

Employment & Employee Benefits Developments | Fall 2013 Health Care Compliance Burdens Continue to Weigh on Employers

Since the beginning of the year, the United States Departments of Labor, the Treasury and Health and Human Services (collectively, the “Departments”), as well as the Internal Revenue Service, have issued a variety of rules and regulations with which group health plans must comply, both now and over the course of the next year. Coupled with the Supreme Court’s recent DOMA decision, employers and other plan sponsors of group health plans (collectively referred to throughout as “plan sponsors”) should be reviewing their plan documents, policies and procedures, and participant communications to make sure they are complying with the most up-to-date rules and regulations.

In this issue, we provide an overview of these rules and regulations, including the new requirements imposed on HIPAA-covered entities and business associates and the new participant communications required under the Patient Protection and Affordable Care Act. We also summarize some of the key health care reform requirements that are set to take effect in 2014 so that plan sponsors can be prepared for the impact these requirements will have on financial and administrative planning, both now and in the coming years.

Health Benefits for Same Sex Couples After DOMA Rulings

The IRS, DOL and the Treasury recently ruled that, effective Sept. 16, 2013, same-sex couples must be recognized as married for federal tax purposes if such marriage was valid under state law, regardless of whether the couple resides in a state that has legalized or recognizes same-sex marriage. This ruling comes almost three months after the Supreme Court’s decision to strike down Section 3 of the Defense of Marriage Act, which defined “marriage” as a legal union between members of the opposite sex and defined “spouse” as an individual of the opposite sex for purposes of all federal laws.

The ruling applies to any same-sex marriage that was legally performed in any one of the 50 states, the District of Columbia, a U.S. territory or a foreign country. Legally married same-sex couples must now file their 2013 federal tax returns using either a “married filing jointly” or “married filing separately” filing status. Same-sex couples who were legally wed prior to the issuance of the ruling may file tax returns for prior tax years if they wish to be

treated as married for federal tax purposes for those years, as long as the returns are still considered open under the relevant statute of limitations. Because the statute of limitations for filing a refund claim is the later of three years from the date the return was filed or two years from the date the tax was paid, same-sex, legally wed couples can generally choose to file amended returns for the 2010, 2011 and 2012 tax years.

Accordingly, employers that sponsor group health plans should:

- Stop imputing income on the value of premiums paid for same-sex spouses and adjust income tax withholdings for amounts already withheld in 2013;
- Allow employees to make pretax contributions through cafeteria plans for their same-sex spouse’s share of group health plan premiums;

- Claim refunds or adjustments for the overpayment of the employer portion of Social Security and Medicare taxes paid using the special administrative procedures now available under IRS Notice 2013-61 for years before 2013;
- Allow employees to use their dependent care assistance program (“DCAP”) accounts on a pre-tax basis to cover expenses incurred for the care of the dependents of same-sex spouses;
- Modify plan procedures to permit reimbursement of qualified medical expenses, including flexible spending accounts (“FSAs”), health savings accounts (“HSAs”) or health reimbursement accounts (“HRAs”), to pay for their same-sex spouse’s medical expenses on a tax-free basis;
- Provide same-sex spouses the opportunity to elect to continue their health coverage under COBRA if employees lose coverage in a manner that would give rise to a COBRA obligation; and
- Permit same-sex spouses to enroll in their group health plans if an employee or the employee’s same-sex spouse has a special enrollment right under HIPAA.



For more information and additional implications that the Supreme Court’s recent DOMA decision may have on sponsors’ plans, please see SRZ’s Alert “Supreme Court’s DOMA Decision Sparks Changes in Employee Benefits” at www.srz.com/Supreme_Courts_DOMA_Decision_Sparks_Changes_in_Employee_Benefits/.

associates directly liable for compliance with HIPAA’s administrative, physical and technical safeguard standards. Business associates that use subcontractors or other similar vendors must now enter into business associate agreements with their subcontractors or vendors to ensure that all PHI remains protected.

The final rule permits covered entities and business associates to take advantage of a transition period to determine whether any changes need to be made to existing business associate agreements. If a business associate agreement existed before Jan. 25, 2013, complied with HIPAA’s rules in effect at that time and has not been renewed or modified as of Sept. 23, 2013, that agreement will be deemed to comply with the final rule until the later of the date the agreement is modified or renewed or Sept. 22, 2014. HHS has posted a revised model business associate agreement that covered entities and business associates can use for this purpose.

Breach Notification

The final rule has also tightened the requirement for a breach notification. For comparative purposes, a breach notification was required if there was a significant risk that harm would result from the breach. Now, under the final rule, if PHI is used or disclosed in violation of the Privacy Rule, the PHI is presumed to be compromised and a breach notification is required unless an exception applies (e.g., the PHI is recovered before it could have been seen or accessed by the unintended recipient). To rebut this presumption, a group health plan or business associate must establish that there is a low probability that the PHI was compromised by assessing the risk that the PHI was compromised, using a minimum of the following objective factors:

- The nature and extent of the PHI involved;
- The unauthorized person who used or accessed the PHI, or to whom the PHI was disclosed;
- Whether the PHI was actually used, accessed, acquired or viewed; and
- The extent to which the risk that the PHI was compromised has been mitigated.

It is important to note that no breach notification is necessary for secured electronic PHI, and electronic PHI will be considered secured if it is encrypted.

HIPAA & HITECH

Earlier this year, HHS published a final rule amending HIPAA’s Privacy, Security, Breach Notification and Enforcement Rules that affects HIPAA-covered entities and business associates alike.

Business Associates and Business Associate Agreements

The final rule both expands the definition of “business associate” to include subcontractors, certain vendors to group health plans and entities that store protected health information (“PHI”), and makes all business

Notices of Privacy Practices

The final rule requires group health plans to review their notices of privacy practices to ensure that they include statements to the effect that:

- Individuals will be notified of a breach of unsecured PHI;
- Written authorization will generally be required for marketing purposes, disclosures of PHI that constitute a sale of PHI, and the disclosure of psychotherapy notes (if applicable);
- Using or disclosing PHI that is genetic information is prohibited for underwriting purposes; and
- If a covered entity contacts individuals for fundraising purposes, individuals can opt out of receiving such materials.

Notices of privacy practices, to the extent they do not already do so, must be revised and posted on the plan's website or intranet by Sept. 23, 2013 and hard copies must be provided in the plan's next annual mailing. If a plan does not have a website or intranet, it must provide hard copies of the revised notice within 60 days of Sept. 23, 2013.

ACA-Mandated Participant Communications

Summary of Benefits and Coverage

Plan administrators of self-insured group health plans and health insurance issuers of fully insured group health plans must continue to provide a Summary of Benefits and Coverage ("SBC") to participants and beneficiaries. Although SBCs generally must be provided to new hires and upon request, the SBC must also be distributed during open enrollment for the next plan year. For most calendar year plans, open enrollment occurs during October. The Departments have issued an updated template that now requires plan administrators and health insurance issuers to disclose whether their plans provide minimum essential coverage and meet the minimum value standard for the benefits provided (i.e., the plans' share of the total allowed cost of benefits provided under the plans is at least 60 percent of such cost).

If plan administrators and health insurance issuers cannot fit this new information within the eight-page form, they can include it in a cover letter to the SBC. In addition, the Departments have stated that they will extend the

enforcement relief that applied during the first year of applicability to this second year of compliance. This means that for this next plan year, the Departments will not impose penalties on plans and issuers that work diligently and in good faith to provide the SBC in a manner that complies in both form and content with the final regulations.

Notice of Health Insurance Exchanges

It is estimated that more than seven million Americans will enroll in the state exchanges in October 2013. Under the Affordable Care Act, employers (of all sizes) that are subject to the Fair Labor Standards Act must provide a notice of health coverage options to each employee, regardless of the employee's enrollment status in the employer's health plan or whether the employee is a part-time or full-time employee. The Department of Labor has clarified that employers are not required to provide a separate notice to dependents or other individuals who are, or may be, eligible for coverage under the employer's plan but who are not employees (e.g., spouses). The notice must provide an overview of both the Health Insurance Marketplace, or "exchange," as well as the health coverage offered by the employer.

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Beginning Oct. 1, 2013, employers must provide the notice to employees at the time of hiring. The notice can be distributed by the employer's insurer or third-party administrator. For employees hired prior to Oct. 1, 2013, employers must provide the notice no later than Oct. 1, 2013. For employees hired on and after Oct. 1, 2013, the Department of Labor will consider an employer to have timely provided the notice if it is provided within 14 days of an employee's start date.

The Department of Labor has issued a model notice that employers can rely on and has stated that the notice can be provided by first-class mail or electronically if the requirements of the Department of Labor's electronic disclosure safe harbor rule are met. The DOL has confirmed that a third party can distribute the notice in satisfaction of the employer's disclosure obligation. Alternatively, plan sponsors (of both single and multiemployer plans) may choose to draft their own notice to be used in place of the model notice that the DOL has provided or include a cover letter with the DOL's model notice.

Revised COBRA Notices

All COBRA Notices will need to be revised to include information that employees and dependents who lose coverage due to a qualifying event under COBRA are eligible to purchase coverage on an the Health Insurance Exchange.

ACA Implications for Plan Years Beginning in 2014 and Beyond

Plan sponsors of group health plans should be aware of the following provisions of the Affordable Care Act that may impact their plans in the coming years:

Delay of Employer Penalty and Associated Reporting Requirements

Under the Affordable Care Act, "large" employers (employers with 50 or more full-time equivalent employees) may face a penalty if they do not offer a health plan for their employees, or if they offer a health plan that does not provide minimum value or is "unaffordable" (e.g., an employee's share of the premium for employee-only coverage exceeds 9.5 percent of the employee's household income, determined using a safe

harbor such as the employee's W-2 wages). An employee is generally considered to be a "full-time" employee if he or she works an average of 30 or more hours of service per week).

Earlier this year, the Obama Administration announced that it will delay the implementation of the employer penalty and its associated reporting requirements until 2015. The penalty and reporting requirements were initially scheduled to take effect for plan years beginning on or after Jan. 1, 2014. The delay does not affect any other provision of the Affordable Care Act and plan sponsors must therefore continue to prepare to comply with the new requirements.



For more information on the employer penalty and determining large employer status, please see SRZ's Winter 2012 Employment & Employee Benefits Developments Health Care Reform Highlights newsletter at www.srz.com/Employment_Employee_Benefits_Developments_Winter_12/.

Requirement to Offer Dependent Coverage

Large employers that currently do not offer coverage to dependent children up to age 26 must take steps to do so during the 2014 plan year, and offer such coverage during the 2015 plan year, or potentially face a penalty beginning in 2015.

90-Day Waiting Periods

Effective for plan years beginning on or after Jan. 1, 2014, group health plans cannot apply "waiting periods" in excess of 90 days. A "waiting period" is defined as the period of time that must pass before coverage for an eligible employee or dependent becomes effective.

Removal of Pre-Existing Condition Exclusions

Effective Jan. 1, 2014, group health plans and individual health insurance coverage cannot impose any pre-existing condition exclusions. Currently, group health plans and group and individual health insurance coverage cannot impose pre-existing condition exclusions on individuals under age 19.



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Individual Mandate

Earlier this summer, the IRS and the Treasury issued a final rule implementing PPACA’s “individual mandate.” This final rule largely tracks the proposed rule, which the IRS and the Treasury issued in January 2013. The individual mandate provision of PPACA requires nonexempt individuals to maintain minimum essential coverage for each month of the year or pay a penalty; the amount of the monthly penalty for 2014 (due with individuals’ tax returns filed in 2015) will generally be the greater of 1/12 of \$95 per adult and \$47.50 per child (up to a maximum of \$285 per family) or one percent of the individual’s household income. The penalty is phased in through 2016 to a maximum of \$695 per adult (\$2,085 maximum per family) or 2.5 percent of income, if greater. After 2016, the maximum penalty will be adjusted for cost of living.

Essential Health Benefits

Effective Jan. 1, 2014, fully insured group health plans and health plans offered through state exchanges must offer the “essential health benefits package.” The essential health benefits package limits cost-sharing and provides certain levels of coverage.

The Departments have tasked states with the responsibility of defining the specific benefits that will constitute essential health benefits; for reference, New York has chosen the Oxford EPO plan, which is the largest small-group plan in the state, as its benchmark plan for purposes of determining the essential health benefits package.

Essential Health Benefit Categories

At a minimum, essential health benefits must include:

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

No Annual Limits

For plan years beginning on and after Jan. 1, 2014, group health plans can no longer impose annual limits on the dollar value of essential health benefits offered under the plan.

Wellness Incentives

Effective Jan. 1, 2014, group health plans can increase their wellness incentives from the current level of 20 percent of premium costs to 30 percent of premium costs.

Nondiscrimination for Fully Insured Health Plans

PPACA extends the current requirement that self-insured plans not discriminate in favor of highly compensated individuals as to fully insured plans. This requirement, however, has been delayed pending further regulations from the IRS which will detail the specifics of the rule. The rule is expected to become effective beginning the first plan year after such regulations are issued.

Excise Tax on Cadillac Plans

Effective Jan. 1, 2018, high-cost, or “Cadillac,” health plans will be assessed a 40 percent nondeductible excise tax on the value of health coverage that exceeds \$10,200 for an individual and \$27,500 for a family, indexed for inflation. Insurers of fully insured plans will be responsible for the payment of the tax.

Health Plan Identifiers

Plan sponsors of group health plans should be aware that the Centers for Medicare & Medicaid Services have begun accepting applications for Health Plan Identifiers, or “HPIDs.” An HPID is a unique identifier that is intended to increase standardization within HIPAA standard transactions. Most group health plans must obtain an HPID by Nov. 5, 2014. Note that small health plans, which are health plans with annual receipts of \$5 million or less, do not have to obtain HPIDs until Nov. 5, 2015.

Action Items

- ✓ Review and revise, if necessary, notices of privacy practices and HIPAA policies and procedures to reflect the terms of the final rule.
- ✓ Understand HIPAA’s new breach notification standard and make any necessary changes to policies and procedures.
- ✓ Review existing business associate agreements to determine whether any changes are necessary.
- ✓ For business associates, determine whether any subcontractors or vendors are now considered business associates that require their own business associate agreement.
- ✓ Revisit plan design to ensure that, for the plan year beginning in 2014, the plan does not impose: annual limits on the dollar value of essential health benefits; waiting periods in excess of 90 days; or pre-existing condition exclusions.
- ✓ Prepare and distribute notice of coverage options and updated SBCs.
- ✓ Review summary plan descriptions and plan documents to reflect health care reform changes being made under PPACA.
- ✓ Review policies, procedures, plans and forms to recognize the rights of same-sex spouses under federal law.
- ✓ Prepare and distribute the Notice of Exchanges.
- ✓ Apply for an HPID.

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For additional information on the topics raised in this newsletter, or if you would like assistance implementing any of the requirements and recommendations discussed, please contact your Schulte Roth & Zabel attorney or one of the following authors:



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