

Evaluating Your Nonprofit's Options Under the *Affordable Care Act*: The Pros and Cons of Health Insurance Alternatives for Your Employees

July 23, 2013
Venable LLP
Washington, DC

Moderator:

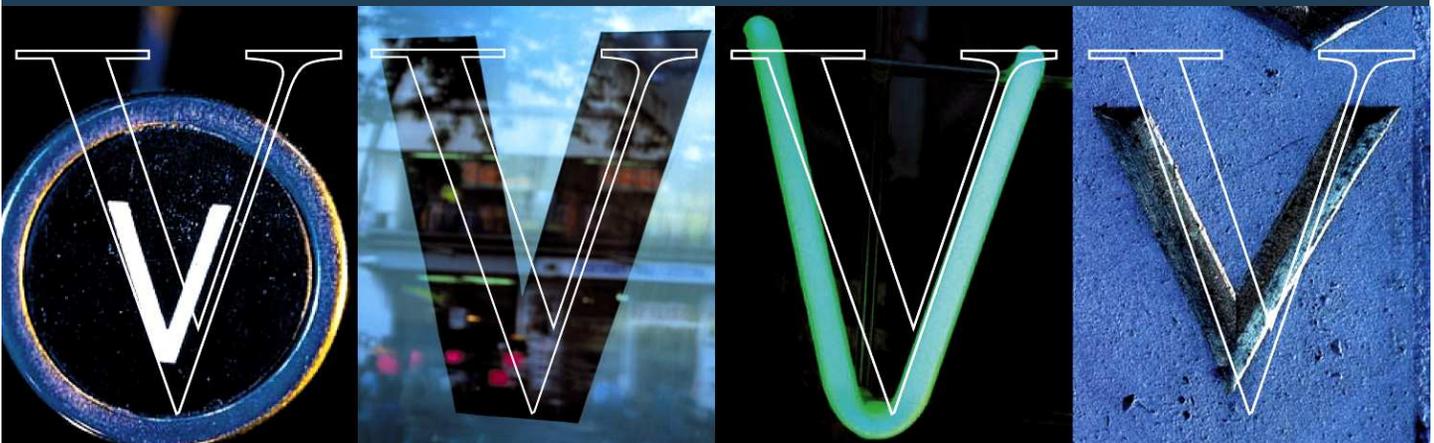
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Panelists:

Anita F. Baker, CPA, CEBS, CliftonLarsonAllen LLP

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Presentation



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Tuesday, July 23, 2013, 12:30 p.m. – 2:00 p.m. EDT
Venable LLP, Washington, DC

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Compliance: What Your Nonprofit Needs to Know](#)

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and the Law: What Your Nonprofit Should Know
about Apps, the Cloud, Information Security, and
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Agenda



- Introduction
- ACA Exchanges
- Shared Responsibility Requirement (A.K.A. the “Employer Mandate”) for Large Nonprofit Employers
- Important Changes for Small Nonprofit Employers
- Additional Requirements for Small and Large Nonprofit Employers
- Alternative Strategies for Small and Large Nonprofit Employers: “Private” Exchanges



ACA Exchanges

The Exchange & Congressional Intent

- The original intent of the Exchange created under PPACA was not to deliver the subsidies, but rather to serve as a *marketplace*
 - It was believed that the Exchange would reduce administrative costs
 - In addition, it was believed that the Exchange would attract multiple insurance carriers, which would promote competition
 - Achieving these two goals could translate into lower premiums
- Early on in the drafting process, it was “private” exchanges that served as the model, not the Massachusetts Connector



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Two Kinds of “ACA” Exchanges

- State-based Exchanges
 - The drafters never envisioned the level of resistance to the law and establishing an Exchange
- Federal Exchange (which includes the Federal-State Partnership)
 - Congress intended the “Federally-facilitated Exchange” to step into the shoes of the State-based Exchange and perform all of the same functions
 - Unsurprisingly, the statute is not “clean,” and therefore, questions have arisen
 - Can a Federal Exchange deliver the premium subsidies?



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What Should You Know About the “ACA” Exchanges?

- Initially, the Exchanges will service (1) individuals and families in the individual market and (2) employees of small employer
 - In 2017, a State may elect to permit the sale of fully-insured large group plans through the Exchange, but a State is not required to do so
- An Exchange may be structured as (1) a governmental agency or (2) an independent nonprofit entity



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What Should You Know About the “ACA” Exchanges? (cont’d.)

- The Exchange is directed to perform specific functions
 - For example, determine eligibility for an advance-refundable tax credit for health insurance and cost-sharing subsidy (i.e., premium subsidies), establish and maintain a web site, and set up a call center to field questions from consumers
- The statute also gives States the authority to permit their Exchanges to prohibit carriers from offering a plan through the Exchange
 - This is known as the “active purchaser” model
 - To date, 7 States have an “active purchaser” Exchange



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The Subsidies Offered Through the “ACA” Exchange

- **GENERAL RULE** – An individual is NOT eligible for subsidies offered through the Exchange if he or she is “eligible” for employer-sponsored coverage
 - So, even if your employees are subsidy-eligible, they CANNOT go to the Exchange and access the subsidies
- **EXCEPTION** – The employer-sponsored coverage (1) is “unaffordable” (i.e., the employee’s contribution for the lowest cost for self-only plan exceeds 9.5% of the employee’s household income) or (2) does NOT provide “minimum value” (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
 - In this case, depending upon an employee’s income, an employee may opt out of employer coverage, go to the Exchange, and access the subsidies



The Exchanges & The Premium Subsidies: Impact on Employers

- **Behavioral Changes**
 - Small employers may drop coverage because (1) they can get out of the “health care game” and (2) a majority of their employees will likely get a better financial deal as long as the premium subsidies are available
 - Although large employers are NOT likely to drop coverage immediately, their employees may want the premium subsidies because (1) they may get a better financial deal as long as the premium subsidies are available and/or (2) the “family glitch” issue
- **Verification Process**
 - If and when employees seek to access a premium subsidy, a verification process will be triggered which will require the employer to communicate with the Exchange in some way (e.g., establish an “electronic data source” that the Exchange may access or receive phone calls from the Exchange directly, attempting to verify plan information for purposes of determining subsidy eligibility)
- **Election to Sell Fully-Insured Large Group Plans**
 - Beginning in 2017, a State may elect to permit the sale of large group fully-insured plans through the Exchange
 - Upon an election, the adjusted community rating rules would apply and it is likely that many of the other minimum standards (e.g., the requirement to provide the “essential health benefits” and the single risk pool rules) will apply



**Shared Responsibility
Requirement
(a.k.a. the “Employer Mandate”)
for Large Nonprofit Employers**

The “Employer Mandate”

- The employer mandate applies to “applicable large employers”
 - Defined as “an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year.”
 - Common law test used for identifying employees



- Total number of employees for this purpose =
 - Total full-time employees for each month in the preceding calendar year; PLUS total number of FTEs for each month in the preceding calendar year; DIVIDED BY 12
 - If the result is not a whole number → round to the next lowest number
 - This calculation includes seasonal employees, but if employer can show that total employee count exceeds 50 (due to seasonal employees) no greater than 4 months during the prior year → mandate does not apply



The “Employer Mandate”

- An employer with 50 or more “full-time equivalent” (FTE) employees would be subject to a penalty tax if:
 - The employer is NOT offering health coverage to at least 95% of its full-time employees and their child dependent(s) (under age 26)
 - This is known as the “No-Coverage” penalty = \$2,000 x all “full-time” employees (minus 30)
 - The employer offers coverage, but the coverage (1) is “unaffordable” (i.e., the required *employee* contribution for self-only coverage exceeds 9.5% of, for example, the employee’s household income or some other “safe harbor” benchmark) or (2) does NOT provide “minimum value” (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
 - This is known as the “Sub-Standard Plan” penalty = \$3,000 x each “full-time” employee that accesses a premium subsidy
- The penalty tax is **only** triggered if the employee purchases health insurance through the Exchange and accesses the premium subsidy
- While effective January 1, 2014, the enforcement of the employer mandate was recently delayed for one year



“Employer Mandate” Penalties Delayed Until 2015

- What does delay mean for large employers?
 - Do not need to offer full-time employees and their dependent children health insurance coverage in 2014
 - No penalties if employer offers no coverage
 - No penalties if coverage offered is “unaffordable” or does not provide “minimum value” in 2014
 - Do not have to file an information return with IRS in 2014
 - Further guidance from IRS on information return is expected to be issued summer 2014



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“Employer Mandate” Penalties Delayed Until 2015 (cont’d.)

- What are some of the implications of delay?
 - More employees will be eligible for the premium subsidies
 - Little incentive for employers to change their plan designs to satisfy the new requirements in 2014, which means more employees will (1) not be offered an employer plan or (2) not be offered “affordable, minimum value” coverage
 - Employer/Employee relations issues when employees are forced back on to their employer plan
 - In 2014, an employee may pay as little as 2% of income for health insurance (because the Federal government picks up the rest of cost)
 - But, in 2015, the employee may be required to pay 9.5% of income for an employer plan (because the employer offers an “affordable” plan); AND, the employee will NOT be eligible for a subsidy

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Penalty Strategy Components

- Defining full-time employees
 - Optional look-back measurement period
 - Capping hours to reduce #s of FT employees
 - Impact of FTEs waived on bottom line
- Employee wage level
 - Implications of over/under 400% FPL
- Minimum value and affordability
 - Where is best place to spend benefit dollars (e.g., premiums, HRA/HSA contributions, etc.)?
 - Employer contribution level: Is it advantageous to make coverage less affordable?



Identifying Full-time Employees: 2014 & Beyond

- Employee engaged in average of 30 “hours of service” per week or 130 hours in a month.
 - Uses common law definition of employee
 - Does not include: leased employees, sole proprietors, partners in partnership, 2% S-corp shareholder
 - Hours of service = hours worked and hours paid but for which no work was performed (e.g., PTO, FMLA, deployment leaves, disability, etc.)
 - Salaried workers use actual hours, or 8 hours/day or 40 hours per week standard.
 - Special rules for employees of educational institutions
 - Seasonal workers: If 120 days or fewer, or 4 calendar months of work, then excluded from calculation of large employer



Safe Harbors: Full-time Employees

- IRS Notice 2012-58 and Dec. 2012 IRS/HHS proposed regulations explain a method employers may use to determine full-time status for ongoing employees, new employees expected to work full-time, and variable hour and seasonal workers.



- **Measurement period:** 3-12 months (employer determined)
- **Administrative period (optional):** Up to 90 days for employee eligibility for coverage determinations, notification and enrollment of employees
- **Stability period:** The greater of 6 months or the duration of the standard measurement period



Defining Which Employees Are Full-time

Strategies

- Select measurement and corresponding stability period to capture fewest number of full-time employees.
- **Limit employee hours** of service to less than 30 hours/week or 130 hours per month.
- If not offering ESI, **limit full-time status to 30** or fewer employees across businesses

Why is this important?

- Employers must **offer** to full-time employees and their children under age 26 health insurance coverage or pay a penalty.
- Penalties are assessed for full-time employees only
- Current FT employees who waive coverage may enroll in ESI in 2015 adding bottom line, non-penalty costs to employers.
- Now is the time to make strategic decisions to limit penalty risk



“Minimum Value” Plan

- Law requires “large” employer to **offer** at least one plan with a minimum 60% actuarial value
 - Desired by employees in order to meet individual mandate = New Benefit Floor
 - Premiums for this level plan should be lower than higher actuarial value plans
- IRS to make Actuarial Value calculators available to employers and plans
- Actuarial Value looks at a variety of components: deductibles, co-payments, co-insurance, as well as employer contributions to HRAs and HSAs.

60% Actuarial Value: On average the plan pays for 60% of the costs for covered benefits and enrollees; on average, pay the remaining 40% through cost-sharing such as deductibles, copayments and coinsurance.



Three Employer Affordability Safe Harbors: W-2 Safe Harbor

IRS Notice 2012-58

- If employee’s premium cost for **self-only coverage is less than 9.5% of their W-2 wages** for the employer, the health insurance is considered affordable *AND*
 - The employer will **not** pay a penalty for that employee
 - The employee may still be eligible for premium tax credits in the Exchange based upon Modified Adjusted Gross Income of Household.
 - Employer is **not** subject to penalty if employee receives tax credit but later employer-sponsored insurance is determined to be affordable.
 - **Affordability for related individuals:** Employers don’t need to make coverage affordable for dependents (e.g. family coverage, employee+1)



Affordability Safe Harbors: W-2 (cont'd.)

- Using total amount of wages = Box 1 of Form W-2
 - Box 1 does not include employee elective deferrals
- Can include wages paid to employees by a third party that are reported on the W-2 and reflecting the 3rd party EIN
- Determined at the end of calendar year on per employee basis using the year's W-2 reportable (e.g., compare 2014 premium cost to 2014 Box 1 W-2 wages)
- Could be used prospectively to set employee contribution level to < 9.5% of wages



Affordability Safe Harbors: FPL

December 2012 Proposed Regulations



- Coverage considered affordable for calendar month if employee's required contribution for lowest-cost self-only coverage that provides minimum value under plan does not exceed 9.5% of Federal Poverty Level (FPL)
 - Determined by calculating FPL for single individual (where individual is employed) for applicable calendar year
 - Divided by 12
 - 2013 FPL for a single person = \$11,490
 - 9.5% of \$11,490 = \$1091.55/year or \$90.96/month



Affordability Safe Harbors: Rate of Pay

December 2012 Proposed Regulations

- Coverage considered affordable for calendar month if employee's required contribution for month for lowest cost, self-only coverage provides minimum value does not exceed 9.5% of a Rate of Pay Safe Harbor Amount
 - **Rate of Pay Safe Harbor Amount** = 130 hours multiplied by employee's hourly rate of pay as of the first day of the coverage period (generally first day of plan year)
 - Salaried employees use monthly salary instead of hourly rate of pay
- Available as long as employer does not reduce hourly rate of pay or monthly wages during calendar year



Important Changes for Small Nonprofit Employers

Definition of “Small Employer”

- Beginning in 2016, “small employer” will be defined as 1 to 100 employees
 - This means that a State’s small group insurance market will be defined as 1 to 100
- Congress decided to phase in this new definition by allowing States to elect to maintain their current definition of 1 (or 2) to 50 until 2016
 - Every State has elected to maintain its current definition of small group
- Why is this important?
 - Because if an employer currently employs, for example, 75 employees, this employer will be part of the State’s large group market
 - In 2016, however, this same employer will now be part of the State’s small group market



Small Group Market Insurance Reforms: The Five Pillars

PILLAR #1 – “Essential Health Benefits”

- Statute said all fully-insured small group plans must cover 10 enumerated *medical services*
 - 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; and Preventive and wellness services and chronic disease management
- HHS gave States the ability to establish an “essential health benefits” benchmark plan
 - In general, the benchmark plan is the plan with the largest enrollment in the State’s small group market
 - In general, the benchmark plan will include the 10 enumerated medical services, but if a benchmark plan does not, HHS requires the State to add the benefit coverage
 - State mandated benefits in place as of 12/31/11 may be considered an “essential health benefit”



PILLAR #2 – “Metal Levels” of Coverage

- All fully-insured small group plans must meet a specified actuarial value (AV) +/- 2% (bronze plan – 60% AV, silver plan – 70% AV, gold plan – 80% AV, platinum plan – 90% AV)
- In its simplest form, AV is a measure of the co-insurance under the plan
 - For example, the insurance coverage pays for 60% of the cost of a covered benefit and the insured is responsible for paying for the remaining 40% of the cost

PILLAR #3 – Cost-Sharing Limitations

- The aggregate amount spent on deductibles, co-payments, and co-insurance cannot exceed the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account (“HSA”) rules for 2014
- In addition, small group plans must limit the annual deductible to no more than \$2,000 for single coverage and \$4,000 for family coverage
 - However, recent HHS guidance permits an insurance company to increase these deductible amounts if doing so would allow the plan to meet specified AV
 - This new guidance gives insurance companies and small employers more flexibility in designing a plan



PILLAR #4 – Premium Rating Rules

- Insurance companies are prohibited from setting premiums based on any employee's health status
- Premium rates may only vary by:
 - Age (but by no more than a 3 to 1 ratio),
 - Tobacco use (but by no more than a 1.5 to 1 ratio),
 - Single or family coverage, and
 - Rating area

PILLAR #5 – Risk Pooling

- All employees of small employers in the small group market are treated as a single risk pool (pooled by insurance company) regardless of where coverage is obtained
 - In other words, health risks inside and outside of the SHOP Exchange will be pooled together (e.g., an individual that purchases a plan through the SHOP Exchange will be part of the same risk pool of an insurance company that sells a health plan to an individual outside of the Exchange)



Additional Requirements for Small and Large Nonprofit Employers

Eligibility for Health Insurance Exchange Notice

- Employers to notify employees upon effective date and/or date of hire:
 - Information about the existence of state/federal exchange, services offered and how to contact
 - Employee **may** be eligible for assistance to purchase insurance via the Exchange
 - Employee loses eligibility for employer contribution to health benefits if purchases insurance via the Exchange
- **Effective Date:** For current employees, employers must issue notices prior to October 1, 2013. For employees hired after this date, the notice must be provided upon hire.



Eligibility for Health Insurance Exchange Notice (cont'd.)

- Notice of coverage options must be provided to each employee, regardless of plan enrollment status (if applicable) or of part-time/full-time status
- Department of Labor has model notice language available on its website
 - Employers who offer a health plan: <http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf>
 - Employers who do not offer a health plan: <http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf>



6056 Information Returns

- Employers subject to the “employer mandate” must provide an information return to (1) the IRS and (2) each of its full-time employees by January 31 of the year following the year health coverage was required to be provided
- The information that must be reported includes:
 - The name, address, and EIN of the employer
 - A certification that the employer is or is not offering health insurance coverage to its employees
 - The number of full-time employees
 - The name, address, and TIN of each full-time employee and the number of months (if any) during which the employee (and any dependents) was covered under the plan
- If an employer certifies that it is indeed offering health coverage, the employer must also report:
 - The length of any waiting period under the plan
 - The months during which coverage was available
 - The premiums for the lowest cost plan offered by the employer
 - The amounts the employer contributes toward its employees’ premiums

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90-Day Waiting Period: Newly Hired, Full-time Employees

- Beginning January 1, 2014, an employer’s waiting period for insurance generally cannot exceed 90 days
 - IRS Notice 2012-59 provided guidance on 90-day waiting limitation (Public Health Service Act § 2708)
- Newly Hired, Full-time Employees
 - If employee is reasonably expected to be full-time, then must be eligible to enroll within 90 days of start date
 - Not permitted to wait until the 1st of the month after 90 days
 - May require employers to allow mid-month enrollment or participate well before 90 days have passed

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Additional Health Plan Fees/Taxes

Comparative Effectiveness Research Plan Fee (2012)

- Effective for plan years ending on or after 10/1/2012
- Requires health insurance and self-insured plans (employer) to pay a per participant fee
- Fee
 - Year 1: \$1/participant
 - Year 2: \$2/participant
 - Due by 7/31/2013
 - 2014: Inflation adjusted rate
 - 9/30/2019: Phased out

Transitional Reinsurance Fee (2014)

- Third Party Administrators pay on behalf of the Plan
 - Remit annual contributions to support reinsurance payments to issuers
 - \$63 per covered employee and their dependents in 2014
 - Phases out: \$42 in 2015; \$26 in 2016
 - First quarterly payment due 1/15/14

Filed on Form 720



Additional Health Plan Fees/Taxes

Health Insurance Industry Tax (HIT) (2014)

- Fee assessed on fully-insured health plans in the individual and small group market
- Tax is a fixed dollar amount assessed based upon insurer's net premiums
 - Nonprofits only pay the tax on 50% of net premiums
 - Plans receiving > 80% of revenues from public programs for the poor, elderly & disabled are exempt from the tax

Cadillac Plan Tax (2018)

- 40% excise tax assessed on health insurer or plan administrator offering "high-cost" health coverage
 - "High cost" = annual premium
 - > \$10,200 single coverage
 - > \$27,500 family coverage
- Tax would be on premiums above the thresholds
- Goal is to generate revenue to help pay for coverage for the uninsured and to make the most expensive plans less attractive.



Alternative Strategies for Small and Large Nonprofit Employers: “Private” Exchanges

What Is a “Private” Exchange?

- At its core, a private exchange is a private business – typically operated by insurance brokers, benefit consultants, or insurers – that sells insurance products to health care consumers through an electronic platform
- What makes private exchanges unique is their ability to enable the health care consumer to shop from among a wide variety of major medical health plans and supplemental insurance products through the use of creative, interactive technology
- Private exchanges offer:
 - The use of defined contribution/fixed contribution funding for group health plans
 - Expanded choice
 - Decision support (e.g., “recommendation technology”)
 - End-to-end transactional services



Private Exchange Models

- **Group Market Private Exchange:** A private exchange that sells “group” health insurance to employees of employers (i.e., employer-sponsored health insurance)
 - Large Employer Private Exchange – This model primarily targets employers with 2,500 or more employees
 - Small- to Mid-Sized Employer Private Exchange – This model targets groups as small as 1 and as large as 2,500 employees
- **Individual Market Private Exchange:** A private exchange that sells health insurance to individuals and families in the individual market outside of the ACA Exchange
- **Web-Based Entity (“WBE”):** A WBE can be considered a private exchange platform that helps a consumer purchase a “qualified health plan” (“QHP”) offered through a State-based or Federally-facilitated marketplace

Group Market Private Exchange: Defined Contribution/Fixed Contribution

- What is a defined contribution/fixed contribution funding?
 - Under a defined contribution/fixed contribution funding model, the employer makes fixed contributions that employees may use to purchase a “defined benefit”
 - This defined benefit is the underlying health plan, which in 2014, will meet all of the ACA requirements
- Advantages?
 - Employers can better manage their costs by deciding how much they want to spend on health insurance each year
 - Then, the employer may determine the rate at which the fixed contribution would increase each year (e.g., based on increases in the Consumer Price Index (“CPI”))

Group Market Private Exchange: Expanded “Employee Choice”

- A private exchange enables the employee to shop from among a wide variety of major medical health insurance products with varying plan designs
 - This includes offering up to 10 to 20 different major medical health plans, ranging from high-cost sharing plans down to low- or no-cost-sharing plans or plans with narrow networks with a cost differential of up to 60%
 - Offering this “inventory” promotes choice and consumerism, which has been proven to reduce health care spending and improve customer satisfaction
- Offering a wide variety of major medical plans is a departure from the current model
- Group market private exchanges will also offer a wide menu of ancillary/supplemental products

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Group Market Private Exchange: Decision Support

- A sophisticated decision support system helps employees determine what major medical health plan or health insurance package is best for them to purchase
 - “Recommendation technology”
 - The employee is asked a series of questions about, among other things, the consumer’s expectations of care utilization (such as pregnancy or prescription drug use), along with the employee’s risk tolerance, financial position, and the amount of an employer subsidy
 - The technology synthesizes the answers to these questions, develops a personalized “profile,” and recommends a plan or an insurance package that may best fit the employee’s needs

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The Future?

- Are private exchanges the future?
 - As health care costs continue to rise, more and more individuals and employers are likely to look to private exchanges
 - Why? Because private exchanges provide a consumer-friendly way to purchase health insurance
 - In the case of employers, it is likely that private exchanges will help those employers who want to hold on to employer-sponsored coverage to continue to provide such coverage
 - Why? Because (1) employers can better manage costs, (2) employees are able to choose their health insurance as opposed to employers deciding on plan options every year, and (3) the customer service found only in a private exchange
- Even if PPACA is modified or halted due to a shift in politics, private exchanges will play a critical role in the future of health care



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Questions?

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Speaker Biographies





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Jeffrey Tenenbaum chairs Venable's Nonprofit Organizations Practice Group. He is one of the nation's leading nonprofit attorneys, and also is an accomplished author, lecturer, and commentator on nonprofit legal matters. Based in the firm's Washington, DC office, Mr. Tenenbaum counsels his clients on the broad array of legal issues affecting charities, foundations, trade and professional associations, think tanks, advocacy groups, and other nonprofit organizations, and regularly represents clients before Congress, federal and state regulatory agencies, and in connection with governmental investigations, enforcement actions, litigation, and in dealing with the media. He also has served as an expert witness in several court cases on nonprofit legal issues.

Mr. Tenenbaum was the 2006 recipient of the American Bar Association's Outstanding Nonprofit Lawyer of the Year Award, and was an inaugural (2004) recipient of the *Washington Business Journal's* Top Washington Lawyers Award. He was one of only seven "Leading Lawyers" in the Not-for-Profit category in the prestigious 2012 *Legal 500* rankings, and one of only eight in the 2013 rankings. Mr. Tenenbaum was recognized in 2013 as a Top Rated Lawyer in Tax Law by *The American Lawyer* and *Corporate Counsel*. He was the 2004 recipient of The Center for Association Leadership's Chairman's Award, and the 1997 recipient of the Greater Washington Society of Association Executives' Chairman's Award. Mr. Tenenbaum was listed in *The Best Lawyers in America 2012* and *2013* for Non-Profit/Charities Law, and was named as one of Washington, DC's "Legal Elite" in 2011 by *SmartCEO Magazine*. He was a 2008-09 Fellow of the Bar Association of the District of Columbia and is AV Peer-Review Rated by *Martindale-Hubbell*. Mr. Tenenbaum started his career in the nonprofit community by serving as Legal Section manager at the American Society of Association Executives, following several years working on Capitol Hill as a legislative assistant.

REPRESENTATIVE CLIENTS

AARP
 American Academy of Physician Assistants
 American Alliance of Museums
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 Air Conditioning Contractors of America
 American Society for Microbiology
 American Society for Training and Development
 American Society of Anesthesiologists
 American Society of Association Executives
 American Staffing Association
 Association for Healthcare Philanthropy

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Association of Corporate Counsel
Association of Private Sector Colleges and Universities
Automotive Aftermarket Industry Association
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HONORS

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Recipient, American Bar Association Outstanding Nonprofit Lawyer of the Year Award, 2006

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PUBLICATIONS

Mr. Tenenbaum is the author of the book, *Association Tax Compliance Guide*, published by the American Society of Association Executives, and is a contributor to numerous ASAE books, including *Professional Practices in Association Management*, *Association Law Compendium*, *The Power of Partnership*, *Essentials of the Profession Learning System*, *Generating and Managing Nondues Revenue in Associations*, and several Information Background Kits. He also is a contributor to *Exposed: A Legal Field Guide for Nonprofit Executives*, published by the Nonprofit Risk Management Center. In addition, he is a frequent author for most of the nonprofit industry organizations and publications and other media, having written or co-written more than 500 articles on nonprofit legal topics.

SPEAKING ENGAGEMENTS

Mr. Tenenbaum is a frequent lecturer for ASAE and many of the major nonprofit industry organizations, conducting over 40 speaking presentations each year, including many with top Internal Revenue Service, Federal Trade Commission, U.S. Department of Justice, Federal Communications Commission, and other federal and government officials. He served on the faculty of the ASAE Virtual Law School, and is a regular commentator on nonprofit legal issues for *The New York Times*, *The Wall Street Journal*, *The Washington Post*, *Los Angeles Times*, *The Washington Times*, *The Baltimore Sun*, *ESPN.com*, *Washington Business Journal*, *Legal Times*, *Association Trends*, *CEO Update*, *Forbes Magazine*, *The Chronicle of Philanthropy*, *The NonProfit Times* and other periodicals. He also has been interviewed on nonprofit legal issues on Voice of America Business Radio, Nonprofit Spark Radio, and The Inner Loop Radio.



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REPRESENTATIVE CLIENTS

Ms. Johnson represents, among others, Allegis Group, Bank of America Corporation, General Dynamics Corporation, and Greater Baltimore Medical Center.

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Christopher Condeluci focuses his practice on employee benefits and tax policy, with a specific emphasis on health care reform, retirement and compensation policy. As former Tax Counsel to the Senate Finance Committee, Chris actively participated in the health reform debate and he is one of the few senior staffers to join the private sector since the enactment of the Patient Protection and Affordable Care Act.

Through his experience on Capitol Hill and the development of this important legislation, Mr. Condeluci helps clients with compliance with the new health care law. He can also advise on shaping any future health care-related legislative initiatives that may affect his clients. Furthermore, Mr. Condeluci has significant technical experience in retirement planning, more specifically tax-qualified retirement plans.

His experience also includes offshore deferred compensation, payroll taxes, education tax incentives (including 529 plans), cafeteria plans and health flexible spending and dependent care arrangements, health savings accounts, fringe benefit programs, and worker classification.

Prior to joining Venable, Mr. Condeluci served as Tax and Benefits Counsel for the U.S. Senate Finance Committee, where he represented the Senate Finance Committee in negotiating details of legislative policy changes on matters relating to health care, retirement, executive compensation, education tax incentives, payroll taxes, insurance tax, S Corporations, and other tax policy issues with Senate Leadership; the Senate Health, Education, Labor and Pensions Committee; the U.S. House of Representatives Committee on Ways and Means; and the U.S. House of Representatives Committee on Education and Labor.

Mr. Condeluci has written articles about retiree medical benefits and the defined benefit pension plan funding rules prescribed under the Pension Protection Act of 2006. He is also the co-author of a chapter on fiduciary issues in welfare plans in an ABA-commissioned book entitled *ERISA Fiduciary Law* and was a significant contributor to the *Health Savings Account Answer Book* and the *ERISA Fiduciary Answer Book* - relating health care reform issues. Mr. Condeluci frequently serves as speaker and commentator on a wide variety of health care, employee benefits and tax policy topics.

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Anita is a member of the AICPA, the Arizona Society of Certified Public Accountants (ASCPA), the International Society of Certified Employee Benefit Specialists (ISCEBS) and the Western Pension and Benefits Conference (WP&BC). Anita has been a speaker to numerous groups including the AICPA and state societies and associations and has authored articles for national employee benefit plan publications. Anita is past chair and a current member of the Executive Committee of the AICPA Employee Benefit Plan Audit Quality Center. Anita is currently serving on the AICPA Technical Standards DOL Subcommittee and is a board member of the ASCPA.

Anita graduated with a Bachelor of Science degree from the University of Minnesota – Duluth in 1985. In addition to being a Certified Public Accountant (CPA), she has obtained the designation of Certified Employee Benefit Specialist (CEBS).

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WHAT YOUR NONPROFIT NEEDS TO DO ABOUT HIPAA—NOW

Whether your nonprofit entity is an employer that provides health insurance to your employees, an organization in the growing health care industry, a hospital, or other medical provider—or you provide services to any of those entities—you need to know about changes to the privacy and security rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which were made by the final omnibus HIPAA rule issued by the U.S. Department of Health and Human Services (HHS) on January 25, 2013 (the “Final Regulations”). These Final Regulations implement changes made under the Health Information Technology for Economic and Clinical Health Act (HITECH). Nearly every organization in the health care industry (and every service provider to those organizations) is affected by these changes.

Among other things, the Final Regulations:

- Directly subject Business Associates,¹ including their Subcontractors (or “downstream” Business Associates), to the HIPAA security rule and many aspects of the HIPAA privacy rule.
- Require amended Business Associate Agreements between Covered Entities and Business Associates to reflect the changes made by the Final Regulations and, for the first time, Business Associate Agreements between Business Associates and their Subcontractors.
- Require Covered Entities to notify affected individuals, the federal government, and the media (in certain circumstances) of any “breach” of Unsecured Protected Health Information (PHI).
- Expand an individual’s right to receive electronic copies of his or her PHI and restrict disclosures to a health plan concerning treatment for which an individual has paid out of pocket in full.
- Permit additional categories of PHI to be used in fundraising, enhance the limitations on the use of PHI for marketing, and prohibit the sale of PHI without individual authorization.
- Significantly strengthen the authority of the federal government to enforce the HIPAA privacy and security rules.

Below is a list of action items for Covered Entities and Business Associates to consider in preparing for the compliance deadline (generally, September 23, 2013). Following the list of action items is a more detailed summary of the changes made by the Final Regulations.

¹ Key terms are defined in the Glossary at the end of this alert.

Action Items for Covered Entities and Business Associates (including Subcontractors)

Except for updating “grandfathered” Business Associate Agreements, Covered Entities and Business Associates, including Subcontractors, have until September 23, 2013 to come into compliance with the Final Regulations. To do so, Covered Entities and Business Associates, including Subcontractors, must:

- Review their current privacy and security compliance program;
- Enter into, or amend, as appropriate, Business Associate Agreements to reflect the Final Regulations;
- Educate Business Associates (including Subcontractors), as necessary, about their responsibility (and the responsibility of their Subcontractors) to safeguard PHI so as to mitigate chances of agents causing upstream liability;
- Conduct a HIPAA security risk analysis and prepare/update a risk management plan. As part of this process, consider implementing encryption and destruction technologies in order to minimize the risk that PHI will be considered Unsecured PHI and, thus, able to be “breached;”
- Create processes to discover breaches of Unsecured PHI;
- Prepare/update a policy about how to handle breaches of Unsecured PHI;
- Draft/update the other HIPAA security and privacy policies;
- Update forms to reflect changes to individual rights;
- Conduct HIPAA training on the updated policies; and
- Update and distribute a Notice of Privacy Practices, as applicable.

Delayed Compliance Deadline for Grandfathered Business Associate Agreements

If a compliant Business Associate Agreement was in place before January 25, 2013, and it is not otherwise renewed or amended after March 25, 2013 (i.e., it is a “grandfathered Business Associate Agreement”), then it generally does not need to be updated to comply with the Final Regulations until September 22, 2014. Agreements that renew automatically through evergreen clauses qualify for this extended compliance date.

Changes Impacting Business Associates (including Subcontractors)

Business Associates, including Subcontractors, will be directly liable (and not simply contractually liable pursuant to their Business Associate Agreements) for complying with certain provisions of HIPAA, including:

- All of the administrative, physical, and technical standards of the HIPAA security rule in the same manner as Covered Entities.
- The use and disclosure requirements of the HIPAA privacy rule in the same manner as Covered Entities.

<p>CAUTION: As of September 23, 2013, entities that create, receive, maintain, or transmit PHI on behalf of a Business Associate (in other words, Subcontractors) will be required to comply with all of the HIPAA provisions that apply to Business Associates because they will, in fact, be treated as Business Associates under the Final Regulations.</p>

Moreover, Covered Entities can be held directly liable for the acts and omissions of their Business Associates that are acting within the scope of their agency. Importantly, this is the case even if the act or omission violates a provision of the Business Associate Agreement. For this purpose, the Final Regulations rely on the federal common law of agency (rather than potentially disparate state laws). An agency relationship is established where a Covered Entity has the right or authority to control its Business Associate’s conduct in the course of performing a service on behalf of the Covered Entity. Similarly, Business Associates can be held directly liable for the acts and omissions of their Subcontractors.

As such, care will need to be taken as Business Associate Agreements are updated or put in place. Where a Business Associate is acting as a Covered Entity's agent, consideration should be given to whether indemnification provisions are appropriate.

Covered Entities and Business Associates Must Provide Notice of a Breach Involving "Unsecured" PHI

Since September 23, 2009, Covered Entities have been required to notify affected individuals within 60 days after a "breach" of Unsecured PHI is discovered. (A breach is deemed "discovered" on the first day that the "breach" is known or should reasonably have been known.) Covered Entities are also required to provide notice to HHS and, in certain circumstances, to the local media.

The threshold for determining whether an unauthorized use or disclosure of PHI constitutes a "breach" for this purpose will change as of September 23, 2013. Under interim final breach notification rules, the security and privacy of Unsecured PHI is deemed to be "breached" where the unauthorized use or disclosure of such information poses a significant risk of financial, reputational or other harm to the individual or individuals whose PHI was compromised.

As of September 23, 2013, the unauthorized acquisition, access, use or disclosure of Unsecured PHI will be presumed to be a breach for purposes of the breach notification rule, unless it can be demonstrated that there is a "low" probability that the PHI has been compromised. While certain exceptions apply to this rule, it is likely to increase the frequency with which potential breaches are reported.

CAUTION:	State law may also require notice of certain breaches of health-related information. Additionally, entities that are not considered Covered Entities or Business Associates subject to HIPAA (and this notice requirement), but which maintain personal health records for consumers, are subject to Federal Trade Commission rules requiring them to provide similar notices of breaches involving such personal health
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Individual Rights and Obligations Related to the Use and Disclosure of PHI

Rights of Individuals to Access Their PHI in Electronic Format

If an individual requests an electronic copy of his or her PHI that is maintained electronically (whether or not in an electronic health record), the Covered Entity must provide the individual with access to the electronic information in the electronic format requested by the individual. If the requested format is not readily producible, the PHI can instead be provided in a readable electronic form as agreed to by the Covered Entity and the individual. Individuals making such a request may be charged for certain (but not all) labor costs and supplies for creating the electronic media (for example, the physical media, such as a CD or USB), if the individual requests that the electronic copy be provided on portable media. The interaction of these rules with permissible charges under state law must be considered.

Mandatory Compliance with Restrictions Requested on Certain Disclosures of PHI

Health care providers must comply with an individual's request for restrictions on the disclosure of his or her PHI if:

- The disclosure would otherwise be made to a health plan;
- The disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law; and
- The PHI pertains solely to a health care item or service for which the health care provider has been paid in full by the individual or person other than the health plan on the individual's behalf.

The Use of PHI in Fundraising and Marketing, and the Sale of PHI

The Final Regulations made significant changes to the rules regarding fundraising, marketing, and the sale of PHI.

The Final Regulations now permit the use of additional categories of PHI in the fundraising activities of Covered Entities. Specifically, Covered Entities may use department of service, treating physician and outcome information for their fundraising purposes. Fundraising communications (whether in person, over the phone, or written) must, however, provide individuals with clear and conspicuous instructions on how to opt out of receiving future

fundraising solicitations. A Covered Entity’s Notice of Privacy Practices must be reviewed to ensure that it includes a statement that an individual has a right to opt out of receiving fundraising communications.

Covered Entities and Business Associates are prohibited from using or disclosing PHI without authorization—even if for treatment and health care operations—where the Covered Entity (or Business Associate) receives direct or indirect payment for such use or disclosure. HIPAA’s marketing restrictions have certain exceptions, including a communication made to provide refill reminders or otherwise communicate about current prescriptions where any financial remuneration received is reasonably related to the cost of making the communication.

Finally, the sale of PHI is prohibited unless an authorization is provided.

Using or Disclosing the “Minimum Necessary” PHI

With certain exceptions, Covered Entities and Business Associates must use “reasonable efforts” to limit their uses or disclosures of, or requests for, PHI to the minimum amount that is necessary to accomplish the intended purpose. Under HITECH, a Covered Entity is automatically deemed to comply with the minimum necessary standard if it limits its use and disclosure of PHI to a “limited data set”—which is essentially de-identified information, except that dates relating to the individual (such as birth dates and dates of hospital admission and discharge) can be included. The Final Regulations provide no further guidance on this issue but promise it in the future.

Rights of Individuals to Get Enhanced Accounting of Disclosures of Electronic PHI

HITECH requires that Covered Entities that use or maintain an electronic health record will need to account for disclosures of electronic PHI for the purpose of treatment, payment, and health care operations. (Accountings for disclosures of non-electronic PHI do not need to include disclosures for treatment, payment, and health care operations.) Individuals will have the right to request an accounting of all such disclosures made in the three-year (rather than the otherwise applicable six-year) period prior to the accounting request. The Final Regulations did not address this requirement, which will not be effective until final regulations are issued on the accounting rules.

Significantly Enhanced HIPAA Enforcement Provisions

HITECH considerably increased the civil monetary penalties that may be assessed under HIPAA against Covered Entities and (new) Business Associates. Specifically, penalties for violations are determined with a tiered approach:

Violation Due to:	Penalty Range (per Violation):
Unknown cause	\$100-\$50,000
Reasonable cause and not willful neglect	\$1,000-\$50,000
Willful neglect (violation corrected within 30 days)	\$10,000-\$50,000
Willful neglect (violation not corrected within 30 days)	At least \$50,000

A \$1.5 million annual cap applies for violations of an identical privacy or security requirement.

The Final Regulations revised the factors that can be considered in determining the penalty amount and amended the definition of reasonable cause. For purposes of assessing penalties, any act or omission that a Covered Entity or Business Associate knew, or by exercising reasonable diligence would have known, violated the HIPAA privacy or security rules will be deemed to be a violation due to reasonable cause, provided the Business Associate did not act with willful neglect.

HITECH requires HHS to perform periodic audits of Covered Entities and Business Associates to ensure that they are complying with the HIPAA privacy and security rules. Under the Final Regulations, when a preliminary review of the facts in either a compliance review or a complaint investigation indicates a possible violation due to willful neglect, HHS must conduct a review to determine whether the Covered Entity or Business Associate is in compliance. HHS may conduct investigations in other circumstances in its discretion. Additionally, HHS is no longer required to resolve investigations or compliance reviews through informal means, meaning that in certain circumstances, HHS may assess penalties without negotiating with impacted Covered Entities and/or Business Associates.

Although not part of the Final Regulations, HITECH also gives state attorneys general the ability to bring civil actions on behalf of residents of their states, and clarifies that an individual who obtains or discloses PHI from a Covered Entity without authorization may be subject to criminal prosecution for a violation of HIPAA.

HIPAA Glossary

The world of HIPAA includes a vocabulary of its own. Key terms that may aid in your understanding include the following:

Business Associate

Generally, a person or entity that performs functions or activities on behalf of, or certain services for, a Covered Entity that involve the use or disclosure of PHI.

Examples include third party administrators, pharmacy benefit managers, claims processing or billing companies, and persons who perform legal, actuarial, accounting, management, or administrative services for Covered Entities and who require access to PHI. They also include certain information technology providers, health information organizations, most entities that provide data or document transmission and storage services with respect to PHI to a Covered Entity, and Subcontractors that create, receive, maintain, or transmit PHI on behalf of a Business Associate.

Business Associate Agreement

A contract between a Covered Entity and a Business Associate or between a Business Associate and a Subcontractor that governs each party's rights and obligations under HIPAA. Business Associate Agreements are required under the privacy rule.

Covered Entities

Health care providers that transmit health information in electronic form in connection with certain transactions; health plans (including employer-sponsored plans); and health care clearinghouses.

We specifically note that employers who sponsor self-insured group health plans will need to take the action items noted in this article on behalf of their health plans. For employers who sponsor fully-insured group health plans, the majority of these obligations will ordinarily fall on the insurance carrier.

Protected Health Information or PHI

Generally, "individually identifiable health information" that is transmitted or maintained in any form or medium, with limited exceptions. "Individually identifiable health information" includes demographic and health information that relates to an individual's health conditions, treatment or payment and can reasonably be used to identify the individual.

Subcontractor

Generally, a person to whom a Business Associate delegates a function, activity, or service. A Subcontractor becomes a Business Associate under HIPAA when it creates, receives, maintains or transmits PHI on behalf of the Business Associate when performing such delegated function, activity, or service.

Unsecured PHI

PHI that is not rendered unusable, unreadable, or indecipherable to an unauthorized person through encryption or destruction, pursuant to guidance published by HHS.



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Is Your Wellness Program Healthy? Final HIPAA Wellness Regulations Issued

The Departments of Labor, Treasury, and Health and Human Services recently issued final regulations on incentive-based wellness programs under the HIPAA nondiscrimination rules. The HIPAA nondiscrimination rules generally prohibit group health plans from discriminating against participants based on their health. The new regulations, which are effective for plan years beginning on or after January 1, 2014, supersede regulations issued in 2006 and set out a safe harbor under which plans may discriminate based on health-related factors (such as medical conditions, claims experience, and the receipt of health care) in order to promote health and prevent disease.

Participatory Wellness Programs

There are two types of wellness programs: participatory programs and health-contingent programs. Participatory wellness programs either do not provide a reward or do not include any conditions for obtaining a reward that are based on satisfying a health-related requirement. Examples of participatory wellness programs include reimbursing employees for gym memberships, free diagnostic testing programs with a reward for mere participation (and with no outcome-based rewards), and education programs with rewards for attendance. Participatory wellness programs are not required to meet the standards set forth under the final regulations because they do not discriminate based on a health status factor, and thus do not need special protection from the otherwise applicable HIPAA nondiscrimination rules. They must simply be offered to all similarly situated individuals.

Health-Contingent Wellness Programs

In contrast, health-contingent wellness programs, which require individuals to satisfy a standard related to a health factor in order to receive a reward, must meet certain criteria to avoid being deemed discriminatory under HIPAA. Specifically, the program must satisfy five requirements.

1. Individuals must be offered the opportunity to qualify for the reward at least once per year.
2. The maximum reward that can be offered is limited to 30% (up from 20% under the 2006 regulations) of the total cost of coverage under the plan (with up to an additional 20% reward permissible for programs designed to prevent or reduce tobacco use).
3. The program must be reasonably designed to promote health or prevent disease.
4. The program must offer a "reasonable alternative standard" to obtain the reward.
5. The availability of a "reasonable alternative" to qualify for the reward must be disclosed in all plan materials describing the wellness program.

Reasonable Alternative Standard

Aside from the increase in the maximum permissible reward, the biggest change to the rules regarding health-contingent wellness programs relates to the requirement to provide a "reasonable alternative standard" to obtain the reward. Specifically, the final regulations create two new subcategories of health-contingent wellness programs: activity-only programs and outcome-based programs.

Activity-only programs require an individual to perform or complete an activity related to a health factor in order to qualify for a reward. Activity-only wellness programs do not, however, require an individual to attain or maintain a specific health outcome. Examples of activity-only programs include walking challenges or diet programs. Alternatively, outcome-based programs are programs that require an individual to meet or maintain a specific health outcome to earn a reward. Examples of outcome-based programs include programs that reward individuals for meeting a certain BMI or not using tobacco products.

As noted above, health-contingent programs are generally required to offer a reasonable alternative standard in order to qualify for a reward. Activity-only programs are required to offer a reasonable alternative to only those individuals who request such an accommodation and are able to demonstrate that it is unreasonably difficult or medically inadvisable for them to satisfy or attempt to satisfy the activity generally required to receive the reward. Thus, for example, if a walking program requires employees to walk 30 minutes a day in order to receive a reward, and an employee is unable to walk due to an injury, then the plan must provide a reasonable alternative by which the employee can attain the reward. For instance, the alternative might be attending a health and fitness educational program; or, if the injury is temporary in nature (such as a broken leg), the plan may waive the standard until the injury is healed.

In the case of outcome-based programs, reasonable alternatives must be offered to any individual who requests an accommodation (regardless of whether they can show it would be unreasonably difficult or medically inadvisable to meet the program's otherwise applicable criteria). For example, if an outcome-based weight loss program requires that employees maintain or achieve a BMI of less than 30 to qualify for a reward and an employee does not wish to or cannot achieve that BMI, then a reasonable alternative might be walking 150 minutes a week. Of course, this alternative would need to comply with the activity-based rules.

Moreover, the following special rules (among others) apply to reasonable alternatives.

1. If the reasonable alternative is an educational program, the plan must help the individual locate an appropriate program and may not require the individual to pay the cost of the program.
2. The time commitment associated with any reasonable alternative must be reasonable.
3. If the reasonable alternative is a diet program the individual cannot be required to pay a membership or registration fee (but can be charged the cost of food).
4. If an individual's physician says a particular plan standard is not medically appropriate for the individual, the plan must provide a reasonable alternative that is deemed medically appropriate by the individual's physician.

Preparing for 2014

Now is a good time to review and re-evaluate your current wellness programs and prepare them for any changes required in 2014. In addition to the HIPAA rules discussed above, there are also other laws that may apply to both your participatory and health-contingent wellness programs, including ERISA and the ADA. If you have any questions about your wellness plans, please contact one of Venable's [employee benefits attorneys](#).

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Tax Bulletin

June 27, 2013

After DOMA: Impacts on Tax and Benefits Planning

What Federal benefits should be afforded to same-sex spouses as a result of the Supreme Court's decision?

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The Supreme Court's rulings yesterday in *United States v. Windsor* and *Hollingsworth v. Perry* will have far-reaching legal implications for same-sex couples in the United States.

In delivering the opinion of the Court in *Windsor*, Justice Kennedy stated:

"DOMA undermines both the public and private significance of state-sanctioned same-sex marriages; for it tells those couples, and all the world, that their otherwise valid marriages are unworthy of federal recognition. This places same-sex couples in an unstable position of being in a second-tier marriage. The differentiation demeans the couple, whose moral and sexual choices the Constitution protects, ... and whose relationship the State has sought to dignify. And it humiliates tens of thousands of children now being raised by same-sex couples. The law in question makes it even more difficult for the children to understand the integrity and closeness of their own family and its concord with other families in their community and in their daily lives.

The federal statute is invalid, for no legitimate purpose overcomes the purpose and effect to disparage and to injure those whom the State, by its marriage laws, sought to protect in personhood and dignity. By seeking to displace this protection and treating those persons as living in marriages less respected than others, the federal statute is in violation of the Fifth Amendment."

These words struck down Section 3 of the Defense of Marriage Act ("DOMA"), which defined the word "marriage" at the Federal level to mean only "a legal union between one man and one woman as husband and wife", and the word "spouse" as only "a person of the opposite sex who is a husband or a wife." *Windsor* did not address Section 2 of DOMA, which allows states to refuse to recognize a same-sex marriage legally entered into in another state.

The Court dismissed *Hollingsworth v. Perry* on procedural grounds, stating that the proponents of California's Proposition 8 did not have standing to appeal the lower courts' rulings declaring the proposition unconstitutional. As a result, the United States District Court's ruling stands, and clears the way for same-sex marriage in California (more below). If the Court had found that the supporters of Proposition 8 had standing, it would have had an opportunity to rule on the constitutionality of same-sex marriage bans across the country.

The combined holdings mean that those couples who were legally married in California (before Proposition 8 and after *Hollingsworth v. Perry*), Connecticut, the District of Columbia, Iowa, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont or Washington (or who will be married in Delaware on or after July 1, or Minnesota or Rhode Island on or after August 1) and reside in one of those states will now be treated as spouses for purposes of over 1,000 Federal laws.

Where a same-sex couple was legally married in one state but now resides in a state that does not recognize same-sex marriage, the couple will not be afforded the benefits of married couples in their state of residence; moreover, as noted by Justice Scalia in his dissent, uncertainty remains as to whether such couple will be considered married for Federal purposes. It is speculated that action by the executive branch may resolve this uncertainty by applying a uniform, Federal agency-wide definition of "marriage" as being determined by the state of celebration, and not the state of residence.

Implications for Same-Sex Spouses

Here are some of the Federal benefits that should be afforded to same-sex spouses as a result of the Supreme Court's decision in *Windsor*:

- The ability to pass wealth from one spouse to the other at death without the payment of Federal

estate taxes, thanks to the marital deduction, and the ability to inherit the first deceased spouse's unused estate and gift tax exemption. These changes will have a substantial and favorable impact on the ability to do estate planning for same-sex spouses.

- Deferral of income recognition when a surviving spouse inherits a deceased spouse's IRA or other qualified retirement plan, as the surviving spouse can "roll over" the account to his or her own retirement account, potentially deferring the required dates for distribution.
- The ability for a wealthier spouse to support a less wealthy spouse without the concern of making taxable gifts, as the marital deduction also applies to gifts between spouses.
- Splitting gifts to treat a gift made by one spouse to a third party as having been made one-half by each spouse.
- Simpler Federal income tax returns. Same-sex spouses may file joint Federal income tax returns, with the resulting "marriage penalty" for spouses who both work and have comparable earnings, and resulting benefits for spouses who have disparate earnings or where one spouse is a homemaker.
- Social Security retirement and death benefits, with the greatest benefit going to those couples where only one spouse has been employed.
- A U.S. citizen spouse should be able to sponsor a non-citizen spouse for legal permanent resident status.
- Military same-sex spouses will be eligible for benefits such as health coverage and housing allowances, as well as the right to be buried together at Arlington National Cemetery.

Because the *Windsor* ruling holds that DOMA has been unconstitutional since its inception, same-sex spouses should re-examine their past income, gift and estate tax returns where the statute of limitations has not expired. If filing joint Federal income tax returns would reduce the income tax liability, taxpayers may amend the returns and request a refund. Like the plaintiff in *Windsor*, estate tax refunds may be claimed as well. The flip side is that those same-sex spouses who engaged in sophisticated estate planning to take advantage of the fact that they were not considered spouses at the Federal level (by creating common-law grantor retained income trusts and the like) should immediately revisit their estate plans.

Clients with children or grandchildren who have entered into same-sex marriages should also re-examine their estate plans, as it may be necessary to modify the definitions of "spouse" and "children" or "issue" to ensure the intended beneficiaries will inherit regardless of whether the documents are interpreted in a state that permits same-sex marriage or a state that does not recognize it.

Employee Benefits Implications

The *Windsor* holding will also have a significant impact on the administration of employee benefit plans for same-sex married couples. Eligibility for employee benefit plans has historically been the purview of plan sponsors. However, such plans are generally governed by Federal law, and thus have been prohibited in certain ways from treating same-sex married couples the same as opposite-sex married couples.

With respect to health benefits, this has meant that, although employers may have provided coverage to the same-sex spouses of their employees, such coverage was often not eligible to be paid for on a pre-tax basis. With the reversal of DOMA, employees with same-sex spouses will now be eligible for the Federal tax advantages applicable to spouses. Similarly, same-sex spouses will now be afforded rights under COBRA when their coverage under an employer plan terminates.

The decision will also have an impact on retirement plans. Many legal provisions relating to such plans are tied to the employee's marital status, including notice and distribution rules. Such plans should now have to recognize any same-sex marriage that is valid under state law for these purposes.

Implications for California Couples

It should be noted that, even though it appears likely that same-sex couples will shortly be able to marry in California, the issue remains complicated. California Attorney General Kamala Harris has said that every California county must now recognize the right of same-sex couples to legally marry, and that such marriages will resume as soon as the U.S. Ninth Circuit Court of Appeals lifts its stay on the District Court ruling that declares Proposition 8 unconstitutional in California and requires the state to permit same-sex marriage. The Ninth Circuit has said that it would wait at least 25 days to put the District Court ruling into effect; consequently, Governor Brown has stated that he expects same-sex

marriages to resume in California in about 30 days. However, proponents of Proposition 8 have indicated that they believe the decision in *Hollingsworth* is only applicable to the two same-sex marriages at issue in that case, and they will continue to seek legal enforcement of Proposition 8.

Many practical questions exist as to how the changes mandated by the Supreme Court's far-reaching decision will be implemented. Accordingly, we encourage those same-sex couples, employers and others who may be impacted by the *Windsor* decision to reach out to a member of Venable's **Tax and Wealth Planning** and **Employee Benefits Groups** to determine how to move forward given this significant change in the legal landscape.

Employee Benefits and Executive Compensation Alert

January 2013

Limited Relief for Employers under Health Care Reform's "Play-or-Pay" Rules

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Proposed regulations issued by the Internal Revenue Service on December 28, 2012 provide some relief to large employers subject to the employer-sponsored coverage mandate under health care reform. The employer mandate is described in detail in our prior alert that can be accessed at the following link:

[Don't Play and Also Pay: Navigating the Employer-Sponsored Health Coverage Mandate.](#)

Although issued as proposed regulations, employers may rely on these rules pending the issuance of final regulations or other applicable guidance. Below are highlights of some of the key changes to the employer mandate incorporated in the proposed regulations.

Key Changes Relating to the Implementation of the No Coverage Penalty

In the event that an employer becomes subject to the no coverage penalty, the employer is generally required to pay a monthly penalty of \$166.67 (adjusted for inflation) multiplied by its total number of full-time employees (excluding the first 30). The new guidance reduces this potential burden in two key ways.

First, the statute states that the no coverage penalty applies if a large employer "fails to offer to its full-time employees (and their dependents)" health coverage. Therefore, the statute could have been interpreted by the IRS to mean that the no coverage penalty was triggered where an employer failed to offer coverage to even just one of its full-time employees. The proposed regulations indicate that the IRS has adopted a more liberal approach—thereby reducing the risk to an employer of triggering the no coverage penalty by providing that the penalty applies only if an employer fails to offer coverage to more than 5% (or, if greater, five) of its full-time employees. Thus, provided at least 95% of full-time employees (and their children)¹ are offered coverage, the no coverage penalty will not apply. This clarification provides employers with a much needed "margin for error" in applying the complex IRS rules defining full-time employees for penalty purposes. Notably, however, if one of these full-time employees who were not offered employer-sponsored coverage purchases health insurance through a state-based or federally-facilitated exchange, the unaffordability penalty may be triggered.

Second, the proposed regulations clarify that the no coverage penalty is not calculated on a controlled group basis. Instead, the penalty is applied company-by-company. Thus, if a company within a controlled group becomes subject to the no coverage penalty, the penalty will be calculated based only on that company's full-time employee count (minus its allocable share of the 30-employee reduction). While the determination of whether an employer is "large" for purposes of the employer mandate (and thus subject to the mandate) continues to apply on a controlled group basis, this change provides significant relief to companies that are part of large controlled groups. The change also provides a planning opportunity for employers who wish to limit their potential overall exposure to the no coverage penalty.

The new guidance also provides significantly more detail on how the IRS will implement its existing guidance defining a "full-time" employee for purposes of applying the no coverage penalty. The regulations incorporate and refine the prior guidance on a safe-harbor for determining full-time status based on a "look back" measurement period. They provide detailed rules on how hours and leaves will be calculated, as well as how breaks in service will be treated. These rules require employers to make nuanced plan design decisions. To ensure consistent application, these decisions will likely need to be captured in plan documents or policies.

New Safe Harbors Apply to the Unaffordability Penalty

Even if an employer offers health coverage to its full-time employees (and their children), it can be subject to penalties if that coverage is deemed "unaffordable" or does not provide "minimum value." Specifically, the employer is required to pay a monthly penalty of \$250 (adjusted for inflation) multiplied

by the number of full-time employees who purchase health insurance through a state-based or federally-facilitated exchange and receive a government subsidy. Generally, coverage is defined as “affordable” if the required employee contribution towards self-only coverage is not more than 9.5% of the employee’s household income. A plan fails to provide minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of those costs. The proposed regulations do not address minimum value, and the IRS plans to propose additional guidance on minimum value in the future.

The proposed regulations do, however, set out three basic safe harbors on which employers can rely in setting employee premiums for self-only coverage at an affordable level without knowing the employee’s “household income.” First, under the W-2 safe harbor, the premium for self-only coverage is affordable unless it exceeds 9.5% of the Box 1 wages reported by the employer for the employee for a given year (or shorter period if the employee was not covered for the full year). Second, a new safe harbor allows an employer to measure the 9.5% against the employee’s rate of pay. Specifically, coverage is deemed affordable if monthly premiums do not exceed 9.5% of the employee’s hourly rate of pay times 130 (or, if salaried, the employee’s monthly salary). Finally, coverage is deemed affordable if it does not exceed 9.5% of the federal poverty line for a single individual.

Transitional Relief

The new proposed regulations will be particularly welcomed by sponsors of non-calendar year plans, in that they provide that, in most cases, the employer penalties will not apply prior to the beginning of the first plan year beginning in 2014. The transitional relief also provides special rules relating to the use of “look back” periods for the 2014 plan year. These rules allow employers some flexibility to shorten their 2013 “look back” periods.

The proposed regulations discussed above are just one small piece of the significant body of guidance relating to the implementation of health care reform issued in the closing weeks of 2012. Please join Venable as we discuss this and other guidance in more detail at the *Changing Landscape for Employer Health Plan* events later this month. Please [click here](#) for more information and to register.

¹ - The proposed regulations require that employer plans offer coverage to dependents—specifically children of employees—to avoid running afoul of the no coverage penalty. In contrast, coverage does not need to be offered to spouses. The proposed regulations define an employee’s dependents for this purpose as employee’s children who are under 26 years of age. (There is a transitional rule that provides some relief to plans that do not currently offer dependent coverage until plan years that begin in 2014.) It is important to note, that the unaffordability penalty, however, remains triggered only if the employee’s required contribution for self-only coverage is more than 9.5% of his or her household income for the taxable year.

Employee Benefits and Executive Compensation Alert

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Don't Play and Also Pay: Navigating the Employer-Sponsored Health Coverage Mandate

On Friday, August 31, the Internal Revenue Service (IRS) issued much anticipated guidance regarding the application of the employer-sponsored health coverage mandate (often called the “play or pay rules” under health care reform). Employers need to begin planning for these rules as soon as possible. While the employer coverage mandate itself does not apply until 2014, it may be necessary to begin tracking the hours of employees as soon as this October in order to facilitate compliance.

The Play or Pay Rules Generally

The employer-sponsored health coverage mandate is designed to require “applicable large employers”¹ either to provide employees with adequate and affordable health coverage or to require those employers to pay certain penalties for their failure to do so. Specifically, penalties are triggered if:

- (1) An employer fails to offer all of its “full time employees” the opportunity to enroll in an employer-sponsored health plan; or (2) the employer-sponsored health plan offered to “full time employees” is “unaffordable” or fails to provide “minimum value”; AND
- Any employee impacted by such a failure purchases individual health insurance coverage through a State-based or Federally-facilitated Exchange and qualifies for a subsidy.²

Failure to Provide Coverage

Employers who fail to provide coverage to all of their “full time employees” are subject to a penalty of \$2,000 per year (assessed on a monthly basis) multiplied by their total “full time employee” count.³ For employers that provide health coverage, the challenge with respect to this rule is identifying all of their “full time employees”—and making sure all such employees are offered coverage. In the event that even one “full time employee” is not offered coverage and subsequently attains subsidized coverage through an exchange, the penalty is applied to all “full time employees.” Thus, with respect to any employees who do receive employer-sponsored coverage, the employer could end up “playing” and “paying.”

Generally, health care reform defines a “full time employee” as any employee working on average at least 30 hours a week. The new IRS guidance clarifies that this definition not only includes those individuals who can be reasonably expected to work on average at least 30 hours a week, but may also encompass certain “variable-hour employees.”

The guidance provides a safe harbor for determining if an employee is full time that allows employers some relief from the need to monitor employee status on a monthly basis. This is especially useful for those employers with high turnover and a significant number of variable-hour employees. Specifically, the guidance allows an employer to monitor the hours of a variable-hour employee over a three to twelve month “measurement” or “look-back” period to determine if the employee averaged 30 or more hours per week during that period. The employer can then rely on those results for purposes of determining whether coverage should be offered to that employee during a subsequent six-to twelve- month “stability period” to avoid the no coverage penalty.

The new guidance also introduces the concept of an administrative period between a measurement period and its corresponding stability period to allow employers to enroll employees determined to be full time based on the prior measurement period. Depending upon the length of the measurement, stability, and administrative periods elected, the first measurement period for some employers may begin as early as October 1, 2012.

Failure to Provide Affordable/Adequate Coverage

The second penalty under the play or pay rules applies to employers who offer all of their full time employees coverage, but such coverage is too expensive or deemed inadequate. The penalty, \$3,000 per year (assessed on a monthly basis), applies only with respect to those full time employees who

actually receive subsidized health coverage through an exchange.

For purposes of this rule, coverage is deemed to be “unaffordable” if the employee premium for the lowest-priced “employee only” plan option available through an employer exceeds 9.5% of that employee’s household income. The new guidance issued last week confirms that employers do not have to actually determine an employee’s household income for purposes of administering this rule. Instead, an employer can assume that an employee’s household income is equal to the W-2 income provided to that employee by the employer for purposes of determining if the coverage it offers is affordable.

This penalty is also triggered if the coverage provided through an employer-sponsored plan does not provide “minimum value.” A plan fails to provide minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. Definitive guidance on how to make this determination has not yet been issued; however, preliminary indications from the government suggest that a calculator will be made available for purposes of making these determinations.⁴ In addition, the government has suggested that certain safe-harbor checklists will be issued to allow employer-sponsored plans to confirm they offer minimum value without performing any calculations.

Additional Guidance Regarding the Limitation of Waiting Periods

Health care reform prohibits employer-sponsored health plans from imposing waiting periods of greater than 90 days. The Departments of the Treasury, Labor, and Health and Human Services issued joint guidance last Friday on the prohibition of extended waiting periods for participation in employer-sponsored plans. Among other things, the new guidance describes the interaction of this rule with the no-coverage penalty discussed above. It clarifies that the use of properly designed measurement periods will not be deemed to be a violation of the 90-day waiting period limitation. It also provides additional information about how this rule should be applied in practice, including with respect to part-time employees.

Preparing for 2014—Avoiding Penalties Is Not as Simple as Merely Providing Coverage

To avoid this result, it is necessary for employers to evaluate which employees are eligible for coverage under existing plans, track the hours of any excluded employees, monitor the income of low-paid full time employees in relationship to plan premiums, and, once further guidance is issued, confirm their plan offers adequate coverage. This is no small task, but with thorough planning, employers can implement the required plan changes and tracking systems necessary to avoid penalties.

Venable’s **Employee Benefits and Executive Compensation Group** looks forward to helping employer-clients continue to navigate health care reform as they prepare for 2014.

¹ The term “applicable large employer” means any employer with fifty (50) or more full time equivalent employees during the preceding calendar year. For this purpose, the hours of part-time employees are aggregated.

² Individuals/families with income of up to 400% of the federal poverty level may qualify for a subsidy. For 2012, this amount is \$44,680 for an individual and \$92,200 for a family of four. Exchanges are the new marketplaces that will offer individual health coverage in 2014.

³ This penalty applies on a controlled group basis, meaning that all full time employees within a group of closely related companies may need to be counted for purposes of calculating the penalty. For purposes of calculating this penalty, the first 30 full time employees can be disregarded.

⁴ Plans with nonstandard features will be able to rely on actuarial certifications in lieu of relying on the calculator.



ACA Employer Shared Responsibility Penalty Delayed

On Tuesday, July 2, the U.S. Department of the Treasury announced it would delay the employer shared responsibility penalty (a.k.a. "pay or play" penalty) contained in the *Patient Protection and Affordable Care Act* (PPACA or ACA) until January 1, 2015. This ACA initiative requires large employers (with 50 or more full time employees plus full-time equivalents) to either offer minimum essential and affordable coverage or pay a penalty. Originally, this aspect of the law was scheduled to take effect January 1, 2014.

"Although the penalty won't be applied this year, many elements of the law will still go into effect," says Nicole Fallon, a health care consultant with CliftonLarsonAllen. "Employers should keep preparing for implementation of other requirements."

Since the announcement, the Obama administration has continued to clarify what this delay means for employers and how it impacts the implementation of other portions of the law scheduled to go into effect January 1, 2014.

What does the delay mean for employers?

Large employers will not need to offer their full-time workers and their dependent children minimum essential and affordable coverage in 2014. They will not have to file an information return with the IRS indicating who their full-time employees are, what coverage they offer, which employees are enrolled, etc. in 2014. The IRS anticipates further guidance will be issued this summer regarding what employers will have to report in information returns in 2015.

However, employers still need to explain available the coverage options to all employees (full and part time), regardless of the employee's enrollment status in the employer plan prior to October 1, 2013. They will also need to provide:

- Descriptions of the new state and federal health insurance exchanges (also called marketplaces), services offered, and contact information
- Details on eligibility for assistance to purchase insurance through the exchanges
- Information regarding the employee's loss of eligibility for employer contribution to health benefits if insurance is purchased through an exchange

(The Department of Labor has model notice language on its website for employers who offer a health plan, as well as employers who do not offer a health plan.)

Employers must also pay various fees under the ACA, including the Patient Center Outcomes Research Institute (PCORI) fee by July 31, 2013, if self insured. (The fee is \$1 per enrollee for 2014, based on the number of employees reported on IRS Form 720.) Similarly, the transitional reinsurance fee of approximately \$63 per enrollee must be submitted at the end of 2014 by employers for self-insured plans and by insurers for fully-insured plans.

Employer responsibilities that have not been delayed include the following:

- Ensuring that the employee waiting period for enrolling in employer-sponsored insurance coverage does not exceed 90 calendar days (beginning in 2014)
- Providing a summary of benefits and coverage when plans are changed
- Ensuring that out-of-pocket maximum limits do not exceed \$6,350 for individuals and \$12,700 for families (\$2,000/\$4,000 for small employers) beginning in 2014



Federal and state exchanges are still scheduled to open October 1, 2013, and all individuals will need to obtain minimum essential coverage in 2014 or pay a penalty when they file their 2014 taxes.

- Reporting the value of the health care coverage on their employees' W-2 forms. (Employers issuing fewer than 250 W-2s are not required to comply per IRS Notice 2011-28 until further guidance is issued.)

What does this mean for individuals and employees?

Federal and state exchanges are still scheduled to open for enrollment October 1, 2013. All individuals will still need to obtain minimum essential coverage in 2014 or pay a penalty when they file their 2014 taxes. (This is the "individual mandate.") People who earn between 100-400 percent of the federal poverty level and do not have access to affordable coverage through an employer will still be eligible for exchange subsidies -premium tax credits, and/or cost sharing assistance. And finally, insurers cannot deny coverage to an individual for a pre-existing condition.

What remains unclear?

Many questions remain unanswered about the law. For instance, how does one determine if employees like truck drivers, adjunct professors, missionaries, and consumer-directed caregivers are full-time employees? Additionally, earlier guidance from the IRS offered employers some transition relief in preparing for the 2014 implementation. The delay notice and corresponding regulations issued as of July 12, 2013, do not address whether the 2014 transition relief will be applicable for determining whether an employer is considered a large employer or identifying which employees are considered full-time for the January 1, 2015, implementation. Therefore, expect additional guidance in the coming months.

What should employers do now?

We recommend that employers continue to evaluate the following in preparation for the January 1, 2015, implementation by answering the following questions:

- Are you a large employer with 50 or more full-time employees plus full-time equivalents (based on the definition that a full-time employee works an average of 30 hours per week of paid time)?
- If you are a large employer, do you offer minimum essential and affordable coverage to at least 95 percent of your full-time employees and their dependent children under age 26?
- If you are a large employer, have you evaluated the cost of not offering coverage to offering coverage in 2015? (CLA's HIP Calculator can help you develop an estimate.)
- Have you evaluated your current systems for tracking employee wages, hours, and premiums on a per employee basis, as well as on a weekly and monthly basis? This information will be needed to use a look-back measurement period in 2014 for the 2015 implementation and will probably be needed for IRS reporting in 2015.

How we can help

CliftonLarsonAllen will continue to monitor the regulatory activity related to the ACA and provide updates on new developments as they unfold in the coming weeks and months. More information can be found at CLACONNECT.COM/HEALTHREFORM.

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Employers Must Pay New Excise Tax on Self-Insured Health Plans By July 31

Employers that sponsor a self-insured health plan have until July 31, 2013, to submit an updated form and payment for a new tax requirement. The new fee was established by the *Patient Protection and Affordable Care Act* (PPACA) to fund the Patient-Centered Outcomes Research Institute (PCORI), a new initiative to improve health decisions by advancing comparative clinical effectiveness research.

"Earlier this month, the IRS finally released the updated form for submitting this tax," observes Anita Baker, managing partner of the employee benefits group at CliftonLarsonAllen. "Employers with self-insured health plans will need to move quickly to meet the initial filing deadline."

Who is responsible for the fee

Internal Revenue Code Section 4376 imposes a new PCORI fee on self-insured health plans. Generally, this is any plan providing accident and health coverage other than through an insurance policy.

Below is a summary of plans for which the PCORI fee applies and those which are exempt:

Plans subject to the fee

- Self-insured medical plans or medical reimbursement plans
- Prescription drug plans
- Self-insured dental or vision plans, if provided without a separate election or premium charge
- Health reimbursement arrangements (HRAs)
- Retiree-only health plans (even though some are exempt from other PPACA mandates)

Plans exempt from the fee

- Separately insured dental or vision plans
- Self-insured dental or vision plans, if subject to separate coverage elections and employee contributions
- Expatriate coverage provided primarily for employees who work and reside outside of the U.S.
- Health savings accounts (HSAs)
- Most flexible spending accounts (FSAs)
- Employee assistance programs (EAPs), wellness programs, and disease management programs that do not provide "significant benefits in the nature of medical care or treatment"

For single-employer plans, the employer is responsible for the fee. In addition, organizations must pay the fee for plans established and maintained by an employer organization. Both for-profit and nonprofit employers are subject to the fee, along with governmental medical reimbursement plans (unless they cover military members or Indian tribes).

"A similar fee applies to insured plans," notes Baker. "That fee is not imposed on the employer, but rather on the issuer of the insurance policy."

How to calculate the fee

Employers can figure out how much they must pay by multiplying the average number of "lives covered" for the plan year by the rate of tax. Fortunately, the tax rate per participant is nominal:



"Employers with medical reimbursement plans will need to move quickly to meet the July 31, 2013, initial filing deadline." — Anita Baker, Employee Benefit Plans Managing Partner

Plan year ending	Rate of tax
Between October 1, 2012 and September 30, 2013	\$1
Between October 1, 2013 and September 30, 2014	\$2
On or after October 1, 2014	To be determined

To determine the number of lives covered, the employer must count not only the employee, but any family members that are covered under the medical reimbursement plan. IRS regulations allow the employer to determine the average number of lives covered by using one of three methods:

1. **Actual count** — The employer determines the total lives covered for each day of the plan year and divides that total by the number of days in the plan year.
2. **Snapshot** — There are two approaches to the snapshot method, but both use the same basic method. A number of lives covered is computed on a date during each quarter, added together, and divided by four.
 - i. Snapshot count: Actual number of lives covered is used for each designated date.
 - ii. Snapshot factor: Computed by taking the sum of the following:
 - Number of participants with self-only coverage
 - Number of participants with other than self-only coverage multiplied by 2.35
3. **Form 5500** — For employers filing an annual Form 5500, Annual Return/Report of Employee Benefit Plan, the average number of lives may be derived from the total participants as reported on the form at the beginning and end of the year, divided by two. Generally, a plan with fewer than 100 participants is not required to file Form 5500.

A special rule applies if an HRA is the only self-insured plan. In that case, the employer may count only the employee as covered (family members are ignored). See IRS Regulation 46.4376-1(c)(2) for more details on these rules and the three methods for calculating lives covered.

When to pay the fee

Employers must submit Form 720, Quarterly Federal Excise Tax Return when paying the tax.

The form is designed for a variety of excise taxes and is normally sent quarterly. However, for the PCORI fee, employers must file the form annually by July 31 of the calendar year immediately following the last day of the plan year. For example, an employer with a 2012 calendar year group health plan must file the form with the PCORI fee by July 31, 2013.

The PCORI fee is computed under Part II of the form, at No. 133. The employer simply enters the average number of lives covered, multiplies by the rate of tax (\$1 per covered life currently), and remits the fee with the form.

"Unfortunately, there is no de minimis exception for small employers. We have many small business and family entities that only have one or two covered lives that are still required to submit the Form 720, just like a large corporation with several thousand employees in a self-insured plan," states Baker. "And the IRS recently announced that this fee is tax deductible, even though it is remitted to the IRS on a tax form," she adds.

How we can help

Some small employers who utilize a third party administrator, such as those whose group health plan is provided through AgriPlan or BizPlan, will have their Form 720 completed by their sponsor. Others who self-administer their group health plan will need to take responsibility for filing this form.

Please contact your CliftonLarsonAllen tax advisor if you have questions. Our employee benefits group can provide assistance to larger employers who need help identifying which components of their health plans are subject to this fee, or determining the best method to assess the annual number of lives covered.

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