credit was 35% of premiums paid by eligible small businesses and 25% of premiums paid by eligible tax-exempt organizations. In 2014, the maximum credit rate rose to 50% for small businesses and 35% for tax-exempt organizations. The Small Business Health Care Tax Credit page on IRS.gov contains a variety of information, including examples of typical tax savings under various scenarios and answers to FAQs.

Waiting Periods

On June 20, 2014, the Departments released final regulations that clarified the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation set forth in Section 2708 of the Public Health Service Act, as added by the Affordable Care Act. The Departments released proposed regulations on the 90-day period waiting period limitation in February 2014. The Departments stated that these final regulations were published without any substantive changes. The final regulations became effective on August 25, 2014. The final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

See the Aon Hewitt bulletin titled “Agencies Issue Final Affordable Care Act Regulations on Orientation Period” (July 2014) under “2014 Developments: A Closer Look.”
On February 20, 2014, the Departments released final regulations implementing the 90-day waiting period limitation under Section 2708 of the Public Health Service Act, as added by the Affordable Care Act. The final regulations require that no group health plan or group health insurance issuer impose a waiting period that exceeds 90 days after an employee is otherwise eligible for coverage. The rules do not require coverage be offered to any particular individual or class of individuals. The regulations also finalize amendments to existing regulations to conform to Affordable Care Act provisions. Specifically, the rules amend regulations implementing existing provisions such as some of the portability provisions added by HIPAA because those provisions of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by the Affordable Care Act. On the same day, the Departments also issued proposed regulations clarifying the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation as part of the Affordable Care Act.


Other Health Care Guidance

Flexible Spending Arrangements and Health Savings Accounts

On April 23, 2014, the IRS issued inflation-adjusted limits for contributions to a Health Savings Account (HSA) for calendar year 2015 (Revenue Procedure 2014-30). For calendar year 2015, the limit on contributions for an individual with self-only coverage under a high-deductible health plan is $3,350 ($6,650 for family coverage). A high-deductible health plan for calendar year 2015 is defined as a health plan with an annual deductible that is not less than $1,300 for self-only coverage ($2,600 for family coverage). The limit on annual OOP expenses is $6,450 for self-only coverage ($12,900 for family coverage). The limit on catch-up contributions for individuals age 55 or older is $1,000.

For a chart that provides the limits for calendar years 2013 through 2015, please see the Aon Hewitt bulletin “IRS Issues 2015 HSA Limits” (April 2014) under “2014 Developments: A Closer Look.”

On March 28, 2014, the IRS issued guidance clarifying the impact of the allowable health FSA carryover on an individual’s eligibility to contribute to an HSA. The guidance took the form of a Chief Counsel’s Memorandum.


Medicare

On October 9, 2014, CMS announced the 2015 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 2015 and will remain at the 2014 (and 2013) rate of $104.90. Higher-income beneficiaries (those with incomes over $85,000 single/$170,000 joint) will pay higher premiums. The Medicare Part B deductible will also remain unchanged at $147.

The 2015 Medicare Part A deductible will increase to $1,260, up from $1,216 in 2014. 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 2015 coinsurance will be $315 per day for days 61 through 90 ($304 in 2014), and $630 per day ($608 in 2014) for the 91st and later days. The daily coinsurance for the 21st through 100th day in a skilled nursing facility will be $157.50 in 2015, up from $152 in 2014.
On April 3, 2014, HHS announced that the Social Security Administration (SSA) is now able to process requests for Medicare Part A and Part B Special Enrollment Periods and reductions in Part B and premium Part A late enrollment penalties for certain eligible people in same-sex marriages. The announcement is in response to the June 2013 Supreme Court ruling in United States v. Windsor, which held that a key section of the federal Defense of Marriage Act (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. Because of the ruling, Medicare is no longer prevented by DOMA from recognizing same-sex marriages for determining entitlement to, or eligibility for, Medicare. (While Medicare is managed by CMS, the SSA is responsible for determining eligibility for, and enrolling people in, Medicare.)

Also in 2014, Aon Hewitt issued a reminder that most employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D are subject to an annual disclosure requirement.

For more information on the disclosure, see the Aon Hewitt bulletin titled “Medicare Part D Disclosure Reminder” (January 2014) under “2014 Developments: A Closer Look.”

Retiree Health

On May 8, 2014, the IRS issued Revenue Ruling 2014-15, which provides guidance to employers funding their retiree health benefits through a wholly owned subsidiary. The guidance cites an issue in the form of a question (e.g., "Does the arrangement described below constitute insurance within the meaning of subchapter L of the Code? If so, does the issuer qualify as an insurance company?"). The ruling concludes that the arrangement is insurance for federal income tax purposes.

Stop-Loss Insurance

On November 6, 2014, EBSA issued Technical Release 2014-01, which provides additional information on the state regulation of stop-loss insurance. In the guidance, EBSA “takes the view that states may regulate insurance policies issued to plans or plan sponsors, including stop-loss insurance policies, if the law regulates the insurance company and the business of insurance.”
Retirement

Audits

On February 21, 2014, the IRS released FAQs regarding the Employee Plans Team Audit (EPTA) program. (An EPTA audit is a special type of pension plan audit that the IRS conducts of the plan or plans of a large employer. EPTA defines a large employer as an employer that maintains qualified pension plans that, in total, have at least 2,500 participants.) The FAQs are designed to help employers (and their advisers) that are going through an EPTA audit or are concerned about going through one in the future to understand the process. The FAQs address general questions, audit details, internal controls, IRS (initial actions), audit impact on employers, and problems and corrections. According to the IRS, the FAQs provide general information and should not be cited as legal authority.

Compliance Programs

On May 9, 2014, the IRS released Notice 2014-35. The Notice applies administrative relief to late filers of Form 5500 that satisfy the requirements of the Notice and the Delinquent Filer Voluntary Compliance Program administered by EBSA.

Defined Benefit Plans

On December 31, 2014, the PBGC’s Participant and Plan Sponsor Advocate issued the First Annual Report of the Participant and Plan Sponsor Advocate. The Advocate position, created by MAP-21, is meant to assist participants and sponsors. The Advocate is responsible for resolving issues between customers and the PBGC, recommending legislative changes, and filing an annual report to Congress. In this first report, the Advocate recognized the PBGC’s commitment to the defined benefit system, but also identified areas for improvement. Recommendations include the PBGC taking a less adversarial approach to enforcement, as well as improving communications, processes, and inter-agency coordination.

Also in 2014, the PBGC posted an announcement regarding developments related to ERISA Section 4062(e) on its website. The PBGC provided information on the enactment of H.R. 83 (Consolidated and Further Continuing Appropriations Act, 2015) that was signed into law by President Obama on December 16, 2014. The law made substantial changes to Section 4062(e). Additionally, the PBGC stated it is ending the moratorium on enforcement of 4062(e) cases that the agency announced in July 2014.

On December 1, 2014, the PBGC published final regulations that included a new table for determining expected retirement ages for participants in pension plans undergoing distress or involuntary termination with valuation dates falling in 2015. 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 regulations substituted Table I-14 with Table I-15 to provide an updated correlation, appropriate for calendar year 2015, between the amount of a participant’s benefit and the probability that the participant will elect early retirement. Table I-15 is used to value benefits in plans with valuation dates during calendar year 2015. The final regulations became effective on January 1, 2015.

On November 17, 2014, the PBGC issued its Annual Report for the 2014 fiscal year. The PBGC, which has been in existence for 40 years as of 2014, covers more than 41 million workers and retirees in private defined benefit pension plans. The report noted that the PBGC’s overall deficit increased to approximately $62 billion, due largely to the declining condition of a few multiemployer plans. On the multiemployer plan
program side, the deficit rose substantially, from $8.3 billion last year to $42.4 billion. The financial condition of the single-employer plan program fared better and showed an improvement, with a drop in deficit from $27.4 billion in the previous year to around $19.3 billion.

**On October 27, 2014,** the PBGC announced that the 2015 maximum yearly guarantee for a 65-year-old retiree will increase to $60,136 (an increase from $59,318 in 2014). The increase is not retroactive; payments to retirees whose plans terminated before 2015 will not change. The maximum guaranteeable monthly benefit for a 65-year-old beneficiary for 2015 is $5,011.36 (as compared to $4,943.18 in 2014). 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 October 24, 2014,** the PBGC announced the 2015 flat-rate premiums for single-employer and multiemployer plans. For the 2015 plan year, the per-participant flat-rate premium for single-employer plans is $57.00 (up from $49.00 in 2014) and $13.00 for multiemployer plans (up from $12.00 in 2014).

**On October 17, 2014,** the PBGC released Technical Update 14-2, which provides guidance on annual financial and actuarial reporting under ERISA Section 4010 and PBGC regulations for plans using pension smoothing rates under MAP-21, which were extended by the HATFA. If a 4010 filing contains actuarial information for 2013 based on segment rates that differ from those the plan ultimately uses, ordinarily the filing would need to be amended. Noting that such amendments would be unduly burdensome, the PBGC’s guidance in part provides that 4010 filings need not be amended solely to revise actuarial information that changed because of a decision to use HATFA rates for the 2013 plan year, though the PBGC also said it was reserving the right to request revised actuarial information on the rates the plan ultimately uses for 2013. The relief applies regardless of when the 4010 filing is submitted (i.e., before or after HATFA was enacted), and the guidance in the Technical Update supersedes any inconsistent guidance in PBGC’s 4010 filing instructions.

**On October 8, 2014,** the PBGC provided instructions for defined benefit plan sponsors when submitting premium payments. The PBGC stated that following these tips will ensure that payments are “quickly and accurately posted to plan accounts.”

If a plan sponsor prefers to pay at the same time that it submits an e-filing via the My Plan Administration Account online premium filing system, the sponsor can securely enter payment information (e.g., account number and bank routing code) when at the payment screen. If a plan sponsor prefers to pay separately from its filing, the sponsor can securely submit the payment electronically via Pay.gov without incurring any additional cost. When a plan sponsor visits the Pay.gov website, it should proceed to the PBGC Premium Insurance Payments form to enter payment information. If a plan sponsor prefers to pay by other methods (e.g., check), it should enter the plan’s EIN/PN and Plan Year Commencement (PYC) Date on the payment.

**On September 29, 2014,** EBSA proposed new rules that would require electronic filing for top hat pension plan statements. Top hat plans in general are pension plans for select groups of management or highly compensated employees. The DOL receives approximately 2,000 top hat plan statements filed in paper form each year, which it converts to electronic format. The DOL has concluded that the current paper filing system is not the most efficient or cost-effective. The proposed regulations would require top hat plan statements to be electronically filed with the Secretary of Labor through the DOL’s website. Once filed, the statements would be posted on EBSA’s website and be available to the public. The plan
administrator would receive an electronic confirmation that the filing had been received by EBSA. In conjunction with the proposed regulations, the DOL also launched its new web-based filing system on September 29. Plan administrators may use it in place of paper-based filing on a voluntary basis until regulations are finalized.

**On September 24, 2014,** the PBGC released guidance (Technical Update 14-1) on the impact of HATFA on PBGC premiums. The guidance superseded any inconsistent guidance in the PBGC's 2014 premium instructions but not guidance in the PBGC's Technical Update 12-1. In Technical Update 14-1, the PBGC provided that plans that redesignate 2013 contributions to 2014 in accordance with IRS Notice 2014-53 (issued on September 11, 2014) should amend their 2014 premium filings to exclude the discounted value of such redesignated contributions from the value of assets used to determine the 2014 variable rate premium. In general, the PBGC noted, such a designation would affect premiums for both 2014 and 2015. If the redesignation is made after the 2014 premium filing, the 2014 filing should be amended to reflect the higher premium. The PBGC also discusses the enforcement policy it will follow for certain 2014 premium filings.

**On September 18, 2014,** the Treasury and IRS released final and proposed regulations on hybrid retirement plans.

The long-awaited final regulations provided additional guidance on certain issues that were not addressed in hybrid plan final regulations issued in 2010. The September 18, 2014 regulations relate to applicable defined benefit plans that use a lump sum-based benefit formula, including cash balance plans and pension equity plans, as well as other hybrid retirement plans that have a similar effect. The regulations provide guidance relating to certain provisions that apply to applicable defined benefit plans that were added to the Code by the PPA, as amended by the Worker, Retiree, and Employer Recovery Act of 2008. These regulations affect sponsors, administrators, participants, and beneficiaries of these plans. The regulations became effective on September 19, 2014. The regulations generally apply to plan years that begin on or after January 1, 2016. However, please see the "Effective/Applicability Dates" section in the preamble for additional information.

The proposed regulations provide guidance regarding certain amendments to applicable defined benefit plans that use a lump sum-based benefit formula, including cash balance plans and pension equity plans, as well as other hybrid retirement plans that have a similar effect. The proposed regulations would permit an applicable defined benefit plan that does not comply with the requirement that the plan not provide for interest credits (or equivalent amounts) at an effective rate that is greater than a market rate of return to comply with that requirement by changing to an interest crediting rate that is permitted under the final hybrid plan regulations, without violating the anti-cutback rules of Section 411(d)(6). These regulations would affect sponsors, administrators, participants, and beneficiaries of these plans.

See the Aon Hewitt bulletin titled “New Final and Proposed Regulations on Cash Balance and Other Hybrid Plans” (December 2014) under “2014 Developments: A Closer Look.”

**On September 11, 2014,** the IRS released Notice 2014-53. The Notice provided guidance on changes to the funding stabilization rules for single-employer pension plans under the Code and ERISA that were made by Section 2003 of HATFA, which was enacted on August 8, 2014.

**On July 8, 2014,** the PBGC announced a moratorium until the end of 2014 on the enforcement of ERISA Section 4062(e) cases. That Section of ERISA allows the PBGC to request increased pension plan funding when a company stops operations at a facility through a shutdown or sale and 20% of the workers in the pension plan lose their jobs. The moratorium applied from July 8 to December 31, 2014.
During that time period, the PBGC ceased enforcement on open and new cases. Companies were to continue to report new 4062(e) events, but the PBGC said it would take no action on those events during the moratorium.

**On June 19, 2014,** the PBGC updated its online My Pension Benefit Account, which is an online service for employees, retirees, and beneficiaries in PBGC-trusteed plans. The latest changes allow users to print an income verification letter, view a list of the documents the PBGC has on file for them, and view any power-of-attorney designations. Additionally, the agency stated it has increased security so that it "can detect any intrusions that may try to create fraudulent accounts." The PBGC announced the latest updates in a *Retirement Matters* blog.

**On May 5, 2014,** the PBGC released final regulations on benefits payable in terminated single-employer plans, which set forth rules on the PBGC’s guarantee of pension plan benefits, including rules on the phase-in of the guarantee. The amendments implement the PPA provision that the phase-in period for the guarantee of benefits that are contingent upon the occurrence of an "unpredictable contingent event," such as a plant shutdown, starts no earlier than the date of the shutdown or other unpredictable contingent event. The final regulations became effective June 4, 2014.

**On April 24, 2014,** the PBGC announced that the Office of Management and Budget approved revisions to the standard termination, distress termination, and missing participants forms and instructions. The forms and instructions are available on the “Plan Terminations” page found on the PBGC’s website. The new forms must be used for terminations for which the first Notice of Intent to Terminate is issued on or after June 1, 2014.

**On March 7, 2014,** the PBGC released final regulations related to reducing regulatory burden. Specifically, based on its regulatory review under Executive Order 13563 (Improving Regulation and Regulatory Review), the PBGC proposed 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, give small plans more time to value benefits, provide for relief from penalties, and make other changes. Earlier, the agency finalized the part of the proposal that eliminated the early payment requirement for large plans’ flat-rate premiums. This latest action finalized the rest of the proposal. The final regulations were effective as of April 10, 2014. The changes are generally applicable for plan years starting on or after January 1, 2014.

**Defined Contribution Plans**

**On November 24, 2014,** the IRS released Notice 2014-74. The Notice amends the two safe harbor explanations in Notice 2009-68, 2009-2 C.B. 423, that can be used to satisfy the requirement under Section 402(f) of the Code that certain information be provided to recipients of eligible rollover distributions. Amendments to the safe harbor explanations reflected in this Notice relate to the allocation of pretax and after-tax amounts, distributions in the form of in-plan Roth rollovers, and certain other clarifications to the two safe harbor explanations. The amendments to the safe harbor explanations (and attached model notices) may be used for plans that apply the guidance in Section III of Notice 2014-54, 2014-41 I.R.B. 670, with respect to the allocation of pretax and after-tax amounts.

**On October 29, 2014,** the IRS released an updated version of its 403(b) Plan Checklist. The compliance checklist (Publication 4546) updates total legal contribution limits to $53,000 for 2015. Other updates include minor language changes to Questions No. 7 and 9.
On October 24, 2014, the Treasury and IRS released a special rule that enables qualified defined contribution plans to provide lifetime income by offering, as investment options, a series of target date funds (TDFs) that include deferred annuities among their assets, even if some of the TDFs within the series are available only to older participants. The guidance provides that, if certain conditions are satisfied, a series of TDFs in a defined contribution plan is treated as a single right or feature for purposes of the nondiscrimination requirements of Section 401(a)(4) of the Code. This special rule permits the TDFs to satisfy those nondiscrimination requirements as they apply to rights or features even if one or more of the TDFs considered on its own would not satisfy those requirements.

According to the IRS, the guidance provides plan sponsors an additional option to “make it easier for employees to consider using lifetime income. Instead of having to devote all of their account balance to annuities, employees use a portion of their savings to purchase guaranteed income for life while retaining other savings in other investments.” A TDF may include annuities allowing payments, beginning either immediately after retirement or at a later time, as part of its fixed income investments, even if the funds containing the annuities are limited to employees over a specified age. The guidance makes clear that plans have the option to offer TDFs that include such annuity contracts either as a default or as a regular investment alternative.

On the same day, the DOL confirmed in an accompanying letter that TDFs serving as default investment alternatives may include annuities among their fixed income investments. The letter also describes how ERISA fiduciary standards can be satisfied when a plan sponsor appoints an investment manager that selects the annuity contracts and annuity provider to pay the lifetime income.

On October 9, 2014, the IRS updated its Section 401(k) Plan Checklist with two new questions. The revised version of the checklist (Publication 4531) now includes questions on whether top-heavy minimum contributions were made and whether the Form 5500 Annual Return/Report of Employee Benefit Plan was filed.

On September 18, 2014, the IRS released proposed amendments to regulations that address the tax treatment of distributions from designated Roth accounts under tax favored retirement plans. The proposed regulations would limit the applicability of the rule regarding the allocation of after-tax amounts when disbursements are made to multiple destinations so the allocation rule applies only to distributions made before the earlier of January 1, 2015 or a date chosen by the taxpayer that is on or after September 19, 2014. (In the guidance the IRS stated that participants may rely on the proposed rules immediately.) The regulations affect administrators of, employers maintaining, participants in, and beneficiaries of designated Roth accounts under tax favored retirement plans.

On the same day, the IRS published guidance (Notice 2014-54) in conjunction with the proposed regulations. The guidance provides rules for allocating pretax and after-tax amounts among disbursements that are made to multiple destinations from a qualified plan described in Section 401(a) of the Code. These rules also apply to disbursements from a Section 403(b) plan or a Section 457(b) plan maintained by a governmental employer described in Section 457(e)(1)(A) (a “governmental Section 457(b) plan”). Section VI of the Notice provides transition rules.

On July 1, 2014, the Treasury and IRS released final regulations on longevity annuities. A longevity annuity is a type of deferred income annuity that starts at an advanced age and continues throughout the rest of the person’s life. The final regulations make longevity annuities accessible to Section 401(k)s, other employer-sponsored individual account plans, and IRAs by amending the required minimum distribution regulations to allow for payments starting in later years. Plan participants could use up to 25%
of their account balance or, if less, $125,000 (adjusted in the future for cost-of-living increases) to purchase a qualifying longevity annuity.

**On June 16, 2014,** the IRS updated its Section 401(k) Plan Fix-It Guide. The update included the 2013 cumulative list of changes in plan qualification requirements. The guide provided an overview of the rules, frequent errors, and tips on how to find and avoid such mistakes.

**On April 29, 2014,** the IRS updated its website with a 403(b) Plan Checklist and Fix-It Guide. The resources are designed to help plans stay in compliance with many of the various IRS rules. The IRS reminded users that this information is not meant to provide a complete description of all plan requirements, nor should it be used as a substitute for a complete plan review.

**IRAs**

**On December 12, 2014,** the Treasury’s Bureau of the Fiscal Service issued a final rule, effective December 15, 2014, establishing the electronic retirement savings bonds needed for implementation of the new retirement savings program first described in the President's State of the Union address in January 2014. The rule was issued in response to the President's January 29, 2014, Memorandum directing the Secretary of the Treasury to develop a new retirement savings security for “new and small-dollar savers.” While the final rule does not refer specifically to “myRA,” the terms and conditions of the program described in the rule match the characteristics of “myRA” as it has been discussed by the Administration.

Participants in the program will be able to establish Roth IRAs that will be invested exclusively in the new savings bonds. The bonds will earn interest at a rate previously available only to federal employees invested in the Government Securities Investment Fund of their Thrift Savings Plan. According to the Treasury, that fund earned an average annual return of 3.39% in the period from December 2003 to 2013. Participation in the program can continue until the IRA account balance reaches $15,000 or 30 years since participation begins, whichever occurs first.

**On November 10, 2014,** the IRS issued additional guidance on application of the one-per-year limit on tax-free rollovers between IRAs. A distribution from an IRA received in 2014 and rolled over within 60 days to another IRA will have no impact on rollovers and distributions involving other IRAs in 2015. Owners of multiple IRAs will have a “fresh start” in 2015 for purposes of the one-per-year limit on tax-free IRA rollovers. The IRS reminds taxpayers that the one-per-year limit does not apply to a rollover from (or to) a qualified plan or to trustee-to-trustee transfers. Roth IRA conversions (traditional IRAs rolled over to Roth IRAs) are also not subject to the limit.

**On July 11, 2014,** the IRS withdrew a portion of a notice of proposed rulemaking related to rollovers from IRAs, in response to a U.S. Tax Court ruling (**Bobrow v. Commissioner**). The **Bobrow** ruling held that an individual could not make an IRA-to-IRA rollover if such a rollover had been made in the preceding one-year period. Following the decision, the IRS issued Announcement 2014-15 in March 2014, which limits IRA owners to one 60-day rollover per year. According to the IRS, the partial withdrawal of the proposed regulation affects individuals who maintain IRAs and financial institutions that are trustees, custodians, or issuers of IRAs.

**On March 20, 2014,** the IRS issued Announcement 2014-15. The announcement addresses the application to IRAs and individual retirement annuities of the one-rollover-per-year limitation of Section 408(d)(3)(B) of the Code and provides transition relief for owners of IRAs. In the announcement, the IRS stated it intended to withdraw proposed regulations and revise Publication 590 to clarify that rules limiting
individual account rollovers to one-per-year apply on an aggregate basis. The guidance was based on
Bobrow v. Commissioner (see above). The one-rollover-per-year limitation under tax Code Section
408(d)(3)(B) applies to all of a taxpayer's retirement accounts, regardless of how many accounts he or
she maintains, the Tax Court said. According to the IRS, the actions being taken by the agency will not
affect the ability of an IRA owner to transfer funds from one IRA trustee directly to another, because such
a transfer is not a rollover and, therefore, is not subject to the one-rollover-per-year limitation of Section
408(d)(3)(B).

Mass Submitter and Pre-Approved Plans

On December 5, 2014, the IRS released Announcement 2014-41, which extends to June 30, 2015, the
deadline for submitting on-cycle applications for opinion and advisory letters for pre-approved defined
benefit plans for the plans’ second six-year remedial amendment cycle. This announcement also provides
a two-day extension (from Saturday, January 31, 2015 to Monday, February 2, 2015) for Cycle D on-cycle
submissions (primarily individually designed plans, including multiemployer plans).

On March 27, 2014, the IRS released Announcement 2014-16. The Announcement informs employers
that beginning May 1, 2014 and ending April 30, 2016, the IRS will accept applications for individual
determination letters from employers under the second six-year remedial amendment cycle for defined
contribution pre-approved plans. According to the agency, opinion and advisory letters for pre-approved
(i.e., master and prototype and volume submitter) defined contribution plans that were restated for
changes in plan qualification requirements listed in Notice 2010-90, 2010-52 I.R.B. 909 (2010 Cumulative
List), and that were filed with the IRS for their second submission period under the remedial amendment
cycle under Revenue Procedure 2007-44, 2007-2 C.B. 54, will be issued soon. Employers using these
pre-approved plan documents to restate a plan for the plan qualification requirements in the 2010
Cumulative List will be required to adopt the plan document by April 30, 2016.

On March 25, 2014, the IRS issued Revenue Procedure 2014-28. This revenue procedure modifies
Revenue Procedure 2013-22, which sets forth the procedures of the IRS for issuing opinion and advisory
letters for Section 403(b) pre-approved plans (i.e., Section 403(b) prototype plans and Section 403(b)
volume submitter plans). Under the program established by Revenue Procedure 2013-22, as modified by
this latest guidance, the deadline to submit applications for Section 403(b) preapproved plan opinion and
advisory letters is now extended through April 30, 2015. According to the IRS, Revenue Procedure
2014-28 also makes certain modifications to the program that will allow more plan sponsors and eligible
employers to participate in the Section 403(b) pre-approved plan program.

On January 23, 2014, the IRS issued guidance (Announcement 2014-4) that extends to February 2,
2015 (from January 31, 2014) the deadline to submit on-cycle applications for opinion and advisory letters
for pre-approved defined benefit plans for the plans’ second six-year remedial amendment cycle.
According to the IRS, the extension applies to defined benefit mass submitter lead and specimen plans,
word-for-word identical plans, master and prototype minor modifier placeholder applications, and
non-mass submitter defined benefit plans. The extension was in response to “recent requests from the
employee benefits community that the IRS develop a pre-approved plan program for defined benefit plans
with cash balance features, as referenced in Section 411(a)(13)(C) of the Code, that would be available
for the second six-year remedial amendment cycle.” The IRS previously extended the application
Missing Participants

On August 14, 2014, the DOL issued a Field Assistance Bulletin that discussed missing participants. In most cases, according to the guidance, the best approach for handling the account of a missing participant in a terminated defined contribution plan after an appropriate search for the participant has failed is to roll over the account into an individual retirement plan (an IRA or annuity) using the regulatory safe harbor for distributions from terminated plans. Field Assistance Bulletin No. 2014-01 provides detailed guidance on fiduciary responsibilities with regard to missing defined contribution plan participants, including required search steps (e.g., using certified mail and free electronic search tools), rollovers, and alternative distribution options if the plan fiduciary is unable to find an individual retirement plan provider to accept a rollover distribution. The DOL noted that some fiduciaries have concluded that it would be acceptable to use 100% income tax withholding for missing participants, thus effectively transferring the account balances to the IRS. In its view, this option would violate ERISA.

The DOL also noted that the USA PATRIOT Act’s customer identification and verification provisions are causing some fiduciaries to hesitate in setting up individual retirement plans or bank accounts for missing participants. Compliance with those provisions, the DOL explained, will not be required at the time an employee benefit plan establishes an account for a missing participant and transfers the funds. The PBGC has begun the process of formulating regulations on how it will include distributions from terminated defined contribution plans in its existing missing participants program for defined benefit plans in the future. When those regulations have been finalized, the DOL will reevaluate its current guidance.

Premium Payments

On May 9, 2014, the IRS released final regulations clarifying the rules regarding the tax treatment of payments by qualified retirement plans for accident or health insurance. The final regulations set forth the general rule under Code Section 402(a) that amounts held in a qualified plan that are used to pay accident or health insurance premiums are taxable distributions unless described in certain statutory exceptions. The final regulations do not extend this result to arrangements under which amounts are used to pay premiums for disability insurance that replace retirement plan contributions in the event of a participant’s disability. These regulations affect sponsors, administrators, participants, and beneficiaries of qualified retirement plans. The regulations apply for years beginning on or after January 1, 2015. However, taxpayers may elect to apply the regulations to earlier taxable years.

Qualification and Determination Letter Processing

On December 19, 2014, the IRS released Announcement 2015-01, which describes changes to the processing of employee plans determination letters that will take effect in 2015. According to the IRS, these changes are being adopted as a result of a process improvement strategy designed to promote case processing efficiency. The changes to the determination letter procedures described in the Announcement will be reflected in Revenue Procedure 2015-6, which will be published in the IRB 2015-01 and become effective on February 1, 2015. Revenue Procedure 2015-6 will set forth the IRS’s procedures for issuing determination letters on the qualified status of employee plans.

The IRS stated that when the agency receives determination letter applications, it will check applications for completeness. If the application is incomplete, the IRS will contact the applicant in writing to request more information. Applicants will have 30 days from the date of the letter to respond, or the IRS will move to close the case.
On December 5, 2014, the IRS released Notice 2014-77. The Notice contains the 2014 Cumulative List of Changes in Plan Qualification Requirements (2014 Cumulative List) described in Section 4 of Revenue Procedure 2007-44. The 2014 Cumulative List is to be used by plan sponsors and practitioners submitting determination letter applications for plans during the period beginning February 1, 2015 and ending January 31, 2016.

Reporting and Disclosure

Also in 2014, the IRS released a Retirement Plan Reporting and Disclosure Requirements Guide. Administrators or sponsors of retirement plans are generally required by law to report certain information to the IRS, the DOL, and the PBGC and provide disclosure to affected parties depending on the plans’ type, size, and circumstances. The Retirement Plan Reporting and Disclosure Requirements Guide is meant to be used as a quick reference tool for certain basic reporting and disclosure requirements for retirement plans under the Code and provisions of ERISA administered by the IRS. This guide was prepared by the IRS and reviewed by the Treasury, DOL, and PBGC. The IRS stated that this guide should be used in conjunction with the DOL Retirement Plan Reporting and Disclosure Guide.

On August 27, 2014, the IRS posted a draft version of the 2014 Form 5500-EZ, Annual Return of One-Participant (Owners and Their Spouses) Retirement Plan. The form was identical to the 2013 version. Sponsors of defined benefit pensions, defined contribution profit-sharing plans, and money purchase plans whose benefits are limited to owners or partners and their spouses must annually file Form 5500-EZ returns.

On May 22, 2014, the IRS announced it would begin a one-year pilot program in June 2014 to help small businesses with retirement plans that owe penalties for not filing reporting documents (Revenue Procedure 2014-32). By filing current and prior year forms during this pilot program, penalties can be avoided. The IRS is reaching out to certain small businesses that maintain retirement plans and may have been unaware that they had a filing requirement. The agency projects that this program will bring a significant number of small business owners into compliance with the reporting requirements. Plan administrators and sponsors that have already been assessed a penalty for late filings are not eligible for this program. This program is open only to retirement plans generally maintained by certain small businesses, such as those in an owner-spouse arrangement or eligible partnership.

On May 9, 2014, the IRS announced the creation of a one-year pilot program (Revenue Procedure 2014-32) offering relief to plan administrators who fail to timely file a Form 5500 Series Annual Return/Report. The administrative relief provided under this Revenue Procedure applies only to plan administrators and plan sponsors of retirement plans that are subject to the reporting requirements of Sections 6047(e), 6058, and 6059 of the Code, but that are not subject to the reporting requirements of Title I of ERISA. The relief provided under Revenue Procedure 2014-32 becomes effective June 2, 2014 and remains in effect until June 2, 2015. Returns submitted after June 2, 2015 will not be entitled to the relief provided by the Revenue Procedure. The IRS stated that after the temporary pilot program ends, the agency will consider whether the pilot program should be replaced with a permanent program. The agency has determined that any permanent program that is offered will include a fee or other payment.

On March 11, 2014, EBSA released proposed regulations that contain a proposed amendment to the final regulations (issued February 2012) under ERISA requiring that certain service providers to pension plans disclose information about the service providers’ compensation and potential conflicts of interest. This amendment would require covered service providers to furnish a guide to assist plan fiduciaries in reviewing the disclosures required by the final regulations if the disclosures are contained in multiple or lengthy documents. According to EBSA, the guide must specifically identify the document, page or other
specific locator, such as section, that enables the employer to quickly and easily find fee information. This amendment will affect pension plan sponsors and fiduciaries and certain service providers to such plans.

Rollovers

See also “IRAs.”

On November 24, 2014, the PBGC released final regulations on the Title IV treatment of rollovers from defined contribution plans to defined benefit plans. In April 2014, the PBGC proposed to amend its regulations to clarify the treatment of benefits resulting from a rollover distribution from a defined contribution plan to a defined benefit plan, if the defined benefit plan was terminated and trusted by the PBGC. Under the proposal, a benefit resulting from rollover amounts generally would not be subject to the PBGC's maximum guaranteeable benefit or phase-in limitations and would be in the second-highest priority category of benefits in the allocation of assets. The PBGC finalized that proposal. Except for making minor clarifications suggested by commenters, the final regulations are the same as the proposed regulations. In the final regulations, the PBGC stated that this rulemaking was part of the agency's efforts to enhance retirement security by promoting lifetime income options. The final regulations became effective on December 26, 2014.

On April 3, 2014, the Treasury and IRS issued Revenue Ruling 2014-9, which provides simplified safe harbor due diligence procedures a plan administrator may use in order to be deemed to have reasonably concluded that an amount was a valid rollover contribution. Revenue Ruling 2014-9 provides two new streamlined safe harbor due diligence procedures that, in the absence of evidence to the contrary, will give rise to the presumption that the administrator of the receiving plan reasonably concluded that a rollover was valid. The guidance provides analysis and situational examples that employers may experience when processing rollovers of qualified plans.

The guidance is "designed to make it easier for people to roll over their retirement savings to a new employer plan when they change jobs, helping them preserve and accumulate assets for retirement." According to the IRS, the Revenue Ruling simplifies the rollover process by introducing an “easy way for a receiving plan to confirm the sending plan’s tax-qualified status. The plan administrator for the receiving plan can now simply check a recent annual report filing for the sending plan on a database that is readily available to the public online. This eliminates the need for the two plans to communicate (with the individual as go-between), expedites the rollover process, and reduces associated paperwork.”

On April 1, 2014, the PBGC released proposed regulations that would clarify the treatment of benefits resulting from a rollover distribution from a defined contribution plan or other qualified trust to a defined benefit plan, if the defined benefit plan was terminated and trusted by the PBGC. The regulations were in response to clarifications provided by the Treasury and IRS in Revenue Ruling 2012-4 (issued February 2012) regarding certain rollover qualification requirements. Under the proposed regulations, benefits earned from a rollover generally would not be affected by PBGC's maximum guarantee limits. Additionally, rollover amounts generally would remain untouched by PBGC's five-year phase-in limits. Normally, benefit increases from changes to a plan in the five years before it ends are partially guaranteed. For instance, 20% of the increase is paid after one year, 40% after two years, and so on. Under the proposed regulations, these restrictions generally would not apply.

Same-Sex Marriage (Windsor Decision)

On May 15, 2014, the IRS released Notice 2014-37, which provided that the sponsor of a Section 401(k) or 401(m) safe harbor plan may adopt a midyear plan amendment to reflect earlier guidance issued by
the IRS on the Supreme Court’s ruling in *United States v. Windsor*. Notice 2014-37 consists of only one question and answer that addresses midyear plan amendments for safe harbor plans and amplifies Q&A-8 in the IRS’s earlier Notice 2014-19, issued on April 4, 2014, on plan amendment deadlines.

**On April 4, 2014,** the Treasury and IRS released Notice 2014-19, which provided long-awaited guidance on the application (including the retroactive application) of the U.S. Supreme Court's decision in *United States v. Windsor* and Revenue Ruling 2013-17 to qualified retirement plans. The June 2013 Windsor ruling struck down Section 3 of the federal DOMA, which defined marriage as the union of one man and one woman for purposes of federal law. Revenue Ruling 2013-17, released September 2013, states that qualified retirement plans must treat all legally married same-sex couples as spouses effective as of September 16, 2013.

Notice 2014-19 provided that a plan must be amended to comply with Windsor and Revenue Ruling 2013-17 if the plan's terms are inconsistent with either. If a plan defines "spouse" by reference to Section 3 of DOMA or only as a person of the opposite sex, for instance, it must be amended. The deadline for amendments was the later of December 31, 2014, or the applicable date under Revenue Procedure 2007-44 (the IRS’s general amendment guidance for qualified plans). For periods of time prior to Windsor, plan sponsors may, but are not required to, reflect the case ruling. Also, if a plan recognized same-sex spouses before September 16, 2013 only if the plan participant was domiciled in a state that recognized same-sex marriages, it will not be treated as failing to comply with qualification requirements for that reason. On the same day, the IRS also updated FAQs on same-sex marriage for retirement plans that provide additional guidance on both Revenue Ruling 2013-17 and Notice 2014-19.
Other HR-Related Topics

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

- EEOC Guidance;
- Federal Contractors;
- Family and Medical Leave Act;
- Immigration: E-Verify and I-9 Form;
- IRS Business-Related Guidance, Fringe Benefits, Taxation, and Tables;
- Priority Guidance Plans;
- Social Security;
- Stock Options and Appreciation Rights;
- Veterans; and
- Wage.

EEOC Guidance

On July 14, 2014, the Equal Employment Opportunity Commission (EEOC) issued enforcement guidance on pregnancy discrimination and related issues. The document provided guidance regarding the Pregnancy Discrimination Act (PDA) and the Americans with Disabilities Act (ADA) as they apply to pregnant workers. According to the EEOC, the enforcement guidance updates prior guidance on this subject in light of legal developments over the past thirty years. The guidance includes discussions of:

- When employer actions may constitute unlawful discrimination on the basis of pregnancy, childbirth, or related medical conditions in violation of Title VII of the Civil Rights Act of 1964, as amended by the PDA;
- The obligation of employers under the PDA to provide pregnant workers equal access to benefits of employment such as leave, light duty, and health benefits; and
- How Title I of the ADA, which went into effect over a decade after the PDA and was amended in 2008 to broaden the definition of disability, applies to individuals with pregnancy-related impairments.

On March 10, 2014, the EEOC and the Federal Trade Commission (FTC) published two technical assistance documents that detail how federal laws enforced by the agencies apply to employment background checks. The first document, “Background Checks: What Employers Need to Know,” reminded employers that when performing background checks, they must comply with federal laws that protect applicants and employees from discrimination, all of which are enforced by the EEOC. Additionally, employers must also comply with the Fair Credit Reporting Act, enforced by the FTC. The employer document details what to do before obtaining background information, as well as using and disposing of such information. The summary also provided a number of links to various EEOC and FTC technical resources and related information.

In the second document, “Background Checks: What Job Applicants and Employees Should Know,” the agencies provided information about an individual’s rights under federal law when an employer or prospective employer performs a background check. This summary also provided links to previous EEOC and FTC resources.
In related news, during the week of March 6, 2014, the EEOC also posted technical assistance publications (a fact sheet and question-and-answer document) addressing workplace rights and religious dress and grooming under the Civil Rights Act.

**Federal Contractors**

**On December 3, 2014,** the DOL’s Office of Federal Contract Compliance Programs (OFCCP) released final regulations that prohibit federal contractors and subcontractors from discriminating on the basis of sexual orientation and gender identity. The final regulations implement Executive Order 13672, which was signed by President Obama on July 21, 2014. (That Executive Order amended Executive Order 11246 and directed the Secretary of Labor to prepare regulations implementing the new protections.)

**On October 1, 2014,** the DOL issued final regulations to implement Executive Order 13658, Establishing a Minimum Wage for Contractors, which was signed by President Obama in February 2014. The Executive Order seeks to raise the hourly minimum wage paid by those contractors to workers performing work on covered federal contracts to: $10.10 per hour, beginning January 1, 2015; and beginning January 1, 2016, and annually thereafter, an amount determined by the Secretary of Labor. The Executive Order directed the Secretary to issue regulations by October 1, 2014, to the extent permitted by law and consistent with the requirements of the Federal Property and Administrative Services Act, to implement the Order’s requirements. These final regulations establish standards and procedures for implementing and enforcing the minimum wage protections of Executive Order 13658. As required by the Order, the final regulations incorporate to the extent practicable existing definitions, procedures, remedies, and enforcement processes under the FLSA, the Service Contract Act, and the Davis-Bacon Act. The final regulations became effective on December 8, 2014.

**On September 24, 2014,** the DOL’s Veterans’ Employment and Training Service (VETS) issued final regulations on the annual reporting requirements for certain federal contractors and subcontractors with respect to the hiring and employment of veterans. The final regulations create a new form, the “Federal Contractor Veterans’ Employment Report VETS-4212,” and apply to VETS-4212 forms filed in 2015. Among other changes, contractors will be able to aggregate some of the information on hired and employed veterans, and the regulations eliminate obsolete reporting rules applicable to contracts entered into before December 1, 2003.

*See the Aon Hewitt bulletin titled “DOL Issues Final Regulations on Veterans Reporting” (October 2014) under “2014 Developments: A Closer Look.”*

**On September 15, 2014,** the OFCCP announced a proposed rule that would prohibit federal contractors from maintaining pay secrecy policies. Under the terms of the proposal, federal contractors and subcontractors may not fire or otherwise discriminate against any employee or applicant for discussing, disclosing, or inquiring about their compensation or that of another employee or applicant.

President Obama signed Executive Order 13665 on April 8, 2014, instructing the Secretary of Labor to propose a rule within 160 days to require pay transparency among federal contractors. The proposed rule would amend the equal opportunity clauses in Executive Order 11246 to afford protections to workers who talk about pay. It would also add definitions for compensation, compensation information, and essential job functions, terms which appear in the revised clauses. The proposal would also establish two types of defenses that contractors can use against allegations of discrimination under Executive Order 13665.
On August 19, 2014, the OFCCP posted Directive 2014-02 on Gender Identity and Sex Discrimination. The Directive “reaffirms that in compliance evaluations and complaint investigations, OFCCP fully investigates and seeks to remedy instances of sex discrimination that occur because of individuals’ gender identity or transgender status.” Directive 2014-02 follows the July 2014 issuance of President Obama’s Executive Order 13672, which prohibits federal contractors from discriminating on the basis of sexual orientation or gender identity. The President’s Executive Order amended two existing orders by including sexual orientation and gender identity in the list of classes protected from employment discrimination under Executive Order 11246, covering federal contractors, and amending Executive Order 11478 to explicitly prohibit gender identity discrimination by federal government agencies.

The purpose of the OFCCP directive was to clarify that existing agency guidance on discrimination on the basis of sex under Executive Order 11246 includes discrimination on the basis of gender identity and transgender status. The OFCCP directive did not address gender identity or sexual orientation as “stand-alone” protected categories which were created under the President’s Executive Order.

On August 6, 2014, the DOL issued proposed regulations that would require federal contractors and subcontractors to submit an annual Equal Pay Report on employee compensation to the OFCCP. The new requirement would apply to employers that:

- File Employer Information Reports (EEO-1 Reports);
- Have more than 100 employees; and
- Hold federal contracts or subcontracts worth $50,000 or more for at least 30 days.

The summary compensation data collected would include compensation paid to employees by sex, race, ethnicity, and specified job categories, as well as other relevant data points, such as hours worked and the number of employees. The additional information would supplement contractors’ EEO-1 Reports.

The DOL proposed the regulations in response to the Executive Order issued by President Obama on April 8, 2014 that directed the Secretary of Labor to establish new regulations requiring federal contractors to provide this data.

On June 13, 2014, the DOL’s Wage and Hour Division (WHD) released proposed regulations implementing Executive Order 13658, Establishing a Minimum Wage for Contractors, which was signed by President Obama in February 2014. The Executive Order seeks to increase efficiency and cost savings in the work performed by parties that contract with the federal government by raising the hourly minimum wage paid by those contractors to workers performing on covered federal contracts to: $10.10 per hour, beginning January 1, 2015; and beginning January 1, 2016, and annually thereafter, an amount determined by the Secretary of Labor. The Executive Order directs the Secretary to issue regulations by October 1, 2014, to the extent permitted by law and consistent with the requirements of the Federal Property and Administrative Services Act to implement the Order’s requirements. The proposed regulations would establish standards and procedures for implementing and enforcing the minimum wage protections of Executive Order 13658. The proposed regulations would incorporate existing definitions, procedures, remedies, and enforcement processes under the FLSA, the Service Contract Act, and the Davis-Bacon Act.

On March 13, 2014, the OFCCP launched a new database to help contractors find qualified workers with disabilities and veterans and to assist contractors with establishing relationships with national organizations and local community groups that have access to these workers. The latest resource supplements the agency’s existing Employment Resources Referral Directory.
Family and Medical Leave Act

On June 20, 2014, the WHD released proposed regulations revising the definition of spouse under the Family and Medical Leave Act (FMLA). The regulations are in response to the United States Supreme Court's decision in United States v. Windsor, which found Section 3 of the federal DOMA to be unconstitutional. According to the WHD:

- The DOL proposed to move from a “state of residence” rule to a rule based on where the marriage was entered into (sometimes referred to as “place of celebration”).
- The proposed definition of spouse expressly referenced the inclusion of same-sex marriages in addition to common law marriages and would encompass same-sex marriages entered into abroad that could have been entered into in at least one state.
- The DOL proposed to define spouse as “Spouse, as defined in the statute, means a husband or wife. For purposes of this definition, husband or wife would refer to the other person with whom an individual entered into marriage as defined or recognized under state law for purposes of marriage in the state in which the marriage was entered into or, in the case of a marriage entered into outside of any state, if the marriage is valid in the place where entered into and could have been entered into in at least one state. This definition would include an individual in a same-sex or common law marriage that either (1) was entered into in a state that recognizes such marriages or, (2) if entered into outside of any state, is valid in the place where entered into and could have been entered into in at least one state.”

Immigration: E-Verify and I-9 Form

On October 6, 2014, the United States Citizenship and Immigration Services (USCIS) announced the launch of myE-Verify, a new website for employees. MyE-Verify allows employees to create and maintain secure personal accounts and access identification features. The program provides employees with a free and secure way to participate in the E-Verify process by accessing features dedicated for employees, including Self Check, Self Lock, and the Employee Rights Toolkit. For added security, individuals will have their identities verified through Self Check, in order to create a myE-Verify account. The myE-Verify accounts and Self Lock will initially be accessible to individuals in five states (Arizona, Colorado, Idaho, Mississippi, and Virginia) as well as the District of Columbia. In future releases, USCIS will roll out myE-Verify across the country with plans for additional features focused on employees and job seekers.

On October 3, 2014, the USCIS announced that effective January 1, 2015, E-Verify transaction records more than 10 years old will be deleted from its system. Employers will no longer have access in E-Verify to cases created prior to December 31, 2004. E-Verify is taking this action to comply with the National Archives and Records Administration’s retention and disposal schedule.

E-Verify created a Historic Records Report, which included all transaction records for cases more than 10 years old. However, the report was only available until December 31, 2014. As it is best practice to record the E-Verify case verification number on any related Form I-9, USCIS is encouraging employers to retain the Historic Records Report with Form 1-9.

IRS Business-Related Guidance, Fringe Benefits, Taxation, and Tables

On December 10, 2014, the IRS issued Notice 2014-79. The Notice includes the 2015 optional standard mileage rates used to calculate the deductible costs of operating an automobile for business, charitable,
Beginning on January 1, 2015, the standard mileage rates for the use of a car, van, pickup, or panel truck will be:

- 57.5 cents per mile for business miles driven, up from 56 cents in 2014;
- 23 cents per mile driven for medical or moving purposes, down half a cent from 2014; and
- 14 cents per mile driven in service of charitable organizations.

The Notice also includes the basis reduction amounts for those choosing the business standard mileage rate, as well as the maximum standard automobile cost that may be used in computing an allowance under a fixed and variable rate plan.

On November 21, 2014, the IRS released Revenue Ruling 2014-32. Revenue Ruling 2014-32 updates previous IRS guidance (Revenue Ruling 2006-57) on the use of smartcards, debit or credit cards, or other electronic media to provide qualified transportation fringe benefits to employees. The Revenue Ruling also provides guidance on the use by employees of debit cards for paying mandatory shipping fees on transit passes. Finally, the Revenue Ruling provides that after December 31, 2015, employers may no longer provide qualified transit fringe benefits under a bona fide cash reimbursement arrangement in cases in which a terminal-restricted debit card is the only readily available transit pass in the employer’s geographic area.

On October 30, 2014, the IRS released Revenue Procedure 2014-61, which provides annual inflation adjustments for more than 40 tax provisions, including the tax rate schedules, and other tax changes. Included in Revenue Procedure 2014-61 is the updated guidance for 2015 on the maximum contribution levels for a number of employee fringe benefits adjusted for cost-of-living expenses. These updated amounts include the following:

- Adoption Assistance—For taxable years beginning in 2015, the credit allowed for an adoption of a child with special needs is $13,400. For taxable years beginning in 2015, the maximum credit allowed for other adoptions is the amount of qualified adoption expenses up to $13,400. The available adoption credit begins to phase out for taxpayers with modified adjusted gross income in excess of $201,010 and is completely phased out for taxpayers with modified adjusted gross income of $241,010 or more. (Section 3.19 of Revenue Procedure 2014-61 details adjusted items relating to adoption assistance programs.)

- Health FSA Annual Dollar Limit—The annual dollar limit on employee contributions to employer-sponsored health care FSAs increases to $2,550, up from $2,500.

- Personal Exemption and Standard Deductions on Individual Income Taxes—The personal exemption for 2015 rises to $4,000, up from the 2014 exemption of $3,950. However, the exemption is subject to a phase-out that begins with adjusted gross incomes of $258,250 ($309,900 for married couples filing jointly). It phases out completely at $380,750 ($432,400 for married couples filing jointly).

- Qualified Transportation Expenses Under Code Section 132(f)—The monthly limit on the qualified transportation benefits exclusion for qualified parking provided by an employer to its employees is $250 for 2015. The monthly limit on the qualified transportation benefits exclusion for transportation in a commuter highway vehicle and transit pass provided by an employer to its employees is $130.

On October 29, 2014, the IRS released guidance (Notice 2014-68) on the treatment of leave-based donation programs to aid victims of the Ebola disease outbreak for income and employment tax purposes. Under the leave-based donation guidance, employees may donate their vacation, sick, or personal leave in exchange for employer cash payments made to qualified tax-exempt organizations providing relief for the victims of the Ebola outbreak in Guinea, Liberia, or Sierra Leone. Employees can forgo leave in exchange for employer cash payments made before January 1, 2016. Under this special
relief, the donated leave will not be included in the income or wages of the employees. Employers will be permitted to deduct the amount of the cash payment.

On September 19, 2014, the Treasury and IRS announced the special per diem rates effective October 1, 2014, which taxpayers may use to substantiate the amount of expenses for lodging, meals, and incidental expenses. This annual Notice provides the 2014-2015 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. Use of a per diem substantiation method is not mandatory and a taxpayer may substantiate actual allowable expenses if the taxpayer maintains adequate records or other sufficient evidence for proper substantiation.

On July 15, 2014, the IRS published final regulations regarding IRS truncated taxpayer identification numbers (TTINs). When not prohibited by the Code or other guidance, the regulations allow the use of a TTIN in place of a taxpayer’s social security number (SSN), IRS individual taxpayer identification number (ITIN), IRS adoption taxpayer identification number (ATIN), or employer identification number (EIN) on payee statements and certain other documents. The TTIN displays only the last four digits of a taxpayer identifying number; with either asterisks (*) or “X’s” replacing the first five digits of the identifying number. The regulations affect individuals that furnish or receive payee statements and other documents that Code, regulations, or other published guidance requires to be furnished to another person to the extent that a TTIN may appear in lieu of the SSN, ITIN, ATIN, or EIN of the payee or document recipient. The regulations became effective on July 15, 2014. For dates of applicability, please refer to the specifics found in the final regulations.

On March 21, 2014, the IRS released Notice 2014-11, which provides the maximum vehicle values for 2014 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. The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2014 for which the vehicle cents-per-mile valuation rule may be applicable is $16,000 for a passenger automobile and $17,300 for a truck or van. The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2014 for which the fleet-average valuation rule may be applicable is $21,300 for a passenger automobile and $22,600 for a truck or van. This Notice applies to employer-provided passenger automobiles first made available to employees for personal use in calendar year 2014.

Priority Guidance Plans

On November 7, 2014, the Treasury and IRS released the first quarter update to the 2014–2015 Priority Guidance Plan. The 2014–2015 Priority Guidance Plan contains 317 projects that are priorities for allocation of the resources of their offices during the 12-month period from July 2014 through June 2015 (the plan year). The plan represents projects the Treasury and IRS intend to actively work on during the plan year and does not place any deadlines on completion of projects. Projects on the 2014–2015 plan provide guidance on a variety of issues important to individuals and businesses, including international taxation, health care, retirement, and implementation of legislative changes.

In addition to the items on the 2014–2015 plan, the Appendix lists the more routine guidance that is generally published each year. This first quarter update to the 2014-2015 plan reflects five additional projects that have become priorities and guidance that has been published during the period from August 1, 2014 through September 30, 2014.
Social Security

On July 28, 2014, the Social Security and Medicare Boards of Trustees issued their annual financial review of programs (2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds). According to the report, Social Security's retirement and disability programs have dedicated resources sufficient to cover benefits for the next 19 years, until 2033. The projected depletion date for the separate Social Security's Disability Insurance Trust Fund is 2016. The Medicare Hospital Insurance Trust Fund (Part A) will have sufficient funds to cover its obligations until 2030, four years later than was projected in 2013, and 13 years later than was projected in the last report issued prior to passage of the Affordable Care Act.

Stock Options and Appreciation Rights

On June 20, 2014, the IRS ruled that nonstatutory stock options and stock-settled appreciation rights were not subject to taxation as nonqualified deferred compensation plans under Code Section 457A where the service recipient was a foreign corporation and the options and stock appreciation rights were granted to a service provider that was a limited liability company treated as a partnership for U.S. income tax purposes. In Revenue Ruling 2014-18, the IRS determined that each stock right was either a nonstatutory stock option meeting the requirements of IRS 409A regulations or a stock appreciation right meeting the requirements of 409A regulations and was at all times by its terms settled, and is settled, in service recipient stock. Accordingly, the stock rights were exempt from Code Section 457A.

Veterans

On April 24, 2014, the Obama Administration announced the launch of the Veterans Employment Center, an integrated, online tool connecting veterans and transitioning service members and their spouses with both public and private-sector employers. The online resource includes public and private job opportunities, a resume-builder, military skills translator, and other career and training information. With this tool, “employers will be able to search and view veteran, service members, and spouse resumes in one comprehensive location.”

Wage

On October 7, 2014, the WHD announced in a policy statement that it will not enforce the FLSA wage requirements for home care workers under final regulations issued in 2013 for a period of six months. The regulations extend the FLSA’s 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. They are still effective as of January 1, 2015, but enforcement will not be pursued from January 1, 2015 to June 30, 2015. For the six months after that (July 1, 2015 to December 31, 2015), the DOL will “exercise prosecutorial discretion in determining whether to bring enforcement actions.”
2014 Developments: A Closer Look

The following Aon Hewitt bulletins provide in-depth analysis and insights for many of the legislative and regulatory developments in 2014.

Annual Aon Hewitt Publications

_Aon Hewitt’s 2015 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 2015 Limits for Benefit Plans is available [here](#).

Aon Hewitt Publications on Federal Developments

January 2014

_Into the Woods—Latest Round of FAQs Addresses Details of Cost Sharing, Wellness, Preventive Services, and Transitional Reinsurance Fee_

The FAQs issued on December 19, 2013 and January 9, 2014 by the Departments addressed employer implementation issues under the Affordable Care Act, including:

- The annual limit on OOP costs;
- Wellness programs;
- Preventive care;
- Expatriate health plans;
- Fixed-indemnity insurance; and
- The transitional reinsurance fee.

The Aon Hewitt bulletin on the FAQs is available [here](#).

_Medicare Part D Disclosure Reminder_

This Aon Hewitt bulletin is a reminder of an annual disclosure requirement applicable to most employers that provide prescription drug coverage to individuals who are Medicare 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. The annual disclosure must occur for any employer that provides prescription drug coverage to anyone who is Medicare Part D-eligible.

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 in this bulletin, 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.

This Aon Hewitt bulletin discusses:
How to complete the notification;
Who must complete the notification;
The deadline for completing the notification; and
The content of the disclosure notification.

The Aon Hewitt bulletin on the Medicare Part D disclosure reminder is available [here](#).

**Yes, Employers, There Is an Escape Clause!—Christmas Eve Guidance Exempts Some EAPs and Limited Scope Dental and Vision Plans From HIPAA and Affordable Care Act**

On December 24, 2013, the Departments brought good cheer to employers—proposed regulations that would exempt certain plans from parts of HIPAA and the Affordable Care Act by expanding the definition of "limited excepted benefits" to include:

- EAPs that do not provide significant benefits in the nature of medical care;
- Self-insured limited scope dental and vision benefits, regardless of whether participants pay a separate contribution; and
- "Wraparound" employer-provided secondary medical coverage for individuals who purchase coverage in the public Exchanges because the employer's primary medical coverage is unaffordable for them.

Under the proposed regulations, EAPs, limited scope dental and vision plans, and wraparound coverage that meet the requirements would be exempt from certain requirements under HIPAA and the Affordable Care Act.

This Aon Hewitt bulletin provides an overview of the proposed regulations and is available [here](#).

**February 2014**

**IRS Eases Employers Into Employer Mandate**

The Treasury and IRS released final regulations on the employer mandate under the Affordable Care Act, giving small employers another year of transition relief and making it slightly easier for large employers to comply in 2015. The final regulations were released on February 10, 2014.

This Aon Hewitt bulletin provides an overview of the final regulations and their potential impact on employer-provided health coverage under the Affordable Care Act. Highlights include:

- Employers with at least 50 but less than 100 FTEs are not required to comply with the employer mandate until 2016.
- Employers that employ 100 or more FTEs must comply with the employer mandate beginning in 2015 or risk a penalty. For 2015 only, a large employer that offers minimum essential coverage (MEC) to at least 70% of its FTEs and their eligible non-spouse dependents will not be subject to the “Failure to Offer” penalty, but could still be liable for the “Targeted” penalty if the coverage is not affordable or does not provide minimum value.
- An overview of the rules for determining who is an FTE, including the permissible methods for counting hours and nuances for various categories of employees.
- Additional transition rules for 2015.

This Aon Hewitt bulletin is available [here](#).
Retirement Savings Proposals—Summary of Key Provisions
Three different proposals emerged from Washington D.C. in 2014, each seeking to improve access to retirement plan savings vehicles. Each of these proposals was primarily targeted at employees of small employers who do not currently sponsor defined benefit or defined contribution retirement plans. This Aon Hewitt bulletin provides a high-level summary of the following three proposals:

- myRA (Announced by President Obama in the January 28 State of the Union Address);
- The Retirement Security Act of 2014 (RSA-2014) (Introduced by Sens. Collins (R-ME) and Nelson (D-FL) on January 29); and
- The Universal, Secure, and Adaptable Retirement Funds (USARF) Act (Introduced by Sen. Harkin (D-IA) on January 30).

A comparison chart is also included in this bulletin.

This Aon Hewitt bulletin is available [here](#).

The Wait Is Over—Government Issues Final Regulations on 90-Day Waiting Period
Under the Affordable Care Act, 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 after December 31, 2013. The three Departments charged with administering the Affordable Care Act—Treasury, DOL, and HHS—published final regulations implementing the 90-day waiting period on February 24, 2014.

The final regulations contain rules that provide guidance on the employer mandate penalty, permit the use of an orientation period for FTEs before the waiting period commences, and provide for the phase-out of HIPAA certificates of creditable coverage. This Aon Hewitt bulletin, which describes the changes made in the final regulations as well as the impact of the final and proposed regulations on employer group health plans, is available [here](#).

April 2014

Final Guidance on Transitional Reinsurance Fees for 2014 and Fee Set for 2015
With relatively few changes, HHS finalized regulations on the transitional reinsurance fees that group health plans must pay beginning in 2014. The final regulations, released on March 5, 2014:

- 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
- Set the 2015 maximum cost-sharing amounts.

The Aon Hewitt bulletin is available [here](#).
In Perfect Harmony—IRS Clarifies Health FSA Carryover Impact on Eligibility to Contribute to an HSA
The IRS has issued guidance clarifying the impact of the allowable health FSA carryover on an individual’s eligibility to contribute to an HSA. The guidance took the form of a Chief Counsel’s Memorandum issued on March 28, 2014.

This Aon Hewitt bulletin provides background information and an overview of the guidance and is available here.

IRS Issues 2015 HSA Limits
On April 23, 2014, the IRS issued inflation-adjusted limits for contributions to an HSA for calendar year 2015 (Revenue Procedure 2014-30). In addition, the IRS provided revised minimum deductible amounts and MOOP limits. The attached chart, which provides the limits for calendar years 2013 through 2015, is available here.

Treasury and IRS Issue Final Regulations for Reporting Compliance With Affordable Care Act Mandates
The Treasury and the IRS issued final regulations on March 10, 2014 for employers and insurers to report compliance with two of the Affordable Care Act’s most significant provisions—the employer shared responsibility rules (the employer mandate) and the requirement that all Americans either carry health insurance or pay a tax (the individual mandate). This Aon Hewitt bulletin discusses the application of the reporting rules to employers and group health plans.

The Aon Hewitt bulletin is available here.

May 2014
Checking Your Health Plan’s ID: The Deadline for Employers to Obtain a Health Plan Identifier Is Just Six Months Away
Group health plans, including self-insured employer-provided group health plans, must obtain a unique HPID by November 5, 2014. This Aon Hewitt bulletin discusses the requirements regarding HPIDs and the procedure for obtaining an HPID.

The Aon Hewitt bulletin is available here.

June 2014
It’s Time for Spring Cleaning: Agencies Provide Needed Cleanup on COBRA, CHIP, Health FSA Rollovers, and Group Market Reforms
The Departments completed some Affordable Care Act “housekeeping” as follows:

- Updated model notices under COBRA and the CHIP Reauthorization Act to better coordinate with the availability of coverage under the Health Insurance Marketplace (the government Exchange);
- Clarified special enrollment periods to enroll in an Exchange, including a special enrollment into the federally facilitated Exchange for existing COBRA eligibles/enrollees until July 1, 2014; and
- Issued FAQs that address cost-sharing limits, preventive services, health FSAs, and SBCs.

This Aon Hewitt bulletin provides an overview of the releases and is available here.
July 2014

**Agencies Issue Final Affordable Care Act Regulations on Orientation Period**
The Departments issued final regulations regarding the definition of an “orientation period” for purposes of implementing the Affordable Care Act’s rule prohibiting a group health plan from imposing a waiting period that exceeds 90 days before an otherwise eligible individual may enroll. The final regulations, which are effective for plan years beginning after 2014, also prescribe the conditions under which a plan may consider an employee’s orientation period as part of its eligibility rules rather than the waiting period.

The Affordable Care Act prohibits grandfathered and non-grandfathered group health plans and insurance issuers from imposing a waiting period that exceeds 90 days before an individual otherwise eligible for health coverage may enroll in the plan, but permits a “bona fide orientation period” before the 90-day waiting period begins.

This bulletin highlights the key conditions that orientation periods must satisfy under the final regulations, in addition to explaining when an offer of coverage must be made in order to avoid an employer shared responsibility penalty.

The Aon Hewitt bulletin is available [here](#).

**Dueling Rulings—Federal Appeals Courts Disagree on Legality of Subsidies in Federal Exchanges**
On July 22, 2014, within the space of a few hours, two federal courts of appeals issued conflicting rulings on the legality of subsidies used to purchase health insurance in the federal health Exchange, setting up a battle at the U.S. Supreme Court in 2015 over the issue.

The Aon Hewitt bulletin, which provides a brief overview of the court rulings, is available [here](#).

**Maybe They’re in the Box?—IRS Issues Draft Reporting Forms (But Not the Instructions) for Individual and Employer Mandates Under Affordable Care Act**
The IRS issued draft forms for employers to use to report compliance with the employer mandate to offer health care coverage to FTEs under the Affordable Care Act, as well as the individual mandate to purchase health care coverage.

Reporting is required in early 2016 with respect to the 2015 calendar year. Both mandates carry penalties for non-compliance. The Affordable Care Act requires employers and group health plans to file under two sections of the Code to establish compliance with the employer mandate and the individual mandate.

The Aon Hewitt bulletin, which discusses the draft reporting forms, is available [here](#).

September 2014

**IRS Issues New Affordable Care Act Guidance for Cafeteria Plans, PCORI Fees, and FTE Status**
On September 18, 2014, the IRS issued guidance for employers regarding several aspects of the Affordable Care Act, from status changes under cafeteria plans to calculating the PCORI fee to determining FTEs under the employer mandate.

This Aon Hewitt bulletin, which provides a brief overview of the guidance, is available [here](#).
October 2014

2014 “To Do” List for Employers to Avoid Penalties—and Worse—in 2015
Even after four years of employer implementation of the Affordable Care Act, the biggest and most challenging compliance items—the employer mandate, employer reporting, and the high-cost excise tax—are still to come. To navigate what will be the biggest compliance year of the Affordable Care Act, Aon Hewitt has prepared a 2014 “To Do” list to help employers prepare for 2015.

The Aon Hewitt bulletin is available here.

Better Late Than Never—CMS Issues HPID Guidance for November 5th Deadline
With just over five weeks to go until the November 5, 2014, deadline for most group health plans to obtain a unique HPID, CMS published a list of FAQs providing guidance to sponsors of group health plans.

The following Aon Hewitt bulletin provides highlights of the guidance and is available here.

DOL Issues Final Regulations on Veterans Reporting
On September 25, 2014, VETS published final regulations that revise the reporting obligations of federal contractors and subcontractors under the Vietnam Era Veterans’ Readjustment Assistance Act. The new obligations apply beginning with 2015 annual reporting.

This Aon Hewitt bulletin, which includes information regarding the new VETS-4212 Report and the rescission of the VETS-100 Report, is available here.

Final Regulations Exempt Some EAPs, Dental Plans, and Vision Plans From Affordable Care Act and HIPAA
Employers can add certain EAPs, dental plans, and vision plans to the list of excepted benefits that are exempt from requirements of HIPAA and the Affordable Care Act, according to guidance released by the Departments. The final regulations, which were issued September 26, 2014, are applicable to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

The Aon Hewitt bulletin, which provides an overview of the final regulations, is available here.

One HPID to a Customer—CMS Okays One HPID for an ERISA “Wrap” Plan
With days to go until the November 5, 2014 deadline for a group health plan to obtain an HPID, CMS announced on October 27 a simplified procedure for a group health plan to use if the plan comprises several component benefits. Such a plan, often referred to as an ERISA “wrap” plan, now has the option of obtaining a single HPID for the entire arrangement or separate HPIDs for the component benefits.

The Aon Hewitt bulletin, which provides an overview of the latest guidance, is available here.

Right Before Columbus Day, Look What’s Been Discovered—New FAQ on Reference-Based Pricing and MOOP Limits!
The Departments released guidance under the Affordable Care Act on the application of MOOP limits and reference-based pricing structures on October 10, 2014.

The Aon Hewitt bulletin, which provides an overview of the latest guidance, is available here.
November 2014

*Turns Out You Can Be Too Thin! HHS, Treasury Say “Skinny Plans” Don’t Offer “Minimum Value”*

An employer group health plan that fails to provide participants and beneficiaries with substantial coverage for in-patient hospitalization services, often referred to as a “skinny plan,” does not satisfy the requirements for providing “minimum value” under the Affordable Care Act, according to guidance released on November 4, 2014 by HHS and the Treasury.

The following Aon Hewitt bulletin, which provides an overview of the guidance (Notice 2014-69), is available [here](#).

December 2014

*New Final and Proposed Regulations on Cash Balance and Other Hybrid Plans*

The PPA added several important provisions to the Code, ERISA, and the Age Discrimination in Employment Act aimed specifically at cash balance and other hybrid defined benefit pension plans. The PPA was subsequently amended by the Worker, Retiree, and Employer Recovery Act of 2008 in certain respects applicable to hybrid defined benefit pension plans.

On September 19, 2014, final and proposed regulations regarding hybrid defined benefit plans were published in the Federal Register. These new regulations modified and expanded on prior final and proposed regulations that were published on October 18, 2010. The 2010 final regulations dealt primarily with age discrimination issues, including rules applicable to conversions of traditional defined benefit pension plans to hybrid plans. The 2010 proposed regulations dealt primarily with interest crediting rates not exceeding a market rate of return.

The 2014 final regulations are largely consistent with the 2010 final and proposed regulations, but include a number of clarifications and other modifications relating to:

- Payment of the account balance as a lump sum (i.e., “whipsaw relief”);
- Definitions of lump-sum based benefit formulas, formulas with an effect similar to a lump-sum based formula, and variable annuity formulas;
- Age discrimination safe harbor (i.e., the “similarly situated” test);
- Conversion of a traditional defined benefit plan to a cash balance or other hybrid defined benefit plan; and
- Market rate of return limitation on interest crediting rates.

The 2014 proposed regulations deal primarily with guidance to transition impermissible interest crediting rates to satisfy the requirements not to exceed a market rate of return, as provided in the 2014 final regulations.

The Aon Hewitt report, which provides details about the proposed and final regulations, is available [here](#).
Resources

To stay current with the latest HR-related legislative and regulatory updates in 2015, read the Aon Hewitt Washington Report, available here.

If you would like to subscribe to the weekly Aon Hewitt Washington Report (published on Mondays), please email us here.

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 2014 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.
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