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Connecting the Dots for Nonprofits on Healthcare Reform:

The Exchanges, the Premium Subsidies, and the Employer Mandate

September 12, 2013

Venable LLP

Washington, DC

Moderator:

Jeffrey S. Tenenbaum, Esq., Venable LLP

Panelists:

Chris Bartnik, Wells Fargo Insurance

Thora A. Johnson, Esq., Venable LLP

Christopher E. Condeluci, Esq., Venable LLP

Presentation

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Thursday, September 12, 2013, 8:30 a.m. – 10:00 a.m. ET
Venable LLP, Washington, DC

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Upcoming Venable Nonprofit Legal Events

September 18, 2013 – Keeping Up with Technology and the Law: What Your Nonprofit Should Know about Apps, the Cloud, Information Security, and Electronic Contracting

October 24, 2013 – The IRS Final Report on Nonprofit Colleges and Universities: Lessons for All Tax-Exempt Organizations

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Agenda

- Introduction
- The Exchanges and The Subsidies
- Preparing for the Employer Mandate
- Employer Strategies
- Other Fees and Market Reform Provisions

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The Exchanges and The Subsidies

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The Drivers of Health Care Reform?

- Reform Insurance Laws
  - Mandate certain insurance standards
    - For example, “Essential Health Benefits,” “Actuarial Value,” Cost-Sharing Limitations, “Grandfather” Rules
- Coverage - Priority #1
  - Expand Medicaid
  - Provide premium subsidies to help low- to middle-income people purchase health insurance
    - The new health insurance Exchanges created under PPACA became the mechanism through which these subsidies could be accessed

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The Exchange – The “Concept”

- The original intent of the Exchange created under ACA 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

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
    - 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
- An Exchange may be structured as (1) a governmental agency or (2) an independent non-profit entity

What Should You Know about the ACA Exchanges?

- 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
  - To date, 7 States have an "active purchaser" Exchange

The ACA Exchanges – The "Reality"

- October 1st will be a "soft" launch for most ACA Exchanges
  - Many State-based Exchanges – and even HHS with the Federally-facilitated Exchange – have been forced to de-scope the capabilities they planned to have available to consumers during the initial weeks of operation
  - This includes on-line capabilities, real-time enrollment, decision support and education tools, which won't be fully functional until some future date

The ACA Exchanges – The "Reality"

- What are some of the other challenges?
  - IT, IT, IT – establishing an Exchange is one of the most complex IT projects ever initiated by Federal and State governments in the area of health care
  - Verification of data
    - It is likely that not all State-based Exchanges will have completed the necessary rounds of testing with the Federal Data Services Hub by Oct. 1st
    - The debate over whether the Federal government will be able to accurately verify income for purposes of determining subsidy eligibility persist, who to believe?
  - Privacy and security
    - HHS Inspector General raised concerns of unauthorized use of personal information
    - Concerns over mishandling of personal information by the "assisters"

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The Subsidies Offered through the "Public" 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

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The Exchanges & The Premium Subsidies: Impact on Employers

- How will they impact employers?
  - *Behavioral Changes*
    - Small employees 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)

The Exchanges & The Premium Subsidies: Impact on Employers

- Implications of one-year delay of "employer mandate" penalties
  - *Employer Response*
    - No incentive for employers to change their plan designs to satisfy the new requirements in 2014
    - This means more employees who would otherwise be considered "full-time" (i.e., working 30 hours a week) (1) will not be offered an employer plan or (2) will be offered an employer plan that is "unaffordable" or does not provide "minimum value" in 2014
  - *Employer/Employee Relations Issue*
    - If an employee accesses a premium subsidy in 2014, they 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

Preparing for the Employer Mandate

Preparing for the Employer Mandate

DETERMINING IF THE MANDATE APPLIES

- 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

Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Was generally effective January 1, 2014
- Delayed until January 1, 2015
- Many questions on how it will be implemented in 2015

Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Penalty for Failure to Provide Coverage
  - If greater than 5% of "full-time" employees (or 5, if greater) are not offered coverage and even ONE "full-time" employees obtains a subsidy through an Exchange → the "no coverage" penalty is triggered
  - Penalty applies on an employer-by-employer basis

Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Penalty for Failure to Provide Coverage
  - Penalty = $2,000/year * TOTAL number of "full-time" employees
    - Assessed on a monthly basis ($166.67/employee/month)
    - First 30 "full-time" employees are disregarded

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Safe harbor for determining if an employee = "full-time"
  - If an employee averages 30 or more hours of service per week during a measuring period → he or she should be treated as "full-time" (i.e., offered coverage) during the subsequent stability period

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- An "hour of service" is each hour for which an employee is paid, or entitled to payment:
  - For the performance of duties for the employer; and
  - On account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Preparing for the Employer Mandate

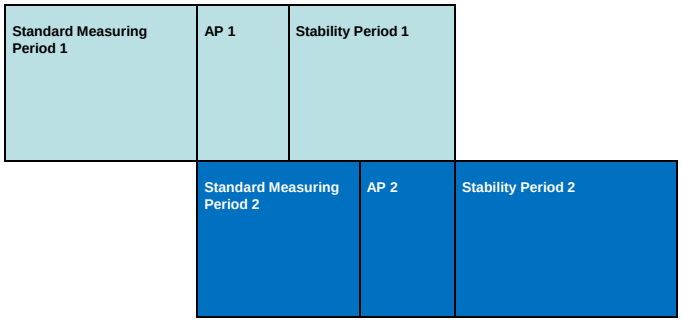
IDENTIFYING FULL-TIME EMPLOYEES

- Standard measuring period = 3-12 months
- Stability period = 6-12 months period immediately following the standard measuring period (and any applicable administrative period)
- Administrative period = up to 90 day period between a standard measuring period and a corresponding stability period

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

Ongoing Testing of Employees



Ongoing Testing of Employees

November 1, 2013 – October 31, 2014	**First Standard Measuring Period** The hours of all employees will be measured for this period to determine if they are "full-time" under the new rules (i.e., average 30+ hours per week).
November 1, 2014– December 31, 2014	**First Standard Administrative Period** During this period, the employer will review the hours during the first standard measuring period and will offer coverage to any employee identified as full-time based on hours from the first standard measuring period. This offer of coverage will extend through the entire first stability period. The employer should maintain documentation of the offer of coverage.
November 1, 2014 – October 31, 2015	**Second Standard Measuring Period**
January 1, 2015 – December 31, 2015	**First Standard Stability Period** Coverage will be maintained for all employees identified as "full-time" based on hours during the first standard measuring period (provided those employees elect coverage and pay applicable premiums).
November 1, 2015 – December 31, 2015	**Second Standard Administrative Period**
November 1, 2015 – October 31, 2016	**Third Standard Measuring Period**
January 1, 2016 – December 31, 2016	**Second Standard Stability Period**

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- At Date of Hire
  - Any individual reasonably expected to complete at least 30 hours of service per week is automatically considered a "full-time" employee
  - All other employees = variable hour employees
  - "Seasonal employees" also = variable hour employees (even if they are initially expected to complete 30 or more hours of service per week)

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Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- No penalties apply during the first three calendar months of employment
- Initial measuring period = 3-12 months
  - Overlaps with first full standard measuring period after employment begins
- Initial measuring period + administrative period cannot extend beyond the last day of the first calendar month beginning on or after the one year anniversary of the employee's start date ("13-month rule")

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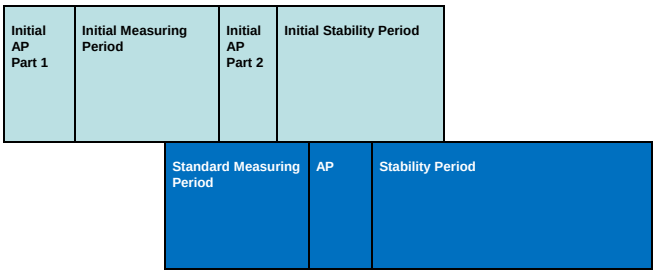
Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

Testing for New Variable Hour Employees



Testing for New Variable Hour Employees

August 15, 2015	Date of Hire
August 15, 2015 – August 31, 2015	**Initial Administrative Period, Part 1** The purpose of this initial administrative period, Part I, is to begin the initial measuring period on the first of the following month. Essentially, all variable hour employees hired in August will begin their initial measuring period on September 1st. This reduces the number of potential initial measuring periods from 365 to 12.
September 1, 2015 – August 31, 2016	**Initial Measuring Period**
November 1, 2015 – October 31, 2016	**Standard Measuring Period** This is the first full standard measuring period commencing after the employee is hired.
September 1, 2016–September 30, 2016	**Initial Administrative Period, Part 2**
October 1, 2016–September 30, 2017	**Initial Stability Period** Coverage will be maintained if the employee is identified as "full-time" based on hours during the initial measuring period (provided the employee elects coverage and pays the applicable premiums).
November 1, 2016–December 31, 2016	**Standard Administrative Period**
November 1, 2016 – October 31, 2017	**Next Standard Measuring Period**
January 1, 2017 – December 31, 2017	**Standard Stability Period** Coverage will be maintained if the employee is identified as "full-time" based on hours during the standard measuring period (provided the employee elects coverage and pays the applicable premiums).

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Change in Employment Status Rule
  - If a **new** variable hour or seasonal employee has a material change in employment status (and would have been considered full-time on their date of hire had they been hired into this new role)→ must be offered coverage by the earlier of:
    - The first day of the fourth month following the change, or
    - The first day of the employee's initial stability period (if full-time based on hours or service during initial measuring period)
  - Rule does not apply to ongoing employees

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Special rules apply to "rehires"
- Rehires can only be classified as new employees if not credited with **any** hours of service for at least:
  - 26 consecutive weeks, or
  - A period of greater than 4 consecutive weeks that exceeds the number of weeks the employee previously worked for the employer
- If the "newness" standard is not met → prior status still applies

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Penalty for Providing "Unaffordable" Coverage
  - Applies if:
    - Employee's share of the premium for lowest-cost employee-only coverage would exceed 9.5% of the employee's income, or an "affordable" plan does not provide "minimum value"—pay at least 60% of the allowed costs under the plan, AND
    - The employee receives a subsidy from an Exchange

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Penalty for Providing "Unaffordable" Coverage
  - Penalty = $3,000/year/employee
  - Only applies to employees who actually receive subsidized coverage through an Exchange
  - Assessed on a monthly basis ($250/employee/month)

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Safe harbors for determining if the cost of coverage exceeds 9.5% of employee's income
  - Form W-2 Compensation
  - Rate of Pay
  - Federal Poverty Limit

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Minimum Value (60%) = plan's anticipated spending for benefits provided under any particular EHB-benchmark plan for any State
- Takes into account
  - All amounts paid towards essential health benefits
  - Current year employer HSA contributions
  - Current year employer HRA contributions (that may not be used to pay premiums
  - Reduced cost-sharing attributable to wellness programs designed to prevent or reduce tobacco use (but not other wellness programs)

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Calculating Minimum Value
  - Must use MV Calculator (unless within a safe harbor)
  - Percentage can then be adjusted based on actuarial analysis of plan features that are outside the parameters of the calculator
- Proposed Safe Harbors
  - **OPTION 1:** $3,500 combined medical and Rx deductible, 80% cost-sharing, $6,000 out-of-pocket maximum
  - **OPTION 2:** $4,500 combined medical and Rx deductible, 70% cost-sharing, $6,400 out-of-pocket maximum, $500 HSA contribution
  - **OPTION 3:** $3,500 medical deductible, $0 Rx deductible, 60% medical cost-sharing, 75% Rx cost-sharing, $6,400 out-of-pocket maximum, Rx co-pays of $10/$20/$50, with 75% co-insurance for specialty drugs

Preparing for the Employer Mandate

THE EMPLOYER EXCHANGE NOTICES

- "Notice of Coverage Options"
- Must be distributed to all employees by October 1, 2013 and to all new employees thereafter
- Includes
  - Basic information about the exchanges
  - Detailed information about coverage available through the employer

Employer Strategies

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Employer "play or pay" mandate- 2015

No minimum essential coverage: employer does not offer coverage for all full-time employees (working 30 hour per week) and at least one employee obtains subsidized exchange coverage

$2,000 annually ($166.67 per month) times total number of full-time employees of employer
- Exclude first 30 FT Employees

Applicable large employer
- 50 or more full-time equivalent employees

$3,000 annually ($250 per month) per each full-time employee that receives premium tax credit /cost-sharing reduction from an exchange
- Penalty is capped at penalty assessed for not offering minimum essential coverage
- No penalty applies to employees enrolling in Medicaid

Offers unaffordable coverage or coverage that does not meet minimum AV (60% AV): employee obtains subsidized exchange coverage

Amounts will be indexed in 2015

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What is the employer Play or Pay mandate?

Step 1
"Fair"
Employee Access

Offer MEC to employees working ≥30 hrs/week (130 hrs./month)

Step 2
"Acceptable"
Health Insurance

"Minimum Value" (60% Actuarial Value)

Step 3
"Affordable"
Employee Contributions

*< 9.5% of Household Income (or one of three safe harbors)
* Amount indexed in 2015

Insurance Exchange < 400% of Federal Poverty Level (FPL)

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What are the main risks faced by employers under the Play or Pay mandate?

For employers with 50 or more FTEs:

- Identify all FT employees as defined by the ACA
- Offer MEC to all FT employees – at least 95% of FT employees
- MEC must be affordable and meet minimum value requirements
- Educate employee population on Exchanges and employer options as well as the individual mandate penalty

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Play or Pay – Accessibility to MEC

Step 1
"Fair"
employee access

Offer MEC to full-time employees

- ≥30 hrs/week (130 hrs/mo)
- 90 days from Date of hire (DOH)

Required Actions

- Offer MEC to all full-time employees
  - Review plan designs to ensure plan meets MEC requirements
    - Beware of excepted benefit plans- not MEC
    - For 2014, consider offering MEC plans ("skinny MEC" or similar plans); assist employees to avoid imposition of individual mandate penalty/be uninsured if not currently eligible for subsidized marketplace coverage
- Modify waiting periods to 90 calendar days from date of hire
- Monitor/manage work hours below 30 hours per week

Play or Pay – Accessibility to MEC (continued)

Step 1
"Fair"
employee access

Offer MEC to full-time employees

- ≥30 hrs/week (130 hrs/mo)
- 90 days from Date of hire (DOH)

Required Action

- Identify all full-time employees
  - Measurement periods for variable hour and seasonal employees
    - Standard measurement period (SMP) for ongoing/IMP for new hires
      - Different SMP and IMP for salaried vs. hourly
    - Document measurement periods
    - Confirm systems support administration (work with payroll vendor)
    - Implement a "test" or official measurement period based on plan renewal date

Play or Pay – Minimum Value

Step 2
"Acceptable"
health insurance

"Minimum Value" (60% actuarial value)

Required Action

- Assess Actuarial Value of benefit plan(s):
  - HHS calculator
  - Actuary
  - Healthcare reform modeling tool such as Wells Fargo Insurance Health Care Reform Analyzer tool
  - Contributions to HSA and HRA included in AV
- Consider plan choices and how contribution structure should be based on lowest AV plan
- Determine viability of a buy-down or buy-up option
  - Buy-down plan – more affordable plan that allows employees to enroll family in employer plan and pay for premiums pre-tax

Play or Pay – Affordable Coverage

Step 3
"Affordable" contributions for employee only coverage

★ **< 9.5% of household income or safe harbor**

Required Action

- Box 1 of W-2 Form
- Rate of pay (times 130 times 9.5%); rate of pay may not decrease
- 100% of Federal Poverty Level
- For affordability purposes employer can use non-smoker rate to establish plan's affordability
  - No other wellness incentives considered for affordability other than in 2014 if wellness program was in effect prior to 5/3/13 and reward was available on 5/3/13

★ Amount will be indexed in 2015

Play or Pay – Affordable Coverage (continued)

Step 3
"Affordable" contributions for employee only coverage

★ **< 9.5% of household income or safe harbor**

Required Action

- Unsure if other wellness incentives may be considered for 2015
- Consider contribution structure to encourage desired migration and account for state differences (Medicaid, Medicare, other)
  - Cafeteria plan model
  - Salary-based contributions
  - Spousal surcharges – UPS approach
- Develop communication strategies

★ Amount will be indexed in 2015

What should employers do?

- Determine if they are subject to the Play or Pay mandate
  - Uncertain if six-month rule will be extended to 2014
- Identify and quantify financial risks under the ACA
  - Implement and manage measurement periods- for calendar year plans measurement period must commence no later than 10/15/13.
    - SMP – 10/15/13-10/14/14; AP – 10/15/14-12/31/14; SP – 1/1/15-12/31/15
  - Review systems to confirm management of hours and measurement periods
  - Assess financial impact of Play or Pay mandate on business operations

What should employers do?

- Assess changes to be implemented to plan designs, contributions and eligibility criteria
  - Determine actuarial value of plans
  - Determine affordability of plans
  - Identify newly eligible employees
  - Determine if reclassification of employees is required
- Educate key staff and employees
  - Educate key staff on Play or Pay mandate and ACA strategy
  - Educate employees on individual mandate, exchanges and Medicaid expansion (when applicable)
- Monitor developments

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Communication Strategies

Topic	Description
Basic PPACA Questions & Answers	▪ Short list of questions to address key elements of the legislation
Medicaid Expansion	▪ Based on states that have elected to expand Medicaid
Individual Mandate	▪ Description of the requirement and what they need to do to be compliant for January 1, 2014
Employer Mandate	▪ Employer requirements and impact on current and future plan offerings
Insurance Exchanges	▪ Mandatory notice required by October 1, 2013 ▪ Employees will need additional information to understand their options ▪ Additional burden for multi-site employers

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Questions?

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Appendix

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Planning for New Assessments

PCORI Fees

- For calendar year plans applies from 2012 through 2018
- Annual fee based on average number of covered lives
  - $1 for first year
  - $2 for subsequent years (as adjusted for inflation)
- Reported on IRS Form 720 (Quarterly Federal Excise Tax Return) and paid annually
- Generally due by July 31

Planning for New Assessments

TRANSITIONAL REINSURANCE PROGRAM FEES

- Three year fee to fund transitional reinsurance pool (2014-2016)
- Uniform contribution rate of $63/year/covered life for 2014
- Collected annually

Planning for New Assessments

"CADILLAC" TAX

- First applies in 2018
- 40% non-deductible tax on "excess benefits"
- Excess benefit = benefits provided in excess of annual limit ($10,200/$27,500 for 2018)

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- Effective for plan years beginning on or after January 1, 2014
- Plans may not apply a waiting period that exceeds 90 days
  - "Waiting Period" = the period of time that must pass before coverage becomes effective for an employee or dependent who is **otherwise eligible** to enroll in the plan
- Rule is not violate if an employee fails to elect coverage within 90 days

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- One day = One day
  - The 90-day period is calculated based on calendar days
  - Weekends and holidays are counted
  - If the 91st day falls on a weekend or holiday → plan may provide coverage sooner
- Waiting periods that will no longer work
  - Three months
  - 1st of the month or 1st payroll period following 90 days of employment

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- Rule is still in proposed form—no more restrictive provision in the final rules will apply to plans before January 1, 2015
- For participants who are mid-waiting period when rule becomes effective (January 1, 2014 for calendar year plans), the restriction will apply.
  - So, if January 1, 2014 is the 92nd day of a 120 day waiting period for an employee, the employee must become eligible for coverage as of January 1, 2014

Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Prohibitions on:
  - Pre-existing condition exclusions
    - Requirement to issue notices of creditable coverage is anticipated to be eliminated as of December 31, 2014
  - Lifetime and annual dollar limits on essential health benefits
  - Rescission

Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Limit on Out-of-Pocket Maximum
  - Applies beginning in 2014 to non-grandfathered employer-sponsored plans
  - 2014 Maximum = the 2014 out-of-pocket limit for high deductible health plans (then indexed for inflation)
    - $6,350 for self-only coverage and $12,700 for coverage for more than one person
- Limit on Deductibles
  - Only apply to individual and small group market

Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Required coverage for:
  - Children through age 26
  - If not grandfathered:
    - Preventive care (on a first-dollar basis)
    - Direct access to OB/GYN
    - Certain emergency care
    - Clinical trials for cancer and other life-threatening diseases

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Evaluating Your Plan Design

ADDING AUTOMATIC ENROLLMENT

- Applies to employers with over 200 employees
- Plans will be required to automatically enroll new full-time employees and continue the enrollment of current participants
- Notice and opportunity to opt-out is required
- Effective date is unclear—waiting on guidance

Speaker Biographies

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our people

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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 2012-14 editions of *The Best Lawyers in America* 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.

AREAS OF PRACTICE

Tax and Wealth Planning
Antitrust
Political Law
Business Transactions Tax
Tax Controversies and Litigation
Tax Policy
Tax-Exempt Organizations
Wealth Planning
Regulatory

INDUSTRIES

Nonprofit Organizations and Associations
Credit Counseling and Debt Services
Financial Services
Consumer Financial Protection Bureau Task Force

GOVERNMENT EXPERIENCE

Legislative Assistant, United States House of Representatives

BAR ADMISSIONS

District of Columbia

REPRESENTATIVE CLIENTS

AARP
American Academy of Physician Assistants
American Alliance of Museums
American Association for the Advancement of Science
American Bureau of Shipping
American College of Radiology
American Institute of Architects
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

EDUCATION

J.D., Catholic University of America, Columbus School of Law, 1996

B.A., Political Science, University of Pennsylvania, 1990

MEMBERSHIPS

American Society of Association Executives

California Society of Association Executives

New York Society of Association Executives

Association of Corporate Counsel
Association of Private Sector Colleges and Universities
Automotive Aftermarket Industry Association
Brookings Institution
Carbon War Room
The College Board
Council of the Great City Schools
Council on Foundations
CropLife America
Cruise Lines International Association
Foundation for the Malcolm Baldrige National Quality Award
Gerontological Society of America
Goodwill Industries International
Homeownership Preservation Foundation
The Humane Society of the United States
Independent Insurance Agents and Brokers of America
Institute of International Education
International Association of Fire Chiefs
Jazz at Lincoln Center
The Joint Commission
LeadingAge
Lincoln Center for the Performing Arts
Lions Club International
Money Management International
National Association of Chain Drug Stores
National Association of Music Merchants
National Athletic Trainers' Association
National Board of Medical Examiners
National Coalition for Cancer Survivorship
National Defense Industrial Association
National Fallen Firefighters Foundation
National Fish and Wildlife Foundation
National Hot Rod Association
National Propane Gas Association
National Quality Forum
National Retail Federation
National Student Clearinghouse
The Nature Conservancy
NeighborWorks America
Peterson Institute for International Economics
Professional Liability Underwriting Society
Project Management Institute
Public Health Accreditation Board
Public Relations Society of America
Recording Industry Association of America
Romance Writers of America
Texas Association of School Boards
Trust for Architectural Easements
United Nations High Commissioner for Refugees
Volunteers of America

HONORS

Recognized as "Leading Lawyer" in the 2012 and 2013 editions of *Legal 500*, Not-For-Profit

Listed in *The Best Lawyers in America* for Non-Profit/Charities Law, Washington, DC (Woodward/White, Inc.), 2012-14

Recognized as a Top Rated Lawyer in Taxation Law in *The American Lawyer* and *Corporate Counsel*, 2013

Washington DC's Legal Elite, *SmartCEO Magazine*, 2011

Fellow, Bar Association of the District of Columbia, 2008-09

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

Recipient, *Washington Business Journal* Top Washington Lawyers Award, 2004

Recipient, The Center for Association Leadership Chairman's Award, 2004

Recipient, Greater Washington Society of Association Executives Chairman's Award, 1997

Legal Section Manager / Government Affairs Issues Analyst, American Society of Association Executives, 1993-95

AV® Peer-Review Rated by *Martindale-Hubbell*

Listed in *Who's Who in American Law* and *Who's Who in America*, 2005-present editions

ACTIVITIES

Mr. Tenenbaum is an active participant in the nonprofit community who currently serves on the Editorial Advisory Board of the American Society of Association Executives' *Association Law & Policy* legal journal, the Advisory Panel of Wiley/Jossey-Bass' *Nonprofit Business Advisor* newsletter, and the ASAE Public Policy Committee. He previously served as Chairman of the *AL&P* Editorial Advisory Board and has served on the ASAE Legal Section Council, the ASAE Association Management Company Accreditation Commission, the GWSAE Foundation Board of Trustees, the GWSAE Government and Public Affairs Advisory Council, the Federal City Club Foundation Board of Directors, and the Editorial Advisory Board of Aspen's *Nonprofit Tax & Financial Strategies* newsletter.

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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Thora Johnson focuses on tax-exempt organizations, employee benefits and executive compensation matters. She advises clients on the establishment and operation of tax-exempt organizations, including private foundations, public charities, trade associations, and title holding companies. She also counsels clients on the establishment and operation of qualified and non-qualified deferred compensation plans and health and welfare benefit plans. She routinely reviews and drafts employee benefit plans, summary plan descriptions, and other employee communications and negotiates vendor contracts. She regularly works with clients to structure comprehensive compliance programs and procedures to comply with the privacy and security requirements of HIPAA. She has broad expertise in health plan compliance, including ERISA, the Internal Revenue Code, HIPAA (privacy and portability), and PPACA. She has been helping employers navigate health care reform from its enactment in March 2010, and is a frequent speaker and writer on the topic.

AREAS OF PRACTICE

Employee Benefits and Executive Compensation

Tax and Wealth Planning

Healthcare

Business Transactions Tax

Tax Controversies and Litigation

Tax Policy

Tax-Exempt Organizations

Wealth Planning

INDUSTRIES

Nonprofit Organizations and Associations

BAR ADMISSIONS

Maryland

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EDUCATION

J.D., *with honors*, University of Maryland School of Law, 1996

Notes & Comments Editor, *Maryland Journal of International Law and Trade*

M.A., Middlebury College, 1993

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Phi Beta Kappa

REPRESENTATIVE CLIENTS

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

HONORS

Recognized in the 2013 edition of *Legal 500*, Employee Benefits and Executive Compensation

Recognized in the 2013 edition of *Chambers USA* (Band 2), Employee Benefits and Executive Compensation, Maryland

Recognized in the 2012 edition of *Chambers USA* (Band 2), Employee Benefits and Executive Compensation, Maryland

Recognized in the 2011 edition of *Chambers USA* (Band 2), Employee Benefits and Executive Compensation, Maryland

Recognized in the 2010 edition of *Chambers USA* (Up and Coming), Employee Benefits and Executive Compensation, Maryland

ACTIVITIES

Ms. Johnson is a member of the Maryland State Bar Association and its Study Group for Employee Benefits, as well as the Tax Section of the District of Columbia Bar, the Tax Section of the American Bar Association, and the American Health Lawyers Association. She also regularly assists in pro bono matters involving charitable organizations and employee benefits. She is a trustee of the Friends School of Baltimore and has served as a director of a local charity whose mission is to help individuals find and keep entry-level, nonprofessional jobs.

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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.

AREAS OF PRACTICE

Employee Benefits and Executive Compensation

Healthcare

Legislative and Government Affairs

Tax and Wealth Planning

Tax Policy

GOVERNMENT EXPERIENCE

Staff Member, United States House of Representatives, Office of Representative Richard R. Chrysler (R-MI)

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BAR ADMISSIONS

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EDUCATION

J.D., LL.M, Employee Benefits Law, with honors, John Marshall Law School, 2003

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HONORS

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Christopher J. Bartnik CLU, RHU, REBC, CLF
Senior Vice President
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Chris Bartnik is the Health & Welfare Practice Leader for Wells Fargo Insurance Services' Mid Atlantic Region, which includes Washington, D.C., Virginia, Maryland, West Virginia, Kentucky, North Carolina, and South Carolina. The Health & Welfare Practice assists clients in the analysis, design, implementation, communication and administration of employee benefits plans. Chris has over 19 years of experience in the employee benefits field and has extensive knowledge in managing employee benefit programs from both an employer and consultant perspective.

Prior to joining Wells Fargo Insurance Services, Chris was the Director of Vendor Relations for the Ahold USA Corporate Benefits Department. In this role Chris had plan design, administration, and vendor management responsibilities for health and welfare programs covering eleven operating companies with employee populations ranging from 150 to 20,000 lives (35,000 employees in total) and an annual budget in excess of $250 million. While at Ahold USA, Chris was the project leader for an enterprise wide initiative to standardize benefit plan offerings and consolidate vendors that yielded savings of $11.5 million. Chris also oversaw the implementation of an outsourced benefits administrator with responsibility for enrollment, fulfillment, bill reconciliation and eligibility services.

Chris has also worked as an Associate for Mercer Human Resources Consulting where he was the project leader for several local employers. He has also held positions with New York Life, and the insurance brokerage divisions of Oppenheimer & Company and Merrill Lynch.

Chris is a frequent speaker on various health and welfare topics for Wells Fargo Insurance Services. Chris has been quoted in the Washington Post, Washington Business Journal, Benefits Selling Magazine, and The Self-Insurer Magazine. He has also moderated roundtable discussions for the Greater Washington Board of Trade, presented to several local human resources organizations, the Mid Atlantic Association of Financial Professionals, and lectured at Penn State University and Marymount University on benefit and compliance related topics. In 2006, he founded the Greater Washington Employer Benefit and Work/Life Survey in conjunction with four local Human Resources associations.

Chris received his B.S. in Insurance and M.B.A. from the Pennsylvania State University. He has also been awarded the professional designations of Chartered Life Underwriter (CLU), Registered Health Underwriter (RHU), Registered Employee Benefit Consultant (REBC), and Chartered Leadership Fellow (CLF) from the American College in Bryn Mawr, PA. Chris is an active member of the Society for Human Resource Management (SHRM) and the Society of Financial Services Professionals.

Additional Information

VENABLE® LLP

Employee Benefits and Executive Compensation Alert

September 2013

The Impact of IRS Recognition of All Legal Same-Sex Marriages on Employee Benefit Plans

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On August 29, 2013, the Internal Revenue Service (IRS) issued Revenue Ruling 2013-17, which answers many questions raised by the Supreme Court's ruling in *United States v. Windsor* earlier this summer. In *Windsor*, the Court held that Section 3 of the Defense of Marriage Act (DOMA), which defined marriage as a union between a man and a woman for federal law purposes, was unconstitutional because it denied same-sex couples equal protection under the law. Revenue Ruling 2013-17, the IRS's first formal response to the *Windsor* decision, holds that for all federal tax purposes:

- The term "marriage" includes a marriage between two individuals of the same sex, provided those individuals are lawfully married under state law (or the laws of a territory or foreign jurisdiction with the legal authority to sanction marriage);
- A same-sex marriage sanctioned under the laws of the state or territory in which it was performed will be recognized, even if the married couple lives in a state that does not recognize same-sex marriage;
- A same-sex (or opposite-sex) couple is not considered married by virtue of entering into a registered domestic partnership, civil union or other similar formal relationship recognized under state law (but not classified as a marriage under the laws of that state).

These general principles will apply for all tax purposes, including income, employment, and estate taxes, on a prospective basis as of September 16, 2013. The Revenue Ruling also permits affected same-sex couples to rely on its holdings with respect to original, amended, and adjusted tax returns (and claims for credits or refunds) for tax years still falling within the IRS's statute of limitations (generally, 2010, 2011, and 2012). The remainder of this alert summarizes what we know now about how these rules will affect employee benefit plans (acknowledging the IRS's promise that there is more guidance to come).

Implications for Qualified Retirement Plans

In a set of Frequently Asked Questions released contemporaneously with Revenue Ruling 2013-17, the IRS explicitly provides that qualified retirement plans "must treat a same-sex spouse as a spouse for purposes of satisfying the federal tax laws relating to qualified retirement plans." The FAQs specifically emphasize that this is the case even if the plan is operated by an employer in a state that does not recognize same-sex marriage.

Beginning September 16, 2013, plan sponsors must treat the same-sex spouse of any plan participant as that participant's spouse for all purposes under the plan. The new rule impacts, among other things, surviving spouse beneficiary provisions, qualified joint and survivor annuity and qualified pre-retirement survivor annuity requirements, required minimum distributions, hardship withdrawal rules, and qualified domestic relations orders.

The IRS acknowledges that Revenue Ruling 2013-17 does not address the application of the *Windsor* decision to periods before September 16 and states that it expects to issue future guidance for this purpose. This guidance will also include instructions to plan sponsors regarding required plan amendments and any necessary corrections relating to past plan operations.

Implications for Health Plans

The forthcoming employee plan guidance should also address health plans. The existing guidance, however, provides helpful direction for plan sponsors who currently offer health coverage to same-sex couples. Prior to DOMA, employers were not permitted to provide health coverage to the same-sex spouses of their employees on a tax-free basis (unless the employee's same-sex partner otherwise qualified as the employee's dependent for health plan purposes). As a result, employers were required

to treat the value of such coverage as taxable to the employee. Additionally, employees were not permitted to pay premiums for their same-sex spouse's coverage on a pre-tax basis through a cafeteria plan, but rather had to pay them on an after-tax basis.

As a result of the new Revenue Ruling, employers should now cease treating coverage provided to employees' same-sex spouses as taxable.[1] The FAQs noted above also clarify that the classification of such benefits as taxable for open tax years can be corrected. Specifically, for those years:

- Employees will be permitted to file amended Form 1040s to reflect a reduction in their taxable income in an amount equal to the value of the coverage provided to their same-sex spouses (whether such coverage was initially paid for by the employer or by the employee on an after-tax basis); and
- Employers will be permitted to seek refunds of any Social Security and Medicare taxes paid with respect to those amounts. Generally, refund requests would need to cover employer and employee payments of these taxes (with the employee share returned to employees). Future guidance will establish streamlined administrative procedures for this process.

What Should Employers Do Now?

Employers should take the following steps:

- As of September 16, employers should provide same-sex spouses the same rights as opposite-sex spouses under their retirement plans.
- Employers that offer same-sex health benefits should immediately: (i) stop imputing taxes on the share of the premiums paid by the employer on behalf of same-sex spouses, and (ii) if the employer sponsors a cafeteria plan, take employee contributions toward that coverage on a pre-tax basis.
- Review plan documents, forms, and notices to identify provisions affected by these changes.
- Determine whether any individuals with "domestic partner" status should be changed to "spouse" status. To the extent necessary, request additional information from same-sex couples covered under their plans to determine whether such couples are legally married.

Venable's **Employee Benefits and Executive Compensation Group** continues to closely monitor the quickly developing law related to same-sex marriages. Please contact any member of the practice group for additional guidance on how these rules will affect your employee benefit plans.

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1 As noted above, the Revenue Ruling applies only to legally married couples. As such, plans that provide coverage to domestic partners will need to continue the existing practice of imputing income with respect to most non-married partners.

VENABLE® LLP

Articles

July 2013

What Your Nonprofit Needs to Do about HIPAA – Now

AUTHORS

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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.

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.

> **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.

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 records.

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
Willfull 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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VENABLE® LLP

Articles

April 2013

Association Health Plans and Health Care Reform: A Trap for the Unwary

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Trade and professional associations that sponsor health plans for their members, and organizations participating in such plans, need to be aware of an important issue arising under the Patient Protection and Affordable Care Act ("PPACA"). Specifically, depending on how the association health plan ("AHP") is structured, insurance coverage might need to comply with the "small group market" provisions of PPACA, even though the AHP covers hundreds, if not thousands, of participants. The "small group market" provisions of PPACA are onerous and would affect the economics of, and possibly the viability of, AHPs beginning on January 1, 2014. The good news is that with proper structuring before January 1, 2014, an AHP should be able to avoid the "small group market" requirements and be treated as a "large group market" plan under PPACA.

Small Group and Large Group Markets

PPACA imposes different requirements on "small group market" and "large group market" insurance policies. Currently, in most states, the "small group market" includes plans covering 50 or fewer employees, and the "large group market" includes plans covering more than 50 employees. Beginning in 2016, PPACA will provide (as a matter of federal law) that the "small group market" includes plans covering 100 or fewer full-time equivalent employees (FTEs), and the "large group market" includes plans covering more than 100 FTEs. Given the nature of the requirements imposed on "small group market" plans, the insurance operations of an AHP would be significantly and adversely affected if it were viewed as covering "small group market" plans. For example, insurance for "small group market" plans must provide "essential health benefits," impose only limited cost sharing, and provide minimum actuarial value. In addition, insurers are permitted to vary premium rates for a particular type of insurance based only on coverage category (e.g., self-only, family, etc.), geographic area, age (using wide bands), and tobacco usage.

AHP – A Single Employee Benefit Plan, or a Funding Vehicle for Multiple Employee Benefit Plans?

For an AHP, the key issue is whether it is viewed as a single benefit plan, or alternatively, whether the AHP is viewed as a mere funding vehicle for multiple participating employer benefit plans. If the AHP is viewed as a single benefit plan, the number of participants will be determined collectively by reference to all participating employers, and the AHP would typically avoid the "small group market" provisions of PPACA. By contrast, if the AHP is viewed as a mere funding vehicle for multiple participating employer benefit plans, the number of participants will be determined separately by reference to each employer's plan, and some, if not most, of the covered employers are likely to be subject to the "small group market" provisions of PPACA.

Over the years, the U.S. Department of Labor ("DOL") has issued numerous rulings addressing whether a health plan covering multiple, unrelated employers (such as an AHP) is a single benefit plan, or a mere funding vehicle for multiple participating employer benefit plans. DOL looks at the details of the health insurance arrangement, including whether the group of covered employers is a *bona fide* group, and has adequate control over the arrangement. The DOL standards involve subtleties that need to be carefully considered.

In relatively short order, trade and professional associations should review the structure of their AHPs in light of DOL guidance, and, if necessary, make structural changes to achieve characterization as a single benefit plan (exempt from the "small group market" provisions of PPACA). Employers participating in AHPs also should ascertain whether the plans in which they participate are likely to need to deal with this issue.

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WELLS FARGO INSURANCE

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Legislative update

In this issue

- Health care reform: Viability of limited medical plans
- HHS clarifies income verification process for health insurance exchange
- Updated Affordable Care Act open enrollment checklist
- Maximum 60-day waiting period for health benefit plans in California
- Massachusetts repeals "Fair Share Contribution" and "Employee HIRD Form" requirements, makes other changes to its health care law

Together we'll go far

Health care reform: Viability of limited medical plans

Notwithstanding the recently announced delay of the effective date for complying with the "play or pay" rules under the Patient Protection and Affordable Care Act (ACA), some employers are actively searching for cost-effective strategies to address situations where they have a large number of lower-paid, full-time employees who are not currently participating in employer-provided group health plan coverage. One particular strategy — involving the use of a very narrowly crafted, limited self-insured group health plan — has garnered national attention over the past several months. When reviewing the viability of such "skinny" benefit plan strategies, employers need to understand both the potential risks and rewards of such an approach.

Background

Under the ACA's "play or pay" rules, an employer with 50 or more full-time employees is subject to an excise tax if it does not at least offer "minimum essential coverage" (MEC) to at least 95% of its full-time employees and their dependents up to age 26. On an annualized basis, this excise tax (the "no offer" penalty) will be equal to $2,000 multiplied by the total number of full-time employees, excluding the first 30 full-time employees. However, even if such an employer does offer MEC, it can still be subject to an excise tax, if the group health plan coverage offered by the employer fails to satisfy certain federal standards with respect to:

- "Affordability" – the employee cost of single-only coverage must not exceed 9.5% of household income
- "Minimum value" – the plan must pay for at least 60% of allowable claims covered under the terms of the plan.

In this situation, failure to meet either standard for any full-time employee may allow the employee to obtain federally subsidized public health insurance exchange coverage, which may result in either an annualized excise tax or the "inadequate offer" penalty, equal to $3,000 per year for each such employee.

Based on ACA guidance issued to date, MEC is broadly defined to include any employer-provided group health plan, including any grandfathered plan, but excludes excepted health benefits, such as fixed-dollar indemnity products. Federal regulators reiterated in recently proposed regulations that a group health plan can constitute MEC without covering all 10 "essential health benefits" categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Currently, only individual and small group-insured health insurance products are required to cover all 10 essential health benefits. Neither large group-insured health insurance products nor self-insured group health plans are subject to the ACA's essential health benefits requirement, and the minimum value of such plans is based only on the percentage of essential health benefits actually covered under the terms of the plan that are paid by the plan, as opposed to participants, pursuant to cost-sharing plan design elements.

"Skinny" minimum essential coverage plans

Due to the "play or pay" rules, employers with large numbers of lower-paid, full-time employees are faced with the choice of:

- Being potentially forced to offer robust, benefit-rich group health coverage that may be too costly for many lower paid employees to purchase
- Incurring substantial cost increases by subsidizing that coverage to the extent necessary to satisfy the federal affordability standard (and perhaps to meet insurance carrier minimum participation underwriting standards)
- Facing exposure to significant excise tax penalties

To address these issues, some health insurance carriers are starting to offer new products that take advantage of the ACA guidance issued to date; specifically, the knowledge that self-insured MEC group health plans do not need to include all ten essential health benefits. To date, the only essential health benefits that group health plans are required to cover are certain designated preventive and wellness services on a first-dollar basis — and that is only because such plans would likely be nongrandfathered where such coverage is mandatory. Thus, these new products propose to offer only preventive and wellness services, and perhaps a few other essential health benefits, to minimize the overall cost of coverage. Other excepted benefits, such as a fixed-dollar hospital indemnity product, can be wrapped around this "skinny" self-insured MEC group health plan to make the overall package appear more robust and attractive to lower-paid employees.

Potential rewards

The cost of a "skinny" MEC group health plan generally would be far less than that of providing more comprehensive benefits or paying the applicable excise taxes. It is estimated that the cost of the "skinny" MEC component (which is the only portion that would be subject to federal "affordability" rules) could be between $40 and $100 per month, per employee. The cost of any excepted benefits wrapped around the "skinny" MEC could be offered to employees without any employer subsidization.

Thus, with a "skinny" MEC strategy, employers can avoid potential liability under the $2,000-per-worker, no-offer penalty for failing to offer any sort of MEC. It also would put employers in a better position to be able to potentially subsidize the cost of their "skinny" MEC self-insured group health plans, and satisfy the affordability standard under the $3,000 inadequate-offer penalty imposed on each full-time employee who obtains federally subsidized public exchange coverage.

However, it is not likely that a "skinny" MEC would satisfy the minimum value standard. While large group-insured products and self-insured plans are not required to include coverage of all ten essential health benefits, the minimum value standard is determined by dividing (1) the anticipated covered medical spending on the essential health benefits actually provided under the group health plan, taking into account the plan's cost-sharing plan design elements, by (2) the total anticipated allowed charges for all essential health benefits provided to a standard population. As a result, a "skinny" MEC cannot satisfy the 60% minimum value standard unless some additional essential health benefits are included in addition to first-dollar preventive and wellness services.

Employers considering a "skinny" MEC approach should evaluate these implications and consult their legal advisors for additional guidance.

HHS clarifies income verification process for health insurance exchange

In response to widespread criticism of their initial guidance that suggested that a "self-attestation" will be used, the Centers for Medicare & Medicaid Services' Department of Health & Human Services (HHS) released clarifying guidance on August 5, 2013. This guidance concerns the process that health insurance exchanges ("Marketplaces") will use to verify an applicant's income for the purpose of qualifying for advance payments of the premium tax credit and cost-sharing reductions (federal subsidies) that offset the cost of health insurance purchased through the Marketplaces.

HHS stated that the following multistep process will apply:

1. An applicant must attest, under penalty of perjury, that they are not providing false or fraudulent information. The federal government has the authority under the Affordable Care Act to assess fines of up to $25,000 for negligent infractions, and/or as high as $250,000 for willful infractions.
2. The applicant's provided projected household income will be compared with information available from the Internal Revenue Service (IRS) and Social Security Administration (SSA).
   - If the submitted data cannot be verified using IRS and SSA data, then the information will be compared with wage information from employers provided by Equifax, a national credit-reporting and income database firm.
   - If Equifax data cannot substantiate the submitted data, then the Marketplace will request an explanation or additional information from the applicant to substantiate the applicant's household income. Once this request is made, an applicant who is otherwise eligible for federal subsidies will receive the subsidy for up to 90 days (which may be extended based on good faith), provided the applicant attests to the Marketplace that he or she understands that any federal subsidies are subject to reconciliation by the IRS. If the additional information is not timely submitted, eligibility for the federal subsidies will be based on IRS and SSA data. However, if IRS data is unavailable, the Marketplace will discontinue any federal subsidies.
3. The IRS will reconcile federal subsidies when the individual files their annual tax returns at the end of the year, and will recoup overpayments and provide refunds where appropriate, subject to statutory limits.

The primary source of confusion about this process is which group of applicants a Marketplace will choose to request additional documentation from, if the submitted data cannot be verified with IRS and SSA data. For 2014 only, HHS indicated that Marketplaces could choose to request additional documentation from a statistically significant sample of the applicant group only when all of the following conditions apply:

- The Marketplace has IRS data
- The applicant's submitted annual household income is more than 10% below the IRS and SSA data
- Equifax data is unavailable
- The individual has not provided a reasonable explanation for the IRS and SSA data inconsistency In all other cases, the Marketplace is required to request additional documentation.

In its August 5, 2013 guidance, HHS clarified that all federally facilitated Marketplaces will use a 100% sample size in situations where a Marketplace can use a statistically-significant sample to request additional data from applicants whose submitted household income is more than 10% below the IRS and SSA data. However, state-based Marketplaces are allowed to use other sample sizes, provided they are statistically significant for 2014.

Thus, assuming the federal data hub that will underlie all Marketplaces becomes operational, this multistep income verification process should minimize, but not eliminate, fraud and abuse with respect to this aspect of Marketplace operation.

Updated Affordable Care Act open enrollment checklist

We have updated our Patient Protection and Affordable Care Act (ACA) Open Enrollment Checklist to reflect mandated group health plan changes for 2013 and 2014, as well the most recent ACA guidance, including the delay of the employer "play or pay" mandate and the employer reporting requirements. This checklist can be used to facilitate ACA compliance with your next plan renewal. The checklist is available here: Affordable Care Act Open Enrollment Checklist.

Maximum 60-day waiting period for health benefit plans in California

The California Department of Managed Health Care has confirmed that the maximum 60-day waiting period rule applies to all health benefit plans in California, including small group and large group plans. This clarifies an ambiguity mentioned in the June 2013 Legislative Update.

Beginning January 1, 2014, all health maintenance organizations (HMOs) and all individual and group policies of health insurance in California may apply a waiting period of up to 60 days as a condition of employment, if applied equally to all eligible employees and dependents, and if consistent with the Affordable Care Act under federal law. *See California Health and Safety Code section 1357.51(c) (as amended by Senate Bill X1-2, which was enacted into law on May 9, 2013) and California Insurance Code section 10198.61(c) (as amended by Assembly Bill X1-2, which was enacted into law on May 9, 2013).*

It is unclear if the new 60-day waiting period rule is effective January 1, 2014, regardless of whether the HMO contract, insurance policy, or employee benefit plan follows a calendar year or fiscal year. Some insurance carriers have indicated that they will apply the new waiting period on the first day of the contract, insurance policy, or employee benefit plan year in 2014. Further guidance from the state's Department of Managed Health Care or Department of Insurance on this issue would be welcome. The new rule applies to all health benefit plans that cover residents of California, regardless of the situs of the contract or group master policyholder.

The above rules supersede similar rules found in Assembly Bill 1083 (enacted into law on September 30, 2012), which imposed a maximum 60-day waiting period only on HMOs and Blue Cross/Blue Shield plans in California.

Please contact your Wells Fargo Insurance representative for assistance in complying with the new maximum 60-day waiting period for employees and dependents in California.

Massachusetts repeals "Fair Share Contribution" and "Employee HIRD Form" requirements, makes other changes to its health care law

Effective July 1, 2013, Massachusetts has repealed the Fair Share Contribution (FSC) program, and the employer obligation to obtain Health Insurance Responsibility Disclosure (HIRD) forms from employees. Both provisions were part of Massachusetts' 2006 health care reform initiative. Employers must still make an employer health insurance responsibility disclosure to Massachusetts' Health Connector, and maintain a Section 125 cafeteria plan with changes required by federal law, to avoid the free rider surcharge. Finally, Massachusetts has enacted laws that require employers to provide employees with a new state-specific health care notice, and to begin making a new employer medical assistance contribution to the Department of Unemployment Assistance (DUA).

Fair Share Contribution Program

The FSC program generally requires employers with 11 or more full-time-equivalent employees working in Massachusetts to pay a penalty of $73.75 per employee per quarter if FSC program requirements are not met. Effective July 1, 2013, the FSC program has been repealed as part of the Commonwealth's 2014 budget legislation. *See 2013 Massachusetts Acts Chapter 36 (H. 3538) sections 108 and 219.*

As a result of the repeal, the last filing period for employers under the FSC program is the calendar quarter ending June 30, 2013. According to a DUA Advisory issued by the Massachusetts Executive Office of Labor and Workforce Development, DUA will continue to maintain its Fair Share Unit until all liabilities through June 30, 2013 are accounted for. The notice also states that the FSC online filing website will continue to be available and operational for employers that need to file for a calendar quarter ending on or before June 30, 2013.

Employee HIRD form

Employers with 11 or more full-time-equivalent employees working in Massachusetts are generally required to obtain employee HIRD forms from employees who decline to enroll in the employer's group medical plan, or who decline to use the employer's Section 125 cafeteria plan to make pretax contributions for medical coverage. Effective July 1, 2013, this obligation has been repealed as part of the state's 2014 budget legislation. *See*

2013 Massachusetts Acts Chapter 36 (H. 3538) sections 113 and 219.

Employers are not required to obtain employee HIRD forms on or after July 1, 2013. However, whenever an eligible employee waives coverage under the employer's group medical plan, the employer should still obtain the employee's waiver in paper or electronic form, as evidence that the employee was in fact offered coverage under the plan and has coverage from another source. This evidence is important under the Affordable Care Act, and to comply with percentage participation requirements for group insurance policies.

Employer HIRD

Employers with 11 or more full-time-equivalent employees working in Massachusetts are generally required to submit an annual report to the Connector, between October 1 and November 15 of each year, with information about its group medical and Section 125 cafeteria plans. This obligation is not repealed by the state's 2014 budget legislation. *See Massachusetts General Laws chapter 176Q section 17(a); and 2013 Massachusetts Acts Chapter 36 (H. 3538). See also 956 Code of Massachusetts Regulations section 10.03.*

In the past, the employer health insurance responsibility disclosure was included as part of the FSC program filing. With the repeal of the FSC program, it is not clear how employers will make the required annual disclosure. As of early August 2013, the Connector has not announced the new disclosure procedure for employers.

To determine whether an employer has 11 or more full-time-equivalent employees, follow these steps:

1. Identify all Massachusetts employees who have been employed for at least one calendar month during the calendar year
2. For each calendar quarter (for example, July 1 through September 30), determine the number of payroll hours for each of these employees; include paid leave, sick time, vacation time, jury duty time, and so on
3. Add all of these payroll hours together and divide by 500 to obtain the number of full-time-equivalent employees

Free rider surcharge

Employers with 11 or more full-time-equivalent employees working in Massachusetts are generally required to maintain a Section 125 cafeteria plan that satisfies regulations issued by the Connector, to avoid liability for the free rider surcharge (which is otherwise triggered when an employee or family member incurs $50,000 in free care from a hospital during a fiscal year). This obligation is not repealed by the Commonwealth's 2014 budget legislation. *See Massachusetts General Laws chapter 176Q section 18; and 2013 Massachusetts Acts Chapter 36 (H. 3538).*

According to the Connector's regulations, a Section 125 cafeteria plan enables an employer to avoid the free rider surcharge only if the plan permits all full-time and part-time employees to make pretax employee contributions to purchase medical coverage on an individual or group basis under an insurance policy or self-insured plan, maintained by the employer or provided through the Connector or through another distribution channel unrelated to the Connector. *See 956 Code of Massachusetts Regulations sections 4.03 and 4.06.*

For example, if an employee purchases an individual medical insurance policy from the Connector, the employee could make pretax contributions under the employer's Section 125 cafeteria plan to pay for that coverage. The Connector calls this arrangement the Commonwealth Choice Voluntary Plan, and requires employers to follow certain administrative procedures designed to facilitate the flow of employee pretax dollars from the employer to the Connector for this purpose.

Effective January 1, 2014, however, federal law is amended to prohibit Section 125 cafeteria plans from allowing employees to make pretax contributions to purchase individual health insurance policies from an insurance marketplace like the Connector. *See new Code Section 125(f)(3).* As a result of this change in federal law, the Connector has sent letters to employers participating in the Voluntary Plan to inform them that their Voluntary Plan accounts through the Connector will end on December 31, 2013, and that it will no longer accept employee pretax contributions to pay for coverage from the Connector after that date.

As of early August 2013, the Connector has not announced its amendment of regulations governing the free rider surcharge, to eliminate the Connector as a required coverage source for section 125 cafeteria plans. In the absence of additional guidance from the Connector, employers should inform employees making pretax contributions for coverage from the Connector that this arrangement is ending on December 31, 2013. Employers may also wish to contact their benefits attorney to amend their section 125 cafeteria plans to comply with this change in federal law.

New employer notice to employees

Effective July 1, 2013, employers with 11 or more full-time-equivalent employees are required to provide all employees in Massachusetts with a notice regarding:

- The employer's compliance with its health insurance responsibility disclosure to the Connector
- The opportunity for eligible employees to enroll in the employer's group medical plan and/or Section 125 cafeteria plan

The notice must be provided in a manner and form prescribed by the Connector, which has not made an announcement regarding these requirements as of early August 2013.

Employer medical assistance contribution

Effective January 1, 2014, employers with an average of six (6) or more employees are required to make an employer medical assistance contribution to DUA, to help support health care–related programs in Massachusetts. *See 2013 Massachusetts Acts Chapter 36 (H. 3538) sections 109 and 212.*

The contribution is equal to 0.36% of the employer medical assistance contribution wage base, which currently is the first $14,000 in wages paid to an employee during the calendar year. Based on the current wage base, the contribution would be $50.40 per employee per year.

Employers that are newly subject to unemployment insurance are exempt from the obligation to make employer medical assistance contributions for a minimum of 12 consecutive months. The contributions are then phased in as follows:

- 0.12% of the employer medical assistance contribution wage base, for the first calendar year that the employer is subject to the contribution
- 0.24% of the employer medical assistance contribution wage base, for the second calendar year that the employer is subject to the contribution
- 0.36% of the employer medical assistance contribution wage base, thereafter.

Please contact your Wells Fargo Insurance representative for assistance in complying with these employer obligations in Massachusetts.