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Radnor Benefits Group is pleased to bring you our bi-weekly version of **Compliance Corner**, a newsletter tailored to your needs and interests relating to the challenging world of compliance. Please feel free to contact us with any questions. We have a robust professional compliance team that can make the complex simple on your behalf.



## Compliance Corner

**December 20, 2011**

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## Reminders and Announcements

### Next *Compliance Corner* Scheduled for Jan. 4, 2012

Due to the New Year's Day closure, the next edition of *Compliance Corner* will be published on Jan. 4, 2012. Benefits Compliance wishes all of our readers a joyful holiday season and happy new year!

## Health Reform Updates

### Health Care Reform Litigation Update

On Monday, Nov. 14, 2011, as previously announced, the Supreme Court agreed to review three of the five separate appeals challenging the constitutionality of PPACA. Within the three appeals, the court selected for review only those issues tied to the overall question of how governmental power is divided between national and state governments, including: 1) the constitutionality of the individual mandate, 2) the issue of whether the mandate may be severed from the rest of PPACA, 3) the issue of jurisdiction or whether the Anti-Injunction Act bars the lawsuit before the tax is actually enforced, and 4) the constitutionality of PPACA's expansion of the federal Medicaid program.

On Dec. 19, 2011, the Supreme Court announced that it will hear oral arguments on these issues for three days beginning on March 26, 2012, and ending on March 28, 2012, totaling 5 1/2 hours of actual argument. The court is expected to issue a decision by late June, in the middle of the presidential election year.

### [Supreme Court Argument Calendar](#)

### Initial HHS Proposal Gives States Flexibility to Define Essential Health Benefits

On Dec. 16, 2011, HHS released a "pre-rule" bulletin to provide information and solicit comments on the regulatory approach that HHS plans to propose to define essential health benefits (EHB) under PPACA, § 1302(b). Non-grandfathered plans in the individual and small group markets inside and outside of the exchanges must cover EHB beginning in 2014. Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Under HHS' intended approach as announced in the bulletin, states would have the flexibility to select an existing health plan to set the benchmark for the items and services included in the EHB package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state
- One of the three largest state employee health plans
- One of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benchmark plan selected by the state and modified as necessary to reflect the 10 coverage categories.

The bulletin addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments and coinsurance, which will be addressed in future bulletins. Final rules are expected to be issued sometime next year. HHS is accepting comments on the proposal, which are due by Jan 31, 2012, and may be sent to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov).

### [Essential Health Benefits Bulletin Fact Sheet](#)

### [HHS Issues CO-OP Program Regulations](#)

On Dec. 13, 2011, HHS issued final regulations implementing the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to encourage the establishment of consumer-governed, private, nonprofit health insurers (referred to as CO-OPs). CO-OPs are designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options. Starting Jan. 1, 2014, CO-OPs will offer health plans through the new, competitive health care marketplaces in each state, called the Affordable Insurance Exchanges. In addition to offering health plans through an exchange, CO-OPs may offer health plans outside of an exchange.

Two types of loans are available under the program: startup loans for costs associated with establishing a CO-OP, and solvency loans to help CO-OPs satisfy state solvency and reserve requirements. The final regulations address eligibility standards for the CO-OP program, establish terms for loans and provide certain basic standards that organizations must meet to participate in the program and become CO-OPs. The regulations are effective Feb. 13, 2012, and finalize proposed regulations that were issued in July 2011.

### [Regulations Fact Sheet](#)

### [End Date Announced for Claims Under Early Retiree Reinsurance Program](#)

Congress appropriated \$5 billion for the Early Retiree Reinsurance Program (ERRP), established under PPACA, and directed the Secretary of HHS to set up the program within 90 days of enactment. By law, ERRP is

scheduled to end when its resources have been used to pay claims. Due to the significantly high response from employers, the program stopped taking applications as of May 6, 2011.

On Dec. 9, 2011, CMS notified plan sponsors that \$4.5 billion had been paid and issued further guidance informing plan sponsors that claims incurred after Dec. 31, 2011, will not be accepted. HHS has also announced that any claim list that includes a claim incurred after that date will be rejected in its entirety. Claims incurred on or before Dec. 31, 2011, but paid after that date may still be submitted, but not until the claim has been paid.

Reimbursement requests received after the \$5 billion has been fully exhausted will be held in the order of receipt, pending availability of funds. Sponsors with reimbursement requests on hold can expect to:

- Receive an email notifying them that their reimbursement requests have been placed on hold pending availability of funds;
- Have access to information about the position of their requests in the list of held reimbursement requests; and
- Be paid in the order in which reimbursement requests were received, if additional funds become available. In such cases, reimbursement requests will be honored until there are not sufficient funds to pay a reimbursement request in its entirety, at which time, that request will be partially paid and the balance will be paid if and when additional funds become available. Each time a partial payment is processed, the plan sponsor will receive an email notification regarding the specific amount paid and the balance remaining to be paid.

In addition to the news release and notice, HHS issued an updated state-by-state list of amounts paid to approved sponsors.

[Notice](#)  
[News Release](#)  
[Update](#)

## **HHS Releases FAQs Concerning Implementation of Exchanges**

On Nov. 29, 2011, HHS Released 13 FAQs addressing implementation issues for states and federally facilitated exchanges. The FAQs cover a range of topics, including funding responsibility and resources, information exchanges through federally managed data "hubs," and shared eligibility verification services. Among them are FAQs focused on issues raised by federally facilitated exchanges.

[FAQs](#)  
[New Release](#)

## **Federal Updates**

### **Without Congressional Action, Transit Benefits to Be Adjusted in 2012**

Unless Congress acts before the end of 2011, the monthly tax exclusion for employer-provided transit pass and vanpool benefits will decrease to \$125 in 2012, from the current \$230. Meanwhile, the monthly tax exclusion for employer-provided parking benefits is scheduled to increase by \$10 to \$240 for 2012.

The limits for these qualified transportation fringe benefits provided by employers were previously adjusted on a temporary basis between Feb. 17, 2009, and Dec. 31, 2011, with passages of both the American Recovery and Reinvestment Act of 2009, and the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010.

However, beginning Jan. 1, 2012, Revenue Procedure 2011-52 provides that the monthly exclusion for employer-provided transit pass or vanpool benefits is \$125, and the monthly exclusion for qualified parking benefits is \$240. Thus, it appears that without congressional action to keep these limits in line with the limits for preceding years, employers and employees should be prepared to comply with the new limits.

Employers need to decide whether to restrict to \$125 employees' monthly salary deductions for 2012, or instead allow employee salary deductions of up to \$240 per month for transit passes and vanpools. If salary deductions for transit passes and vanpool benefits are permitted up to \$240 per month and the law does not change, amounts in excess of \$125 per month will be taxable for 2012.

### [Revenue Procedure 2011-52](#)

## **IRS Announces 2012 Standard Mileage Rates**

On Dec. 9, 2011, the IRS announced in IRS Notice 2012-1 the 2012 optional standard mileage rates that employees, self-employed individuals and other taxpayers may use to calculate deductible costs of operating automobiles (including vans, pickups and panel trucks) for business, medical, moving and charitable purposes. Beginning on Jan. 1, 2012, the standard mileage rates for cars, vans, pickups or panel trucks will be:

- 55.5 cents per mile for business miles driven (unchanged from the midyear adjustment that became effective on July 1, 2011)
- 23 cents per mile driven for medical or moving purposes (a 0.5-cent decrease from the rate of 23.5 cents that was in effect for the last six months of 2011)
- 14 cents per mile driven in service of charitable organizations (unchanged from the midyear adjustment that became effective on July 1, 2011)

IRS Notice 2012-1 contains the standard mileage rates, the amount a taxpayer must use in calculating reductions to the basis for depreciation taken under the business standard mileage rate, and the maximum standard automobile cost that a taxpayer may use in computing the allowance under a fixed and variable rate plan. Additional information about using the standard mileage rate may be found in Revenue Procedure 2010-51. Finally, use of the standard mileage rate is not mandatory, and taxpayers always have the option of calculating the actual costs of using a vehicle rather than using the standard mileage rates.

### [IRS Notice 2012-1](#)

### [Revenue Procedure 2010-51](#)

### [Press Release](#)

## **IRS Releases Fall Edition of Retirement News for Employers**

On Nov. 23, 2011, the IRS released the fall 2011 edition of *Retirement News for Employers*, as well as FAQs on Form 8955-SSA reporting. The newsletter contains a number of articles, citations and links related to retirement plans, including:

- "Paying Retirement Plan Benefits": Distribution methods depend on the plan, participant and beneficiary elections
- "Maximize Your Retirement Savings in 2012": Making salary deferral contributions

- "SEPs and SIMPLEs": Amendment procedures and contribution limits
- "Disaster Relief for Retirement Plans and IRAs"
- "Priorities for the Current Fiscal Year": From the IRS exam director
- Webinars available
- Revised Forms, including Form 5300, 5558 and 8955-SSA
- Recurring Columns, including "Mark Your Calendar" and "DOL News"  
[Click here](#) to view the newsletter.

### [FAQs on Combined Form 8955-SSA Reporting for 2009 and 2010](#)

### [FAQs on Large Form 8955-SSA Filings](#)

## **DOL Reissues Interim Policy on Electronic Distribution of Participant-level Fee Disclosures**

On Dec. 8, 2011, the DOL issued Technical Release 2011-03R, which revised the department's interim policy regarding the use of electronic media to satisfy the disclosure requirements under the department's final participant-level fee disclosure regulation.

According to the DOL, the revised and reissued interim policy is identical to the original, except as necessary to clarify two points. First, the revised policy explicitly states that its alternative electronic disclosure method can be used to provide disclosures through a continuous access website. Second, the revised policy clarifies that investment-related information required by the participant-level fee disclosure rules may be furnished "as part of, or along with" pension benefit statements, but those disclosures may not rely on Field Assistance Bulletin 2006-03. Electronic disclosures of investment-related information must instead be made in accordance with the interim alternative method or the DOL's general safe harbor, which requires a recipient's affirmative consent unless a computer or other electronic system is an "integral part" of an employee's employment duties.

### [DOL Technical Release 2011-03R](#)

#### [News Release](#)

On Nov. 23, 2011, the IRS released the fall 2011 edition of Retirement News for Employers, as well as FAQs

## **IRS Issues 2011 Cumulative List of Changes for Cycle B Plans**

On Dec. 13, 2011, the IRS issued Notice 2011-97, which includes the 2011 Cumulative List, the list of statutory, regulatory and guidance changes that the IRS will look for when reviewing individually designed retirement plan documents submitted for determination letters during the Cycle B submission period. Remedial amendment Cycle B generally applies to an individually designed plan if the last digit of the plan sponsor's employer identification number is 2 or 7. The Cycle B submission period begins Feb. 1, 2012, and ends Jan. 31, 2013.

The 2011 Cumulative List generally reflects law changes under the Pension Protection Act of 2006; the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007; the Heroes Earnings Assistance and Relief Tax Act of 2008; the Worker, Retiree, and Employer Recovery Act of 2008 (WRERA); the Small Business Jobs Act of 2010; and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Qualification requirements that were not on the 2010 Cumulative List are designated on the 2011 Cumulative List as new.

Sponsors of individually designed Cycle B plans, and their advisors, should carefully review the 2011 Cumulative List to ensure that their plan documents and determination letter applications address the issues the IRS has identified for review. Due to the small number of new items that could affect 401(k) plans, and the specialized nature of those items, many 401(k) plans that were already up-to-date with items on the 2010 list may discover that they do not have to make any documentation changes in response to the 2011 list.

### [IRS Notice 2011-97](#)

## State Updates

### Colorado

On Dec. 5, 2011, the Colorado Department of Labor and Employment (DLE) issued a press release relating to a partnership with the DOL aimed at reducing misclassification of employees as independent contractors. The press release announces that the DOL and the Colorado DLE recently signed a memorandum of understanding on such misclassification, and that the two entities will embark on new efforts to protect the rights of employees by reducing the practice of misclassifying employees. According to the press release, the memorandum of understanding arose as part of the DOL Misclassification Initiative. Ten other states have also signed such memorandums, including Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Montana, Utah and Washington. Employers should be aware of the increased attention given to the misclassification issue by the DOL and by state agencies.

[Colorado DLE Press Release](#)  
[DOL Misclassification Web Page](#)

### New Mexico

On Nov. 21, 2011, the New Mexico Insurance Division issued Bulletin No. 2011-012. The bulletin is directed toward all group health plans and health insurers offering group or individual health insurance coverage in New Mexico. The purpose of the bulletin is to advise such insurers and plans of the application of internal claims and appeals and external review processes to all traditional fee-for-service indemnity health plans (except for grandfathered indemnity plans). In the past, there have been no New Mexico state appeals procedures for indemnity plans. As a result of PPACA, and pending the establishment of a permanent rule for internal and external review procedures for indemnity plans, indemnity plans are required to comply with New Mexico's currently available internal and external review procedures. The bulletin provides more information on those procedures, as well as contact information for any related questions.

[Bulletin No. 2011-012](#)

### New York

On Dec. 12, 2011, the governor signed both A05502-B and A07779 into law. The first legislation, A05502-B, prohibits insurers or employers from requiring patients to use mail-order plans for prescription drugs, except for plans negotiated by unions. Instead, insureds have the choice of having prescriptions filled either through mail order or in person, without any added copayments or fees. A similar law is already in effect in Maryland. The second legislation, A07779, is similar to the first in that it requires every policy that provides prescription drugs to provide the same coverage for prescription fertility drugs, whether purchased through a mail-order pharmacy or not, without an additional copayment, coinsurance, deductible or other fees. Both changes to the law are effective Jan. 11, 2012.

[A05502-B](#)  
[A07779](#)

## Frequently Asked Questions

## If an FSA participant does not cash an FSA reimbursement check, what happens to the unclaimed FSA reimbursement funds?

The exact answer would depend on a particular state's escheat or unclaimed property laws. Most states have laws requiring individuals or entities in possession of unclaimed property for a certain number of years to transfer such property to the state's custody. As background, under an escheat law, the state becomes the owner of the unclaimed property, whereas under an unclaimed property law, the state becomes the custodian of the unclaimed property, and the true owner can reclaim the property at any time. Some state or unclaimed property laws also require the employer to make a good faith effort to locate the individual to whom the uncashed FSA check was written. Thus, state law should be reviewed before implementing a practice with respect to unclaimed FSA reimbursement funds.

That said, state escheat and unclaimed property laws arguably apply only to unclaimed benefit checks that are outstanding for the applicable period under the state law. So, FSA plan sponsors might be able to avoid the application of these state laws by drafting their plans so that undisbursed benefit funds are forfeited prior to the shortest applicable unclaimed property period under state law. Plans that include this forfeiture provision should address how the forfeited amounts are treated. For example, the plan could require that such forfeitures be used to offset administrative costs of the plan, reduce required salary reductions (also known as a premium holiday) or be distributed as an experience dividend, (thereby complying with ERISA's exclusive benefit rule, which generally prohibits a plan from using plan assets in ways other than benefitting plan participants or defraying administrative costs relating thereto). Any premium holiday or experience dividend must be allocated among employees on a reasonable and uniform basis, and neither can be based on a weighted average or individual claims experience. Plan sponsors considering this option should also think carefully about whether to add some sort of restoration feature to the plan in order to pay out the unclaimed benefit if the missing individual ever returns and requests it. However, some state courts have held that attempts to avoid escheat laws through contract drafting are unenforceable and contrary to public policy, meaning that the state law would apply regardless of the plan's provisions. As a consequence, it may not be possible to avoid the application of state escheat laws through plan drafting. Further, while some courts have held that ERISA preempts state escheat and unclaimed property laws with respect to unclaimed employee benefits, other courts have held that ERISA does not preempt such laws. Thus, before implementing any policy with regard to the use of the funds relating to an uncashed FSA reimbursement check, a plan sponsor should seek the advice of outside counsel.

## Acronyms Glossary

<b>ADA</b>	Americans with Disabilities Act
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act
<b>DOL</b>	U.S. Department of Labor
<b>EBSA</b>	Employee Benefits Security Administration
<b>EEOC</b>	Equal Employment Opportunity Commission
<b>ERISA</b>	Employee Retirement Income Security Act
<b>FLSA</b>	Fair Labor Standards Act
<b>FMLA</b>	Family and Medical Leave Act

**FSA** Flexible Spending Arrangement  
**HHS** U.S. Department of Health and Human Services  
**HIPAA** Health Insurance Portability and Accountability Act  
**HRA** Health Reimbursement Arrangement  
**HSA** Health Savings Account  
**IRC** Internal Revenue Code  
**IRS** Internal Revenue Service  
**OTC** Over-the-counter Item or Drug  
**PPACA** Patient Protection and Affordable Care Act (aka health care reform)

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