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THE CICOTTE LAW FIRM, LLC

ERISA AND EMPLOYEE BENEFITS + CORPORATE

March 2013 Newsletter

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Regulations Issued on Individual Mandate: The IRS recently released regulations relating to the requirement for individuals to maintain minimum essential health coverage.

Employer Mandate Provisions: Employers have less than one year to decide whether they will provide affordable employer sponsored health coverage or pay a penalty.

Cycle C Submission Period: The Cycle C submission period began on February 1, 2013 for individually designed single employer retirement plans to file determination letter applications.

IRS Releases New EPCRS Guidance: The IRS released Revenue Procedure 2013-12 to revise and update its EPCRS guidance to assist plan sponsors in correcting plan failures. Revisions include the ability for plan sponsors of 403(b) plans to correct plan failures using the same correction methods available to qualified plans with similar plan failures

Updated ACA Guidance on Contraceptive Mandate: Proposed regulations were recently issued to establish accommodations for eligible religious organizations relating to the contraceptive mandate requirements under the Affordable Care Act.

HHS Issues Final HIPAA Regulations: Final regulations comprising four final rules relating to HIPAA privacy were released to provide greater protections for protected health information. The regulations generally reflect modifications under the HITECH Act and GINA.

Sandy Brown Accepts New Position: Our colleague Sandy Brown has accepted a new position with SIGN Fracture Care International.

Individual Mandate Regulations Issued

The IRS recently released proposed regulations relating to the Affordable Care Act ("ACA") requirement for individuals to maintain minimum essential coverage ("MEC").

Under the ACA, a nonexempt individual must maintain MEC or make a shared responsibility payment. Unless otherwise exempt, this requirement, also known as the individual mandate, is effective for months beginning on January 1, 2014.

Starting in 2014, the individual mandate requires nonexempt taxpayers to either (i) maintain MEC each month for themselves and any nonexempt family members; (ii) qualify for an exemption; or (iii) include an additional payment with their Federal income tax return ("shared responsibility payment").

A taxpayer is liable for the shared responsibility payment if s/he or any nonexempt individual who may be claimed by the taxpayer as a dependent for a taxable year does not have MEC in a month included in that taxable year. Married taxpayers filing a joint return are jointly liable for any shared responsibility payment imposed for the applicable tax year.

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The Employer Mandate: Should Employers Pay or Play?

The Treasury Department has released proposed regulations under the Affordable Care Act ("ACA") regarding employers' shared responsibility for health coverage, also known as the Employer Mandate. Employers have less than a year to determine whether they will comply with the ACA's employer mandate provisions and provide employees affordable employer sponsored health care, or pay a penalty.

The Employer Mandate or Employer Shared Responsibility provisions generally go into effect on January 1, 2014.

General Rule

Starting in 2014, employers employing at least 50 full-time employees and full-time equivalents will be subject to the Employer Mandate under Internal Revenue Code ("Code") Section 4980H.

Under these provisions, if employers do not provide affordable health coverage that provides a minimum level of coverage to their full-time employees, they may be subject to an employer shared responsibility payment if at least one of their full-time employees receives a premium tax credit for purchasing individual coverage on one of the Affordable Insurance Exchanges.

To be subject to the employer shared responsibility provisions, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 ("large employer"). For example, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees. Or, 100 half-time employees equals 50 full-time employees. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours per week.

Employers who employ fewer than 50 full-time employees, or the equivalent, are not subject to the employer shared responsibility provisions. An employer with at least 50 full-time employees or equivalents will not be subject to an employer shared responsibility payment if the employer offers affordable health coverage that provides a minimum level of coverage to its full-time employees.

Each year, employers will determine, based on their *current* number of employees, whether they are considered a large employer for the *next year*. For example, if an employer has at least 50 full-time employees, (including full-time equivalents) for 2013, it *will* be considered a large employer for 2014 who is subject to the shared responsibility provisions. These provisions apply to all employers, including for-profit, non-profit, and governmental employers.

Liability to Provide Shared Responsibility Payment

Employers that satisfy the 50 full-time employee, or equivalent, threshold, generally will only be liable for the employer shared responsibility payment *if*:

- (i) the employer does not offer health coverage or offers coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange (the "a" penalty); or
- (ii) the employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer failed to offer coverage to that employee, or because the coverage offered was either unaffordable to the employee or failed to provide minimum value (the "b" penalty).

Coverage is considered affordable for an employee as long as his/her share of the premium for employer-provided coverage does not cost the employee more than 9.5% of that employee's annual household income. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement.

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"Coverage is considered affordable for an employee as long as his/her share of the premium for employer-provided coverage does not cost the employee more than 9.5% of that employee's annual household income."

Individual Mandate Regulations Issued -Continued from p. 1

Minimum essential coverage includes the following types of coverage: (i) employer sponsored; (ii) individual market; (iii) Medicare; (iv) Medicaid; (v) Children's Health Insurance Program; (vi) certain types of Veterans health coverage; and (vii) TRICARE. Conversely, MEC does not include specialized coverage, such as coverage only for vision care or dental care, workers' compensation, disability policies, or coverage only for a specific disease or condition.

Generally, all U.S. citizens are subject to the individual mandate provisions. However, individuals may be deemed exempt from the MEC and shared responsibility payment requirements in a given month if the individual:

- Is a member of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and holds a religious conscience exemption certification granted by an Affordable Insurance Exchange ("Exchange");
- Is neither a citizen or national of the United States, and is either a nonresident alien or not lawfully present in the United States;
- Is incarcerated, other than incarceration pending the disposition of charges;
- Is a member of a federally recognized Indian tribe;
- Is a member of a recognized health care sharing ministry;
- Has suffered a hardship, certified by an Exchange, that prevented the individual from obtaining coverage under a qualified health plan;
- Does not have access to affordable MEC (*e.g.* required contribution for health care coverage exceeds 8% of the individual's household income;
- Has a household income for the taxable year that is below the threshold requirement to file a Federal income tax return; or
- Experiences a short coverage gap (*e.g.* is without MEC for less than three consecutive months);

If an individual receives an exemption certification from an Exchange, the taxpayer who is responsible for accounting for that individual's coverage must provide information about the certification on the taxpayer's Federal income tax return.

A taxpayer is liable for the shared responsibility payment with respect to any nonexempt individual who is included in the taxpayer's shared responsibility family. The maximum annual amount of the shared responsibility payment for a taxpayer is the national average premium for the bronze level plan available through Exchanges that provides coverage for the applicable family size involved.

The annual amount of the shared responsibility payment is the lesser of (i) the sum of the monthly penalty amounts for each individual in the shared responsibility family; or (ii) the sum of the monthly national average bronze plan premiums for the shared responsibility family.

Employers should be aware of the requirements relating to the individual mandate that may affect their employees' health care coverage options beginning next year.

"A taxpayer is liable for the shared responsibility payment with respect to any nonexempt individual who is included in the taxpayer's shared responsibility family."

Cycle C Retirement Plan Submission Period Underway

Sponsors with Cycle C plans should begin preparing for submission by making certain their plans are properly amended in accordance with the 2012 Cumulative List and any other relevant qualification requirements.

The Cycle C submission period opened on February 1, 2013, and runs through January 31, 2014 for individually designed single employer plans to file determination letter applications. Cycle C plans generally include plan sponsors with an EIN ending in 3 or 8, and governmental plans that do not elect Cycle E.

IRS Releases New EPCRS Revenue Procedure

The IRS released Revenue Procedure 2013-12 to update and revise its Employee Plans Compliance Resolution System ("EPCRS"). Rev. Proc. 2013-12 modifies and supersedes prior EPCRS program guidelines set forth in Rev. Proc. 2008-50.

Significant changes to EPCRS include the following:
(i) expanded corrections for 403(b) plan failures;
(ii) revised submission procedures for the Voluntary Compliance Program ("VCP"); and
(iii) changes to safe harbor correction methods and fee structures.

Revenue Procedure 2013-12 is generally effective April 1, 2013; however, plan sponsors may elect to use the revised guidelines immediately. Plan Sponsors desiring to use the prior EPCRS guidelines have until March 31, 2013 to correct plan failures under Revenue Procedure 2008-50.

403(b) Plan Failures

Plan sponsors may now correct failures arising from noncompliance with the form and operational requirements of the 403(b) final regulations and other guidance issued by the IRS. The revised guidance now generally permits 403(b) plan sponsors to correct plan failures in the same manner as a qualified plan with the same type of failure. Plan sponsors may also use the VCP to correct a failure to timely adopt a written 403(b) plan.

Revised Submission Procedures

All VCP submissions made under Rev. Proc. 2013-12 must include recently released IRS Forms 8950 and 8951. Additionally, all VCP submissions under the new guidance must be mailed to the IRS Service Center in Covington, KY, instead of the former Washington, D.C. address. With regard to anonymous VCP submissions, the individual representing the plan sponsor must satisfy the power of attorney requirements and provide a statement to that effect under penalty of perjury.

Other revisions to submission procedures include substantially revised and replaced appendices. Appendix C was revised to consist of two parts: (1) a model VCP compliance statement; and (2) various schedules (formerly Appendix F) containing standardized failure descriptions and correction methods. The optional acknowledgement letter has also been revised and is now the new Appendix D.

Safe Harbor Correction Methods

Appendix A of Rev. Proc. 2013-12 includes consistent safe harbor correction methods for certain missed deferrals in safe harbor 401(k) plans, 403(b) plans, and SIMPLE IRAs. With regard to qualified nonelective contributions ("QNECs"), Appendix A clarifies that QNECs must satisfy the definition of QNEC in Treasury Regulation Section 1.401(k)-6 when used to correct a failed ADP, ACP, or multiple-use test under the safe harbor correction method. Under current regulations, this means that forfeitures may not be used to fund QNECs.

Reduced VCP fees may apply if a plan's sole failure is late adoption of a proposed plan amendment associated with a favorable determination letter. Additionally, multiple plan failures may be eligible for reduced fees. Finally, late adoption of a written 403(b) plan may also qualify for a reduced fee if it is the plan's sole failure and the submission is mailed by December 31, 2013.

Miscellaneous Revisions

Other miscellaneous revisions include limited expansion of correction for 457(b) plans sponsored by tax-exempt entities, and reduced Audit CAP sanctions for certain late amender failures found during the determination letter application process.

* * * *

Plan sponsors should regularly review retirement plans for compliance with applicable law and use the IRS guidelines provided in Revenue Procedure 2013-12 to timely correct any plan failures. For assistance with plan review or correcting failures under the IRS' EPCRS programs please contact our office.

"Plan sponsors may also use the VCP to correct a failure to timely adopt a written 403(b) plan."

Employer Mandate

-Continued from p. 2

To determine whether coverage provides minimum value, employers can input specific information about the plan, such as deductibles and co-pays, into a minimum value calculator and get a determination as to whether the plan provides minimum value by covering at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.

A minimum value calculator may be downloaded at http://cciio.cms.gov/resources/files/mv-calculator-final-2-20-2013.xlsm.

Determining an Employer's Shared Responsibility Payment

For purposes of determining the shared responsibility payment, a full-time employee does not include a full-time equivalent. The amount of the shared responsibility payment generally is equal to the number of full-time employees the employer employed for the year, minus 30, multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. For example, an employer with 75 full-time employees that fails to provide coverage to its employees would be liable for yearly penalties totaling $90,000 (75 FTE - 30 equals 45 FTE, times $2,000 for each FTE = $90,000). The penalty would be payable in monthly installments of $7,500.

For employers that provide coverage to at least 95% of full-time employees, but have at least one full-time employee who receives a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000.

The amount of the payment for any calendar month is capped at the number of the employer's full-time employee for the month, minus 30, multiplied by 1/12 of $2,000. This "cap" ensures that the payment for an employer that offers coverage can never exceed the payment that the employer would owe if it did not offer coverage.

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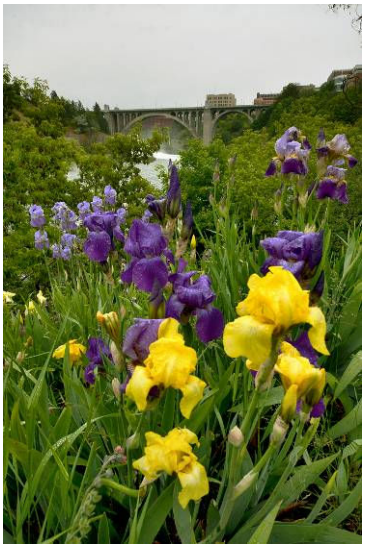
Factors employers must consider when deciding whether to play or pay will vary extensively depending on each employer's circumstances and line of work.

Employers should begin now to evaluate goals for their business and implement an appropriate strategy to manage requirements relating to the employer mandate. Employers may contact our office for a fact specific analysis and recommendation relating to the employer mandate requirements.



"For purposes of determining the shared responsibility payment, a full-time employee does not include a full-time equivalent."

Updated Guidance to ACA Contraceptive Mandate

The Obama Administration recently released proposed regulations relating to coverage for women's recommended preventive care, including contraceptive services, without cost sharing.

The proposed regulations amend the authorization to exempt group health plans established or maintained by certain religious employers with respect to the requirement to cover contraceptive services. In addition, the proposed regulations also establish accommodations for group health plans established or maintained by eligible organizations, including student health insurance coverage arranged by eligible organizations that are religious institutions of higher education.

Religious Employer Exemption

Group health plans of "religious employers" are exempted from having to provide contraceptive coverage, if they have religious objections to contraception.

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Updated Guidance to ACA Contraceptive Mandate -Continued from p. 5

The proposed regulations will simplify the existing definition of a "religious employer" as it relates to contraceptive coverage.

The proposed regulations will eliminate criteria that a religious employer (i) have the inculcation of religious values as its purpose; (ii) primarily employ persons who share its religious tenets; and (iii) primarily serve persons who share its religious tenets.

For purposes of the exemption, the definition of "religious employer" follows a section of the Internal Revenue Code ("Code"), and primarily includes churches, other houses of worship, and their affiliated organizations as defined in the Code. This proposed change is intended to clarify that a house of worship would not be excluded from the exemption because, for example, it provides charitable social services to persons of different religious faiths or employs persons of different religious faiths.

The Departments believe that this proposal would not expand the universe of employer plans that would qualify for the exemption beyond that which was intended under previous rules.

Accommodation of Religious Organizations

Additionally, the regulations propose accommodations for additional non-profit religious organizations, while also separately providing enrollees contraceptive coverage with no co-pays.

An eligible organization would be defined as an organization that (i) opposes providing coverage for some or all of any contraceptive services required to be covered under Section 2713 of the Public Health Service Act, on account of religious objections; (ii) is organized and operates as a non-profit entity; (iii) holds itself out as a religious organization; and (iv) self-certifies that it meets these criteria and specifies the contraceptive services for which it objects to providing coverage.

Under the proposal, eligible organizations would not be required to contract, arrange, pay, or refer for any contraceptive coverage for which they object on religious grounds. Furthermore, the proposal provides that plan participants would receive contraceptive coverage through separate individual health insurance policies, without cost sharing or additional premiums. The issuer would work to ensure a seamless process for participants to receive contraceptive coverage.

With regard to insured group health plans, the eligible organization would provide the self-certification to the health insurance issuer, which in turn would automatically provide separate, individual market contraceptive coverage at no cost for participants. Issuers, generally, would find that providing such contraceptive coverage is cost neutral because they would be insuring the same set of individuals under both policies and would experience lower costs from improvements in women's health and fewer childbirths.

Under self-insured group health plans, the eligible organization would notify the third party administrator, which in turn would automatically work with a health insurance issuer to provide separate, individual health insurance policies at no cost for participants. The costs of both the health insurance issuer and third party administrator would be offset by adjustments in Exchange user fees that insurers pay.

"The costs of both the health insurance issuer and third party administrator would be offset by adjustments in Exchange user fees that insurers pay."

Eligible non-profit organizations that are institutions of higher education that arrange for student health insurance coverage may also receive an accommodation comparable to that for an eligible organization that is an employer with an insured group health plan.

Employers or other organizations that fall under one of the above categories should familiarize themselves with the process for an exemption or accommodation, and to determine whether they would qualify under the proposed regulations.

HHS Issues Final HIPAA Regulations

The Department of Health and Human Services Office of Civil Rights ("HHS") recently released final regulations reflecting statutory modifications under the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and the Genetic Information Nondiscrimination Act ("GINA").

The changes in the final regulations generally provide increased protection and control of personal health information ("PHI") and are effective on March 23, 2013. However, covered entities and business associates have until September 23, 2013 to comply with the applicable requirements of the rule.

The final regulations are generally comprised of four final rules, which have been combined to reduce the impact and number of times certain compliance activities need to be undertaken by the regulated entities. The following four rules comprise the HHS omnibus final rule:

- Final modifications to the HIPAA Privacy Rules mandated by the HITECH Act, and certain other modifications to improve the rules;
- Final rule adopting changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act;
- Final rule on Breach Notification for Unsecured PHI under the HITECH Act, which replaces the breach notification rule's harm threshold with a more objective standard and supplants an interim final rule; and
- Final rule modifying the HIPAA Privacy Rule as required by GINA to prohibit most health plans from using or disclosing genetic information for underwriting purposes.

Some of the more significant modifications apply to business associates. The final regulations broaden the definition of business associate and make business associates of covered entities directly liable for compliance with certain HIPAA Privacy and Security Rules. Accordingly, the definition of business associate includes (i) a Health Information Organization, an e-Prescribing Gateway, or other person that provides data transmission services with respect to PHI to a covered entity, and that requires routine access to the PHI; and (ii) a person who offers a personal health record to one or more individuals on behalf of a covered entity.

Additionally, the final regulations require business associates to (i) comply with the security rules with regard to electronic PHI; (ii) report breaches of unsecured PHI to covered entities; (iii) ensure that subcontractors agree to the same restrictions and conditions applicable to the business associate; and (iv) comply with the requirements of the privacy rule that apply to the covered entity.

Furthermore, the regulations provide that the business associate provisions of HIPAA apply to subcontractors. Thus, a business associate includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate. The regulations also provide that a subcontractor is "a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate. Therefore, a subcontractor is a business associate where that function, activity, or service involves the creation, receipt, maintenance, or transmission of PHI.

"The final regulations broaden the definition of business associate and make business associates of covered entities directly liable for compliance with certain HIPAA Privacy and Security Rules."

Although covered entities are not required to have a business associate agreement ("BAA") with a subcontractor of a business associate, the business associate must have a BAA with their subcontractor. Covered entities and business associates will be held liable for the acts of their business associate agents, regardless of whether a BAA is in place.

HHS has provided an updated sample BAA for use by covered entities and business associates. The sample agreement may be found at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html.

With regard to breach notification, covered entities and business associates must now conduct a risk assessment to determine the probability that PHI has been compromised. Factors covered entities and business associates must consider include:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated, such as through a confidentiality agreement or other arrangement to prevent further disclosure.

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Sandy Brown Accepts New Position

Our colleague Sandy Brown has accepted a new position with one of her clients, SIGN Fracture Care International. In her new role she will be responsible for legal compliance, risk management, human resources and contract management. She will also have oversight and reporting responsibility for the firm's financial matters.

SIGN works in developing countries by collaborating with local surgeons to develop training and implants to support their efforts to provide effective orthopaedic surgery to the poor. SIGN also designs and manufactures surgical implants and instruments for the surgeons' use.

We wish Sandy all the best in her new endeavor!

HHS Issues Final HIPAA Regulations

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Covered entities and business associates must consider each of the factors above. If there is a low probability that PHI was compromised, breach notification is not required.

Under the final regulations, the definition of underwriting purposes provides that health plans may not use or disclose PHI that is genetic information for underwriting purposes. All plans subject to the HIPAA Privacy Rule are subject to this prohibition.

With respect to health plans, the regulations define underwriting purposes as:

- Rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the plan, coverage, or policy (including changes in deductibles or other costsharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);
- The computation of premium or contribution amounts under the plan, coverage, or policy (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);
- The application of any pre-existing condition exclusion under the plan; and
- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

* * * *

Prior to the compliance date in September, covered entities and business associates should review their policies and procedures relating to HIPAA and make necessary changes to ensure they will be in compliance with updated HIPAA requirements. For assistance in updating HIPAA policies and procedures, or revising business associate agreements, please contact our office.

About the Cicotte Law Firm

The Cicotte Law Firm is located in Kennewick, WA, and represents employers in several states in all aspects of benefits law, handling diverse employment, labor, tax and corporate matters.

The Firm's practice covers all areas relating to employee benefits including consumer-directed health plans (HRAs, HSAs, & FSAs), assistance with health reform (PPACA) and all other health plan issues, advising on fiduciary responsibilities, maintaining legal compliance with non-discrimination requirements, analyzing unusual benefit claims, representing employers in labor relations matters where pension or welfare benefits are involved, advising on the federal tax implications of complex benefits-related issues, and examining the ERISA status of compensatory arrangements.

Our corporate practice involves formation, corporate compliance, negotiations, mergers and acquisitions, SEC compliance, and HR liaison activities.

The Firm also assists clients with licensing agreements, non-compete agreements, and nondisclosure agreements.

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